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To: Members of the Informal Shadow Oxfordshire Health & Wellbeing Board

Notice of a Meeting of the Informal Shadow Oxfordshire Health & Wellbeing Board

Thursday, 22 March 2012 at 9.30 am

Long Room, Oxford Town Hall, Oxford OX1 1BX

Peter G. Clark
County Solicitor

March 2012

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

Membership

Chairman – Councillor Keith R. Mitchell CBE
Vice Chairman - Dr Stephen Richards

Board Members:

Councillor Mark Booty *(West Oxfordshire District Council)*	Chairman of the Health Improvement Board
Sue Butterworth	Chair of Public Involvement Board
Councillor Louise Chapman *(Oxfordshire County Council)*	Chairman of the Children & Young People's Board
Councillor Arash Fatemian *(Oxfordshire County Council)*	Chairman of the Adult Health & Social Care Board
John Jackson	Director for Social & Community Services
Dr Mary Keenan	Vice Chairman of the Children & Young People's Board
Dr Joe McManners	Vice Chairman of the Adult Health & Social Care Board
Dr Jonathan McWilliam	Director of Public Health
Councillor Val Smith *(Oxford City Council)*	Vice Chairman of the Health Improvement Board
Jim Leivers	Director for Children, Education & Families

Notes:

- ***Date of next meeting: 26 July 2012***

Declarations of Interest

This note briefly summarises the position on interests which you must declare at the meeting. Please refer to the Members' Code of Conduct in Part 9.1 of the Constitution for a fuller description.

The duty to declare …
You must always declare any "personal interest" in a matter under consideration, ie where the matter affects (either positively or negatively):

(i) any of the financial and other interests which you are required to notify for inclusion in the statutory Register of Members' Interests; or

(ii) your own well-being or financial position or that of any member of your family or any person with whom you have a close association more than it would affect other people in the County.

Whose interests are included …
"Member of your family" in (ii) above includes spouses and partners and other relatives' spouses and partners, and extends to the employment and investment interests of relatives and friends and their involvement in other bodies of various descriptions. For a full list of what "relative" covers, please see the Code of Conduct.

When and what to declare …
The best time to make any declaration is under the agenda item "Declarations of Interest". Under the Code you must declare not later than at the start of the item concerned or (if different) as soon as the interest "becomes apparent".
In making a declaration you must state the nature of the interest.

Taking part if you have an interest …
Having made a declaration you may still take part in the debate and vote on the matter unless your personal interest is also a "prejudicial" interest.

"Prejudicial" interests …
A prejudicial interest is one which a member of the public knowing the relevant facts would think so significant as to be likely to affect your judgment of the public interest.

What to do if your interest is prejudicial …
If you have a prejudicial interest in any matter under consideration, you may remain in the room but only for the purpose of making representations, answering questions or giving evidence relating to the matter under consideration, provided that the public are also allowed to attend the meeting for the same purpose, whether under a statutory right or otherwise.

Exceptions …
There are a few circumstances where you may regard yourself as not having a prejudicial interest or may participate even though you may have one. These, together with other rules about participation in the case of a prejudicial interest, are set out in paragraphs 10 – 12 of the Code.

Seeking Advice …
It is your responsibility to decide whether any of these provisions apply to you in particular circumstances, but you may wish to seek the advice of the Monitoring Officer before the meeting.

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

AGENDA

1. Welcome by Chairman, Councillor Keith R. Mitchell CBE

2. Apologies for Absence and Temporary Appointments

3. Declarations of Interest - see guidance note opposite

4. Petitions and Public Address

5. Note of Decisions of Last Meeting

9.30
5 mins

To approve the Note of Decisions of the meeting held on 24 November 2011 (**HWB5**) and to receive information arising from them.

6. Approval of Terms of Reference for the Partnership Boards

9:35
5 mins

Person Responsible: Members of the respective Partnership Boards
Reports presented by: Peter Clark, Head of Law & Governance

Action required: To approve the draft Terms of Reference for the following Partnership Boards as set out at HWB6:

- ***Adult Health & Social Care Partnership Board***
- ***Oxfordshire Children & Young People's Partnership Board***
- ***Health Improvement Partnership Board***

7. Overview of the new and emerging powers and duties of the Health & Wellbeing Board

9:40
5 mins

Person(s) Responsible: Members of the Health & Wellbeing Board
Person giving report: Director of Public Health

Dr McWilliam will give an overview **(HWB7)** of new and emerging powers and duties in so far as they relate to member organisations and of the Board itself.

Action Required: To note the new powers and duties.

8. Priorities from the Joint Strategic Needs Assessment for Health and Wellbeing as summarised in the Director of Public Health Annual Report

9:45
10 mins

Person(s) responsible: All Members of the Board
Person giving report: Director of Public Health

Dr McWilliam will give an overview from the fifth Director of Public Health Annual Report (attached at **HWB8**) which reviewed the Joint Strategic Needs Assessment (JSNA) data from the last four years; with a view to reviewing County priorities for health and wellbeing and to make recommendations for the Health & Wellbeing Board.

Action Required: to note the overview.

9. Proposed outcome measures and target indicators for the Adult Health & Social Care Partnership Board

9:45
25 mins

Person(s) responsible: Members of the Adult Health & Social Care Board
Persons giving the report: Chairman and Vice Chairman of the Adult Health & Social Care Board

Councillor Arash Fatemian and Dr Joe McManners will present proposals for tackling the highest priorities for Adult Health and Social Care as set out in **HWB9**.

Action required: To approve proposals for tackling the highest priorities for Adult Health and Social Care.

10. Proposed outcome measures and target indicators for the Children & Young People's Partnership Board

10:20
25 mins

Person(s) responsible: Members of the Children & Young People's Partnership Board
Person(s) giving the report: Chairman and Vice-Chairman of the Children & Young People's Partnership Board

Councillor Louise Chapman and Dr Mary Keenan will present proposals for tackling the highest priorities for the Children & Young People's Partnership Board as set out in **HWB10**.

Action Required*: *To approve the highest priorities and outcomes for the Children & Young People's Partnership Board.

11. Proposed outcome measures and target indicators for the Health Improvement Partnership Board

10:45
25 mins

Person(s) responsible: The Health Improvement Partnership Board
Person(s) giving the report: Chairman and Vice-Chairman of the Health Improvement Partnership Board

Councillors Mark Booty and Val Smith will present proposals for tackling the highest priorities for Health Improvement as set out in **HWB11.**

Action Required: To approve the proposals for tackling the highest priorities for Health Improvement.

12. Progress report on establishment of the Public Involvement Board

11:10
15 mins

Person(s) responsible: Members of the Public Involvement Board
Person giving the report: Chairman of Public Involvement Board

Sue Butterworth will give an oral update on progress in relation to the establishment of the Public Involvement Board and on the principles of operation.

This item is for information.

13. Joint Health & Wellbeing Strategy and Forward Plan

11:25
5 mins

Person(s) Responsible: Members of the Health & Wellbeing Board
Person giving the report: Director for Social & Community Services

John Jackson, Director for Social & Community Services will lead a discussion on the process and timing for the production of the draft Joint Health & Wellbeing Strategy **(HWB13).**

Action Required: To agree the process and timing for the production of the draft Joint Health & Wellbeing Strategy.

14. Implications of the Health & Wellbeing Board priorities for the work of partner organisations

11.30
10 mins

Person(s) responsible: Members of the Health & Wellbeing Board
Person giving the report: Chairman and Vice - Chairman of the Health & Wellbeing Board and Chairman of the Health Improvement Board

Dr Stephen Richards and Councillors Keith Mitchell and Mark Booty will lead some reflections on today's Board discussions in relation to the day to day work of the Clinical Commissioning Group and the County and District Councils.

OXFORDSHIRE COUNTY COUNCIL
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INFORMAL SHADOW OXFORDSHIRE HEALTH & WELLBEING BOARD

OUTCOMES of the meeting held on Thursday, 24 November 2011 commencing at 11.00 am and finishing at 12.25 pm

Present:

Board Members:	Councillor Keith R. Mitchell CBE – in the Chair
	Dr Stephen Richards (Vice-Chairman) District Councillor Mark Booty Councillor Val Smith Dr Jonathan McWilliam Sue Butterworth Councillor Arash Fatemian John Jackson Councillor Louise Chapman Dr Mary Keenan Jim Leivers
Officers:	
Whole of meeting	Joanna Simons, Peter Clark and Julie Dean (Oxfordshire County Council).
Part of meeting	Matthew Tait (Buckinghamshire & Oxfordshire NHS Cluster).

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

If you have a query please contact Julie Dean Tel: (01865) 81532 (Email: julie.dean@oxfordshire.gov.uk)

	ACTION
1 Welcome by the Chairman, Councillor Keith R. Mitchell CBE	
2 Apologies for Absence and Temporary Appointments	
An apology was received from Dr. Joe McManners, Vice Chairman, Adult Health & Social Care Board	

3 Declarations of Interest - see guidance note opposite	
There were no Declarations of Interests from Board members.	
4 Petitions and Public Address	
Cllr Peter Skolar, Chairman of the Oxfordshire Joint Health Overview & Scrutiny Committee, addressed the Board wishing it well for the future and urging it to keep in mind the advantageous position it holds, in light of its standing, to promote the integration of the different agencies involved, in order that unnecessary logistical problems could be avoided.	
5 Draft Terms of Reference for the Board	
Peter Clark, County Solicitor & Monitoring Officer presented the Board with draft Terms of Reference for consideration (HWB5). The draft Terms of Reference for the Health & Wellbeing Board were **AGREED** subject to the following amendments: - **Responsibilities** – third bullet point becomes the second and vice versa; - **Membership** – clarification that the Chairman of the Public Involvement Board be the Chairman of HealthWatch; - **Governance** – the Health & Wellbeing Board to meet three times per year. The sub-Boards to determine the frequency of their meetings etc; and - the implicit reference to integration to be made explicit within the overall text of the Terms of Reference.	))))) Peter Clark/Glenn Watson))))
6 Setting the Scene	
The Board noted a presentation and paper given by Dr Jonathan McWilliam, Director of Public Health (HWB6) that aimed to set the scene for the work of Oxfordshire's Health and Wellbeing Board. It painted a high-level picture of the task before the Board and gave an overview of the possible priorities for discussion. A copy of the presentation is attached.	)) All to note))

7 General Principles	
John Jackson, Director for Social and Community Services, presented a paper (HWB7), which set out an envisaged structure for the Oxfordshire Health and Wellbeing apparatus. A draft Statement of General Principles for the work of the Board was also presented. Following a question and answer session, the Board noted the paper and **AGREED** the Statement of General Principles for the Work of the Health & Wellbeing Board..	All to note.
8 The Role of the other Boards	
The Board **NOTED** the presentations given by Councillor Mark Booty, Chairman of the Health Improvement Board; Cllr Arash Fatemian, Chairman of the Adult Health & Social Care Board; and Cllr Louise Chapman, Chairman of the Children & Young People's Board on the vision, the context, the proposed membership, the direction of travel and priorities of their respective Boards (HWB8 (a),(b) & (c).	))) All to note)))
9 Development of the Public Involvement Board	
Sue Butterworth, the future Chair of the Public Involvement Board, outlined the progress and plans for the commissioning of Oxfordshire's HealthWatch; and plans for developing the Public Involvement Board within the proposed Health & Wellbeing Board arrangements (HWB9). The Board **NOTED** the report and thanked Sue Butterworth for her presentations.	All to note
10 Towards a Joint Health and Wellbeing Strategy	
The Board **NOTED** a short verbal summary given by John Jackson on the steps that would now be taken towards the production of a draft Joint Health & Well Being Strategy, for consideration at the next meeting. Further consultation on its development was to take place with key stakeholders. It was envisaged that the Strategy would be short and accessible which would be conducive to good engagement from the public. Plans were in place for the draft Strategy to be the subject of discussion at the first meetings of the respective Boards.	)))) All to note))))

11 Next Steps	
The Board **NOTED** a verbal summary by Jonathan McWilliam of the next steps to be taken: • The Partnership Boards would agree their draft Terms of Reference for submission to the Health & Wellbeing Board for approval; • They would finalise their outcomes/priority work plans which would feed into the draft formal Strategy for approval at the next meeting of the Health & Wellbeing Board; • Throughout the above process, the Public Involvement Board would be shaping up some firm proposals for public participation to submit to the March meeting; The Board **AGREED** that there would be three meetings a year on dates to be determined shortly.	
12 Close of meeting	
The meeting closed at 12.25 pm.	
13 The following papers had been included for information only	
HWB13a Health and Wellbeing – information on relevant legislation **HBW13b** Performance Framework for Public Health **HWB13c** Outcome Framework for Adult Health and Social Care **HWB13d** Outcome Framework for Children and Young People	

..... in the Chair

Date of signing .....

Oxfordshire Shadow Health and Wellbeing Board

Adult Health and Social Care Partnership Board

Terms of Reference

Purpose:

The Oxfordshire Shadow Health and Wellbeing Board is the principal structure in Oxfordshire with responsibility for promoting the health and wellbeing of the people of the county.

The Adult Health and Social Care Partnership Board exists to support the Health and Well Being Board in this purpose by delivering service change and improved outcomes through partnership working.

Responsibilities:

To achieve its purpose, the Adult Health and Social Care Partnership Board (Partnership Board) has the following responsibilities:

- To demonstrate effective partnership working across Oxfordshire to meet peoples' health and social care needs and to achieve effective use of resources
- To deliver the priorities and objectives arising from the Joint Health and Wellbeing Needs Assessment (JSNA) for Oxfordshire,
- In particular to
    a. *Report on the delivery of identified joint existing key performance targets for the NHS and County Council*
    b. *Contribute to the overall joint strategy and make specific recommendations on the key outcomes for each of the adult client groups in Oxfordshire and for strategic issues that cut across more than one adult client group*
    c. *Be responsible for holding Joint Management Groups (JMG's) to account for the delivery of the joint commissioning strategies and comment on the joint governance of pooled budgets*
- To meet the performance measures agreed by the Health and Wellbeing Board.

Membership

The core membership of the Partnership Board is:

- The County Council Cabinet Member for Adult Services who is also the Chairman of the Board
- Oxfordshire Clinical Commissioning Group GP who is also Vice Chairman
- Director for Social and Community Services, County Council
- Director for Transition and Partnerships, Clinical Commissioning Consortium
- Oxfordshire Clinical Commissioning Group GP
- District Council Councillor
- Public Involvement Board representative(s)

In attendance

- Deputy Director, Joint Commissioning, Oxfordshire County Council
- Chairman, Joint Management Groups
- Head of Partnerships, NHS Oxfordshire
- Partnership Development Manager, District Councils
- Strategy & Performance Manager, Oxfordshire County Council

It is proposed that a wide range of stakeholders can be invited to Board meetings at the discretion of the Chairman. They may attend as expert witnesses and to report on implementation of plans.

Governance

The meetings of the Partnership Board and its decision-making will be subject to the provisions of the County Council's Constitution including the Council Procedure Rules and the Access to Information Procedure Rules, insofar as these are applicable to the Partnership Board in its shadow form.

The Partnership Board will also be subject to existing scrutiny arrangements with Oxfordshire's Health Overview and Scrutiny Committee providing the lead role.

Members of the Group will be subject to the Code of Conduct applicable to the body which they represent.

The Partnership Board will meet at least three times a year. Dates, times and places of meeting will be determined by the Chairman of the Partnership Board.

The County Council's Joint Commissioning Team will service the meetings of the partnership board including the preparation and circulation of agendas and minutes.

The Health and Wellbeing Board will agree terms of reference and membership for the Partnership Board. It will also agree its priorities, proposed outcomes and performance measures.

The partnership board will review the terms of reference on an annual basis

Peter Clark

County Solicitor and Monitoring Officer

March 2012

Oxfordshire Shadow Health and Wellbeing Board

Children and Young People's Partnership Board

Terms of Reference

Purpose:

The Oxfordshire Shadow Health and Wellbeing Board is the principal structure in Oxfordshire with responsibility for promoting the health and wellbeing of the people of the county.

The Children and Young People's Partnership Board exists to support the Health and Wellbeing Board in this purpose by delivering service change and improved outcomes through partnership working.

Responsibilities:

To achieve its purpose, the Children and Young People's Partnership Board (Partnership Board) has the following responsibilities:

- To demonstrate effective partnership working across Oxfordshire to meet peoples' health and social care needs and to achieve effective use of resources
- To deliver the priorities and objectives arising from the Joint Health and Wellbeing Needs Assessment (JSNA) for Oxfordshire,
- In particular to
    a. *Contribute to the overall joint strategy and make specific recommendations on the key outcomes for children and young people in Oxfordshire and as they move into adulthood.*
    b. *Report on the delivery of joint existing key performance targets for children and young people for the NHS and County Council*
    c. *Be responsible for holding the Joint Management Group (JMG) to account in relation to Children and Adolescent Mental Health Services (CAMHS)and comment on the joint governance of pooled budgets for children*

d. *Contribute to the development of pooled budgets where they will enable delivery of key outcomes*

- To meet the performance measures agreed by the Health and Wellbeing Board.

Membership

The core membership of the Partnership Board is:

- The County Council Cabinet Member for Children's Services who is also the Chairman of the Board
- Oxfordshire Clinical Commissioning Group GP who is also Vice Chairman
- Director for Children's Services, County Council
- Assistant Director Public Health
- Oxfordshire Clinical Commissioning Group GP representative
- Chair, Oxfordshire Safeguarding Children Board
- District Council Member
- Public Involvement Board representative(s)

In attendance

- Sara Livadeas, Deputy Director, Joint Commissioning, Oxfordshire County Council
- Sarah Breton, Lead Commissioner, Children & Young People
- Val Johnson, Partnership Development Manager, Oxfordshire's District Councils
- Hannah Farncombe, Safeguarding Manager
- Public Engagement Team (to support the Public Involvement Board representatives)

It is proposed that a wide range of stakeholders can be invited to Board meetings at the discretion of the Chairman. They may attend as expert witnesses and to report on the implementation of plans.

Governance

The meetings of the Partnership Board and its decision-making will be subject to the provisions of the County Council's Constitution including the Council Procedure Rules and

the Access to Information Procedure Rules, insofar as these are applicable to the Partnership Board in its shadow form.

The Partnership Board will also be subject to existing scrutiny arrangements with Oxfordshire's Health Overview and Scrutiny Committee providing the lead role.

Members of the Group will be subject to the Code of Conduct applicable to the body which they represent.

The Partnership Board will meet at least three times a year. Dates, times and places of meetings will be determined by the Chairman of the Sub Board.

The County Council's Joint Commissioning Team will service the meetings of the partnership board including the preparation and circulation of agendas and minutes.

The Health and Wellbeing Board will agree terms of reference and membership for the Partnership Board. It will also agree its priorities, proposed outcomes and performance measures.

The Partnership Board will review the Terms of Reference on an annual basis.

Peter Clark

County Solicitor and Monitoring Officer

March 2012.

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Oxfordshire Shadow Health and Wellbeing Board

Health Improvement Partnership Board

Terms of Reference

Purpose:

The Oxfordshire Shadow Health and Wellbeing Board is the principal structure in Oxfordshire with responsibility for promoting the health and wellbeing of the people of the county.

The Health Improvement Partnership Board exists to support the Health and Wellbeing Board in this purpose by delivering service change and improved outcomes through partnership working.

Responsibilities:

To achieve its purpose, the Health Improvement Partnership Board (or H Imp B) has the following responsibilities:

- To demonstrate effective partnership working across Oxfordshire to meet peoples' health and social care needs and to achieve effective use of resources
- To deliver the priorities and objectives arising from the Joint Health and Wellbeing Needs Assessment (JSNA) for Oxfordshire,
- In particular to
    - *Bring a coordinated and coherent approach to influencing a broad range of determinants of health to bring about health improvement*
    - *Work together to recommend priority areas to improve health in order to make a real and measurable difference to outcomes*
    - *Recommend actions and responsibilities to make that improvement a reality*
    - *Hold each other to account for making the agreed change and for reporting progress*
- To meet the performance measures agreed by the Health and Wellbeing Board.

Membership

The core membership of the Sub Board is:

- Chairman – District Council representative
- Vice Chairman – District Council representative
- County Councillor
- Clinical Commissioning Group representative
- Director of Public Health
- Assistant Director of Public Health

- District Council officer representative
- Public Involvement Board representative

In attendance
- Chief Fire Officer as Chairman of the Safer Communities Business Group

It is proposed that a wide range of stakeholders can be invited to Board meetings at the discretion of the Chairman. They may attend as expert witnesses and to report on implementation of plans.

Governance

The meetings of the Partnership Board and its decision-making will be subject to the provisions of the County Council's Constitution including the Council Procedure Rules and the Access to Information Procedure Rules, insofar as these are applicable to the Partnership Board in its shadow form.

The Board will also be subject to existing scrutiny arrangements with Oxfordshire's Health Overview and Scrutiny Committee providing the lead role.

Members of the Group will be subject to the Code of Conduct applicable to the body which they represent.

The Partnership Board will meet at least three times a year. Dates, times and places of meeting will be determined by the Chairman of the Partnership Board.

The County Council's Joint Commissioning team will service meetings of the Partnership Board including the preparation and circulation of agendas and minutes.

The Health and Wellbeing Board will agree terms of reference and membership for the Partnership Board. It will also agree its priorities, proposed outcomes and performance measures.

The partnership board will review the terms of reference on an annual basis

Peter Clark

County Solicitor and Monitoring Officer

March 2012.

Informal Shadow Oxfordshire Health & Wellbeing Board
22 March 2012

Overview of the new and emerging powers and duties of the Health & Wellbeing Board.

Summary
This paper sets out the latest information from guidance and policy documents published in the last 2 months. This covers the expanding remit of Health and Wellbeing Boards, the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy. This information will have relevance to developing role of the Health and Wellbeing Board in Oxfordshire.

The expanding remit of the Health and Wellbeing Board (H&WB)

The remit of the health and well-being Board is increasing with each successive document emanating from central government. A summary of powers and duties of Local Authorities and NHS organisations is included at annex 1.

The main points are:

- Local authority led H&WBs are increasingly seen as the overseer of health in counties across England - rather like a local 'Ministry of Health and Wellbeing' with the chair acting as Minister.
- The basic function of the H&WB is to set a strategic direction for health, well-being and social care across a patch, pulling together the efforts of local government the NHS and the new Healthwatch organisations.
- H&WBs are also increasingly seen as a means to hold Clinical Commissioning Groups to account for delivery of a strategic plan and to take a view on the fitness of the local Clinical Commissioning Group to carry out its functions.
- The H&WB is also accountable for delivering the JSNA. The JSNA will pull together a very wide range of local information on health and the factors underpinning health and will use it to formulate strategic priorities for action in the County. The JSNA is now the joint responsibility of the Local Authority and the Clinical Commissioning Group
- The JSNA will become a driving force in health and social care planning. It needs to be refreshed by March 2012 and completely overhauled by March 2013.
- The H&WB is also accountable for producing a health and well-being strategy. This is again a joint effort between local government and Clinical Commissioning Groups. Priority setting for a first health and well-being strategy for Oxfordshire is currently underway and the first strategy will be prepared to influence strategic priority setting in the County Council and the Clinical Commissioning Group later in 2012.

- Local Authorities are being encouraged to delegate functions and budgets to H&WBs where they feel this as appropriate so as to drive forward the integration of health and social care and tackle the broader determinants of health such as housing issues.

In summary, the H&WB is becoming an increasingly powerful body in overseeing the health of this population. We are confident that our local H&WB arrangements are fit for purpose and the 4 supporting Partnership Boards give a depth and a practicality to this work that is lacking in other counties.

Annex 1 - roles and responsibilities for local government, clinical commissioning groups and other agencies in delivering health and well-being boards, JSNAs and health and well-being strategies

Taken from 'JSNAs and joint Health and Wellbeing Strategies – draft guidance' (published January 2012)

Summary of responsibilities

1. <u>Health and Wellbeing Boards</u>

a. Establishment of the H&WB Board

- Power to appoint additional Board members
- Power to exercise functions jointly with other H&WB Board(s)

b. Functions of Board

- Power to request information to enable or assist its functions, from the Local Authority or any H&WB Board members or representatives
- Duty to prepare JSNA
- Duty to involve third parties in preparation of JSNA and JHWS – Healthwatch, people living or working in the area, District councils
- Power to consult anyone appropriate in producing JSNA
- Duty to prepare JHWS
- Duty go consider NHS Commissioning Board mandate and statutory guidance in developing JSNA and JHWS
- Duty to consider Health Act flexibilities in producing JHWS
- Power to state views on how commissioning of Health and Social Care services, and wider health related services could be more closely integrated (within JHWS)

c. Associated functions

- Duty to promote integrated working between commissioners and using health act flexibilities (like pooled budgets and lead commissioning)
- Power to encourage integrated working across wider determinants of health

d. Ensuring alignment of commissioning plans

- Duty to be involved in preparing or revising CCG commissioning plan
- Duty to provide an opinion on whether it has taken account of the JHWS.
- Power to write to NHS Commissioning Board (NHSCB) with that opinion on CCG commissioning plan (copy to CCG).
- Power to give an opinion to NHS CB on final published plan
- Duty to review how well the CCG commissioning plan has contributed to the delivery of the JHWS

- Duty to give a view on how well the CCG has contributed to the delivery of the JHWS as part of annual performance assessment of CCG

2. <u>Clinical Commissioning Group</u>

a. Establishment of H&WB Board

- Duty to send representative to H&WB Board

b. Functions of H&WB Board

- Duty to cooperate with H&WB Board in exercise of its functions
- Duty to provide information when requested by H&WB Board to enable or assist its functions
- Duty to prepare JSNA for local authority area (equal duty of all partners)
- Duty to prepare JHWS for local authority area

c. Other associated functions

- Duty to have regard for JSNA and JHWS in exercise of relevant commissioning functions

d. Ensuring alignment of commissioning plans

- Duty to involve H&WB Board in preparing or revising the commissioning plan, including consulting on whether it has taken proper account of JHWS
- Duty to include statement of the final opinion of the H&WB Board in the published commissioning plan
- Duty to review how well the commissioning plan has contributed to the delivery of the JHWS and to seek opinion of H&WB Board on this.

e. Other duties, contributed through JSNA and JHWS

- Duty to exercise functions with a view to scrutinising continuous improvement in quality of services
- Duty to act with a view to secure continuous improvement in outcomes achieved
- Duty to exercise functions with regard to need to reduce inequalities between patients in outcomes and access to services
- Duty to promote the involvement of patients, their carers and reps in decisions about provision of health services
- Duty to promote innovation in the provision of health services
- Duty to exercise functions with a view to securing integration in the provision of health services, H&SC services, to improve quality of patient services or reduce inequalities between patients in outcomes or access to services

3. <u>Local Authorities</u>

a. Establishment of H&WB Board

- Duty to send representative to H&WB Board

- Power to appoint additional members to the Board as appropriate (in initial set up only)

b. Functions of H&WB Board

- Duty to provide information when requested by H&WB Board to enable or assist its functions
- Duty to prepare JSNA for local authority area (equal duty of all partners)
- Duty to prepare JHWS for local authority area
- Duty to publish JSNA
- Duty to publish JHWS

c. Other associated functions

- Duty to have regard for JSNA and JHWS in exercise of relevant commissioning functions
- Power to delegate any local authority function (except scrutiny) to he H&WB Board

4. <u>NHS Commissioning Board</u>

a. Establishment of H&WB Board

- Duty to send representative to H&WB Board when requested (not a permanent member)

b. Functions of H&WB Board

- Duty to provide information when requested by H&WB Board to enable or assist its functions
- Duty to participate in preparation of JSNA for local authority area (equal duty of all partners)
- Duty to participate in preparation of JHWS for local authority area

c. Other associated functions

- Duty to have regard for JSNA and JHWS in exercise of relevant commissioning functions

5. <u>Local Healthwatch</u>

a. Establishment of H&WB Board

- Duty to send representative to H&WB Board

b. Functions of H&WB Board

- Duty to provide information when requested by H&WB Board to enable or assist its functions

c. Ensuring alignment of commissioning plans

- Duty to get a view on how well the CCG has contributed to the delivery of the JHWS as part of annual performance assessment of CCG.

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DIRECTOR OF PUBLIC HEALTH FOR OXFORDSHIRE

ANNUAL REPORT V

Reporting on 2010-2011
Recommendations for 2011-2013
Produced: November 2011

Director of Public Health for Oxfordshire
Annual Report V

Purpose of this report

This is an independent report produced by the Director of Public Health for Oxfordshire.

Its purpose is to use the best available science to point the way forward to better health and wellbeing for Oxfordshire.

This report reviews the previous four years of Director of Public Health annual reports, re-assesses priorities and makes recommendations for change.

This report reanalyses the scientific information in the Joint Strategic Needs Assessment (JSNA) and other key data*, and draws conclusions about:

- **Is this topic still a priority for Oxfordshire?**
- **What progress has been made against recommendations in the previous four annual reports?**
- **What further recommendations need to be made to improve health and well-being in this county?**

It is appropriate to review the previous four years of annual reports because we stand at the point of change: The advent of a new government and the prevailing economic situation means that all public sector organisations are undergoing fundamental change.

The planned abolition of PCT's and Strategic Health Authorities and their replacement by GPs in a leading role fundamentally changes the way health services are driven. We are also accommodating radical change and significant cost reductions in local government. In addition, more emphasis is placed than ever before on local people driving local change. At the same time local hospitals and community services are merging to form large NHS Trusts which are more independent and have more freedoms than ever before.

Throughout all this change public health is 'coming home' to local government after a three decades sojourn in the NHS.

We stand at the point of change, and yet at the same time we serve the same population whose problems and issues change only gradually from decade to decade.

Amid so much change, it is highly appropriate to take a fresh view of old problems, review progress and set out clearly and concisely where our efforts need to be placed.

This annual report aims to carry out these tasks.

It is intended that this report is used by planners of services across the County. Its production has been timed explicitly to influence the new Health and Wellbeing board as it sets its priorities. It is therefore deliberately pithy, brief and concise yet wide ranging: it is intended to be used, not to gather dust on shelves.

I hope you enjoy it and more importantly, use it.

Dr. Jonathan McWilliam
Director of Public Health for Oxfordshire
November 2011.

* *(there is a list of the sources used at the end of the report.)*

Contents

Chapter 1 - The Demographic Challenge.

Introduction

The previous four Director of Public Health annual reports have highlighted the challenges posed to services by the growing number and proportion of older people in Oxfordshire. It is a blessing that long lives and good health are increasing steadily in this County, but service planners face the challenge of redesigning services to meet the needs of older people in the face of changing expectations and a harsher fiscal environment.

What does the Joint Strategic Needs Assessment say about the Demographic Challenge?

- The number of older people in Oxfordshire continues to grow as expected.
- The growth in the number of people aged 85+ is roughly in line with the England average, *But: The growth in the number of older people is not uniform across the County. It is markedly higher in our more rural districts than in the City. West Oxon has the highest rates, followed in descending order by Cherwell, South and Vale with the City far below. This is shown in the figure 1.*
- The *proportion* of older people in the population also continues to increase, which means that every pound spent from the public purse has further to go.
- The cost of caring for older people increases markedly with age, rising into the last year and month of life. This is true for both health care and social care. This is shown in figures 2.
- Older people rightly demand and expect a flexible range of services built around their individual needs so that they can maintain independence and stay close to home for as long as possible. A new generation of services is required to meet these needs.
- An increasing number of people are engaged in caring for elderly friends and relatives and many more volunteer their help. Many of these people are elderly themselves. We are dependent upon these friends, relatives and volunteers. Support to enable carers to care and the framework which makes volunteering possible must be husbanded.
- These challenges are faced by the whole of our society. The predicament we are in as a nation and our ability to fund the services as a country have been spelt out clearly in the recent Dilnot report.
- There are wide variations in referrals for older people in all parts of the NHS and social care systems. This lack of standardisation warrants further investigation.
- Access to services for the elderly population living in rural areas is a continuing cause for concern.
- There is a growing number of people with dementia in the County who require access to new emerging treatments.

Key Data.

The following charts tell the whole story. Figure 1 shows the number of people aged 85+ rising into the future. Note the different experiences of the Districts within Oxfordshire, with West having the greatest increase and the City far below the rest. The fact remains that the overall rate of growth is just above the national average.

Figure 1 - Projected population - England, Oxfordshire and districts - estimated percentage growth from 2008 in those aged 85 years and over

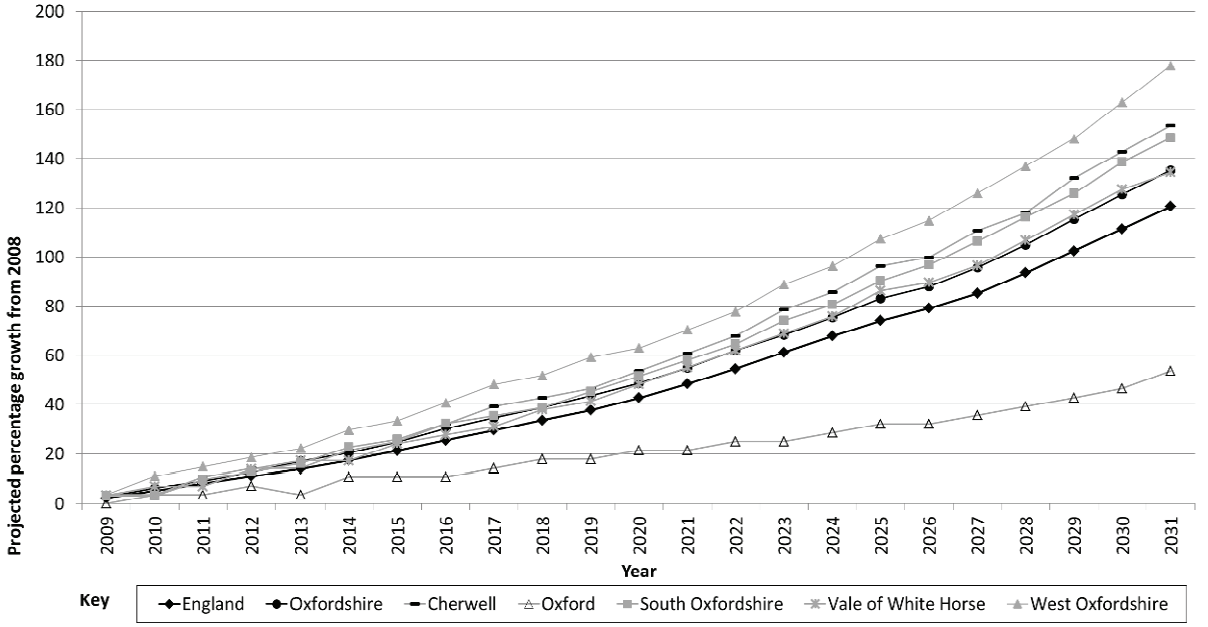
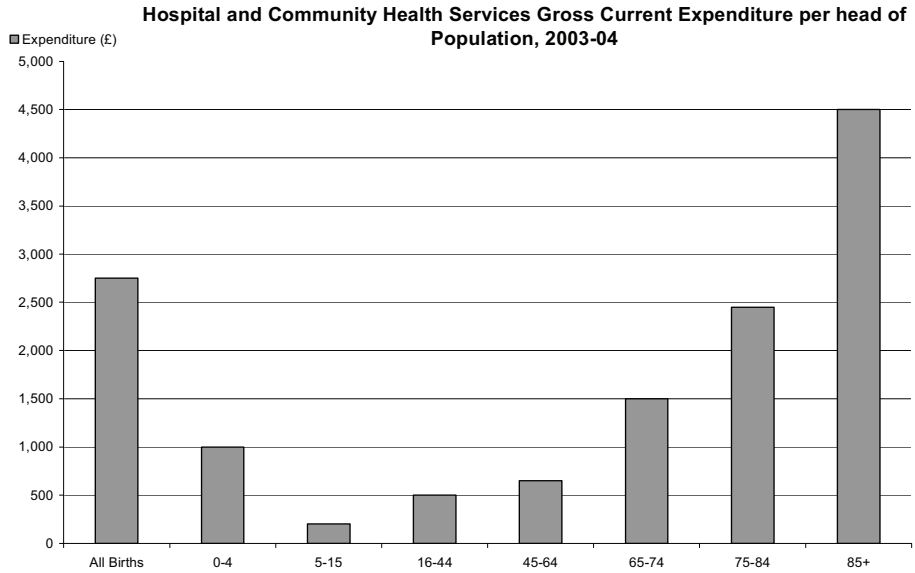


Figure 2 - Department of Health data showing how the cost of health care rises rapidly with increasing age.



The same picture is true of social care and this puts extra pressure on Local Authority budgets. For example, the average age of a person entering a care home in 2011/12 is 86 and the average age of a person starting a care package is 84. Compared with a person aged over 65, a person aged over 85 is 3.5 times more likely to require a new care package and 4 times more likely to require a care home

placement. A person over 90 is 4 times more likely to need a care package and 5 times more likely to need a care home. As the number and proportion of older people in the population grows, the pressure on health and social care to find new ways of doing things will increase. The only solution is to work together as one, particularly with the NHS.

Is 'The Demographic Challenge' Still a Priority for Oxfordshire?

Most certainly, IT IS.

This is the absolute immediate priority and it dwarfs all other priorities in this report. New approaches to the care of older people must be found if the public sector is to remain solvent: we cannot wait.

The recipe for success is becoming clearer all the time. The basic principles bear repeating here. They are:

1. Preventing disease where possible in the middle decades, investing in services backed by scientific evidence.
2. Minimising the impact of disease once it has begun e.g. through early detection programmes and expert patient approaches.
3. Having a single set of service priorities and goals across Oxfordshire's public sector so that public spending in this County is properly aligned (expressed as clear outcome measures and explicit targets).
4. Finding solutions which treat health and social care as though they were a single service.
5. Working hand in glove with the public at all stages.
6. Creating a smooth 'flow' of services from prevention through treatment-and-care and on into rehabilitation.
7. Balancing 'everyday' services for the common conditions faced by the vast majority with 'specialist' services for those with rarer conditions and commissioning these specialist services selectively and with great care.
8. Balancing services which are 'closer to home' while delivering modern, high quality services.
9. Commissioning services using tight specifications based on outcomes, the best evidence and delivery of explicit results.
10. Looking intelligently at wherever REFERRALS are made from one part of the 'system' to another and reducing those which are unnecessary. The decision to refer is the decision to open the public purse, this includes all types of referrals. These include
    - Self referrals by the public to A&E or to GPs.
    - GP referrals to consultants.
    - Referrals from community specialists to consultants.
    - Referrals from one consultant to another (a particular worry in Oxfordshire).
    - Referrals and applications for social care.

    (NB looking at referrals *is* a two-edged sword, as the same careful analysis *can* also result in some increases in referrals where quality is found wanting).
11. Working in partnership with private providers of care.
12. Caring for Oxfordshire's carers and supporting volunteers.

13. Working with older people to put their care into their own hands wherever we can afford to do so.
14. Focussing on high quality end-of-life care.
15. Creating a climate in which communities can draw on their own resources to help themselves.
16. Identifying and using the contribution other organisations can make – not just the NHS and adult social care. Issues like transport, housing, the fire and rescue service and trading standards, are crucial.

What Progress has been made Against Recommendations in the Previous Four Annual reports?

In summary:

- This topic is now well-recognised as being of prime importance.
- Oxfordshire has made good progress in recognising this challenge early on.
- Partnership working is strong and scrutiny committees have made a valuable contribution. We have the opportunity to strengthen this further through the new Health and Wellbeing Boards.
- The importance of good care for our carers has also been recognised and there has been a welcome increase in resources used to fund helpful initiatives such as carers' breaks. This work needs to be further strengthened.
- Preventative services such as screening services (e.g. the new bowel screening programme) and immunisations services (e.g. 'flu jabs') continue to perform well.
- The care of people with dementia is also improving steadily since a specific group was formed to take this forward. This needs to be maintained.

However:

- We have not been immune from structural challenges which are part of the way England's health and social care system is set up. As the 'Dilnot Report' highlighted, it is difficult to marry seamlessly the 'free-at the-point-of-delivery' NHS system with a social care system which is gate-kept by means-testing and thresholds for care. This has shown itself in our struggles to manage the care of people at discharge from hospital into community hospitals or to other provision.
- The ***scope*** of potential joint work for older people is usefully set out in our 'Ageing Successfully' strategy, **but** this is too weak on action planning and ***delivery*** of concrete results to drive work forward. This needs to be rectified.
- We have also yet to identify and agree a set of outcome measures relevant for Oxfordshire for the care of older people for all public sector organisations. Without this we have no compass to steer by and no yardstick to measure progress. This must be a major priority for the new Health and Wellbeing Board.
- We have yet to strike the right balance in this County between 'District General Hospital' services for the majority and 'Specialist and Super-specialist' services for the few. It is a great boon to have internationally renowned hospitals on our doorstep, but it is another two-edged sword. Because we can only spend each pound of public money once, we need to look carefully at referral rates from one consultant to another all of which commit tax payer's money. We need to secure the right balance between high quality care and affordability.

Recommendations

1. Strategic Priorities for the Health and Wellbeing Board

By March 2012 Oxfordshire's Health and Wellbeing Board should establish an effective subgroup specifically designed to take forward practical work that will make an impact on all of these issues. Specifically the subgroup should:

- Be led by adult social care and clinical commissioning Group representatives working together with NHS provider trusts, other service providers the voluntary sector, public representatives and carers.
- Agree clear outcome measures and process targets for 2012, 2013 and 2014 which bind together the efforts of all organizations in a single direction.
- Set clear local trajectories for each outcome measure and performance targets. Performance against these should be monitored and reported publicly through the Health and Wellbeing Board.
- Ensure that plans are produced to correct poor performance.
- The work program should include the commissioning of practical services which will:
    - prevent disease in older people through screening and immunization programs (e.g. screening programmes such as Bowel screening health checks etc and flu jabs).
    - increase the number of carers offered help and support.
    - demonstrate evidence of effective use of the new direct payments for older people.
    - demonstrate that variations in all referral rates will be looked at systematically and action taken.
    - ensure that lengths of hospital stay are minimized while quality is kept high and the figures for delayed transfers of care are reduced.
    - strengthen the careful monitoring and control of specialist-to-specialist referrals for older people so that quality is balanced against cost.
    - show that readmission of patients to hospital or unnecessary admission of patients to nursing homes and long-term care is minimized.
    - ensure good end-of-life care and high quality care for people with dementia.

2. Strategic Priorities for the Oxfordshire Clinical Commissioning Group

By March 2012 Oxfordshire's Clinical Commissioning Group should be fully engaged in joint planning through the Health and Wellbeing Board for improving the care of older people in Oxfordshire, and should plan a general review of the variations in self-referrals, GP referrals and consultant to consultant referrals for Oxfordshire's population.

3. Need for Strong Public Involvement

By June 2012 the Health and Wellbeing Board should ensure that its Public Involvement Board is fully engaged with older people across the County and is in a position to insert their views directly into the planning process.

4. Need to Scrutinise Plans

By September 2012 Oxfordshire's Joint Health Overview and Scrutiny Committee should scrutinize the Health and Wellbeing Board's arrangements for care of older people and should expect to be able to scrutinize a concrete plan based on the items in the recommendations above.

Chapter 2 - Breaking the Cycle of Deprivation

Introduction

Previous annual reports have made the case for concentrating the efforts of all organisations on 'Breaking the Cycle of Deprivation'.
What do we mean by this? We mean that in this County there are a relatively small number of wards where social disadvantage and poorer life chances are handed down from generation to generation. Previous reports have shown that these areas are found primarily in parts of Banbury and Oxford and larger market towns.

This message has been grasped by organisations and mainstream services ***are*** beginning to be re-shaped to focus on these areas. The overall objective has to be to level-up standards across the County where possible.

The question arises, **'is this still an issue, or have we solved it'.**

This chapter attempts to answer this question.

This question is now particularly acute as GP Commissioners arrive on the scene to invest half-a-billion pounds of public money in health services per year.
GP commissioners will build up a county plan from locality plans; it will be a challenge for them to face the need to redistribute resources to break the cycle of deprivation.

What does the Joint Strategic Needs Assessment say about Breaking the cycle of deprivation?

On this topic we can safely let the Joint Strategic Needs Assessment findings do the talking for us. Key indicators from this and companion documents show that:

Indicator 1 - Child Poverty

The County's Child Poverty Strategy shows that in Oxfordshire there are 15,660 children living in poverty, which is almost 12% of all children in the county. (Poverty is defined as living in a household with 60% less than the average household income*). The experience of poverty is not just about lack of money, it's about life chances for young people - a young person participating in a local workshop summed it up as follows "Poverty…. It's what's in your life, not what's in your bank account".

Four out of five children living in poverty live in our towns and the City and one fifth live in rural areas. (12,315 in the City, Banbury and larger market towns and 3,345 in rural areas). This is low compared to the national average, **but** variations between parts of the county tell the critical part of the story.

- **Almost one in four (23%) of children in Oxford City (5800 children) are living in poverty.**
- **Ten wards in Oxford, one in Banbury and one in Abingdon are in the worst 25% in England for levels of child poverty, these are Banbury Ruscote, Barton & Sandhills, Blackbird Leys, Carfax, Churchill, Cowley Marsh, Iffley Fields, Littlemore, Lye Valley, Northfield Brook, Rose Hill & Iffley, Abingdon Caldecott.**

* In this case, the average used is the Median which is the middle of the range of all household incomes

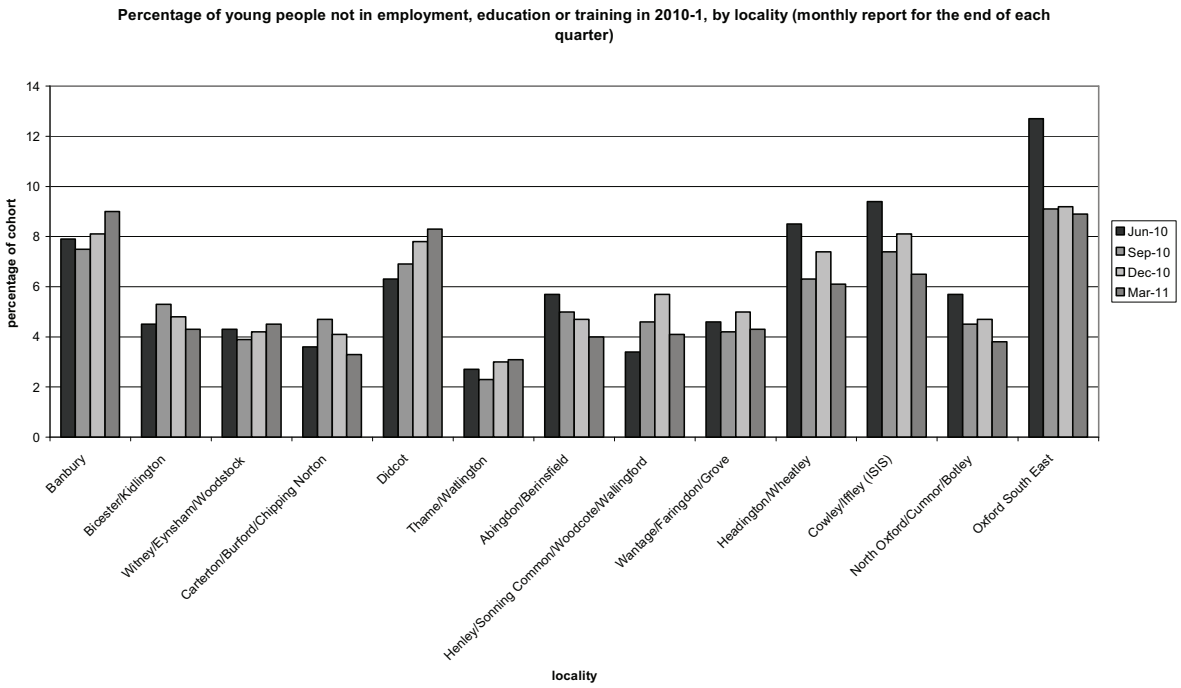
This indicator shows clearly the areas where our attention needs to be focussed to break the cycle of deprivation.

Indicator 2 - Young People Not in Education, Employment or Training

This provides a useful indicator of overall life chances for our young people. Being in education, employment and training helps to provide young people with the skills they need to step out of the cycle of deprivation. The overall picture across the County has improved since 2009 following focussed action, but a closer look within the county shows where the major problems lie. Banbury, socially disadvantaged areas of Oxford and Didcot have a higher percentage of young people who are not in education, employment or training than elsewhere in the County. Rates in Didcot and Banbury are the only places where rates are still increasing.

5.9% young people in Oxfordshire aged 16-18 were classified as NEET in 2010-11. This was higher than the South East average of 5.4% for the same period but lower than the England average, which was reported as 7.3% at the end of 2010.

Figure 3 - Percentage of Young People Not in Employment, Education or Training



Indicator 3 - Unemployment and Benefit Claimants.

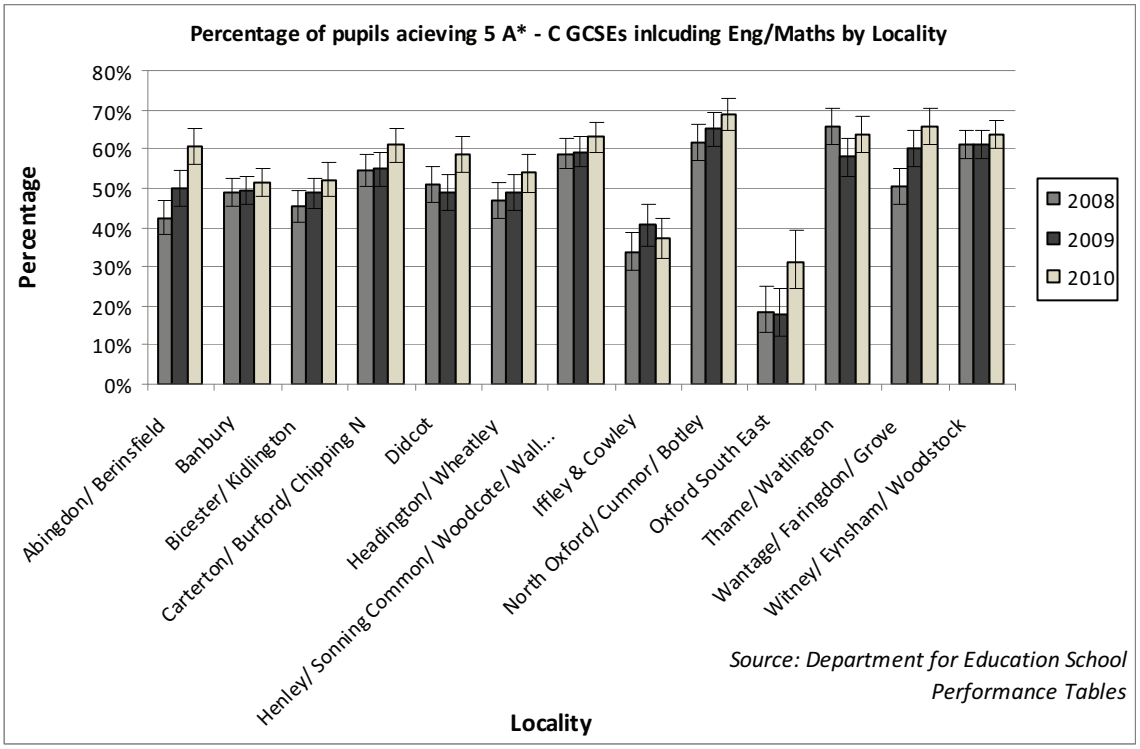
Being in regular work helps individuals and families to improve their life chances and so helps to break the cycle of deprivation. The rate of people claiming Job Seekers Allowance (JSA) in England has been declining slowly since the peak in April 2009, and seems to have levelled off during 2010-11 but is still above pre-recession levels. The number of people claiming unemployment benefits in Oxfordshire has largely mirrored national trends through the recession, and, thankfully, has always remained well below the England average.

However, some parts of the county have percentages of people claiming Jobseekers Allowance (JSA) which are well above England averages, especially in parts of the City and Banbury.

For example, 5.9% of people of working age in Blackbird Leys are claiming Job Seekers Allowance, 4.6% in Northfield Brook and 4.8% in Banbury Ruscote, compared with an Oxfordshire rate of 1.8% and an England rate of 3.7% (figures from Dept for Work and Pensions, April 2011).

Indicator 4 - Educational attainment

Figure 4 - GCSE Attainment

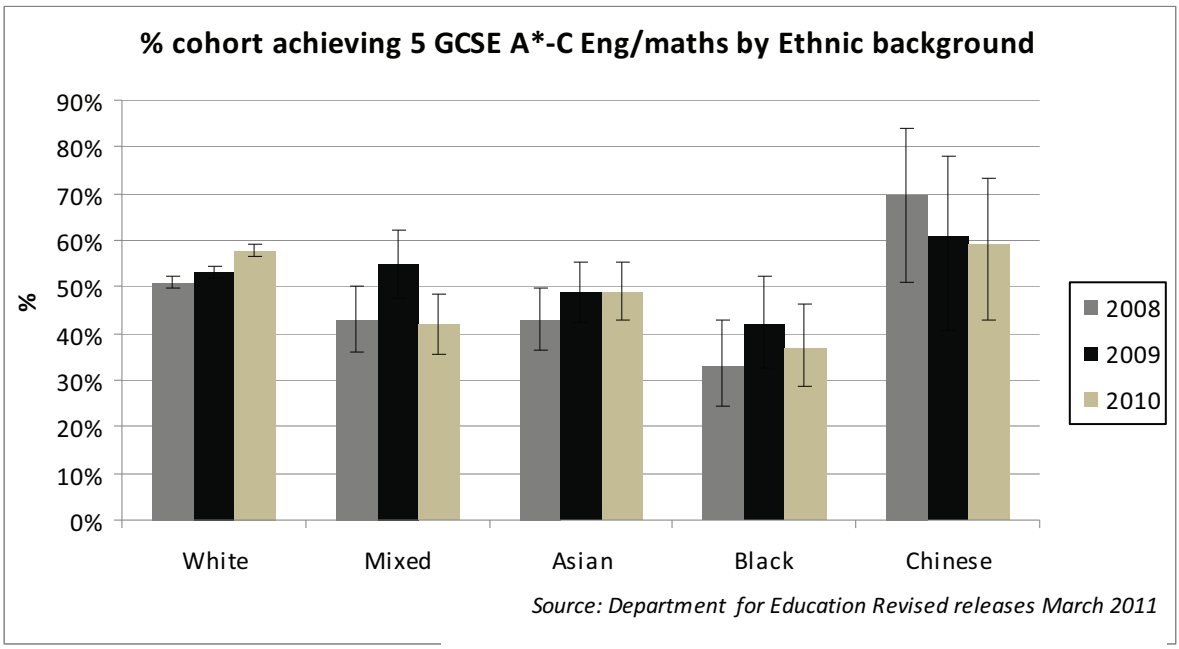


In 2010 the number of young people achieving at least 5 GCSEs with grades of A*-C including English and Maths has risen in almost all areas of the County since 2009. The only exception was the Iffley/Cowley locality in Oxford which will feature in next year's annual report. The 2011 data still awaits full analysis but shows a small fall against national trends.

As the chart shows, there are still stark differences between different areas of the county. Achievement rates in North Oxford/Cumnor/Botley are more than twice as high as those 5 miles away in South East Oxford area which covers the wards of Blackbird Leys, Rose Hill and Iffley, Littlemore and Northfield Brook.

There are also some remaining inequalities in achievement rates by ethnic group. These are shown in figure 5 which shows that results for black, Asian and mixed ethnic children were significantly poorer than their white counterparts.

Figure 5 - GCSE Attainment by Ethnic grouping



Indicator 5 - Teenage Pregnancy

In terms of the 'cycle of deprivation', teenage pregnancy is both a challenge and a success - there are still inequalities across the County, **but targeted action has shown that previously very high rates in the City have fallen steadily over the last 5 years.** This is a major success.

Overall the Oxfordshire under 18 conception rates is decreasing, broadly in line with rates in England. Oxfordshire has the 17th 'best' rates for all Local Authorities in the Country and those Local Authorities with lower rates tend to be smaller authorities in leafy shires with few areas of deprivation.

For Oxfordshire teenage pregnancy remains a useful and relevant measure of social disadvantage and poor life chances for children, young people and families. The most recent analysis shows that **Oxfordshire has 8 hotspot wards with particularly high rates**; hotspots are defined as those wards with more than 60 conceptions per year per 1,000 females aged 15-17 years. This is a cause for concern, but is also an improvement thanks to the attention we have given to this problem: the 8 current hotspots compares with 10 last year and 18 the year before that. The 8 current hotspots include 5 wards in Oxford, 1 in Banbury (the highest) and 1 each in Witney and Didcot. The wards with the highest rates are:

- Grimsbury and Castle (the highest), Banbury
- Northfield Brook, Oxford.
- St. Mary's, Oxford.
- Iffley Fields, Oxford.
- Barton and Sandhills Oxford.
- Blackbird Leys, Oxford.
- Didcot Park, South Oxfordshire.
- Witney Central, West Oxfordshire.

Indicator 6 - Crime

Overall crime rates in all districts of Oxfordshire continued to fall throughout 2010-11. The total number of crimes reported in the County fell by 4% in 2010-11 with violent crimes falling by 20%, Criminal Damage by 9.4% and burglary by 13%.
The picture here is once again uneven across the County. The greatest number of crimes occur in Oxford City, though crime rates there have been falling at proportionately higher rates than that in other parts of the county. Public order offences are more prevalent in the city centre while incidents of domestic burglary and domestic violence are more scattered. A summary of local crime figures highlights crime rates which are higher than the national average is included below.

Figure 6 - Local Crime figures 2010/2011 showing offences per 1,000 resident population. Rates which are higher than the national average are larger and in bold

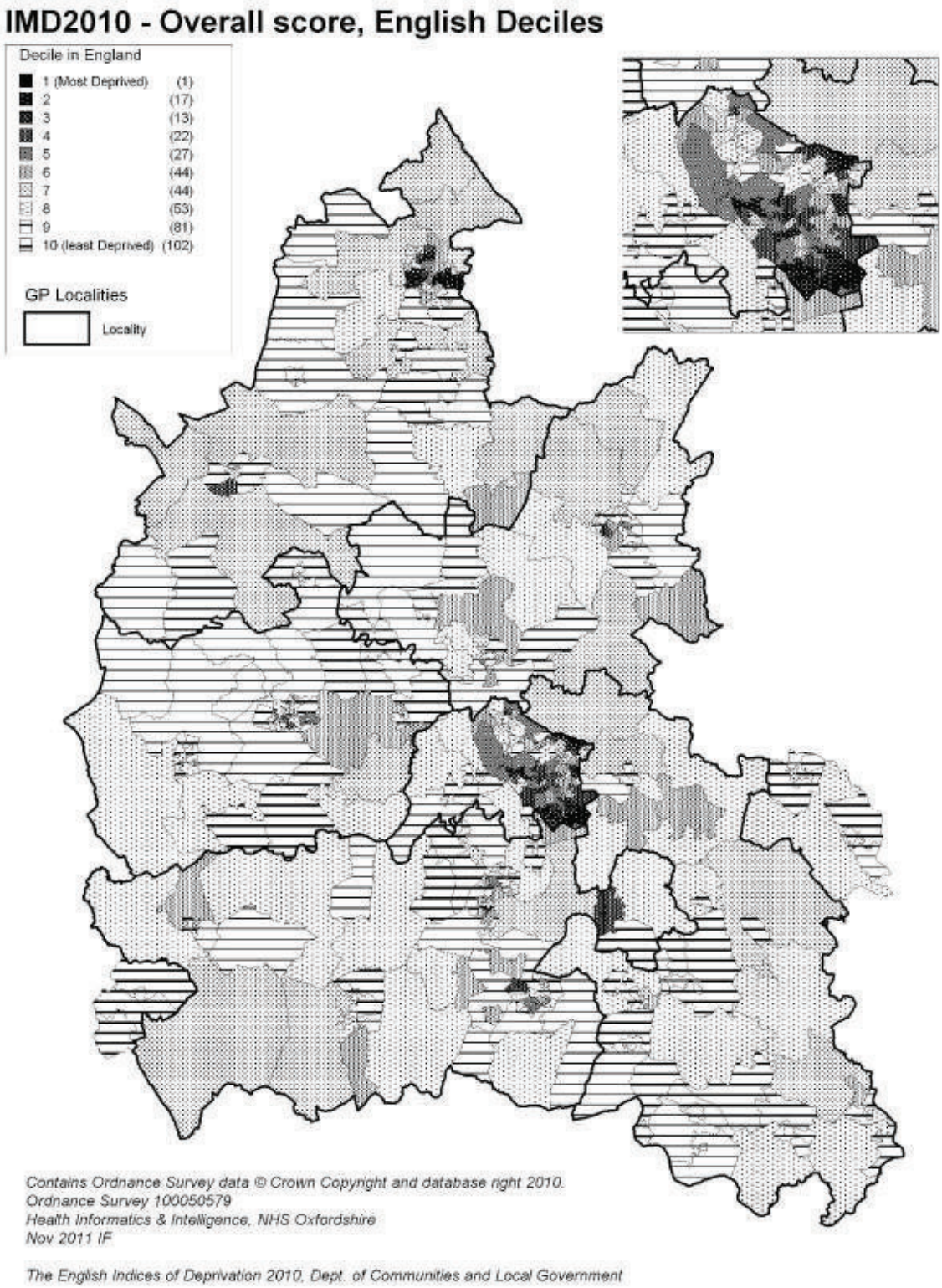
	OXFORD CITY	SODC	WODC	VALE	CHERWELL	England AVERAGE
Burglary	**9.7**	7.6	5.0	4.4	5.4	9.6
Criminal damage	**15.4**	9.7	9.1	7.9	10.7	12.7
Drug offences	**6.6**	2.1	1.2	3.1	3.1	4.2
Fraud and forgery	**5.2**	**4.2**	2.1	2.1	**4.7**	2.7
Offences against vehicles	7.7	5.1	3.4	3.0	4.0	8.2
Other offences	**1.7**	0.6	0.5	0.4	0.9	1.2
Other theft offences	**49.7**	14.1	12.8	11.2	18.2	19.3
Robbery	**1.7**	0.2	0.2	0.1	0.4	1.4
Sexual offences	**1.5**	0.7	0.6	0.7	0.9	1.0
Violence against the person	**23.0**	9.1	9.7	9.2	14.8	14.8

Data supplied by Home Office based on data collected by police forces in England and Wales between 2010 and 2011

Indicator 7 - Index of Multiple Deprivation (IMD)

The Index of Multiple Deprivation 2010 combines a number of indicators (such as the income deprivation affecting children index used above), chosen to cover a range of economic, social and housing issues, into a single deprivation score for each small area (called Lower Super Output Areas – LSOA) in England. This allows each area to be ranked relative to one another according to their level of deprivation.

Figure 7 - Map showing Index of Multiple Deprivation 2010 by Small Area (LSOA)



The 2010 IMD scores confirm that in general Oxfordshire is, for most, an affluent place to live. 324 out of 404 small areas are in the top 50% of most affluent places within England. However, on closer examination, the typical picture of disadvantage confined to small areas persists. Northfield Brook is the small area of Oxford which is the most deprived, the next 17 small areas which are most deprived all fall within Oxford City, Banbury and one small area of Abingdon.

Indicator 8 - Early Death and Areas of Social Deprivation

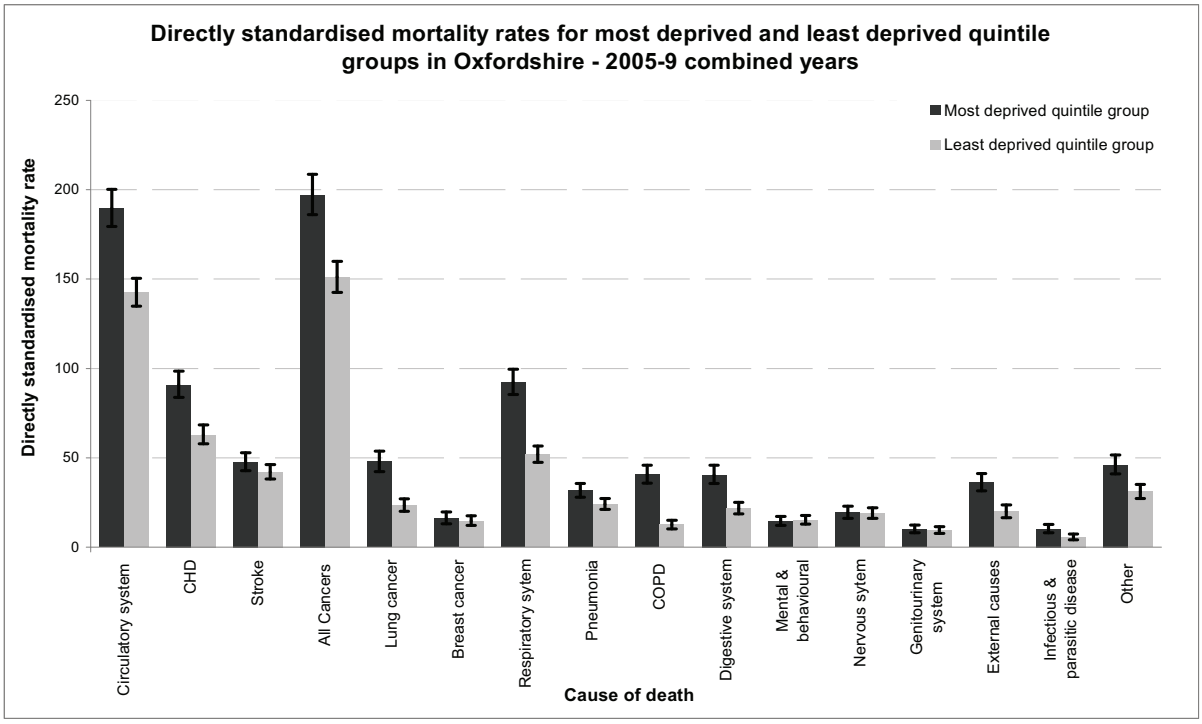
The chart below shows death rates across the county and the causes of death from 2005 to 2009.

For each cause of death the left hand column shows death rates in the 20% most socially deprived wards and the right hand column shows death rates in 20% most affluent wards.

The chart shows clearly that:

- Death rates in socially deprived wards are higher across the board than in affluent areas (i.e. the chances of dying at a younger age are higher).
- This is particularly apparent in the most common causes of death - circulatory diseases (e.g. coronary heart disease (CHD) and stroke and cancer).

Figure 8 - Comparing Mortality Rates in deprived and affluent wards



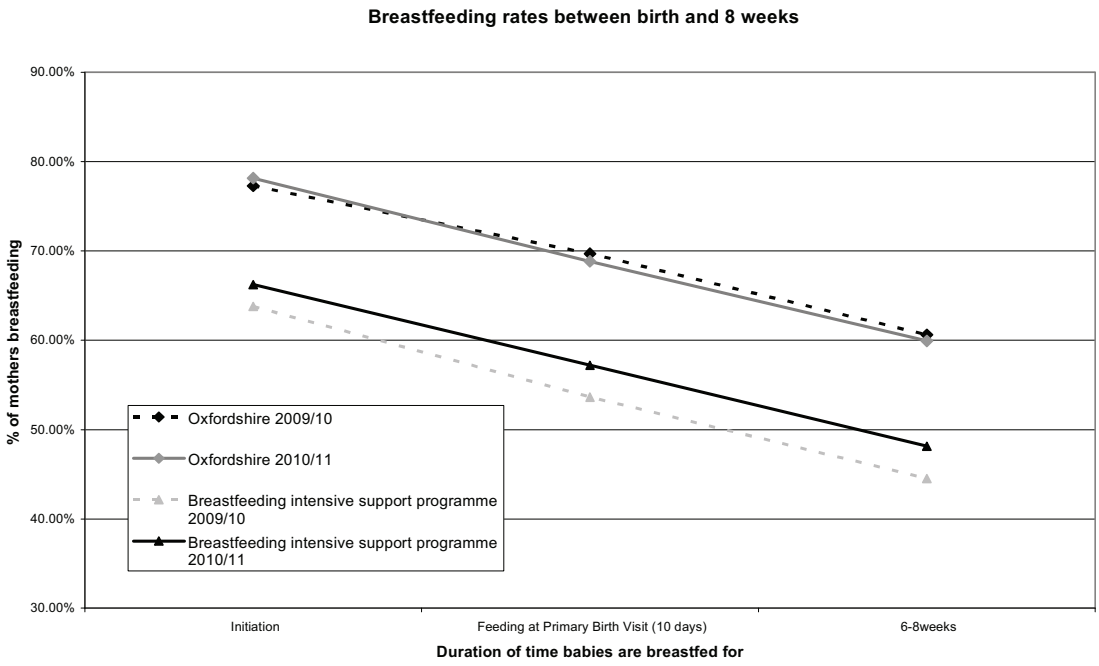
Indicator 9 - Breast Feeding Levels

Breastfeeding gives children a fantastic start in life. The percentage of mothers breastfeeding across Oxfordshire is high (79%) compared with national levels (74%), this is a good result. However, there are inequalities across Oxfordshire with not all mothers choosing to breastfeed their children. In 2009, areas of Oxford and Banbury were identified as having significantly lower breastfeeding rates than the rest of Oxfordshire. An intensive support service was set up, working out of general practices serving the populations with the poorest uptake. The practices were Blackbird Leys Health Centre - Oxford, both Donnington Health Centres - Oxford, Windrush Surgery - Banbury, 12 Horse Fair - Banbury, West Bar Surgery – Banbury

and The Orchard Health Centre - Banbury. The service was designed to support mothers in choosing to breastfeed and then provide practical help to continue feeding during the first weeks of life

Figure 9 shows that as expected, breastfeeding decreases as time goes by. The two top lines show breastfeeding rates for the whole county for the last two years. The bottom two lines show breastfeeding rates for the practices in Oxford and Banbury serving the areas with the lowest rates. This shows that, whilst the county average has been static, the extra support offered in the most deprived areas has improved rates across the board by about 4 percentage points. This is a good result.

Figure 9 - Breastfeeding rates between birth and 8 weeks, for 2009/10 and 2010/11



Indicator 10 - Obesity in Children

Being obese* in childhood puts your health on the back foot throughout life, and any obesity is a cause for concern (see chapter 4, dedicated to this topic). In *this* chapter we look at obesity rates in children in different parts of the County as a marker for where our effort is most needed to break the cycle of deprivation.
In Oxfordshire we measure obesity carefully in schoolchildren at two ages: reception year (around age 4 to 5) and year 6 (around age 10 to 11).
Figures 10 and 11 compare levels of obesity between the Districts within Oxfordshire and with the national average.

* Overweight and obesity are defined as abnormal or excessive fat accumulation that may impair health.
Body mass Index (BMI) is a simple index of weight-for-height that is commonly used to classify overweight and obesity in adults. It is defined as a person's weight in kilograms divided by the square of his height in meters (kg/m^2).
The WHO definition is:

- a BMI greater than or equal to 25 is overweight - that is a 6 foot man weighing 13 stone 3 has a BMI of 25, whereas a female who is 5 foot 4 weighing 10 stone 6 has a BMI of 25
- a BMI greater than or equal to 30 is obesity - that is a 6 foot man weighing 15 stone 12 has a BMI of 30, whereas a female who is 5 foot 4 weighing 12 stone 7 has a BMI of 30

BMI provides the most useful population-level measure of overweight and obesity as it is the same for both sexes and for all ages of adults

In reception year, all Districts are below the national average. The City has the highest rates, followed by Cherwell and West Oxfordshire. (The very high figure for 2008/9 in West Oxfordshire is almost certainly inaccurate, due to a data recording error).
By year 6 however the picture changes, with Oxford City significantly higher than the national average with almost 1 in 5 (almost 20%) children obese with the other districts comfortably lower than the national average grouped around the 14-15% obese mark.

Figure 10 - Obesity amongst children in Reception Year 2006 to 2009 (Academic Years). England, Oxfordshire and Districts within Oxfordshire

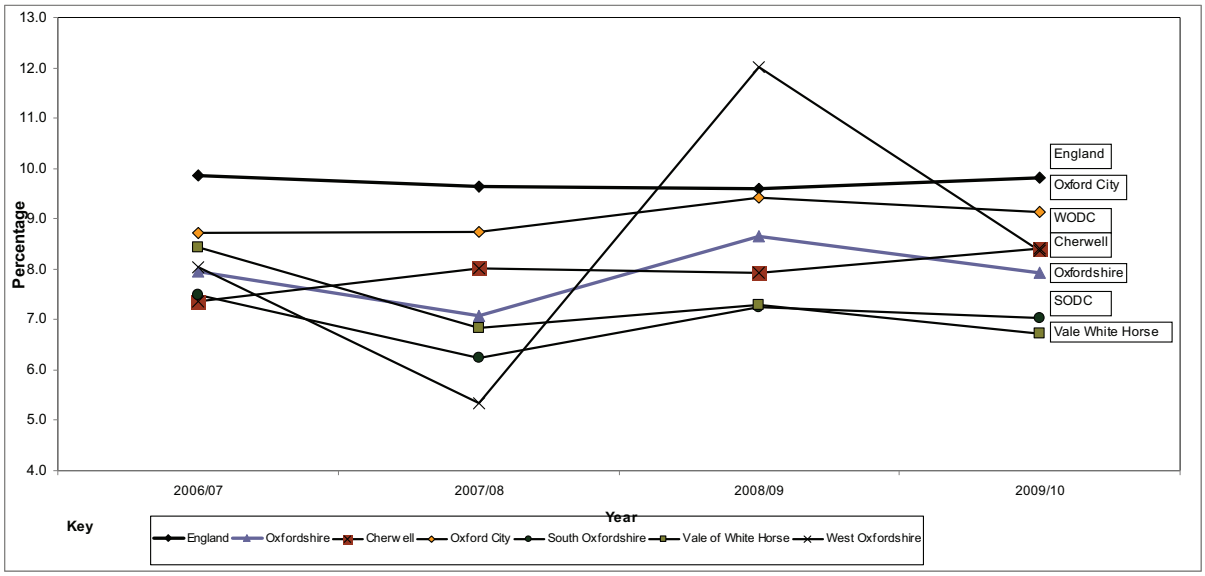
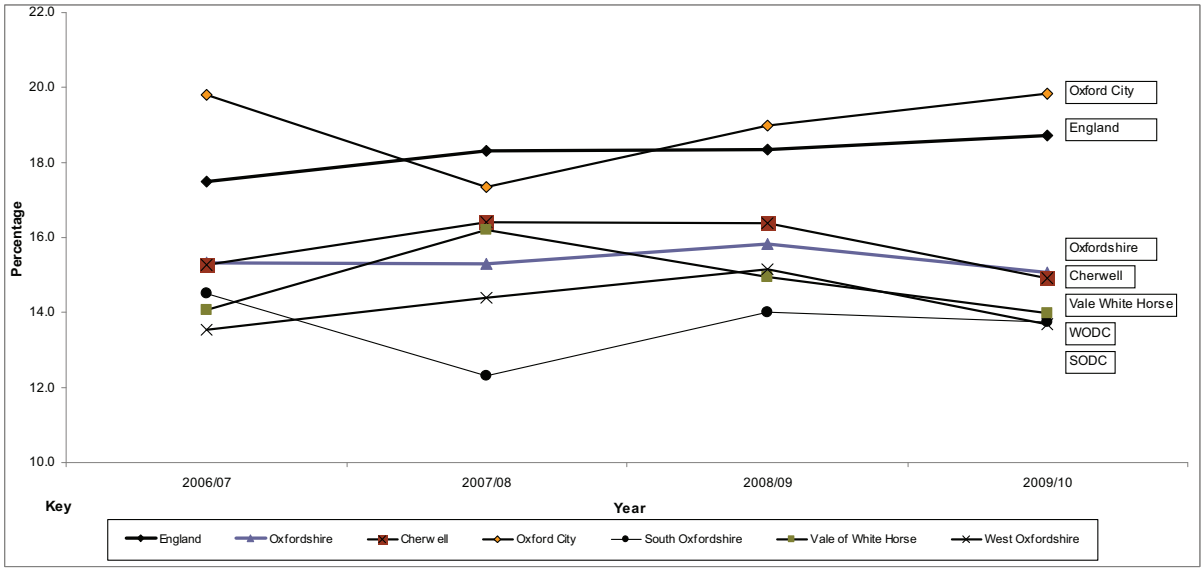


Figure 11 - Obesity amongst Year 6 children 2006 to 2009 (Academic Years). England, Oxfordshire and Districts within Oxfordshire



Is Breaking The Cycle Of Deprivation Still a Priority for Oxfordshire?

Unquestionably yes.

The statistics quoted above paint the picture eloquently:-

Breaking the cycle of deprivation is *the* major long-term social challenge facing Oxfordshire.

As a problem overall, its impact on health is only surpassed by the demographic challenge posed by an ageing population.

We **HAVE** recognised this challenge over the past 4 years and we **HAVE** begun to make a difference and this is a great step forward, but it is clear that efforts will need to be maintained over successive decades if we are to beat this problem.

The issue still overwhelmingly affects the most socially disadvantaged parts of Oxford City and Banbury and consequently, this is where the focus for action must lie. Since we have recognised this issue as a major problem in this County, promising work has begun. It is vital that these green shoots are nurtured with care.

We seem to get the best results when we focus on:

- **making a difference to *specific families in specific areas*** through direct contact and action
- **Re-designing existing *mainstream* services at the margin** to give a slightly enhanced focus on deprived areas as opposed to designing stand-alone, short term initiatives. Stand-alone initiatives are always harder to sustain in times when finances are under pressure, and sustainability has to be the watchword.

What Progress has been made Against Recommendations in the Previous Four Annual reports?

Breaking the cycle of deprivation is now recognised as a major plank in Local Authority and NHS policy in Oxfordshire. This is a major achievement and all organisations should take credit for this. The altruistic use of the Local Area Agreement reward grant on this topic bears witness to this and is to be applauded. Important new initiatives and new ways of working have sprung out of this recognition, in particular:

- The family intervention project which has targeted help to the specific families who need it the most
- Work to target schools with poor educational attainment
- Reductions in teenage conceptions in the “hotspot” areas
- Fewer young people as a whole Not in Education, Employment and Training (NEET)
- Job Clubs linking with local employers to offer opportunities
- Apprenticeships, internships and volunteering opportunities for young people.
- Benefits advice available from Citizens Advice Bureau advisors in GP practices in Banbury as well as Oxford
- Further Local Area Agreement reward funding being made available for skills development and improving employability.

However the watchword here is <u>persistence</u>. This means persistence over time despite changes in fiscal policy, and organisational change.

The most pressing challenges in Oxfordshire are to:

- Ensure that the new Oxfordshire Clinical Commissioning Group is fully supportive of Breaking the Cycle of Deprivation as a policy and that their locality structure will enable them to focus on these areas in the County when the need arises.
- Ensure that 'Breaking the Cycle of Deprivation' continues to be a very visible major plank of policy across all organisations in Oxfordshire as partnership structures are reviewed and renewed. This should incorporate the implementation of the Child Poverty Strategy. It will be vital for the Health and Wellbeing Board to adopt this topic as a major priority and it will also be vital for the Community Safety Partnership and the Local Enterprise Partnership to play their parts also.

Recommendations

1. A Strategic Priority for the Health and Wellbeing board

By March 2012 the Health and Well-Being Board should have adopted Breaking the Cycle of Deprivation as a major priority for the public sector in the County.
A Children and Young People's Board should have been set up to continue the work of the Children's Trust on this topic and should report regularly on a basket of outcome measures and key performance targets designed to show progress to the main board. This should include setting specific local trajectories for 2012, 2013 and 2014. The Health and Wellbeing Board should require improvement plans to be in place where progress is not on target.

2. A Strategic Priority for Oxfordshire Clinical Commissioning Group

By March 2012 Oxfordshire's Oxfordshire Clinical Commissioning Group should be a fully signed-up partner to programmes of work designed to break the cycle of deprivation in Oxfordshire under the auspices of the Health and Wellbeing Board.

3. A Strategic Priority for the Community Safety Partnership and Local Enterprise Partnership

By June 2012 the Community Safety Partnership and Local Enterprise Partnership should have identified focussed action that they will oversee to play their part in Breaking the Cycle of Deprivation.

Chapter 3 - Mental Health: Avoiding a Cinderella Service

It is appropriate to conclude that services combating mental illness and promoting mental wellbeing HAVE improved over the last four years in Oxfordshire.

Four years ago mental health was definitely a 'Cinderella issue' - this is no longer the case. The challenge will be to sustain this improvement during a tough fiscal climate, especially as the impact of recession works its way through peoples' personal circumstances.

The analysis below shows why this conclusion is drawn.

What does the Joint Strategic Needs Assessment (JSNA) say about Mental Health?

Measuring and assessing mental health and wellbeing is difficult. Why? Because mental health is such a complex thing - it is so complex and so tied in with peoples social circumstances that it is hard to define. It isn't neat and tidy like diabetes.

Having said that, the JSNA sheds very useful light on the subject -
For example, we know that:

- Mixed anxiety and depression is the most common mental disorder - it is estimated to affect around 35,000 people in Oxfordshire at any one time (9% of adults). It isn't possible to say whether this level is rising or falling, but we DO know that more people than ever before are now receiving treatment for these common conditions.
- Levels of major mental illnesses like schizophrenia recorded by GPs are stable and are not rising.
- Oxfordshire's suicide figures show a decrease to bring County levels in line with national averages after a worrying upward trend.
- Rates of Accident and Emergency attendances for deliberate self-harm such as overdoses have fallen steadily over the last 4 years.
- National data shows early signs that people with mental health problems are becoming less stigmatised. The National 'Attitudes to Mental Illness survey 2011' shows that:
    - the percentage of people agreeing that 'Mental illness is an illness like any other' increased from 71% in 1994 to 77% in 2011.
    - the percentage saying they would be comfortable talking to a friend or family member about their mental health rose from 66% in 2009 to 70% in 2011.
    - the percentage saying they would feel uncomfortable talking to their employer about their mental health fell to 43%, compared to 50% in 2010.

What Evidence is there of service improvement?

The consensus among local professionals is that:

- The need to improve services which help to get people back into work and achieve independent living has been recognised, and these services are now being strengthened.
- Mental health service commissioning is much improved. Services are specified in contracts in much more detail.
- Much better services are in place for common conditions - e.g. more counselling in general practice and improved access to 'talking therapies'.
- The commissioning of dementia services is much improved in line with the national dementia strategy.
- Carers for people with mental health problems are benefitting from a welcome increase in GP-referred carers breaks.
- Joined up early intervention services for children and families will help to spot psychological problems early and will make treatment more accessible.

Is This Still a Priority for Oxfordshire?

Absolutely. The sea may be calmer, but it is by no means all plain sailing from here on. The next raft of challenges includes:

- Maintaining what we have achieved with tightening resources.
- Untangling the way we pay for NHS services within the 'payment by results system'. This tries to fix a standard price for standard treatments and works fine for physical illness…… mental illness however is much more complex as it resists being packaged up and neatly priced. It is hard to see how this will work smoothly.
- The move to join up all mental health services cradle to grave as part of the national 'No Health Without Mental Health' initiative.
- GP Commissioners will be taking the reins of NHS commissioning fully over the next year or so. We will need to keep focus and direction during this change.
- The long term impact of the recession will filter through to increase common psychological conditions - this is an inequalities issue as areas of social disadvantage experience higher levels of unemployment and other stresses.
- The recently created Oxford Health NHS Foundation Trust has now expanded into the physical health arena from its traditional base in providing mental health services. The impact of this is as yet unclear, but it will be important to keep focus here too.

What Progress has been made Against Recommendations in the Previous Four Annual reports?

Good Progress has been made:

- Mental health is now firmly on the agenda as a major concern - it is no longer such a Cinderella service.
- There is a much improved focus on older people and on dementia services.
- The creation of a large pooled budget for mental health services will help to 'glue' together the NHS and Local Authorities in commissioning services.
- More emphasis has been given to carers for people with mental health problems.

BUT

- We have struggled to set authoritative outcome measures for mental health - an issue that is currently being wrestled with at national level.

Recommendations

1. Strategic Priority of this Topic
By June 2012 Oxfordshire's Health and Wellbeing Board should ensure that a cradle to grave strategy is in place for mental health in Oxfordshire. It should ensure that all of its sub-groups are playing their part to commission integrated services for children, adults and older people.

2. Need to Review Pooled Budgets
By June 2012 Oxfordshire's Health and Wellbeing Board should ensure that the pooled budgets for mental health are reviewed and are working effectively to implement mental health commissioning.

3. Need for Outcome measures
By June 2012 Oxfordshire's Health and Wellbeing Board should ensure that meaningful outcome measures and trajectories are agreed for mental health services in Oxfordshire.

4. Strengthening the Public Voice
By June 2012 the Health and Wellbeing Board should ensure that its Public Involvement Board is fully engaged with mental health service users and carers and is in a position to put forward their views forcefully into the planning process.

5. Strategic Priority for Oxfordshire Clinical Commissioning Group
By June 2012, Oxfordshire Clinical Commissioning Group should have agreed to make the further improvement of the commissioning of NHS mental health services a priority, and they should be doing this through playing a full role as strategic partners in Oxfordshire's Health and Wellbeing Board.

Chapter 4 - The Rising Tide of Obesity

Previous annual reports highlighted the importance of halting the advance of obesity* in our society. This is important because:

- Obesity is on the increase in epidemic proportions in affluent Western society.
- Once obesity is established in childhood it is very hard to shake off in later life.
- Obesity reduces lifespan by around nine years.
- Obesity can lead to high blood pressure and long term conditions such as diabetes heart disease and stroke and cancer which lead to premature death and drive the costs of health and social care which we cannot afford.
- The risk of getting diabetes is up to 7 times greater in obese women and up to 5 times greater in obese men.
- The risk of developing diabetes is up to 20 times greater for people who are very obese (Body Mass Index over 40*).
- Obesity adds £1 million **every year** to the cost of the NHS in Oxfordshire alone.
- 10% of all cancer deaths among non-smokers are linked to obesity.
- Obesity decreases mobility making independent living harder.

A **reduction in 10% of body weight** gives the following benefits, even if you do not return into a normal weight category:

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

What does the Joint Strategic Needs Assessment say about Obesity?

The key facts from the JSNA are:
For Adults:

- Levels of obesity in over 16s are gradually increasing nationally, but levels in Oxfordshire are not quite so high in comparison (22% for Oxon compared with 24 % nationally).
- National rates for adult obesity continue to creep up around 1-2% per year, but the most recent figures for Oxon show a slight fall - enough to be welcomed cautiously but this could be just a 'blip' in our favour.

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* Overweight and obesity are defined as abnormal or excessive fat accumulation that may impair health.
Body mass Index (BMI) is a simple index of weight-for-height that is commonly used to classify overweight and obesity in adults. It is defined as a person's weight in kilograms divided by the square of his height in meters (kg/m^2).
The WHO definition is:

- a BMI greater than or equal to 25 is overweight - that is a 6 foot man weighing 13 stone 3 has a BMI of 25, whereas a female who is 5 foot 4 weighing 10 stone 6 has a BMI of 25
- a BMI greater than or equal to 30 is obesity - that is a 6 foot man weighing 15 stone 12 has a BMI of 30, whereas a female who is 5 foot 4 weighing 12 stone 7 has a BMI of 30
- a BMI greater than or equal to 40 is morbidly obesity - that is a 6 foot man weighing 21 stone 1 has a BMI of 40, whereas a female who is 5 foot 4 weighing 16 stone 9 has a BMI of 30

BMI provides the most useful population-level measure of overweight and obesity as it is the same for both sexes and for all ages of adults

For Children:

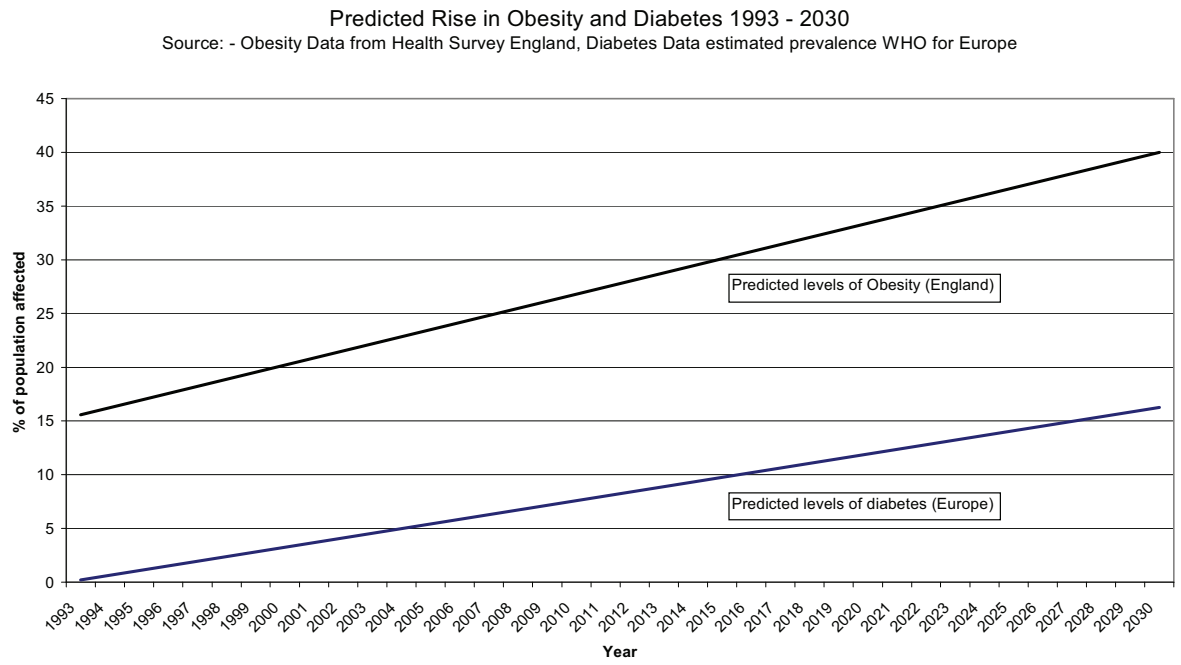
- Among children, levels of obesity are too high at around 8% of reception year children, rising to 15% of year 6 children. This shows that eating too many calories and taking too little exercise gradually increases weight year on year, with year 6 levels being almost double reception levels. This feeds through into ever increasing levels of obesity in young adults.
- The relatively 'good' county average masks the familiar pattern of social deprivation - Chapter 2 has already drawn attention to the fact that obesity levels are significantly higher in the City compared with the rest of the County.

However, that said, it isn't all bad news

- The trend in levels of childhood obesity has been pretty static both nationally and in Oxfordshire in recent years (2006-2010). This is good news as our aim is to halt the rising tide as a first step.
- Also, Oxfordshire's children do have lower levels of obesity than their National counterparts, with Oxon reception year levels around 1% lower than nationally (8% compared with 9%) and year 6 levels around 4% lower (15% compared with 19%).
- Oxon can take further comfort from recent data on exercise levels in adults. It transpires that **Oxfordshire is the sportiest and most active county in England according to the latest Active People survey results released by Sport England** earlier this year. Since 2005 the percentage of people in Oxfordshire participating in regular activity each week has risen year on year to 26%, **the highest in England**, with an increase of 514 people participating regularly compared in the last year. GO Active (Get Oxfordshire Active) is one of the projects in Oxfordshire that has contributed to this increase as a good example of Local Government and the NHS working in partnership. For example, since January 2009 over 13,000 people have taken part in GO Active activities such as Dance, Nordic Walking and Rounders across the county and independent research has shown that 84% of those involved are leading a more active lifestyle as a result.

Trends in chronic disease associated with obesity continue to show an upward trend. Figure 12 shows a worst case scenario for diabetes which we may face based on the "Foresight Report" which looked in detail at obesity levels using data from England and World Health Organisation predictions of worse case scenario diabetes levels across Europe.

Figure 12 - Predicted rises in Obesity and Diabetes



Is This Still a Priority for Oxfordshire?

The fight against obesity is the most important lifestyle challenge for the population of Oxfordshire. We are doing well as a County, but *can* do more to tackle this problem.

The risks of obesity are obvious. The benefits of losing weight are very clear, and yet, on the whole the trend is still going up. Why? Because, on the whole, in Western society as it stands, just by living an 'average' life, it is easier to become obese than it is to maintain a normal weight.

There is some comfort in the data for Oxfordshire, but not enough to justify taking our foot off the accelerator for a second. If we do not continue efforts to turn back the "rising tide" we may not be able to afford to treat the ensuing chronic disease and high levels of physical disability which will result. It is imperative that we continue to tackle obesity as a partnership, with each partner playing a full role.

There is huge scope here for District Councils to link the efforts of GP commissioners, road and transport planners public health staff, health visitors and schools to continue the fight against obesity. It is particularly important to take a cradle-to-grave approach to try to prevent people becoming obese in the first place - an approach which starts before the birth of the child and continues throughout life.

What Progress has been made Against Recommendations in the Previous Four Annual reports?

Progress against recommendations has been generally good. The calls for stronger partnership working have been heeded, and obesity was taken seriously as a priority by the Health and Wellbeing Partnership, a body that will be subsumed with the new Health and Wellbeing Board. These actions have helped us to be in a strong place in Oxfordshire going forward.

However:
It has proved difficult to measure reliably levels of adult obesity and physical activity in the general population. It was hoped that reliable information might be available through general practice but this has run into practical and statistical difficulties and is probably beyond our scope currently. We will need to continue to use national estimates and one-off surveys as a proxy to measure progress.

Successful work on obesity depends on good joint working between organisations. **Following the major re-structuring of public sector organisations over the last year, the major task facing us is to maintain, re-vamp or re-create the strong partnership work we traditionally enjoy in Oxfordshire.** It will be particularly important to connect District Councils, GP Commissioners, County Council, schools and the new Public Health Team as it transits to the County Council. The new Health and Wellbeing Board will have a pivotal role to play in driving this work forwards.

Recommendations

1. Strategic Priority for the Health and Wellbeing Board and its Health Improvement Board

By March 2012, Oxfordshire's Health and Wellbeing Board and its subsidiary Health Improvement Board should adopt the fight against obesity as a major priority, should set local targets for Oxfordshire and should regularly monitor progress against these targets. As part of this process, all Local Authorities, GP Commissioners and Healthwatch are recommended to adopt the fight against obesity as an important corporate priority.

2. Requirement for a re-vamped County Strategy

By June 2012, the new Public Health Team should agree and coordinate a cradle-to-grave strategy to prevent and treat obesity, on behalf of all organisations in Oxfordshire. This should include working together with all Local Authorities and GP Commissioners. This should be adopted by the Health and Wellbeing Board

3. Need to Retain Strong Partnership Working of the Sports Partnership Board

By June 2012, the Sports Partnership Board which has instigated and co-ordinated the “Go Active” project (that allowed countywide co-ordination of physical activity initiatives between District Councils and Health Services) should ensure that the scheme is made sustainable going into the future.

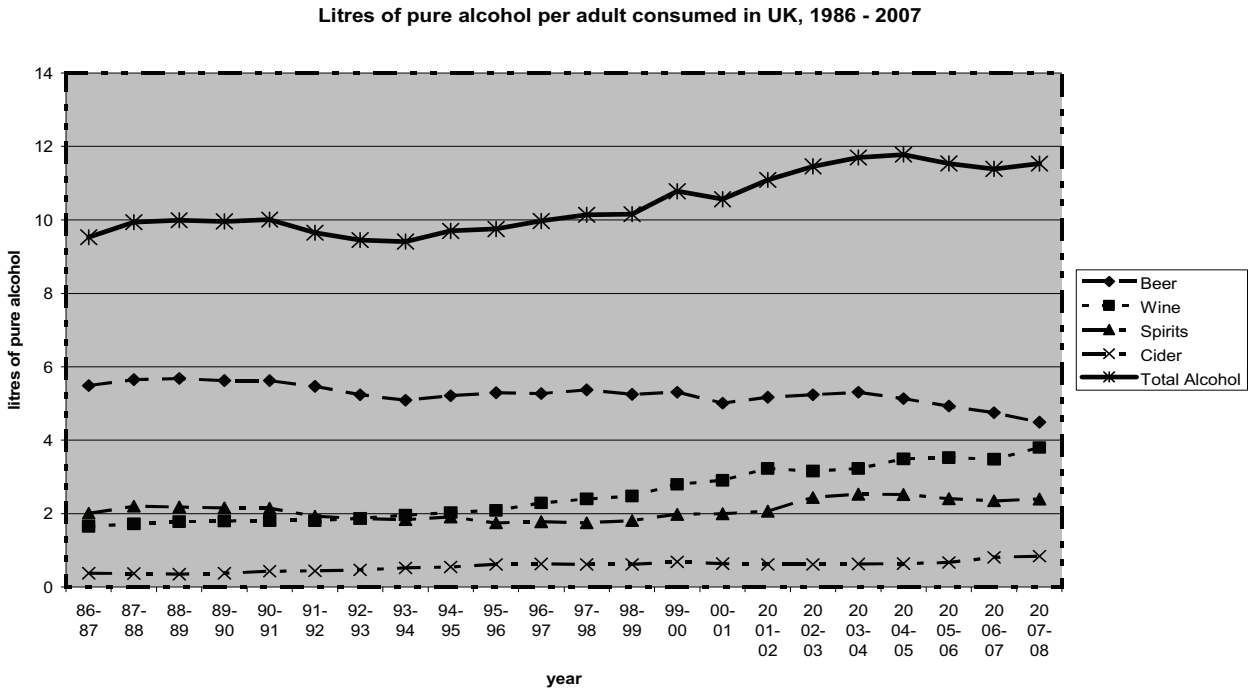
Chapter 5 - Alcohol: What's Your Poison?

Last year's Annual Report established that drinking too much alcohol was a cause of major concern for the future of health in Oxfordshire for the following ten reasons:

1. **Alcohol consumption has risen in the last 40 years**

   In England, average adult alcohol consumption has risen by 40% since 1970. The graph below shows the recent trends in consumption.

Figure 13 - Alcohol Consumption in the UK



Source: Institute of Alcohol Studies Factsheet "Drinking in Great Britain" www.ias.org.uk

2. **Many Adults exceed recommended drinking levels** and one in five drinks at hazardous levels
3. **Alcohol consumption in young people has increased** with heavy drinking and binge drinking a concern in this group. Consumption among young women has been increasing rapidly.
4. **Alcohol, without doubt, causes disease** and early death. It is a poison.
   - In England in 2006, 16,236 people died from alcohol-related causes.
   - The number of deaths from alcohol-related liver disease has almost doubled in the last decade.
   - Alcohol causes cancers of the liver, bowel, breast, throat, mouth, larynx and oesophagus; it causes osteoporosis, reduces fertility and causes accidents of all kinds.
   - Alcohol is responsible for around 950,000 unnecessary admissions to hospital nationally per year, and this is rising (an increase of 70% in the 6 years between 2002/03 and 2008/09).
5. **Alcohol is getting cheaper and more easily available**

The real cost of alcohol has fallen: a unit of alcohol cost 67% less in 2007 than in 1987.

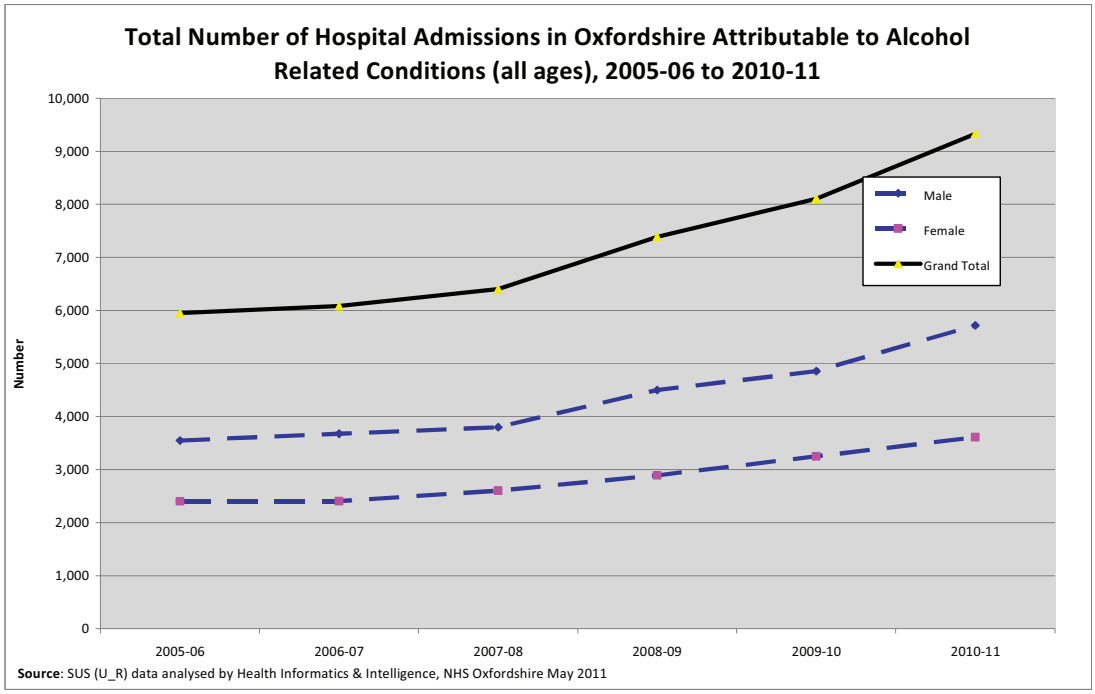
6. **The health benefits of alcohol are overstated**

Despite recent media coverage, attempts to define a 'safe' level of drinking are fraught with difficulty. Although above the age of 40 years, drinking a small amount of alcohol may reduce the risk of heart disease and stroke. For those who drink above this low level, and for those under 40 years who drink any amount, alcohol **increases** the risk of heart disease and stroke. For those of any age, drinking any amount of alcohol increases the risk of cancer, there is no safe limit. Across England, for every hospital admission that alcohol 'prevents', alcohol causes 13 people to be admitted.

7. **Alcohol damages the family and social networks**
8. **Alcohol fuels antisocial behaviour** and changes the character of our towns, especially in the evening at weekends
9. **Alcohol damages front-line services** and the economy and places a huge financial burden on the taxpayer.
10. **Hospital admissions for alcohol related harm in Oxfordshire are rising**

Local statistics show the burden of disease related to alcohol in Oxfordshire. The graph below shows how hospital admissions due to alcohol related conditions are rising steeply and the position is worse than last year.*

Figure 14 - Hospital Admissions attributed to Alcohol



* This calculation takes into account health conditions and other causes of admission to hospital (i.e. accidents) that are either wholly or partially attributable to alcohol. The greatest proportion of alcohol related admissions to Oxfordshire hospitals in 2010-2011 related to the following health conditions;

- Breast cancer, Cataracts, Heart rhythm problems, Unspecified chest pain, Urinary tract infections

What Does the Joint Strategic Needs Assessment say about Alcohol?

Last year's report set out the scene fully:
There are two main points to make.
1) The trends in Oxfordshire mirror the national trends well -
All indications are that levels of drinking are gradually rising and that services are expending more and more effort to respond to the results in terms of ill health, accidents and crime.
2) Although the trend is going up, on the whole, Oxfordshire's levels are better than the England average.
In short, we do have a big problem to deal with even though other's have it worse.

Is This Still a Priority for Oxfordshire?

This topic *SHOULD* be a priority for Oxfordshire and the real solution is through prevention - that means persuading people of all ages to drink sensibly.

However, it is often said that “there is a tide in the affairs of men”, and all the indications are that society as a whole is not yet ready to hear this message. It is highly unlikely that in the current climate the public sector can push back against the wave of cheap booze, relaxed licensing laws and a culture which subtly condones drinking.
As with the early years of public awareness campaigns regarding smoking and seat-belt legislation, the public are not yet prepared to hear the 'prevention' message when it comes to alcohol. It is even more of a tricky issue because, unlike smoking, alcohol in modest doses causes minimal harm, and it is also deeply embedded in social activity…. But then, 20 years ago so was smoking…….

This leaves us with a two-edged strategy:
1) Do what we can to chip away at public attitudes which support drinking to excess through education of all age groups.
2) In the meantime continue to apply sticking plaster to the symptoms through 'harm minimisation' approaches.

We are good at harm minimisation in Oxfordshire and we should be proud of what our blue-light services have achieved working with Local Authorities, the NHS and other partners. Some of the good work done is showcased in the next section.

What Progress has been made Against Recommendations in the Previous Four Annual reports?

Last year's recommendation was a clarion call to strengthen our harm minimisation strategy for Oxfordshire. This has been achieved well. A new strategy is in place and it is being actioned by a well-organised strategy group working across many organisations.

Here are 3 priority areas giving examples of good progress:

1. Community safety
   - Violent crime rates have continued to fall and our cities and town centres are safer. Latest figures for July – Sept 2011 show a decrease of 23% in the number of violent crimes compared with the same three months last year. This is a total of 169 fewer crimes just in those 3 months. The City had the biggest reduction, with 104 fewer violent crimes than in this period last year. This continues a long term trend for falling crime rates across the County. In addition, offering targeted advice to the most vulnerable people in A&E who are injured because of their drinking people has shown a 70% reduction in repeat attendances. The advice is offered to those who have already attended A&E several times and everyone aged under 18 with alcohol related conditions.
2. Health
   - Comprehensive guidelines have been produced for GPs and other practitioners to help with offering advice or referral for help to reduce alcohol related harm. The first step is to use a simple set of questions to get an idea of alcohol intake and then the practitioner can offer help and support accordingly.
3. Children and Young People
   - Lesson plans and follow-up activities for the school curriculum are available for teachers so that the issue of alcohol can be raised for discussion with young people. Work is also underway to help young carers whose parents may be misusing alcohol.

Recommendations

1. Strategic Priority of this topic

By March 2012 the Oxfordshire Community Safety Partnership and The Oxfordshire Drug and Alcohol Action Team should confirm the Alcohol prevention and harm minimisation remain priorities. Within this framework, the multi-agency approach of the Alcohol Strategy Group must be maintained and continually developed.

2. Strategic Alignment and clarity of who-does what

By March 2012, the Oxfordshire Community Safety Partnership and the Oxfordshire Health and Wellbeing Board should have reached agreement that the Oxfordshire Community Safety Partnership will take a lead role on setting outcome measures for alcohol and achieving progress. This progress should be reported to the Oxfordshire Health and Wellbeing Board via its Health Improvement Board.

3. Prevention and Education

By June 2012 an authoritative 'set' of public messages should be widely used throughout Oxfordshire tailored to different audiences, to help people to understand the personal implications of drinking alcohol. This is intended to help people make their own informed choices. These messages should be planned and promulgated through the Oxfordshire Community Safety Partnership working with Oxfordshire's Public Health Team.

4. Harm Minimisation

By June 2012 work the Oxfordshire Community Safety Partnership should conclude work with the Oxfordshire Clinical Commissioning Group to find the best means to develop the offer of brief advice through primary care and other settings, not just targeting those who are drinking at harmful levels but also using the AUDIT screening tool to help everyone understand their current level of drinking and whether there is reason to be concerned.

5. Moving gradually 'upstream' from harm minimisation towards prevention

By June 2012, the Oxfordshire Community Safety Partnership should ensure that essential reactive services are maintained to minimise alcohol related harm, (for example, through Nightsafe initiatives), **And** continue to move towards prevention in all this work. Specific plans should be drawn up to enhance the preventive element of all harm minimisation programmes. Examples of these approaches are:

- Promoting the work of Street Pastors who provide an important preventive element in keeping the night time economy safe.
- Finding new ways of reducing under-age sales.
- Enforcing licensing conditions.

Chapter 6 - Fighting Killer Diseases

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

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

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

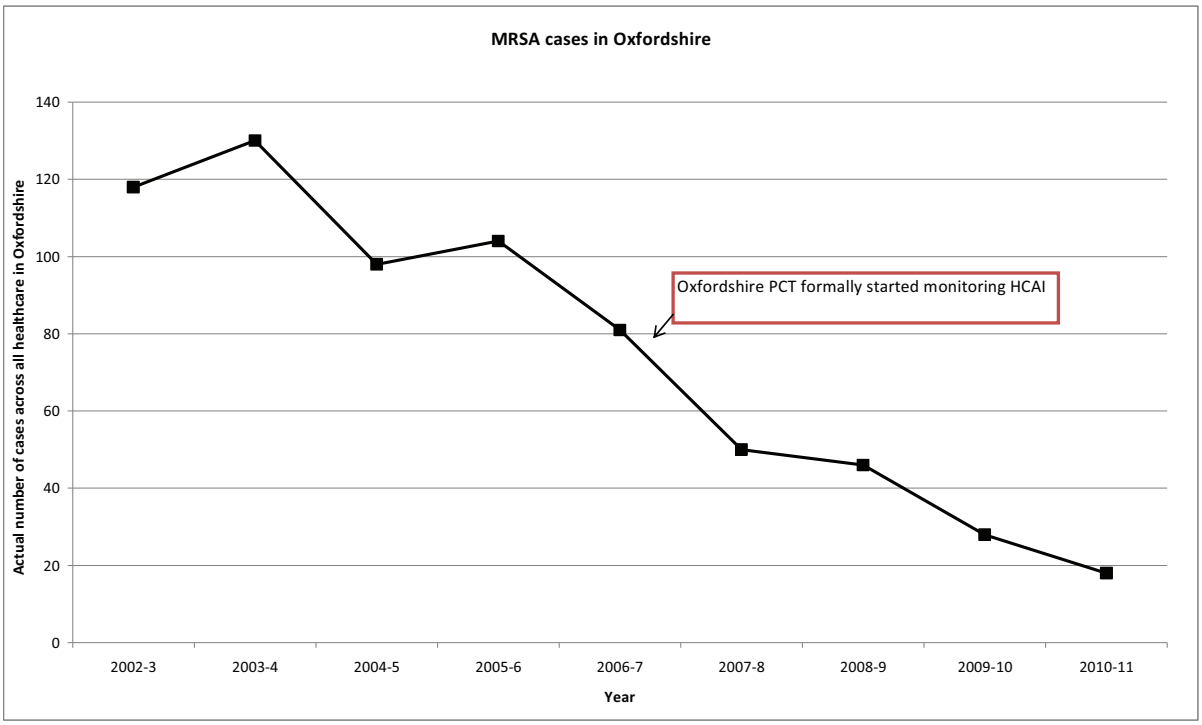
1. Health Care Associated Infections (HCAIs)

Infections caused by superbugs like Methicillin Resistant *Staphylococcus Aureus* (MRSA) and *Clostridium difficile* (*C.diff*.) remain an important cause of sickness and death, both in hospitals and in the community. However numbers of infections **can and have been** reduced through considerable focussed effort in this County.

a) Methicillin Resistant Staphylococcus Aureus (MRSA)

MRSA is a bacterium found commonly on the skin. If it gains entry into the blood stream (e.g. through invasive procedures or chronic wounds) it can cause blood poisoning (bacteraemias). It can be difficult to treat in people who are already very unwell so we continue to look for the causes of the infection and to identify measures to further reduce our numbers. The reduction in MRSA bacteraemia continued its downward trend seen since 2002-3. **This is an impressive achievement for healthcare in Oxfordshire**. Success has been due to improved detection, improved cleanliness, improved clinical procedures, focussed management action and strict surveillance.

Figure 15 - MRSA cases in Oxfordshire

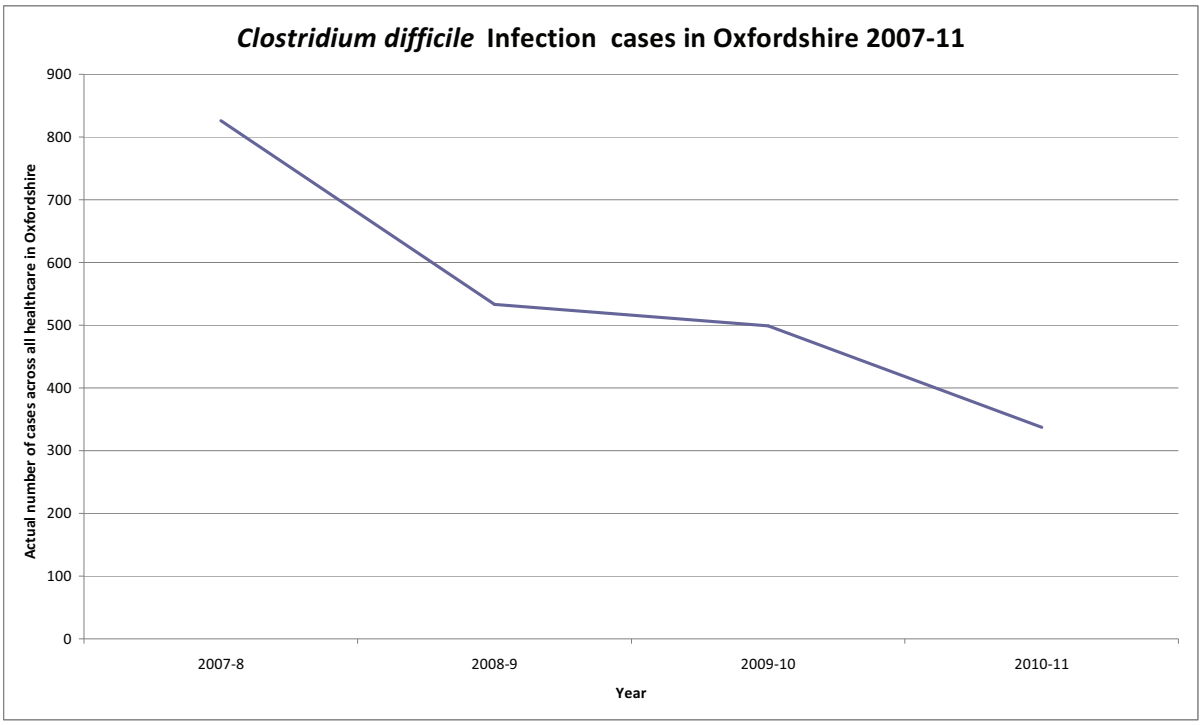


b) *Clostridium difficile* (*C.diff*)

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

A focussed approach on the prevention of this infection is resulting in a steady reduction in cases since 2007/08.

Figure 16 - Clostridium Difficile Infections in Oxfordshire



Work continues in the Oxfordshire health economy to reduce inappropriate antibiotic use, and in healthcare settings improve the speed of isolation of suspected cases and cleanliness of the environment.

2. Tuberculosis (TB) in Oxfordshire

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

In Oxfordshire, the number of cases of TB in 2010 was 61 (28 with lung disease and 33 with other TB). The small increase in numbers in 2010 is related to our success in identifying TB in non-UK born population rather than as a threat to the Public Health.

Figure 17 - Tuberculosis incidence rate in Oxfordshire

Year	Number of Cases	Rate per 100,000 population
2006	53	8.4
2007	76	12
2008	56	8.8
2009	55	8.6
2010	61	9.5

Over the past 4 years the rates of new cases occurring, and the number of cases, has remained highest in Oxford City and Cherwell District Council. The county average rate for new cases is consistently lower than the UK rate. **This is a good achievement.**

Figure 18 - TB incidence rate by Local Authority, Oxfordshire, 2010

Local Authority	Cases	Population	Rate per 100,000 population
Cherwell	14	139,200	10.1
Oxford	32	149,300	21.4
South Oxfordshire	4	130,600	3.1
Vale of White Horse	6	118,700	5.1
West Oxfordshire	5	102,500	4.9
UK			13.9

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

The Chief Medical Officer has set local services a target of recording all TB cases and completing successful treatment in 85% of cases. Oxfordshire's successful treatment rates have risen to 94.5% in 2009 (above the Thames Valley average) compared with 84.2% in 2007 and 89.3% in 2008. High completion rates are an important indicator of good control. This year has seen the TB service introduce an even greater degree of accessibility helping improve the response times to TB.

3. Other Diseases Preventable by Immunisation

a) Childhood immunisations

Immunisation is the most cost-effective medical public health intervention. Levels of immunisation for childhood diseases in Oxfordshire continue to improve, with uptake now amongst the highest levels in the country. The work which has been on-going around data collection and record keeping, involving general practice, community and PCT staff, is resulting in more children being fully immunised.

The new Child Health Information System which went 'live' in mid February 2010 is an absolutely essential tool for keeping information accurate and quality high. The small number of children who are not immunised can now be followed up individually and offered immunisation.

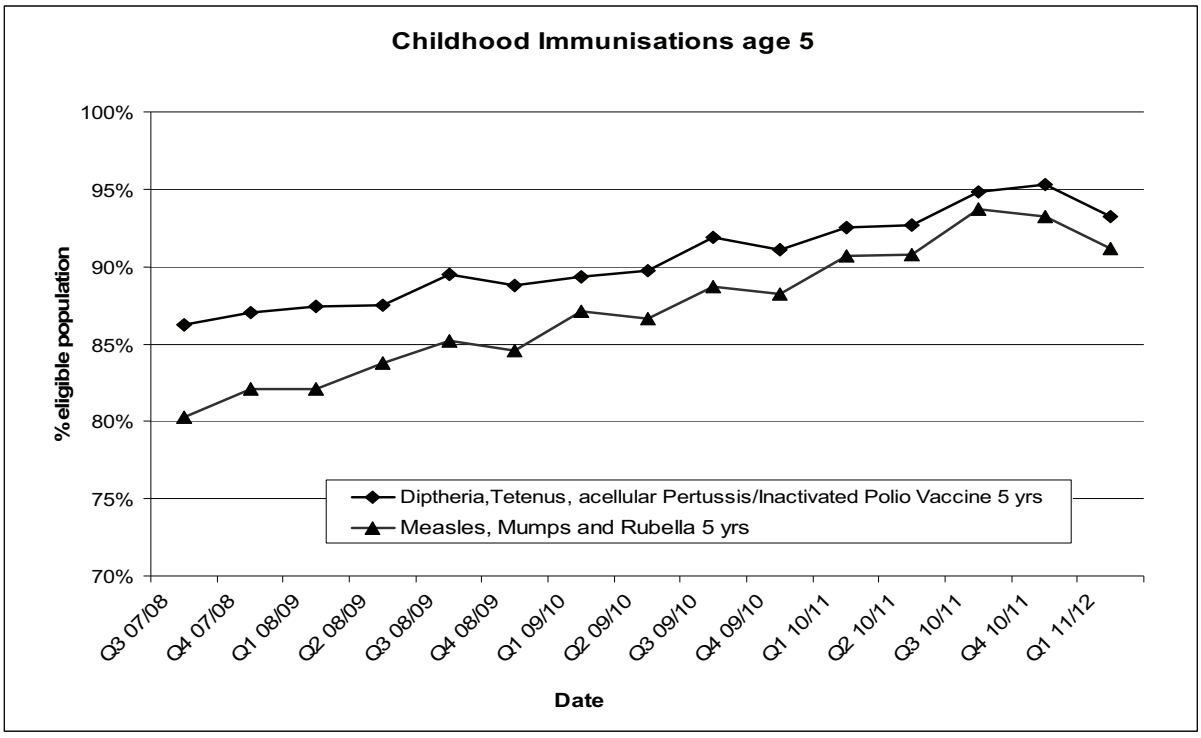
b) Measles Mumps and Rubella vaccine (MMR)

Uptake of this immunisation has risen by 6% over the last year and Oxfordshire's levels are the best in the Region. The importance of this is underlined by considering measles as an example:

In the absence of vaccination there would be approximately 8,000 cases of measles per year on average in Oxfordshire. Of these, approximately 40 people would suffer convulsions as a complication, 8 encephalitis and an average of 1 person per year would die.

The chart below shows the good success we have had in Oxfordshire overall in immunising our children against measles, mumps, rubella, diphtheria tetanus and polio. We will need to ensure that the downturn in the last quarter's data is reversed.

Figure 19 - Childhood Immunisations



c) Human Papilloma Virus vaccine (HPV): preventing cervical cancer

The problem with human papilloma virus (HPV) is that it may go on to cause cervical cancers. It is so common that at least 50% of sexually active men and women get it at some point in their lives although only a handful of the women affected go on to develop cervical cancer.

There is no treatment for the virus itself but a highly effective vaccine is available that protects against HPV types 16 and 18, the types most which between them cause over 70% of all cervical cancers. **HPV vaccination will save the lives of an estimated 400 women each year in the UK with 4 lives saved per year in Oxfordshire.**

We are currently immunising the 3rd cohort of girls with HPV vaccination – these were students in school year 8 during 2010/11 – the uptake for the whole course of 3 injections is expected to be at least 90% in this age group. The catch up programme, offering HPV to all girls up to the age of 18 years, took place during the academic year 2009/10.

This new vaccine is a significant step forward in the prevention of cancer.

4. Sexually transmitted infections

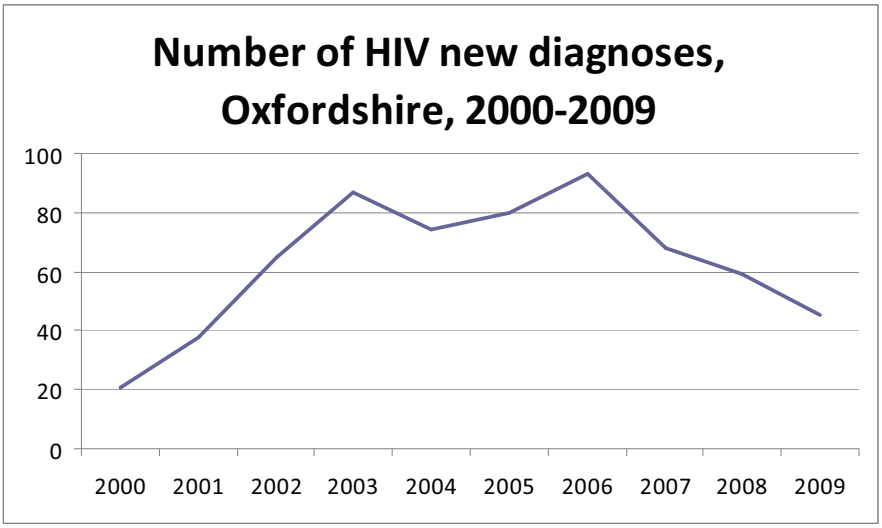
a) HIV & AIDS

HIV continues to be one of the most important communicable diseases in the UK. It is an infection associated with serious morbidity, high costs of treatment and care, and significant mortality.

It affects men and women, straight and gay, can be acquired in the UK or abroad and the best form of protection is still through 'safer sex' techniques.

In 2009, there were 214 new diagnoses of HIV in Thames Valley which is a 19% reduction from 2008. This is a good result. Of these new diagnoses 45 were new HIV diagnoses in Oxfordshire. The Oxfordshire figures continue to fall. We continue to work in partnership to get the prevention message across.

Figure 20 - Number of new HIV diagnosis reported in Oxfordshire, 2000-2009

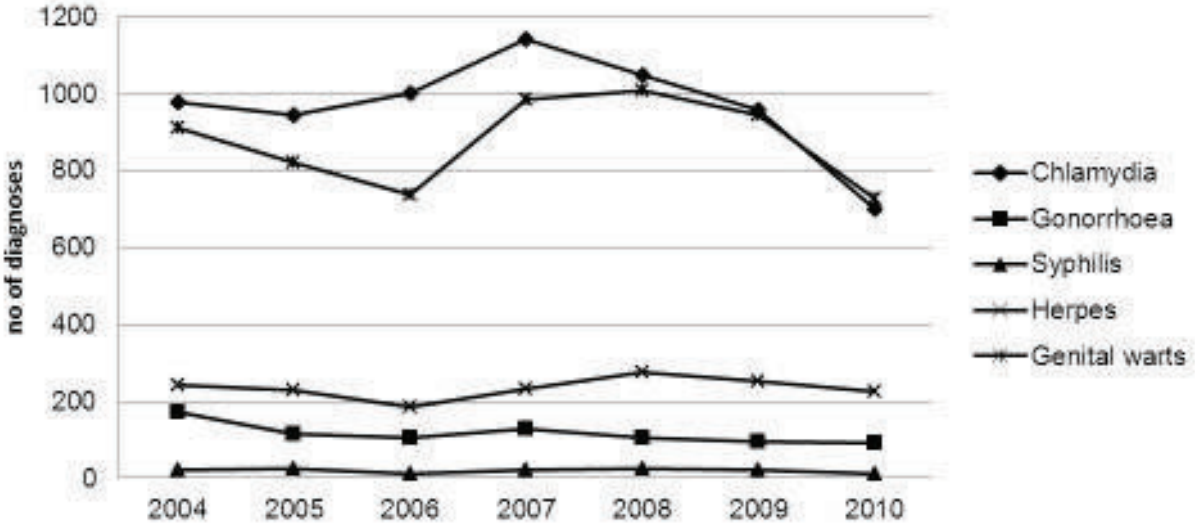


b) Sexual Health

It is important to monitor sexually transmitted diseases carefully to watch for increases in disease, the vast majority of which are preventable through taking basic 'safe sex' precautions. This is an important area to address because if Sexually Transmitted diseases are left undetected and untreated they may result in serious complications such as infertility in later life.

It is heartening to see that all the major sexually transmitted diseases fell during the last year. Chlamydia and genital warts remain the most common although there have been decreases in Chlamydia cases over both 2008 and 2009 from a highpoint in 2007.

Figure 21 - Diagnosed sexually transmitted infections for Oxfordshire residents 2004-2010



Is Fighting Killer Diseases Still a Priority for Oxfordshire?

Improved surveillance and good teamwork with the Health Protection Agency mean that all the major killer infectious diseases are in decline…...for now.

However, this is a trend that can quickly be reversed and it is imperative that we remain vigilant to the threats posed by new diseases emerging, old diseases developing resistance to treatment and peoples behaviour becoming more risky.

Killer communicable diseases are well managed in Oxfordshire but remain an ever-present threat. Constant vigilance is required and careful management will give us the best chance to keep these infections at bay.

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

What Progress has been made Against Recommendations in the Previous Four Annual reports?

All the recommendations from the previous DPH annual reports have been met. Services, surveillance and management of diseases have been steadily improving over the last 4 years.

Recommendations

1. Maintain vigilance and priority during reorganisation
The Director of Public Health and the local Health Protection Agency must work closely during the forthcoming national reorganisation of public health services to maintain surveillance of communicable diseases during 2011/12/13 and take appropriate steps to control these diseases and any new emerging killer diseases.

2. The need to Report on these figures in Public
The Director of Public Health should report on killer infections and infectious diseases in subsequent annual reports.

Documents and Sources of Information used to produce this Report

Joint Strategic Needs Assessment versions 1 - 4
Public Health Surveillance dashboard
Health Protection Agency Infectious Disease data
Oxfordshire Safer Communities Partnerships Alcohol Strategy Group basket of indicators for Oxfordshire
The Child Poverty Needs Assessment for Oxfordshire
Oxfordshire Children and Young Peoples plan indicators
Oxfordshire PCT Performance data
GP Consortia Information packs – March 2011
Learned journals
Data from Govt Departments
Oxfordshire safer communities safer communities partnership performance framework

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Proposed Outcome Measures and Target Indicators for Adult Health and Social Care Partnership Board

The overall goal of the Adult Health and Social Care Partnership Board is to:

- Ensure people can access the health and social care they need as simply as possible
- Support people to live independently and with dignity to reach their full potential
- Improve outcomes for adults who are most likely to need support
- Promote better financial management and greater efficiency

Priority 1 – Integration of health and social care

Closer integration of health and social care has been a recurrent goal of public policy for at least the past 40 years. Different solutions have been proposed including full structural integration into a single system. Other models are geared to overcome barriers and facilitate closer joint working and sharing of resources to give a seamless service. The successful integration of health and social care offers three potential benefits[1]:

- Better outcomes for people, e.g. living independently at home with maximum choice and control
- More efficient use of existing resources and a reduction in the demand on expensive health and social care services by avoiding duplication and ensuring people receive the right care, in the right place at the right time
- Improve access to, experience of, and satisfaction with, health and social care services

Politicians and the Oxfordshire Clinical Commissioning group have made clear their commitment to the integration of health and social care and it's what the public want.[2] In the context of intense financial and demographic challenges facing both services integration offers opportunities to improve outcomes for people and use of resources for organisations.

A key priority is to support carers to have a high quality of life and enable them to continue to care for their family and friends for as long as possible as this is important to them. In 2009 we surveyed 1500 carers, 80% of who said their quality of life was good or acceptable. In 2012/13 there will be a national survey of carers. This will give us a useful benchmark and in future years we will look to improve quality of life. Carers tell us that having a break from their caring role is key to enabling them to continue caring. As such we have initiated a joint health and social care funded scheme which provides direct payments for carers from GPs.

[1] The Kings Fund – Integrating Health and Social Care

[2] "achieving integrated care would be the biggest contribution that health and social care services could make to improving quality and safety" (National Voices 2011)

This suggests that outcomes for Priority 1 should be:

Outcomes for Priority 1	Key Indicator definitions for Priority 1
• Single point of access to fully functioning integrated health and social care community services • Ensure overall satisfaction of people and their carers across health and social care system • Increase the number of carers breaks funded jointly and accessed via the GP • Clinical Commissioning Group formally established	• Fully functioning integrated health and social care community services teams established with a single point of access • Older peoples commissioning strategy agreed • Section 75 pooled budget agreement • Satisfaction of people who use services with their care and support • Patient experience of primary care • Establish a baseline for measuring carer satisfaction • Carers breaks jointly funded and accessed via the GP through a direct payment • Clinical Commissioning Group authorised

Making a real difference in Oxfordshire

If we accept these priorities, the Health and Wellbeing Board in 2012/13 should aim to achieve:

- **a single point of access to fully functioning integrated health and social care community services provided by Oxfordshire County Council and Oxford Health NHS Foundation Trust by 31st August 2012**
- **a single Section 75 agreement to cover all the pooled budget arrangements by September 2012**
- **an interim older peoples commissioning strategy will be implemented by the County Council in April 2012. The intention is to develop a joint older peoples commissioning strategy and joint commissioning arrangements by December 2012 – joint strategy / pooled budget arrangements / lead commissioner**
- **Clinical Commissioning Group authorised by April 2013**
- **More than 60% of people who use social care services in Oxfordshire will say they are very satisfied with their care and support**
- **a baseline for measuring carer satisfaction**
- **More than 51% of people are 'very satisfied' with their GP surgery**
- **800 more carers breaks jointly funded and accessed via GPs**

Priority 2 – Support older people to live independently with dignity by reducing the need for care and support

Ensuing that people can live independently in their own homes is key to the quality of life they can enjoy and it's what people say they want. A key concern raised by older people is that they are "supported to access a range of networks, relationships and activities to maximise independence, health and well-being and community connections (including public health)."[3]

[3] http://www.thinklocalactpersonal.org.uk/_library/Resources/Personalisation/TLAP/MakingItReal.pdf Page 7

The issue of dignity in care is high on the national and local agenda. The NHS Confederation states that the overarching commitment to dignity in care is to help keep us physically and mentally well, to involve us in decisions about our care, to help us get better when we are ill and, when we cannot fully recover, to stay as well as we can and live as independently as we can until the end of our lives. [4]

In 2011/12 we have the highest level of delayed transfers of care in the country. The last published figure for delayed transfers of care in Oxfordshire was 176 (January 2012). A key priority is to improve performance significantly through the work overseen by the 'Appropriate Care for Everyone' programme which brings together the Clinical Commissioning Group, the County Council and the two key NHS providers – Oxfordshire University Hospitals Trust and Oxford Health.

In part, due to the pressures of delayed transfers of care, in the first 10 months of 2011/12, 437 people have been placed in permanent care home placements. This is 15% higher than the corresponding period in 2010/1, and includes a 45% increase in admissions direct from hospitals. In line with its demographic profile Oxfordshire admits relatively few people into care homes; however people who are admitted live in care homes for longer. The Oxfordshire Director of Public Health in his annual report said that the proportion of older people in the population continues to increase, which means that every pound spent from the public purse has further to go. Therefore we wish to support people in the community for longer and ensure that the number of people admitted to care homes does not increase.

A key demographic issue is the growth of people with dementia. This group of people need services provided by appropriately skilled staff, delivered in the right environment. To enable us to develop better services we need to increase the rate of diagnosis of dementia which currently stands at 37.8% (South Central SHA 2011 average is 41.4%) of the expected rate. We would look to increase this to 50%; this would take us above the national average.

To reduce delayed transfers of care and ensure people achieve greater independence and need less expensive care and support or no care at all, we will offer more people a reablement service and look to improve the efficiency of the service. In the first 10 months of 2011/12 1561 people started reablement and 44% of those who completed the service needed no on-going long term care. Local analysis of demand identifies that over 3000 people per year, and national evidence from the department of health indicates that over 50% should need no on-going care. Reablement is defined as "services for people with poor physical or mental health to help them accommodate their illness (or condition) by learning or re-learning the skills necessary for daily living" [5]

A key way people are supported to remain independent is through good quality information and advice. In an national survey 55% of social care service users said that they found information 'very' or 'fairly' easy to find. In Oxfordshire this figure was 53%, and amongst older people 52%.

The outcomes we have chosen to measure our progress are as follows:

[4] http://www.nhsconfed.org/Documents/dignity.pdf page 10

[5] http://www.csed.dh.gov.uk/homeCareReablement/Toolkit/vision/#item2

Outcomes for priority 2	Key Indicator definitions for priority 2
• Reduce people who are in a hospital bed who are medically fit for discharge • Ensure the number of older people permanently admitted to care homes does not increase • Increase our knowledge of who has dementia and what services they are receiving • Increase the number of people receiving a reablement service and increase the proportion of them who need no on-going care at the end of the service • Increase the proportion of people, including carers, who say that they find information easy to find.	• Average number of Oxfordshire residents who are in a hospital bed who are medically fit for transfer • Number of older people permanently admitted to care homes • % of people diagnosed with dementia • Number of people who start the reablement service • % of people who leave the reablement service who need no on-going care. • % of older people who use services who find information easy to find.

Making a Real difference in Oxfordshire
If we accept these priorities, the Health and Wellbeing Board in 2012/13 should aim to achieve:

- **a reduction in delayed transfers of care so that Oxfordshire's performance is out of the bottom quarter**
- **No more than 400 older people permanently admitted to a care home**
- **50% of the expected population with dementia will have a recorded diagnosis**
- **3250 people will receive a reablement service**
- **55% of the people completing the reablement service will be completely reabled and need no on-going care**
- **55% of older people who use adult social care say that they find information very or fairly easy to find**

Priority 3 – Living and working well:
Adults with long-term conditions, physical or learning disability or mental health problems living independently and achieving their full potential

Adults living with physical disability, learning disability, severe mental illness or another disabling long-term condition consistently tell us that they want to be independent, to have choice and control, and to be able to live "ordinary lives" as fully participating members of the wider community.

Consistently national and local strategy development tells us that people define the ability to live ordinary lives in terms of:[6]

- Improved access to information that supports choice and control
- improved access to responsive housing and support
- Improved access to employment, study, meaningful activity and involvement in the community and wider public life

[6] *No Health without Mental Health,* the *Sayce Review*; *Better Mental Health in Oxfordshire, Promoting Independence, a commissioning strategy for people with a physical Disability 2010-15*

- Responsive, coherent services that help people self-manage their care, but flex to provide support as people's needs vary
- Improved support for carers, to help them help the people they care for live as independently as possible

The closer we get to meeting these aspirations the more people will meet their full potential and move towards independence. The outcomes we have chosen to measure our progress are as follows:

Outcomes for priority 3	Key Indicator definitions for priority 3
• Increase the proportion of adults of working age who use services who find it easy to find information • Increase employment of people in contact with secondary mental health services • Increase the proportion of people with a long-term condition who feel able to manage their condition • Increase the proportion of people with learning disabilities and severe mental illness receiving annual health checks	• Number of service users (adults of working age) who find information easily • Number of people receiving mental health service in paid employment at the time of their most recent assessment/review • % of people with a long-term condition who have sufficient support from local services to manage their condition • % of people diagnosed with severe mental illness or a learning disability having an annual health check from their GP

Making a Real difference in Oxfordshire.
If we accept these priorities, the Health and Wellbeing Board in 2012/13 should aim to achieve:

- **55% of working age adults who use adult social care say that they find information very or fairly easy to find**
- **15% of people with severe mental illness using secondary mental health services are in employment**
- **95% of people with a long-term condition will feel able to manage their condition**
- **95% of people living with severe mental illness will have an annual physical health check by their GP**
- **50% of people with learning disabilities will have an annual physical health check by their GP**

Annex 1 Adult Health and Social Care Partnership Board full list of measures

This report identifies the key measures that health and social care can work on together to improve outcomes for people. The list below identifies all of the measures that the Adult Health and Social Care Board would like to monitor to deliver its key priorities –

Priority 1

- Achievement of key milestones for the delivery of integrated community services teams closer to home

- Milestones for joint commissioning arrangements and Clinical Commissioning Group will be met
- (maintain) the overall satisfaction of people who use services with their care and support
- (maintain) overall satisfaction of carers with social services
- (maintain) patient experience of primary care

Priority 2

- (reduce) emergency admissions for acute conditions that should not usually require hospital admission broken down by GP
- (improve) recovery from stroke
- (reduce) emergency admissions within 30 days of discharge from hospital
- (reduce) permanent admissions to care homes
- (reduce) delayed transfers of care
- (increase) the proportion of people who use services and carers who find it easy to find information
- (increase) carer reported quality of life
- (increase) the amount of spending on personal budgets which supports people in their own home
- (improve) Older people's perception of community safety
- (reduce) Falls and injuries in the over 65's
- (reduce) Hip fractures in over 65's
- (reduce) Excess winter deaths
- (reduce) the impacts of dementia
- (increase) efficiency & effectiveness of the reablement service
- (improve) the experience of health care for people at the end of their lives

Priority 3

- (increase) the proportion of people who use services or who care for them who find it easy to find information about support
- (increase) proportion of people feeling supported to manage their own condition
- (increase) proportion of adults with learning disabilities who live in their own home or with their family
- (increase) proportion of adults in contact with acute mental health services who live independently with or without support
- (increase) employment of people with long term conditions, learning disabilities or in contact with secondary mental health services
- (increase) the proportion of people receiving talking therapies
- (reduce) unplanned hospitalisation for chronic conditions
- (increase) the number of acute mental health inpatient admissions that have been gate kept by the Crisis team
- (increase) proportion of people using social care who receive self directed support and those receiving direct payments
- (increase) the proportion of people who use services who feel safe
- (increase) carer reported quality of life
- (increase) the proportion of people with learning disabilities and severe mental illness receiving annual health checks

Informal Shadow Oxfordshire Health & Wellbeing Board
22 March 2012

Proposed Outcome Measures and Target Indicators for the Children and Young People's Board

The overall goal of the Children and Young People's Board is to improve outcomes for all children and young people living in Oxfordshire. This will be achieved through delivery of the four top priorities:

1. Keeping all children and young people safe
2. Raising achievement for all children and young people
3. Narrowing the gap for our most disadvantaged and vulnerable groups
4. Having a healthy start in life and staying healthy into adulthood

Priority 1: Keeping all children and young people safe

Safeguarding children is everyone's business. In order to for children to achieve outcomes in any other areas they need to be safe and secure. Many different agencies are working together to make the child's journey from needing help to receiving help as quick and easy as possible; and improving the effectiveness of the help in promoting the child's safety and development. Practitioners in all agencies work to prevent, identify and protect children living in abusive and neglectful situations. There is excellent multi-agency work around domestic abuse and reducing the impact on children. In Oxfordshire the Safeguarding Children Board runs a multi-agency training programme to support the whole workforce working with children and young people. The Board also provides evidence-based guidance to help practitioners and the Board challenges the different agencies to deliver services to the highest standards.

We know that nationally more children are becoming subject of Child Protection Plans. The 0-4 year olds are the largest single age group subject to plans and in Oxfordshire we have the high rates of children subject to plans, compared to previous years. Despite this we have good performance in responding and assessing children's needs without delay, in line with national best practice. Work to address this priority must continue to focus on promoting good partnership working with families by well-trained and supported workers from a range of professions. The professionals must have the skills, capacity and resources to deliver effective and appropriate interventions to keep children safe. There needs to be public confidence that the system responds promptly and appropriately to all levels of concern. Managers and senior officers must have established methods of appraising the quality of the practice with children and families so that they can lead their organisations in continuous improvement.

There is strong evidence that positive attachment between mother and baby starts in pregnancy and promoting attachment from pregnancy onwards and intervening early where problems are identified, is a key multi-agency priority. Equally, for older children and teenagers, it is vital that they and their families are able to receive help at an early stage as difficulties are merging, so that they are protected from serious problems later on. Early intervention services such as the Children's Centres, Early Intervention hubs and the Health Visiting service are key players in keeping children safe. This means commissioning and delivering services that are evidence based, affordable, timely and focused on early intervention.

Outcomes for Priority 1[1]	Indicator definitions for Priority 1
• Decrease the proportion of child subject to repeat child protection plans	• Percentage of child subject to repeat child protection plans
• Be able to evidence that the majority of interventions are of an adequate, good or outstanding quality[2]	• Quality assurance audit reports from agencies reported and reviewed in OSCB

Making a real difference in Oxfordshire

In accepting these priorities the Health and Wellbeing Board in 2012/13 should aim to achieve:

- **No more than 15% of children who become subject to a child protection plan have previously had a plan.**
- **A regular pattern of quality assurance audits undertaken in the following agencies and reviewed through the OSCB: children's social care; children and adult health services; early intervention; police. Over 50% of interventions showing adequate, or above, overall impact in all agencies' audit reports.**

Priority 2: Raising achievement for all children and young people

In Oxfordshire measures of achievement are often lower than expected and do not match statistical neighbours. In 2011 GCSE results were disappointing.

[1] These are currently *interim* outcomes and indicators until the national consultation on Safeguarding Indicators is completed.
[2] London Safeguarding Children Board multi-agency audit and grading toolkit

The overall picture is a slow pace of improvement, but there is inconsistency between Districts for certain groups and subjects. Early Years shows a better than national average improvement which could be built upon. We know that specific pupil groups in Oxfordshire do not do as well as their peers in comparator authorities. This includes children on free school meals, children from Black and Minority Ethnic Groups and those with special education needs. There is currently specific concern about reading standards at Key Stage 1 in some school.

The Health and Wellbeing Board will aspire to seeing every single child being successful and reaching their potential; thriving in an outstanding learning environment throughout their education wherever they live across the county. Every single school or setting will be judged to be at least good and be aspiring to constantly improve, to become and remain outstanding.

Outcomes for Priority 2	Indicator definitions for Priority 2
• Increase the number of young people achieving 5 GCSE A*-C (including English and Maths).	• Percentage of young people achieving 5 GCSEs at A*-C, including in English and Maths.
• Increase attainment at Key Stage 2.	• Percentage of children attaining at least Level 4 in English and Maths at Key Stage 2
• Increase attainment in literacy at Key Stage 1.	• Percentage of children attaining 2b or above in reading at Key Stage 1.
• Increase the number of schools judged as “good” or “outstanding”	• Ofsted inspection ratings for primary schools. • Ofsted inspection ratings for secondary schools.

Making a real difference in Oxfordshire

In accepting this priority the Health and Wellbeing Board, in 2012/13 should agree to:

- **63% (3900 young people) of young people achieve 5 GCSEs at A*-C including English and maths (currently 57.4%)**
- **80% (4880 young people) of children achieve Level 4 or above in English and maths at the end of Key Stage 2 (currently 74.8%)**

- **76% (5000 children) children achieve Level 2b or above in reading at the end of Key Stage 1 (currently 74.3%.)**
- **Reduce the number of young people not in education, employment or training to 5.5% (950 young people)**
- **88% (204) primary schools and 86% (28) secondary schools with be judged by Ofsted to be good or outstanding.**

Priority 3: Narrowing the gap for our most disadvantaged and vulnerable groups

Over the past three years there has been a real multi-agency focus on 'breaking the cycle of deprivation for families' and on 'narrowing the gap for vulnerable children', driven by national and local priorities. The Health and Wellbeing Board is in a good position to understand the picture in Oxfordshire through the Joint Strategic Needs Assessment (JSNA) and more recently through specific needs assessments e.g. Child Poverty Needs Assessment 2011 and the Director of Public Health's Annual Report 2012.

Through this work we know that:

- There are a relatively small number of wards with persistent deprivation
- 11.7% children live in poverty in Oxfordshire
- Almost 1 in 4 children in Oxford City are living in poverty
- In Oxfordshire 73% of children in poverty are in lone parent families.
- In 2011 only 22% children on Free School Meals achieved 5 or more A*-C GCSEs.

We know that being pregnant under 18 years of age will result in a number of poor outcomes for young women and indeed for their babies, therefore the drive to decrease the trend in conceptions year on year is crucial. More recently the national focus has been on working with 'Troubled Families' in order to reduce worklessness, reduce antisocial behaviour and crime, increase school attendance and reduce the cost of interventions in the longer term. In Oxfordshire it is estimated that there are 810 families who have multiple and complex issues and a Project Team is currently working to identify these. The DCLG[3] have yet to publish the proposed framework for identification of success measures but addressing the needs of these families will be a multi-agency priority during 2012/13

Action to address this priority is cross cutting with both the Adult Health and Social Care Board and the Health Improvement Board. However, taken together it is proposed that addressing teenage conceptions and turning around the lives of troubled families are the two areas that will make a significant impact on this priority in the next year.

[3] Department for Communities and Local Government who lead the national Troubled Families Programme.

Outcomes for Priority 3	Indicator definitions for Priority 3
• Reduce the number of teenage conceptions	• Teenage conceptions rates.
• Turning around the lives of 'Troubled Families'.	• Awaiting confirmation from DCLG[4]

Making a real difference in Oxfordshire

In accepting this priority the Health and Wellbeing Board in 2012/13 should aim to achieve:

- **A sustainable decrease in the teenage conception rate[5]**
- **Targets as required in the new DCLG framework when published**

Priority 4: All children have a healthy start in life and stay healthy into adulthood.

The JSNA shows that overall Oxfordshire is one of the healthiest counties in the country to be born and grow up. Despite this, death rates in socially deprived wards are higher than in affluent areas. Young people being admitted to hospital for self-harm (including ingestions and poisoning) remain a cause for concern. Emergency admission rates to hospital are higher for young children living in wards with high levels of deprivation, especially for viral infections and gastroenteritis. Breastfeeding rates in Oxford and Banbury remain significantly lower than the rest of Oxfordshire. By Year 6, obesity levels in children living in Oxford City are significantly higher than the national average.

An increasing number of young people with longer term or life limiting conditions (such as Autistic Spectrum Conditions or neurological disease) will need to continue receiving care and support into adulthood. We know that the most common causes of emergency admission to hospital for young children (under 5) are respiratory tract infections, viral infections and gastroenteritis. The most common causes of emergency admission for young people (11-17 years old) remains ingestions and poisoning (both alcohol and drug related).

[4] The indicators will be based on the national performance framework for Troubled Families.
[5] Further work needed on understand how the HWB Board can measure progress when data is released with a 14 month delay.

In order to build on the healthy start, the Health and Wellbeing Board will aspire to see that all pregnant women will have access to high quality maternity services and a choice of place of delivery; home' birthing unit or hospital. All children will have access to the full Healthy Child Programme from birth to school entry. Parents will be able to access a wide range of integrated early intervention services. Children with additional needs (including long-term conditions, life limiting conditions and special educational needs) will experience seamless provision from diagnosis, treatment and care, therapy and schooling. There will be easy access to mental health support and where required, diagnosis and treatment (including for Autistic Spectrum Disorder). There will be targeted and specialist services available for the most vulnerable children e.g. Looked After Children. Sick children will be treated as close to home as possible and only be admitted to hospital when clinically needed.

Outcomes for Priority 4	Indicator definitions for Priority 4
• Reducing admission to hospital of young children with respiratory tract infections, viral infections and gastroenteritis. • Reducing number of young people who self-harm. • Effective transition services for young people with mental health problems	• Rate of hospital admissions for young children (0-4 years) with infections and gastroenteritis. • Rate of hospital admission for young people who have self-harmed • New service specification agreed

Making a Real Difference in Oxfordshire

This is a key priority where join up with the work of the Health Improvement Board is essential. High rates of immunisation, continuation of breastfeeding at 6-8 weeks and reducing obesity levels in school children are all important indicators of a healthy start to life and are positive factors in reducing the likelihood of having poor health outcomes in the future.

In order to make a difference in Oxfordshire it is proposed that in 2012/13 the Health and Wellbeing Board should:[6]

- **Reduce the number of young people admitted to hospital for episodes of self-harm by 5% year on year. This means reducing by approximately 10 young people every year.**

- **Reduce the number of young children admitted to hospital with infections by 10% year on year. This means reducing emergency admissions from approximately 3100 to 2890 children.**

- **Review and redesign transition services for young people with mental health problems. This would mean there would be a new service in place from 1st April 2013.**

[6] The targets are numbers for these targets are based on forecast outturn position from Q3 monitoring data and will need to be updated when year end activity is confirmed.

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Informal Shadow Oxfordshire Health & Wellbeing Board
22 March 2012

Proposed Outcome Measures and Target Indicators for Health Improvement Board

The overall goal of the Health Improvement Board (HIB) is to:

- Increased healthy life expectancy
- While reducing differences in life expectancy and healthy life expectancy between communities

Priority 1. Preventing early death and improving quality of life in later years

This priority aims to add years to life and life to years – something we all aspire to. The Joint Strategic Needs Assessment (JSNA) illustrates the local position underpinning this priority.

The biggest killers are heart disease, stroke and cancers. Some of the contributing factors to these diseases are beyond the influence of the individual or of health services – genetics, age and gender, for example. But a wider range of factors can be positively influenced by the lifestyle choices of the individual and early detection through screening.

Work to address this priority must focus on primary prevention (i.e stopping disease before it starts) and early detection of illness. Many of the major causes of illness and early death arise from lifestyle choices such as smoking – still the biggest contributing factor to heart disease, stroke and many cancers. Screening programmes are designed to detect early symptoms of cancers and assess risk of heart disease and stroke. Access to information and high quality services is key, especially for those at higher risk.

This suggest that a major priority for the HIB should be to make sure we are helping people stop smoking, detecting cancer early through screening and checking people for a range of preventable diseases through NHS Health Checks carried out in General Practice.

Outcomes for Priority 1	Indicator definitions for Priority 1
• Increase the number of smoking quitters • Ensure high levels of uptake for cancer screening programmes • Ensure high levels of uptake for NHS Health Checks	• Number of smoking quitters • Cervical screening uptake • Breast screening coverage • Bowel screening coverage • Offer of NHS Health Checks

In addition to this our work must focus on those who are most at risk. The JSNA shows that there are differences between groups of people, with some faring better than others both in terms of their life expectancy and in their chances of living healthy lives into old age. The differences include:

- Women can generally expect to outlive men.
- People living in some parts of the county can expect to live longer. There is variation in life expectancy related to relative deprivation:

- In Cherwell District the gap between the most and least deprived wards is 9.7 yrs for men and 3.6yrs for women
- In the City the gap between the most and least deprived wards is 7.7 yrs for men and 6.5 yrs for women
- For men in deprived parts of South Oxfordshire there is a gap of 3.6 yrs and in West Oxfordshire a gap of 4 yrs.
- There are no differences due to deprivation for women in South or West Oxfordshire
- There are no significant differences in life expectancy by relative deprivation in Vale for either men or women

Not only does deprivation reduce the chance of a long life, it also means people are more likely to be ill for longer periods before death. Local data on levels of a range of diseases show that this is also true in Oxfordshire.

This means that, as well as commissioning services for all, we must also target services at those who need them most.

Making a Real Difference in Oxfordshire.
If we accept these priorities, the Health and Wellbeing Board in 2012/13 should aim to achieve:

- ***100 smoking quitters above the national target.***
  - *The nationally set target for Oxfordshire is approximately 2400 people who quit for at least 4 weeks. The aim is to stretch this target.*
- ***2,000 adults receiving bowel screening for the first time***
  - *This screening is offered to people in their sixties, by post, every 2 years. The aim is to increase awareness and uptake.*
- ***30,000 people invited for Health Checks for the first time***
  - *This check is offered to everyone aged 40 – 74 every 5 years. Invitations are sent from GP practices. The aim is to increase awareness and uptake.*

Priority 2. Preventing chronic disease through tackling obesity

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

Obesity is on the increase in epidemic proportions in our society. Obesity in childhood is hard to shake off in later life and can reduce lifespan by around 9 years. Obesity adds £1m every year to the cost of the NHS in Oxfordshire.

The JSNA shows that there is an upward trend in prevalence of obesity in adults in Oxfordshire, though this is still slightly below the national level. Chronic disease associated with obesity, such as diabetes, is also increasing.

The best ways to tackle obesity are to prevent it, detect it early and take early action, beginning in childhood.

Children in Reception class and Year 6 are weighed and measured every year and results show that around 8% of reception year and 15% of Year 6 children are obese.

This feeds through into every increasing levels of obesity in young adults. Making parents aware of problems early helps them to take action if they choose to.

Levels of obesity are also linked to social deprivation, with more deprived parts of the county showing higher rates of obesity, so some targeting of effort is called for here too.

Physical activity is an important component of maintaining a healthy weight and there is encouragement on this score, with Oxfordshire topping the latest Active People survey as the sportiest and most active county in England. The survey showed that 26% of the population participate in regular activity each week. Maintaining this position will be critical to good health in the County.

Breastfeeding gives the best start to life and has been proven to lead to fewer overweight children and adults. Increasing the number of breastfed babies is the foundation of an obesity strategy for the County. Breastfeeding also brings a host of other benefits such as improved immunity and improved mother-child bonding.

This suggests that outcomes for Priority 2 should be:

Outcomes for priority 2	Indicator definitions for priority 2
• Reduce the number of people who are overweight or obese	• Number of children whose weight is measured • Percentage of children who are obese or overweight at Reception and Year 6 • Breastfeeding initiation and at 6-8 weeks • Proportion of physically active and inactive adults

Making a Real Difference in Oxfordshire.
If we accept these priorities, the Health and Wellbeing Board in 2012/13 should aim to achieve:

- ***Ensure that the obesity level in Year 6 children is held at no more than 15%***
  - *The trend for the number of obese children at year 6 is rising, with 783 children in this category in Oxfordshire in 2011, representing 14.9% of their year group. It is important that this rising trend is halted.*
- ***60% of babies are breastfed at 6-8 weeks of age***
  - *In Oxfordshire almost all babies are breastfed at birth and up to 60% are still breast fed at 6-8 weeks of age, though there are variations in rates that link to deprivation. The national figure for prevalence of breastfeeding at 6-8 weeks in 2011/12 Quarter 3 was 47%. The aim is to narrow inequalities gaps and maintain high rates in Oxfordshire..*
- ***5000 additional physically active adults***
  - *Surveys show that about a quarter of the population undertake physical activity or sport at least 3 times a week (3x30min sessions). The aim is to continue recent increases in participation rates.*

Priority 3. Tackling the broader determinants of health through better housing

The interdependent relationship between health and housing is not new. Since Chadwick established a link between the appalling living conditions of the poor and their ill health in 1842, many of the most significant gains in health that followed stemmed from Local Authority public health measures, such as clean water, sanitation, and reduced exposure to extreme cold. We need to maintain our focus on the contribution that decent housing makes to health improvement and especially on the needs of more vulnerable communities. It is proposed that this priority should address the issue of fuel poverty which affects people across all housing tenures, of all ages and all parts of the county. We will also focus on housing support needs of the most vulnerable.

a. Fuel poverty: This is an issue that affects young and old across the county and gets to the heart of the housing issue.

A household is said to be in fuel poverty if it needs to spend more than 10% of its income on fuel to keep warm. The calculation takes account of household income, fuel prices and energy efficiency of the home. Often the most vulnerable people, the elderly, the disadvantaged and those in poverty, are the most likely to be affected. All types of housing (owner occupied, private rented or social rented) and in both rural and urban areas can be affected. Helping people to escape from fuel poverty will do a great deal to improve the health of the worst off in the county.

b. Inequalities

Many housing organisations work within communities facing some of the worst disadvantage, scattered across the County, affecting old and young alike. The links between poor housing and poor health can easily be seen. People living in poor housing also have:

- Poorer health
- Lower levels of skills and lower qualifications
- Poorer school results
- Higher levels of unemployment.

"*A foot in the Door, a guide to engaging Housing and Health*" (2011) summed up the situation well:

> *"Considering multiple housing deprivation poses a health risk that is of the same magnitude as smoking and, on average, greater than that posed by excessive alcohol consumption, the case for action is clear."*

Local data highlights local housing need in several respects.

- thousands on housing waiting lists
- hundreds living in temporary accommodation
- over 150 living in hostels
- About half of homeless persons aged under 25.
- Thousands of over-crowded households
- a shortage of homes with 3 or more bedrooms for rental to families
- more than a dozen rough sleepers.

The local Supporting People programme provides services that help people do things for themselves. This includes particularly vulnerable groups of older people, people with physical, sensory or learning disabilities, people with mental health problems,

people fleeing domestic violence, homeless people, young people at risk or leaving care, teenage parents, people with drugs and alcohol problems, ex-offenders and refugees.

Approach to Priority 3

a. Members of the Health Improvement Board have agreed that tackling fuel poverty by maintaining and developing work already in progress is an immediate priority.
b. The Board members have also agreed that other housing issues also have to be tackled in partnership. Work is currently underway to determine the specific focus for this work and to identify and recommend outcomes and indicators. These will be advised in due course.

The proposed outcome for Priority 3 is, therefore:

Outcomes for Priority 3	Indicator definitions for Priority 3
• Reduce the number of people who are affected by fuel poverty • *Other overall aim linked to inequalities in housing to be determined.*	• Fuel poverty *Indicators which could be used in the focus on inequalities in housing include:* • *No. of people presenting as homeless or on housing waiting lists* • *No. of families in temporary accommodation* • *Rough sleepers* • *Housing condition indicators e.g. HMO licensing requirements being met*

Making a Real Difference in Oxfordshire.

If we accept these priorities, the Health and Wellbeing Board should aim to achieve:

- ***250 households per year helped to escape fuel poverty as a pilot.***
    - *Currently over 27,000 households in Oxfordshire (10.5%) are designated as "fuel poor", with similar rates across all districts (9.8 – 11.6%). Some rural wards have up to 20% households in fuel poverty.*
- ***A second outcome measure relating to inequalities will be agreed***

Priority 4 Preventing infectious disease through immunisation

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

The Oxfordshire JSNA shows high levels of coverage but some targets are still not being met and there are early signs that our high rates have begun to slip a little:

High levels of immunisation result directly in lower levels of serious diseases. For example, since the measles, mumps and rubella vaccine was introduced in 1988, the number of children who develop these conditions has fallen to an all-time low. All of these diseases can kill or cause lifelong disability.

The proposed outcome for Priority 4 is therefore:

Outcomes for Priority 4	Indicator definitions for Priority 4
• Ensure high rates of coverage for childhood immunisations	• Childhood immunisations from birth • Immunisation boosters at 1 year • MMR immunisations at 2 and 5 years • Human Papilloma Virus vaccination for girls (12 -17yrs) protecting them from cervical cancer. • Flu vaccination for at risk groups aged 6 mth – 65 yrs • Flu vaccination for over 65s

Making a Real difference in Oxfordshire.
If we accept these priorities, and assume a steady birth rate in the county, the Health and Wellbeing Board in 2012/13 should aim to achieve:

- ***8000 children immunised at 12 months (maintaining the high coverage)***
  - *Target coverage for booster in 1 year olds (for Diptheria, Tetanus, Whooping Cough, polio and meningitis) is 96.5%. Oxfordshire performance is on track.*
  - *Target coverage for pre-school booster (for Diptheria, Tetanus, Whooping Cough and Polio) is 95%. Oxfordshire is currently below target, but in the best 20% nationally*

- ***7700 children vaccinated against MMR by age 2 (achieving 95% coverage) and 7300 children receiving MMR booster by age 5 (increasing coverage by 1%)***
  - *Target coverage for the Measles, Mumps and Rubella booster at age 5 is 95%. Oxfordshire is currently below target, but in the best 20% nationally.*

- ***3000 girls receiving HPV vaccination to protect them from cervical cancer***
  - *Target coverage for this vaccination in 12-13 year old girls is 90%. Oxfordshire has been performing well*

- ***80,000 flu vaccinations for people aged 65 or more.***
  - Target coverage for flu immunisations for over 65s is 75%. Oxfordshire has met this target

Oxfordshire Joint Health and Wellbeing Strategy

The Health and Social Care Bill currently making its way through Parliament, places a statutory duty on Local Authorities to establish Health and Wellbeing Boards. By April 2013 the boards are expected to be fully operational.
The Joint Health and Wellbeing Strategy and the Joint Strategic Needs Assessment will both be statutory requirements of the Health and Wellbeing Boards.

What is a Joint Health and Wellbeing Strategy?

Joint Health and Wellbeing Strategies are made up of the top priorities agreed by health and wellbeing board members. These priorities are the focus for joint work and form a basis for (but not the totality of) the members' own commissioning plans and decisions.

The strategy is the mechanism for Local Authorities and Clinical Commissioning Groups to address the needs identified in the Joint Strategic Needs Assessment and to set out agreed priorities for collective action. The priorities should be the things requiring the greatest attention and should focus on the things that can be done together that will make the biggest difference[1]. The strategy should also include details of how success can be measured and what outcomes will be achieved.

What is a Joint Strategic Needs Assessment (JSNA)?

JSNAs are tools to identify the health and wellbeing needs and inequalities of a local population to inform more effective and targeted service provision. They provide a framework to examine all the factors that impact on health and wellbeing of local communities (including employment, education, housing, and environmental factors) providing impartial evidence on which to base local decisions[2].

The JSNA is designed to encourage joined-up responses to complex issues by providing a shared evidence base for planning. Joint health and wellbeing strategies will build on this to identify priorities for commissioning and decommissioning.

The Oxfordshire JSNA is currently available on the Oxfordshire data observatory website; it is planned that the data will be refreshed by March 2012 and redeveloped by March 2013.

http://www.oxfordshireobservatory.info/wps/portal/dataobservatory/data?WCM_GLOBAL_CONTEXT=http://apps.oxfordshire.gov.uk/wps/wcm/connect/occ/DataObservatory%2FData%2FThemes%2FJSNA%2F

Planning timetable for a Health and Wellbeing Strategy in Oxfordshire

- **March 2012** – JSNA data refreshed
- **April 2012** – Joint Health and Wellbeing Strategy drafted from the priorities agreed by the Health and Wellbeing Board in March
- **May / June 2012** – consultation period for Joint Health and Wellbeing Strategy
- **July 2012** – Health and Wellbeing Strategy 2012-2016 agreed by Health and Wellbeing Board. Strategic priorities embedded in member organisations plans for 2012-16
- **March 2013** – JSNA fully revised and published

[1] JSNAs and joint health and wellbeing strategies – draft guidance, Dept of Health, Jan 2012
[2] JSNAs and joint health and wellbeing strategies – draft guidance, Dept of Health, Jan 2012

- **July 2013** – revisions to Joint Health and Wellbeing Strategy agreed based on the 2013 revised JSNA. Revised outcomes set for 2013-16 as appropriate. Strategic priorities embedded in member organisations plans for 2012-2016