Notice of Meeting Public Document Pack

Oxfordshire Joint Health Overview & Scrutiny Committee

Thursday, 13 June 2013 at 10.00 am
County Hall

Membership

Chairman -
Deputy Chairman -

Councillors:	Kevin Bulmer Pete Handley Mark Lygo	Laura Price Alison Rooke Les Sibley	Lawrie Stratford
District Councillors:	Martin Barrett Christopher Hood	Susanna Pressel Rose Stratford	Alison Thomson
Co-optees:	Dr Harry Dickinson	Dr Keith Ruddle	Mrs A. Wilkinson

Notes: ***Date of next meeting:*** *5 September 2013*

What does this Committee review or scrutinise?

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

How can I have my say?

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

For more information about this Committee please contact:

Chairman	-	Councillor E.Mail:
Policy & Performance Officer	-	*Claire Phillips Tel: (01865) 323967* *claire.phillips@oxfordshire.gov.uk*
Committee Officer	-	*Julie Dean Tel: (01865) 815322* *julie.dean@oxfordshire.gov.uk*

Peter G. Clark
County Solicitor

June 2013

About the Oxfordshire Joint Health Overview & Scrutiny Committee

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

About Health Scrutiny

Health Scrutiny is about:

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

Health Scrutiny is NOT about:

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

What does this Committee do?

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

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

A hearing loop is available at County Hall.

AGENDA

1. Election of Chairman for the 2013/14 Council Year

2. Election of the Deputy Chairman for the 2013/14 Council Year

3. Apologies for Absence and Temporary Appointments

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

5. Minutes (Pages 1 - 6)

6. Speaking to or Petitioning the Committee

7. Director of Public Health Update

10.20

The Director of Public Health, Jonathan McWilliam will provide the committee with his regular report on matters of relevance and interest to the committee and will update specifically on the Health and Wellbeing Board.

8. Health and Wellbeing Strategy (Pages 7 - 20)

10:30

The Director of Public Health, Jonathan McWilliam will present the Health and Wellbeing Strategy consultation to the committee.

9. Clinical Commissioning Update (Pages 21 - 22)

10.45

Associate Director of Strategy and Governance, Catherine Mountford will present the regular progress report from the Oxfordshire Clinical commissioning Group.

10. Performance of the 111 number (Pages 23 - 26)

11.00

Oxfordshire Clinical commissioning Group Associate Director of Strategy and Governance, Catherine Mountford and Assistant Director for Major Programmes, Kate Holburn will present a report on the performance of the 111 non-emergency number.

11. Alcohol Addiction: A review of issues, challenges, solutions and possible means for improvement (Pages 27 - 36)

11.20

A discussion with commissioners and service managers on the alcohol addiction and the associated health issues including treatment. The discussion will focus around:

- prevalence of alcohol issues in Oxfordshire
- the services supporting alcohol dependency
- partnership working to tackle alcohol related issues
- opportunities

12. Healthwatch

12.50

Public Engagement Manager, Alison Partridge will update the committee on the progress of the establishment of Healthwatch.

13. Chairman's Report and forward plan

12.55

The Chairman will give a verbal update on issues raised since the last formal meeting in April.

The Committee will also have an opportunity to discuss items for the forward plan.

14. Close of Meeting

13.05

Declarations of Interest

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

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

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

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

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

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

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

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

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

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

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

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OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 25 April 2013 commencing at 10.00 am and finishing at Time Not Specified

Present:

Voting Members:	Councillor Dr Peter Skolar – in the Chair
	District Councillor Rose Stratford (Deputy Chairman)
	Councillor Jenny Hannaby
	Councillor Gill Sanders
	Councillor Keith Strangwood
	Councillor Lawrie Stratford
	District Councillor Martin Barrett
	District Councillor Dr Christopher Hood
	Councillor Susanna Pressel
	District Councillor Alison Thomson
Co-opted Members:	Dr Harry Dickinson
	Dr Keith Ruddle
Officers:	
Whole of meeting	Claire Phillips
	Jonathan McWilliam
	Angela Baker
Part of meeting	

Agenda Item	**Officer Attending**
7	Andrew Stevens,
	Jane Herve
	Tony MacDonald
8,9	Dr Mary Keenan
	Gareth Kenworthy
10	Alison Partridge

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

88/13 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 1)

Apologies were received from Councillors Jim Couchman, Anthony Gearing and Mrs Anne Wilkinson.

89/13 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 2)

No declarations were made.

90/13 MINUTES

(Agenda No. 3)

Councillor Peter Skolar thanked Councillor Rose Stratford for acting as Chairman for the February meeting.

The minutes were approved and there were no matters arising.

91/13 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 4)

Dr Peter Fisher addressed the committee to express his concern about potential changes to services at the Horton Hospital

92/13 PUBLIC HEALTH UPDATE

(Agenda No. 5)

Dr Jonathan McWilliam and Angela Baker addressed the committee.

Measles has been in the national headlines with outbreaks occurring across the country but to date there have been no cases reported in Oxfordshire (Oxfordshire had 6 cases in 2012 and 2 cases in 2011). Public Health England is leading on the communications strategy to encourage vaccinations. The committee encouraged parents to get their children vaccinated with the MMR vaccine.

The Health a Wellbeing Board is now operating as a statutory body and will meet three times a year. The next dates scheduled are:

- 25th July 2013
- 21st November 2013
- 13th March 2014

All meetings are to be held between 2-4pm at County Hall, Oxford.

The Public Information Network and the following three boards will support the Health and Wellbeing board:

- The Health Improvement Board
- The Adult Health and Social Care Partnership Board
- The Children and Young People's Board

While acting in shadow form the Health and Wellbeing board has:

- Developed proposals to pool budgets between Oxfordshire County Council and the NHS
- Engaged with district councils on the issues health and housing
- Looked at the quality of services following the release of the Francis report

The next steps for the board involve updating the joint strategic needs assessment and updating the Health and Wellbeing strategy. Jonathan McWilliam agreed with the committee that that data around ethnicity is very valuable. There are plans to create a 'One Oxfordshire' framework that is flexible and offers opportunities to work at the locality level to address priorities.

93/13 EMERGENCY PLANNING ARRANGEMENTS FOR THE NHS

(Agenda No. 6)

Dr Jonathan McWilliam and Angela Baker addressed the committee.

A new system has been in place since 1st April. The Local resilience forum (LRF) will act as the hub for emergency planning and operate in the Thames Valley area. The group plans and prepares for localised incidents and catastrophic emergencies.

Dr Jonathan McWilliam confirmed that when flooding occurs all partners work together to create an action plan.

94/13 REVIEW OF THE MIDWIFERY LED UNIT IN CHIPPING NORTON

(Agenda No. 7)

The following people addressed the committee:

- Samantha Miller (representing Francis Barnsley) - Cotswold maternity unit supporters
- Sarah Boyd - Chipping Norton NCT
- Georgia Mazower – A mother from the local community and Chair of Governors at the ACE Centre
- Kate Barlow – A mother from the local community

Speakers were pleased the unit was reopening but raised concerns about the evidence in the OUHT report. Concerns were also raised about the timescale the OUHT will set for the unit to meet its targets.

Andrew Stevens, Jane Herve and Tony MacDonald addressed the committee.

The OUHT would like to work together with stakeholders to implement the action plan and create a thriving unit. The action plan consists of 33 recommendations which will act as building blocks for the strategy. No timescale has been set for the unit to meet its targets but the OUHT will review the progress after one year. Andrew Stevens confirmed the Unit will not close after one year if target numbers are not met.

Concern was expressed that the review had painted a wholly negative picture of the past in the Unit which was not generally shared by the community. The Trust will have to work hard to rebuild community support for the Unit.

Jane Herve confirmed Oxford Brookes student placements will restart once the unit is reopened.

The Committee welcomed the reopening of the unit but were keen to ensure that the Unit is given sufficient time to re-establish itself and build up numbers.

The Committee asked the CCG to look into the option of neighbourhood midwives

95/13 CLINICAL COMMISSIONING GROUP UPDATE
(Agenda No. 8)

Dr Mary Keenan and Finance Director, Gareth Kenworthy addressed the committee.

The OCCG have only been acting as an official body since April 1st and have already built strong links with stakeholders for strategic alignment.

The OCCG has focused on developing a plan based on wider transformational service redesign to deliver a financially sustainable health system over a three year period. The OCCG is doing things differently by promoting integrated core joint working, commissioning patient centred services and commissioning for outcomes in the following areas:

- Frail elderly
- Mental health
- Maternity

Dr Mary Keenan confirmed the OCCG will lead on a review of acute services across the county (to invlude services at the Horton Hospital) with a consultation due out later this year. The committee confirmed that it wished to be involved in the consultation from the outset.

96/13 COMMISSIONING INTENTIONS FOR 2013/14
(Agenda No. 9)

Dr Mary Keenan and Finance Director, Gareth Kenworthy addressed the committee.

The top line financial objectives for the OCCG are to:

- Buy services to meet the needs of the population in Oxfordshire
- Work in a finically viable and sustainable way

The main financial risks for the OCCG:

- Benchmarking following the 2013/2014 allocation exercise indicates that OCCG has low funding levels when compared to other authorities but higher than average savings are required.
- The failure of existing QIPP schemes to keep pace means the OCCG start 2013/14 with a significant baseline financial risk. The OCCG have already identified £10 million savings from QIPP and are working hard to make this £13 million.

If there is a deficit the debt would lie with the organisation where the debt has been accrued. A Contract is in place with OUHT but negotiations are still on-going to finalise the activity and finance levels.
Members were concerned about the rising levels of demand for services and how this can be managed in particular whether people will be turned away from treatment in the future.

Dr Kennan confirmed the OCCG are committed to listening to patients through a range of sources including the patient's participation forums, OCCG website and Healthwatch.

97/13 HEALTHWATCH
(Agenda No. 10)

Alison Partridge addressed the committee.

She confirmed that Oxfordshire Rural Community Council has been awarded the Healthwatch contract for the interim period (one year). Alison Partridge confirmed good progress had been made in the past month.

98/13 CHAIRMAN'S REPORT
(Agenda No. 11)

The chairman confirmed new national guidance for HOSC is to be released.

The Chairman thanked the Committee.

The Committee thanked Senior Officer Claire Phillips.

99/13 CLOSE OF MEETING
(Agenda No. 12)

12.40

..... in the Chair

Date of signing .....

Oxfordshire Joint Health and Wellbeing Strategy 2012-2016

Consultation on revisions proposed for 2013-14

Background
Oxfordshire's Joint Health and Wellbeing Strategy was adopted by the Health and Wellbeing Board in July 2012 following extensive public consultation.
You can see the current version of the Oxfordshire Joint Health and Wellbeing Strategy here:
http://www.oxfordshire.gov.uk/cms/sites/default/files/folders/documents/aboutyourcouncil/plansperformancepolicy/oxfordshirejointhwbstrategy.pdf

In the last year there has been regular monitoring of all the outcomes set out in the document. This shows some good progress in improving health outcomes and in how organisations work together. This has been reported to the Health and Wellbeing Board on a regular basis. The latest performance report (March 2013) can be seen here:
http://mycouncil.oxfordshire.gov.uk/documents/s20020/HWB_MAR1413R02.pdf

Review of the Priorities
The Health and Wellbeing Board (H&WB) considered the latest information on the health of the population as set out in the Joint Strategic Needs Assessment. The needs identified in a report to the Board in March 2013 confirmed that the current priorities set out in the Joint Health and Wellbeing Strategy are still relevant.

Discussion on continuing to address these priorities has taken place among members of each of the Partnership Boards who deliver the work of the H&WB. These Partnership Boards are

- Children and Young People Board,
- Adult Health and Social Care Board and
- Health Improvement Board.

The Partnership Boards have

1. considered the progress that has been made in delivering the outcomes set out in the strategy
2. identified unmet need on this issue within Oxfordshire.
3. made some recommendations on the outcomes that should be set for the year ahead

Proposal
It is now proposed that new outcomes are set for 2013-14. The table below sets out proposals for each priority in the Joint H&WB Strategy

1. Rationale for why this remains a priority
2. A summary of where we are now – what is going well and challenges that remain
3. Proposals for further improvement in 2013-14.

Consultation
The proposals are posted on the consultation website and responses can be made for each priority in turn. All responses will be used to make final proposals for discussion at the Oxfordshire Health and Wellbeing Board in July 2013. The closing date for responses is Wednesday 3rd July at 5pm.

Proposed updates to the Oxfordshire Joint Health and Wellbeing Strategy 2013-14

Priority 1 All children have a healthy start in life and stay healthy into adulthood (Children and Young People Board)

Why we are keeping this priority

A healthy start in life begins at conception, runs through pregnancy and on into the first few years of life. Where problems occur, we aim to provide the wide range of services that parents need to support them. There is increasing evidence that demonstrates that outcomes across health, education and social care are determined from very early on in life – even as early as the first stages of pregnancy. For this reason we would like to monitor two new areas that focus on a healthy pregnancy and progress up to the age of 2 years.

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

This priority should be read together with priorities 9 and 11 in the Health and Wellbeing Strategy which proposes the promotion of breastfeeding and improved immunisation for children as further priorities.

Where are we now?

- Although there are more children being admitted to hospital for infections the rate of admission is stable. Numbers have increased in proportion with the increase in population of under 5's. There is also evidence that the length of time spent in hospital is beginning to decrease but we need to maintain a focus on this issue.
- There were 20 less young people admitted to hospital for self-harm in 2012/13.
- From September 2013 up to 20 of the most vulnerable young people with mental health problems will be managed throughout the transition via Children and Adolescent Mental Health Services until they recover.
- Oxfordshire continues to perform primarily well against a range of indicators important for a healthy start in life monitored by the Health Improvement Board. This includes breastfeeding and immunisation. The increasing level of obesity in Year 6 children remains a cause for concern.

Proposed outcomes for 2013-14	**1.1 High % of women who have seen a midwife or a maternity health care professional by 13 weeks of pregnancy (currently 85%)** **1.2 Maintain at least 90% coverage for health visitor progress checks of all 2 year-olds across Oxfordshire** **1.3 Reduce the rate of emergency admissions to hospital with infections by 10%**

Priority 2 Narrowing the gap for our most disadvantaged and vulnerable groups (Children and Young People Board)

Why we are keeping this priority

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

Poverty and disadvantage are known to be strongly linked to poor outcomes and so work focused on reducing the gap between the most disadvantaged and most advantaged groups starting in 'early years' is seen as a key way of improving outcomes for children and families. We would therefore like to propose to monitor the take up of free early education places for 2 year olds.

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

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

Where are we now?

- The Joint Teenage Pregnancy Strategy has led to significant reductions in the teenage pregnancy and conception rates in Oxfordshire so the proposal is that the Health and Wellbeing Board will not continue to monitor this but progress will continue to be monitored by health and social care services.
- The Thriving Families workers are on track to meet their target of working with 100 families. In Year 2 of the programme there will be a much greater focus on outcomes and the effectiveness of the family intervention model. The plan is to evaluate locally and nationally the difference to families by family intervention work.
- Persistent absence rates from school vary across the county but generally improved from 2010/11. Rates in primary schools are lower than the national average but in secondary schools Oxfordshire is higher than the national average.
- The proportion of 'looked after children' who are persistently absent is below the national figure but remains a priority.
- Fixed term exclusions tend to be higher than the national average but the number of fixed term exclusions for terms 1-3 in the current academic year is slightly lower than the corresponding term last academic year, despite being higher in previous terms
- Permanent exclusion rates in Oxfordshire are below the national figure

Proposed outcomes for 2013-14	**2.1 80% of the 1200 2 year olds eligible for free early education in 2013/14 take up places (including 80% of 2 year-old Looked After children)** **2.2 Maintain the current low level of persistent absence (15% lost school days or more) from school for children 'looked after' at 4.3% in 2012/13** **2.3 Maintain the number of looked after children permanently excluded from school at zero** **2.4 Establish a baseline of all children who are persistently absent from school who are also receiving a service from any of the County Council targeted children's services (e.g. Early Intervention Hubs and Children's Social Care)** **2.5 Establish a baseline of children and young people on the autistic**

	spectrum who have had an exclusion from school (over a school year) and work to reduce this number in future years **2.6 Identify, track and measure the outcomes of all 810 families in Oxfordshire meeting the national Troubled Families criteria (improve attendance and behaviour in school; reduce anti-social behaviour and youth offending; increase adults entering work)** **2.7 Improve the free school meals attainment gap at all key stages and aim to be in line with the national average by 2014 (currently the free school meal attainment gap in Oxfordshire is in line or above the gap nationally in all key stages)**

Priority 3 Keeping all children and young people safe (Children and Young People Board)

Why we are keeping this priority?

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

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

In Oxfordshire we have done a great deal of work along with the Police, Health, District Councils and other organisations to prevent child sexual exploitation and to protect and support its victims. This includes setting up the multi-agency dedicated Kingfisher team and increasing capacity by recruiting additional social workers. Nationally and locally there is growing awareness about young people who are victims of sexual exploitation. We need to do more in Oxfordshire and work together as agencies to prevent this type of crime happening.

We know that going missing is a key indicator that a child might be in great danger and they are at very serious risk of physical and sexual abuse and sexual exploitation. Nationally 10,000 children are estimated to go missing from care in a year (UK Missing Persons Bureau 2012). The number of looked after children reported missing from Oxfordshire care homes fell significantly between 2011 and 2012, from 155 episodes to 63 episodes.

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

Quality assurance audits look at the quality of the casework that agencies deliver to reduce the risk of abuse and neglect of children and young people. In 2012/13 a baseline has been established by working with independent auditors to grade the multi agency audits. These grades will make up the baseline performance on which future progress in 2013/14 will be measured.

Keeping children safe is a key priority for all agencies.

Where are we now?

- The Oxfordshire Safeguarding Children Board has overseen a number of multiagency

audits of practice that demonstrate a step change in the way professional practice is delivered.

- Adjustment to the quality assurance audit target (50%) will be determined by the outcome of the 2012/13 baseline exercise, but will be set at a higher percentage than the attainment in 2012/13.
- The prevention of child sexual exploitation continues to be a key priority in Oxfordshire.
- There is a much greater focus on children who go missing from home
- In Oxfordshire we have a low level of repeat child protection plans which is now better than the national average. This will continue to be monitored by social care teams but given the level of improvement it is proposed that it is no longer a monitoring priority for the Health and Wellbeing Board.

Proposed outcomes for 2013-14	**3.1 Reduce the risk for 'high risk' victims of domestic abuse in 85% of cases (managed through Multi-Agency Risk Assessment Conferences) in 2013/14** **3.2 A prevalence report on Child Sexual Exploitation in Oxfordshire will be produced 6 monthly and every child identified as at risk of Child Sexual Exploitation will have a multi-agency plan in place** **3.3 Reduce the episodes/incidents of children and young people who go missing from home (from 1130 episodes involving 654 children in 2012)** **3.4 A regular pattern of quality assurance audits is undertaken and reviewed through the Oxfordshire's Safeguarding Children Board covering the following agencies: children's social care; youth offending service; education services; children and adult health services; early intervention services; services provided by the police. Over 50% of these audits will show a positive overall impact.**

Priority 4 Raising achievement for all children and young people (Children and Young People Board)

Why we are keeping this priority?

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

Early Years and primary school results are better than the national average and this can be built upon. However we know that specific pupil groups in Oxfordshire do not do as well as their peers in similar Local Authorities. This includes children receiving free school meals, children from some Black and Minority Ethnic Groups and those with special education needs.

In 2011/12 there have been improvements in inspection outcomes and significant improvements in the performance of some schools though Oxfordshire has a greater proportion of schools judged by Ofsted as requiring improvement. There have been some signs of improvement in some subject areas and we need to continue to improve at Key Stage 4 with a particular focus on building on the achievements of vulnerable groups. . Overall, the picture shows gradual improvement but there is inconsistency across Oxfordshire and for certain groups of children.

Where are we now?

- There has been significant improvement in reading at Key Stage 1 and achievement at Key Stage 2 maths.
- A higher percentage of pupils in Oxfordshire made expected progress in Key Stage 2 English and maths than nationally
- Pupils achieving 5 or more A*-C GCSEs including English and Maths Oxfordshire has increased slightly in 2011/12 to 57.9%. However, in this measure Oxfordshire is performing below the statistical neighbour and national averages. Overall GCSE results fell below the national average in 2011/12.
- There has been a 0.7% decrease in overall absence levels in both primary and secondary schools in Oxfordshire for the academic year 2011/12. Persistent absence rates from school vary across the council but generally improved from 2010/11. Rates in primary schools are lower than the national average but in secondary schools Oxfordshire is higher than the national average.
- The number of schools falling below the accepted standard fell from 18 to 1
- The percentage of children taught in good/ outstanding primary schools has increased from 59% to 67%
- The proportion of year 12-14s who are Not in Education, Employment and Training is lower than that nationally but we still need to focus on the young people who are 'not known'.

Proposed outcomes for 2013-14	**4.1 Increase the number of funded 2-4 year olds attending good and outstanding early years settings (currently 80.5%)** **4.2 80% of children will achieve Level 2b or above in reading at the end of Key Stage 1 of the academic year 2012/13 (currently 78% for the academic year 2011/12)** **4.3 80% of children at the end of Key Stage 2 will achieve Level 4 or above in reading, writing and maths (currently 78%)** **4.4 At least 70% of young people will make the expected 3 levels of progress between key stages 2-4 in English and 72% in Maths (currently 65% for English and 71% for Maths)** **4.5 Increase the proportion of pupils attending good or outstanding primary schools from 59% to 70% and the proportion attending good or outstanding secondary schools to 75% (currently 67% primary and 74% secondary).** **4.6 Of those pupils at School Action Plus, increase the proportion achieving 5 A* - C to 17% (currently 7%)** **4.5 To reduce the persistent absence rates in primary schools to 2.6% and secondary schools to 7.2% by the end of 2012/13 academic year. (The current rates are 3.0% for primary schools and 8.0% for secondary schools)** **4.6 Reduce the number of young people not in education, employment or training to 5% (currently 5.4%)**

Priority 5 Living and working well: Adults with long-term conditions, physical disabilities, learning disabilities or mental health problems living independently and achieving their full potential
(Adult Health and Social Care Board)

Why are we keeping this priority?

- There is an increasing number of people with long term conditions, physical disabilities, learning disabilities or mental health problems in Oxfordshire
- These people tell us that they want to be independent, to have choice and control so they are able to live "ordinary lives" as fully participating members of the wider community.
- Ensuring access to good health care for people with learning disabilities is an important issue for people with learning disabilities. The physical health check target we set, of at least 50% for adults with learning disabilities, was seen as a step in the right direction towards at least 60% by the end of 2013/14.
- The rate of people with mental health related conditions (Psychosis, Psychoneurosis, Personality Disorder, Dementia) claiming disability living allowance in February 2013 in Oxford City (8.4 per 1000 people) is above the national rate (7.4)

Where are we now?

- Overall the proportion of people who use adult social care who said they found information very or fairly easy to find rose from 71.5% to 73.5%. However for working age adults the figure fell from 71.3% to 69.4%.
- The current measures for people with a severe mental illness receiving a health check are not part of national outcome frameworks and have been difficult to measure, and do not necessarily provide the best indicators of improved outcomes

Proposed outcomes for 2013-14	**5.1 75% of working age adults who use adult social care say that they find information very or fairly easy to find (currently 69%)** **5.2 Number of people with a long-term condition feel supported to manage their condition (baseline and target to be confirmed)** **5.3 All patients within the schizophrenia cohort are supported to undertake a physical health assessment during 2013/14 (current figure to be confirmed)** **5.4 At least 60% of people with learning disabilities will have an annual physical health check by their GP (current figure to be confirmed)** **5.5 Reducing the number of emergency admissions for people with long term conditions (baseline and target to be confirmed)**

Priority 6 Support older people to live independently with dignity whilst reducing the need for care and support
(Adult Health and Social Care Board)

Why are we keeping this priority?

- We know that living at home with dignity is key to the quality of life that older people want to enjoy and that older people and their carers require access to good quality information and advice.
- The proportion of older people in the population continues to increase and the cost of caring for older people increases markedly with age. This is true for both health care and social care.
- The number of referrals to adult social care has grown at a higher rate than that which would be expected through the effects of an aging population.
- 29% of people aged over 65 were living alone at the time of the census. Across districts, it is estimated that the rate is highest in Oxford City, at 36% of the population.

Where are we now?

- 77.7% of older people who use adult social care say that information is very or fairly easy to find
- A reduced number of people were placed permanently in care homes from October 2012 onwards
- 40 new Extra Care Housing places have opened at Thame, 70 at Banbury (Stanbridge) and 20 at Bicester.
- The number of people starting reablement increased in the year and by over 20% on last year's level, but is below the expected level.
- Delayed transfers of care remain high and Oxfordshire is still the worst of any authority nationally.
- 89.9% of people living at home consider they are treated with dignity, down slightly on 2011/12 (91.6%).

Proposed outcomes for 2013-14	**6.1 A reduction in delayed transfers of care so that Oxfordshire's performance is out of the bottom quarter (current ranking is 151/151)** **6.2 Develop a model for matching capacity to demand for health and social care, to reduce delays in transfers of care, by September 2013** **6.3 No more than 400 older people per year to be permanently admitted to a care home from October 2012 (currently 546)** **6.4 Increase the proportion of older people with an ongoing care package supported to live at home (baseline and target to be confirmed)** **6.5 60% of the expected population with dementia will have a recorded diagnosis (currently 49.6%)** **6.6 3250 people will receive a reablement service (currently 2197)** ***OR*** **6.7 Increase proportion of people who complete reablement who need no on-going care from 50% to 55%** **6.8 Maintain the current high standard of supporting people at home with dignity as measured by people themselves (currently 89.9%).**

	6.9 Commission an additional 523 Extra Care Housing places by the end of March 2015, bringing the total number of places to 930 **6.10 Produce an analysis of demand for alternative housing options for older people within Oxfordshire to inform future targets and planning by March 2014** **6.11 Maintain the high number of older people who use health and adult social care and say that they find information very or fairly easy to find (currently 77.7% for adult social care)** **6.12 Reduce number of emergency admissions for older people (baseline and target to be confirmed)** **6.13 Bereaved carers' views on the quality of care in the last 3 months of life (baseline and target to be confirmed)** **6.14 Proportion of adults who use health and social care that say they receive their care and support in a timely way (baseline and target to be confirmed)**

Priority 7 Working together to improve quality and value for money in the Health and Social Care System
(Adult Health and Social Care Board)

Why are we keeping this priority?

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

Where are we now?

- Oxford Health Foundation Trust and the County Council have been working in partnership to deliver integrated community services throughout 2012/13 with significant progress being made with the development of an integrated Single Point of Access and the implementation of the Oxfordshire Discharge to Assess Policy.
- A single section 75 agreement is in place covering all the pooled budget arrangements between the County Council and Clinical Commissioning Group
- The Older People's Joint Commissioning Strategy has been developed by a multi-agency working group, and following public consultation will be reported to County Council Cabinet and Clinical Commissioning Group Executive Board in June 2013.
- Oxfordshire Clinical Commissioning Group has been formally authorised to take on commissioning responsibilities for Oxfordshire from 1 April 2013.
- 61.7% of people who use social care services in Oxfordshire say they are very

satisfied with their care and support, an increase in overall satisfaction for the third successive year. • Achieved above the national average of people satisfied with their experience of hospital care (78.7%), and above the national average of people 'very satisfied' with their experience of their GP surgery (90.1%) • 881 carers' breaks have been jointly funded and accessed via GPs, but carers satisfaction with services (39%) is significantly lower than service users levels of satisfaction. However, a similar picture is emerging nationally.	
Proposed outcomes for 2013-14	**7.1 Implement a joint plan for fully integrated health (community and older adult's mental health) and social care services in GP locality areas by March 2014, leading to improved outcomes for individuals.** **7.2 More than 65% of people who use health and social care services in Oxfordshire will say they are very satisfied with their care and support (currently 64% for adult social care)** **7.3 Achieve above the national average of people satisfied with their experience of hospital care (currently 78.7% against 2011/12 national figure of 75.6%)** **7.4 Achieve above the national average of people 'very satisfied' with their experience of their GP surgery (currently 90.1% against 2012/13 national figure of 87.6%)** **7.5 Increase the number of carers known and supported (baseline and target to be confirmed)** **7.6 Increase the number of carers who say they are very satisfied with services to at least the national average (once comparative data is available) (currently 39%)** **7.7 800 carers breaks jointly funded and accessed via GPs (currently 881)** **7.8 Reduce the number of emergency admissions to hospital (baseline and target to be confirmed)** **7.9 Reduce the number of emergency admissions for acute conditions that should not usually require hospital admission (baseline and target to be confirmed)** **Or** **7.10 Reduce unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) (baseline and target to be confirmed)**

Priority 8 Preventing early death and improving quality of life in later years (Health Improvement Board)
Why are we keeping this priority? • A gap in life expectancy still remains within Oxfordshire, with women likely to live longer than men and those in more deprived areas likely to die sooner and be ill or disabled for longer before death. • Promoting healthy lifestyles and access to screening programmes is a cost effective way of reducing the risk of chronic disease and premature death

Where are we now? • Over 2500 people in Oxfordshire had quit smoking for at least 4 weeks by the end of Q3 • The number of 40-74 year olds invited for NHS Health Checks was on target • Bowel screening invitations were below target at the end of Q3	
Proposed outcomes for 2013-14	**8.1 At least 60% of those sent bowel screening packs will complete and return them (ages 60-69 years)** **8.2 Number of invitations sent out for NHS Health Checks to reach the target of 39,114 people aged 40-74 (Invitations sent in 2012-13 = 40914)** **8.3 At least 50% of those invited for NHS Health Checks will attend (ages 40-74)** **8.4 Smoking cessation outcome to be set (baseline data not yet available)**

Priority 9 Preventing chronic disease through tackling obesity (Health Improvement Board)	
Why are we keeping this priority? • The rates of obesity in the county continue to rise. Data from surveys show a cause for concern. • The percentage of people diagnosed with diabetes by their GP continues to rise across the county. The link between obesity and chronic conditions like diabetes and physical disability are proven. • The rates for breastfeeding initiation soon after birth and continuation to at least 6-8 weeks are good in Oxfordshire. These higher rates need to be maintained. • Measurement of children shows the numbers who are deemed to be overweight or obese at both Reception Class and Year 6 are generally lower than England rates, but show over 15% obesity at year 6. These are year on year snap shot measures so trends cannot be identified.	
Where are we now? • The ambitious target of halting the rise in childhood obesity was not met, though the Oxfordshire rate is still lower that the national rate. • Breastfeeding rates for babies aged 6-8 weeks showed good progress but dipped at the end of the year. • The rates of adults undertaking the recommended level of physical activity continued to increase.	
Proposed outcomes for 2013-14	**9.1 Ensure that the obesity level in Year 6 children is held at no more than 16% (in 2012 this was 15.6%)** **9.2 An increase to 28% of adults who are physically active for at least 30 minutes 3 times a week on average (currently 27.4%)** **9.3 60% of babies are breastfed at 6-8 weeks of age (currently 59.1%)**

Priority 10 Tackling the broader determinants of health through better housing and preventing homelessness **(Health Improvement Board)**	
Why are we keeping this priority? • Changes to the welfare benefit system have potential to put more households at risk of homelessness • New ways of working to provide Housing Related Support need time to develop • Fuel poverty is still a risk for a large number of households. New systems for improving energy efficiency of homes have been introduced and need to be established. • Fuel Poverty work is not funded sustainably.	
Where are we now? • Scoping work and local pilot projects to understand and agree actions to reduce the risk of homelessness are now complete. • The Housing Related Support Group has been established and several services will have to be re-procured in 2013-14 • The annual report from the Affordable Warmth Network for 2012-13 shows that there has been good take-up of information and advice services. Some energy efficiency improvements were made in 363 households across the county. 400 referrals were made to Warm Front resulting in improvements in 105 households	
Proposed outcomes for 2013-14	**10.1 The number of households in temporary accommodation should be held at the level reported in March 2013 (baseline 216 households in Oxfordshire)** **10.2 At least 60% of people receiving housing related support will depart services to take up independent living.** **10.3 At least 86% of households presenting at risk of being homeless and are known to District Housing services will be prevented from becoming homeless (baseline from 2012-2013 when there were 2304 households known to services, of which 1992 households were prevented from becoming homeless. 1992/2304 = 86.5%)** **10.4 Fuel poverty outcome to be determined in Sept 2013**

Priority 11 Preventing infectious disease through immunisation **(Health Improvement Board)**
Why are we keeping this priority? • It is important that immunisation rates remain high throughout the population to maintain "herd immunity" • Responsibility for commissioning immunisation services has been taken on by NHS England. This is done locally through the Thames Valley Area Team. High levels of coverage need to be maintained through this transition to new organisations within the NHS. • The recent epidemic of measles and increased prevalence of whooping cough has caused concern at a national level.

- New immunisations are to be introduced in the next year. From July 2013, a rotavirus vaccination will be offered at 2 months and at 3 months alongside other vaccinations.

Where are we now?

- High coverage rates for most childhood immunisations were achieved across the county.
- Follow up of some families with incomplete immunisation records meant that they were successfully immunised.
- Over 80,000 people aged over 65 received their flu immunisations in 2012-13
- Rates of flu immunisations for people aged under 65 who are at risk of illness are not meeting targets.

Proposed outcomes for 2013-14	**11.1 At least 95% children receive dose 1 of MMR vaccination by age 2 (currently 95%)** **11.2 At least 95% children receive dose 2 of MMR vaccination by age 5 (currently 92.7%)** **11.3 At least 55% of people aged under 65 in "risk groups" receive flu vaccination (currently 51.6%)** **11.4 At least 90% 12-13 year old girls receive all 3 doses of human papilloma virus vaccination (currently 88.1%).**

New Priority 12: Commission safe, high quality, efficient heatlh and social care services for the people of Oxfordshire.
(All Partnership Boards)

Rationale for including this priority

- It is essential that the Health and Wellbeing Board drives a culture of continuous recognition of good practice and potential improvements in the quality of care received by patients and service users. This covers services in the NHS and all other services commissioned by partners.
- The Francis Report (2013) set out a wide range of recommendations for improving quality of services and developing systems of assurance. Most of these are already in place in Oxfordshire and are under review to identify any opportunities for further improvement.
- Oxfordshire Local Healthwatch has now been launched and will establish new perspectives to drive the quality improvement agenda.

Where are we now?

- Existing measures of quality in the Joint Health and Wellbeing Strategy have indicated good performance. We measured the following:
    - Overall the proportion of people who use adult social care who said they found information very or fairly easy to find rose from 71.5% to 73.5%. However for working age adults the figure fell from 71.3% to 69.4%.
    - The proportion of people who use social services and say they are very satisfied with their care and support rose from 61.7% to 64%.
    - People who say they are satisfied with their experience of hospital care –

<table>
<tr><td colspan="2">performance not yet reported.
○ People who say they are very satisfied with their experience of their GP surgery – performance not yet reported.
○ Only 39% of carers are satisfied with support services, significantly lower than service users' levels of satisfaction, but there is a similar picture emerging nationally.
○ People with long term conditions who feel supported to manage their condition – end of year performance not yet reported.
○ People who say they feel supported at home with dignity fell slightly, from 91.6% to 89.9%.
• Discussion at the Health and Wellbeing Board in March 2013 identified the need for review of quality measures and assurance to drive the culture of continuous improvement.</td></tr>
<tr><td>Proposed process for setting additional outcomes for 2013-14</td><td>12.1 It is proposed that a range of patient reported outcome measures will continue to be monitored, as in 2012-13. These are listed as proposed outcome measures under the relevant priorities above.
12.2 In addition there will be a joint review of current systems of quality assurance. These systems are set up for recognising, monitoring, reporting and acting upon concerns about quality of services. This review will be completed by September 2013.
12.3 Recommendations from the review will be the subject of consultation with the public and stakeholders in Oct 2013
12.4 Additional proposals for continual quality improvement in Oxfordshire will be discussed and approved by the Health and Wellbeing Board in November 2013.</td></tr>
</table>

NHS
Oxfordshire
Clinical Commissioning Group

Update on Oxfordshire Clinical Commissioning Group (OCCG)
Joint Health Overview and Scrutiny Committee 13 June 2013

The following paper gives a flavour of the key issues for OCCG three months after authorisation as a statutory NHS body in April 2013. On 30 May we held our second Governing Body meeting, this time at the offices of South Oxfordshire District Council. A great deal of business was discussed and we highlight the following as being of particular interest to the HOSC:

1. Financial plan

The first medium term financial plan for Oxfordshire Clinical Commissioning Group 2013/14 to 2015/16 was approved by the Governing Body on 28th March 2013. As a direct result of relatively low funding allocations and marked increases in urgent care activity, the OCCG budget is already under pressure. To sign contracts OCCG has had to commit all of its non-recurrent funding to address in year activity projections. We are confident that over a period of three years we can re-balance the health economy but there is no doubt that this first year will be extremely challenging.

Following agreement of the OUH contract, the Regional team of NHS England (NHSE) added Oxfordshire to a list of approximately 45 CCGs that have since been subject to a "deep dive" review. This work has been coordinated by the regional team and reported to the National Director of Finance for NHSE. OCCG has not yet had formal feedback from this process other than agreement to move to a financial plan with only 0.5% surplus (rather than the 1% surplus originally planned). It is understood that the Regional team have recognised the level of risk being faced by the CCG and the potential implications for achieving the statutory financial requirement of break even.

2. Older peoples' pool and strategy

The Governing Body has considered a proposal to increase the NHS contribution to the pooled budget and to increase the number of services included. The changes proposed have potential to improve joint decision making, allow greater integration of services leading to higher quality and less waste. Further work is being carried out on issues such as the risk sharing arrangements, the outcomes anticipated and the governance

arrangements to be put in place. It is anticipated that all of these issues will be resolved before consideration at the Oxfordshire County Council (OCC) Cabinet meeting on 18 June. A verbal update will be given at the HOSC meeting.

3. OCCG response to the Francis Report

The Francis report sets out details of appalling patient care at Mid Staffordshire NHS FT and makes a number of recommendations to both Providers and Commissioners. Essentially Francis states that the NHS needs clear systems to collate information on the quality of healthcare and to act to remedy any areas of poor care.

OCCG has chosen to put quality at the centre of the organisation and we have placed a statement on our website explaining how we approach this. We have an established system of quality assurance of commissioned services in Oxfordshire. We use an established range of methods and intelligence to gain assurance of the quality of the services we commission.

We regularly review performance indicators, clinical audits and feedback from patients and GPs and have the ability to undertake more detailed analysis where required. When necessary we take decisive action to address situations where quality falls below the required standard.

This information is not only used to detect areas of poor care but to improve all aspects of healthcare and has highlighted the need to redesign services to improve the quality of care.

Oxfordshire CCG views the recommendations of the Francis report as an opportunity to test and further enhance the mechanisms for ensuring continuous quality improvement.

31 May 2013

Oxfordshire
Clinical Commissioning Group

NHS 111 in Oxfordshire
Oxfordshire Joint Health Overview and Scrutiny Committee – Thursday 13th June 2013

1. Introduction

The NHS 111 service has been introduced to make it easier for the public to access healthcare services when they need medical help fast, but it is not a life-threatening situation. 111 provides patients with the right care, from the right person, in the right place, at the right time.

111 was launched in Oxfordshire on Tuesday 18th September 2012. Oxfordshire Clinical Commissioning Group (OCCG) was an early adopter of 111 nationally, with the Department of Health requiring that all CCGs provide 111 by 1st April 2013.

The service was available 24 hours a day but was launched with limited publicity, a process identified by the Department of Health as 'soft launch'. The service was promoted to the public on Tuesday 8th October- 'hard launch', with publicity including leaflet maildrops to households across the county. In addition to providing patients with triage, advice and information 24/7, 111 serves as the access point to Out of Hours GP care (between the hours of 1830 and 0830 on weekdays and 24 hours at the weekend) within Oxfordshire.

The weeks between soft and hard launch allowed Oxfordshire Clinical Commissioning Group, Oxford Health NHS Foundation Trust (Oxford Health) and South Central Ambulance Service NHS Foundation Trust (SCAS), to ensure the service was robust and would meet the needs of patients locally. These three organisations worked very closely together during planning, implementation and subsequent to launch of the service to ensure that 111 in Oxfordshire reflects the needs of the local population, was informed by local clinicians and provides a service that is well integrated with health and social care provision across acute, emergency and community settings.

On 25th January 2013, the NHS Direct (0845 4647) telephone advice service across Oxfordshire ceased, with callers being advised to ring 111. 111 provides all of the functions that NHS Direct offered, but is also able to dispatch ambulances to patients that require an emergency response and book appointments for Out of Hours GP care.

111 is more than telephone triage; it is a service provided by a number of partner organisations working together to ensure that patients receive the right care, first time. The success of 111 is a combination of call answering, assessing the patient's needs successfully through the nationally approved telephone triage system (NHS Pathways) and then directing that patient correctly to the most suitable, available service that is able to meet their needs.

2. Performance

From the 18th September 2012 to 13th May 2013, 111 in Oxfordshire had answered 116,838 calls.

The Department of Health has set a number of Key Performance Indicators (KPIs) for 111 services nationally to achieve. Two of these indicators are intended to assure the safe and effective management of patients seeking to access care urgently. The first KPI is the percentage of calls that are answered within 60 seconds of the patient contacting 111- this is to ensure that patients get rapid access to assessment and that those calling with life threatening conditions are managed as

quickly as possible. The second KPI measures the percentage of calls that are abandoned and therefore have not been assessed. This serves as a proxy for the number of patients that may seek to access health care by another route.

90% of the 117,000 calls to 111 in Oxfordshire on average have been answered within 60 seconds- the national target is 95%. The percentage of calls normally answered within this target has shown considerable improvement since launch, particularly since mid-April and performance is now usually well above 95%.

Call answering performance during periods of high demand, such as Saturday and Sunday mornings or Bank Holidays, has been less effective but has shown the same general improvement as during the week. Notable challenges to call answering performance occurred during February half-term and during both Christmas and Easter, although the service continued to provide a safe service to Oxfordshire patients during these times. On each of these occasions, OCCG worked with Oxford Health and SCAS to rapidly review and address performance, taking action to ensure that the service swiftly improved. The three organisations work jointly ahead of each week and in particular in advance of periods of known pressure such as Bank Holidays to review demand and ensure staffing levels are appropriate to manage the anticipated volume of callers.

Challenges were also experienced when the NHS Direct telephone service was stopped across Oxfordshire and also during the first part of 2013 as a result of over flow (out of area) calls caused by the rest of the country rolling out their 111 services. As call volumes have stabilised, this has enabled more accurate profiling of the number of call handlers and clinicians required in the call centre during each hour, which has supported the improved call answer performance.

On average 2.9% of calls are abandoned- the patient hangs up the phone prior to their call being answered by a call handler. This can be for a variety of reasons, including that the patient has dialled 111 in error. The national target for abandonment rates is 5%, so SCAS perform well compared to other providers.

3. Patient outcomes within 111

6% of calls to 111 on average result in an ambulance being dispatched. Although 111 is not intended as an emergency service, when NHS Pathways- the triage tool used to assess patients- identifies that an ambulance is required, call handlers can arrange this just as quickly as if the patient had dialled 999 directly. Of these calls, at least 40% of patients are treated on scene by the crews or referred to a GP and do not need transporting to hospital. Nationally, it is expected that up to 10% of 111 calls will be passed immediately across to the 999 Ambulance service for response. Therefore Oxfordshire performs well against other areas and demonstrates the advantage of having 999 and 111 call answering services co-located in a single space.

Only 3% of callers have been advised to attend Accident and Emergency; this has been supported by recent audit and impact analysis. 47% have been directed to primary care such as a GP, either their own during the in hours period (0830 to 1830) or an Out of Hours GP during evenings and weekends. 39% of callers have been managed within 111 and have not required referral to another service.

One of the strengths of 111 is the ability to review patient pathways through and beyond the initial triage, to ensure that community services, such as GP Out of Hours services, Minor Injuries Units and community nursing services are available at times and in locations that are accessible and convenient for patients. Where gaps are identified, commissioners of health services can identify where patients may benefit from services being provided differently. Analysis of these patient pathways is ongoing.

4. Patient satisfaction

Patient surveys about their experience of 111 locally will be conducted every 6 months. The first survey in February, to which 196 patients responded, found high levels of patient satisfaction.

82% of patients that responded to the survey felt that 111 directed them to the most appropriate service and 84% were happy with the service that they received. 89% of patients would recommend 111 to friends and family.

Had 111 not been available, 7% of patients would have attended A&E directly and a further 8% would have dialled 999. The majority of patients (73%) would have contacted primary care.

111 has been the subject of national media interest recently, with attention focussing on negative experiences by patients and healthcare professionals. However, locally the service can demonstrate that it is generally highly regarded by the public.

5. Impact on local services

Nationally, concerns have been raised regarding the impact of 111 on urgent and emergency care services, particularly patient waits at A&E.

Locally, attendances at Accident and Emergency departments have increased significantly between 2011-12 and 2012-13 by approximately 6.5%. However, comparing the months in 2012-13 prior to 111 launching (April to September) and the months post launch, A&E activity has shown a more modest increase, which also reflects usual increased demand over the Winter period for health services.

Ambulance call outs have also shown a significant increase of 16% comparing 2011-12 and 2012-13. However, analysis in 2012-13 of call outs prior to launch and in the months afterwards show demand was very similar in both periods, reflecting that increased demand is not solely due to 111.

6. Accolades, complaints and incidents

Since launch and over the course of nearly 117,000 calls to 111, Oxfordshire Clinical Commissioning Group has received 14 accolades, 6 complaints and 16 concerns about the service from members of the public. Each complaint is fully investigated and responded to by the CCG, in partnership with Oxford Health and South Central Ambulance Service where appropriate.

Incidents are discussed three times per week via a teleconference between Oxfordshire CCG, Oxford Health and South Central Ambulance Service at which initial actions are decided and investigators allocated. Lessons learned and actions taken are added to the record once the investigation is complete. The incidents are reviewed at a monthly Datix Closure Meeting when they are either closed or further work is requested.

There have been 3 serious incidents requiring investigation (SIRIs) since launch of 111 in Oxfordshire, two of which related to OCCG concerns about performance against the Key Performance Indicators. Both of these incidents resulted in actions to improve performance being agreed between OCCG, SCAS and Oxford Health. The third incident is still undergoing investigation.

7. Re-commissioning the service

Oxfordshire Clinical Commissioning Group decided that 111 would be piloted in Oxfordshire, so that its effects on local health and social care services could be fully understood before tendering for the service in a competitive market. OCCG ensured that by working with Oxford Health, the providers of GP Out of Hours care in Oxfordshire and South Central Ambulance Service, the introduction of 111 would be safe and ensure that patients requiring urgent and emergency care would receive this rapidly.

The current contract for 111 services provided by SCAS will end in July 2014. OCCG will shortly begin the process to re-commission 111 locally. It will work with partners across health and social care to ensure that the service meets the needs of patients and professionals, reflects the clinical expertise and knowledge of local services of clinicians and ensures that patients seeking to access care urgently do so in the right place, first time.

111 has the potential to benefit patient care significantly in Oxfordshire, managing flow across community and acute services more effectively, basing decisions about new services on identifiable patient need and offering a robust system to deliver the right care, first time. OCCG will ensure that re-commissioning of 111 makes full use of these opportunities.

Matthew Staples- Senior Commissioning Manager- Unplanned Care, OCCG May 2013

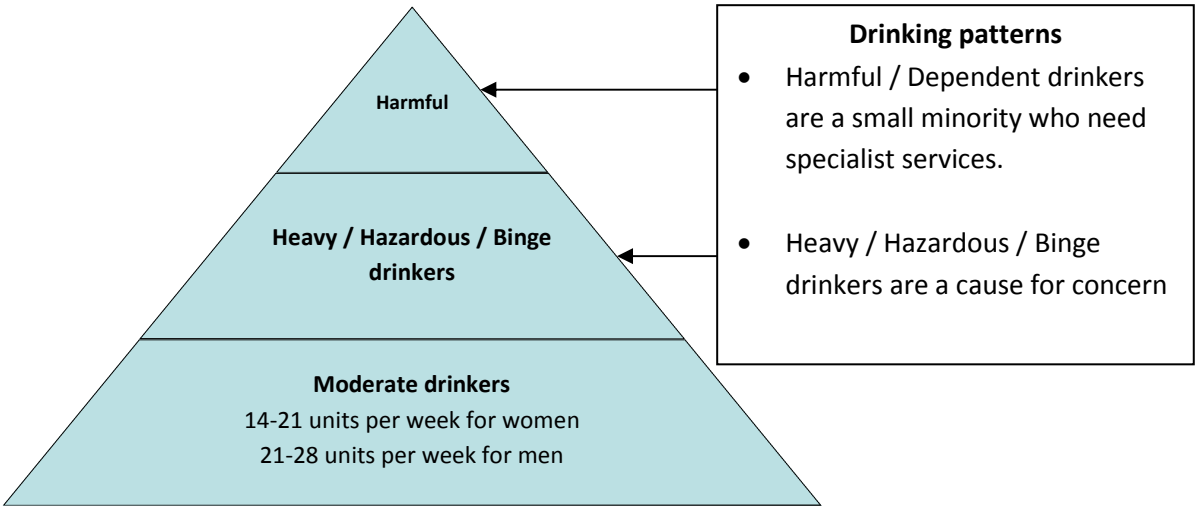
Joint Health Overview and Scrutiny Committee 13 June 2013
Alcohol Related Harm to Health
Briefing Note

Executive Summary

Efforts to reduce the impact of alcohol on health need to start with the individual, be underpinned by national policy and respond to local need. This paper gives an overview of individual responsibility, national policy and local arrangements for reducing alcohol related harm to health. This includes an overview of the approaches to prevention and the treatment services currently available for dependent drinkers.

Background

Communities have drunk alcohol for thousands of years. For the ancient Greeks wine was a significant trade commodity and wine also served important religious, social and medical purposes in Greek society. The consumption of alcohol still has a prominent place in modern society, and can have a positive impact on adults' social wellbeing. Alcohol plays a significant role in the fabric of modern society and also makes a substantial contribution to the economy. The majority of people drink alcohol in a responsible way. It is known however; that even drinking a modest amount has an impact on health. Furthermore, an increasing minority of people are drinking harmful amounts of alcohol and this is reflected in increased alcohol related disease. The Director of Public Health for Oxfordshire has highlighted concerns about alcohol consumption in his Annual Report for several years now.



Most people in the population who drink alcohol do so moderately. A small minority develop dependence on alcohol and may need referral to addiction services in order to reduce or stop drinking. There is a growing concern that, between these "moderate" and "harmful" drinkers there is a growing number of people who are damaging their health by drinking more than the maximum number of units recommended (14-12 units a week for women and 21-28 units a week for men). These higher levels of consumption, whether

spread out over the week or consumed in a binge at the weekend / on holiday, will have a longer term impact on health, exacerbating certain conditions and increasing risk of illness. This paper provides an outline of the likely prevalence of problem drinking in Oxfordshire and the range of provision in place in order to reduce the health related harms. The further impact of alcohol on community safety, family life and social issues are **not** the topic of this paper or discussion. The focus here is on harm to health.

The Scale of the Problem

Estimating the scale of alcohol addiction has proved very difficult for government over the years, as problem alcohol consumption is often hidden. The government's alcohol strategy now estimates **that in a community of 100,000 people**, each year:

- • 2,000 people will be admitted to hospital with an alcohol-related condition;
- • 1,000 people will be a victim of alcohol-related violent crime;
- • Over 400 11-15 year olds will be drinking weekly;
- • Over 13,000 people will binge-drink;
- • Over 21,500 people will be regularly drinking above the lower-risk levels;
- • Over 3,000 will be showing some signs of alcohol dependence; and
- • Over 500 will be moderately or severely dependent on alcohol.

In Oxfordshire there is a population of 435,700 individuals aged 15 – 64 years. According to the estimates set out above this means that

- **2,200 people in Oxfordshire may be moderately or severely dependant drinkers**
- **13,200 people in Oxfordshire may be showing some signs of alcohol dependence**

Local data shows that there were over 6300 in-patient admissions for alcohol attributable conditions in 2010-11 (Source: North West Public Health Observatory (NWPHO) from Hospital Episodes Statistics)

National and Local services and initiatives

Efforts to reduce the impact of alcohol on health need to start with the Individual, rest on national policy and respond to local need. This paper outlines these various elements that make up the national and local picture for prevention and treatment. This is summarised in the diagram below.

A wide range of organisations provide these services. These are all described more fully in the remainder of the paper. Representatives of these services have been invited to attend the meeting of the Health Overview and Scrutiny Committee in June 2013 to explain their work in more detail.

Alcohol – reducing health related harm. An overview

1. Role of individuals and communities
"Responsible drinking" and culture of alcohol use in families and communities

2. National Government role
Policy on licensing, taxation, minimum pricing (?), Social Responsibility Deal

3. Primary Prevention
Curriculum / campaigns in schools, Primary care "day job", Campaigns e.g. Change 4 Life, Alcohol Awareness Week, Pharmacy campaigns, Men's Health Week etc.

4a. Screening
Lead: Public Health & Alcohol Strategy Group.
(Detecting "harmful / hazardous" drinkers)
NHS Health Checks, GPs in primary care, other settings

4b. Brief Advice for harmful drinkers
Lead: Alcohol Strategy Group / DAAT
Primary Care, Non-NHS settings, Accident and Emergency Dept, Early Intervention Hubs (Young People),

5. Referral to Treatment
Local Area Single Assessment and Referral Service (LASARS)
Assessment, information, advice, referral for "hazardous and harmful" drinkers

Increasing intensity of interventions

5a. Treatment for Addiction
Community, Hubs, Hospital, Residential.

Oxford Health - Harm Minimisation Service. Alcohol Interventions and Treatment

Lifeline - Recovery Service. Community Detoxification and Treatment

Young Addaction

5b. Residential Rehabilitation/Detoxification
Range of approved providers

Howard House
Residential Detoxification

6. Recovery Network

Aftercare support

Alcoholics Anonymous

SMART recovery

7. Medical Treatment
a. Treatment for alcohol related diseases- in the community or hospital
e.g. fatty liver disease, alcoholic hepatitis, liver cirrhosis.
b. Treatment for diseases which alcohol exacerbates: Heart disease, some cancers etc

1. The role of the individual, family and community

The statistics and outcomes that we quote are made up of individual stories and choices. Ultimately the reduction in alcohol related harm can only be achieved when individuals choose moderate drinking. These choices then influence the social norms which become the culture of drinking. Normative education in schools is helping young people to know that, in spite of what they might hear, most of their peers are not drinking to excess. Information about the long term damage of drinking above recommended levels needs to be accessible and help inform healthy choices in the whole population.

2. National Strategy and the role of central Government

The role of Government includes taxation policy, which has seen consistent approaches to excise duty on alcohol. There has been consultation on licensing and more local freedom to introduce Late Night Levies aim to reduce public order issues. The naming of the NHS as a "responsible authority" in licensing means that harm to health can now be cited as a reason for changing or refusing licenses to sell alcohol. Consultation on minimum pricing per unit of alcohol was carried out earlier this year and a response from Government is awaited. All these measure are essential to underpin local efforts to inform the population and prevent alcohol related harm.

There has also been a change to how treatment services are commissioned, with more local freedom. The Government Alcohol Strategy was launched in March 2012. It states that:

> "From April 2013, upper tier and unitary local authorities will receive a ring-fenced public health grant, including funding for alcohol services. Local authorities will be supported by Public Health England. They will be free to design services to meet local needs, working in partnership where this makes sense for them. This can maximise the scope for early interventions and can better meet the needs of specific groups.

3. Primary Prevention

The key to reducing alcohol related harm to health is to enable individuals to make healthy choices. Local activity is taken forward by a wide range of organisations and some joint work is overseen by the Alcohol Strategy Group. This includes running information campaigns in schools, a focus on Alcohol Awareness Week each November and Men's Health Week in July, pharmacy campaigns and information through primary care. Primary prevention is also embedded in the "day job" of primary care and is written into the school curriculum. National campaigns, such as Change4Life give information on alcohol consumption too.

The Alcohol Strategy Group is a partnership of local authorities, public health, voluntary sector, police, Trading Standards and other organisations. It oversees the implementation of action plans which cover reducing health related harm as well as community safety issues and attempts to reduce the supply and demand of alcohol to young people.

4. Screening and Brief Advice

a. Screening

The Alcohol Strategy Group also implements actions to promote screening for alcohol use and onward referral for brief advice or treatment. Most people drink alcohol at levels below the maximum recommended number of units (21-28 a week for men, 14-21 per week for women). Those drinking above these levels may be regarded as at risk of harm and so brief advice is indicated. The screening tool will also indicate possible dependence on alcohol for which referral into addiction services may be appropriate. A simple list of questions is used to screen people for alcohol use. This is routinely used with new patients registering in GP Practices and has just been introduced as part of the NHS Health Checks for 40-74 year olds.

b. Brief Advice

Many people who are drinking at above the maximum recommended levels benefit from "brief advice" following this screening. The Alcohol Strategy Group has overseen training for a range of health and other professionals in how to deliver this advice. This is a very effective intervention recommended by the National Institute for Clinical Excellence (NICE). A Community Safety Practitioner based in the Emergency Department at the Oxford University Hospitals Trust also offers brief advice to people who attend with alcohol related conditions or injuries.

5. Treatment for Addiction

This includes services in the community and residential treatment. The range of services is set out below, including detoxification, psycho-social interventions and peer support. Special services for young people are also provided.

a. Services Commissioned for Adults by DAAT Board for the Treatment of Alcohol Dependency

Local Area Single Assessment and Referral Service (LASARS) – Provided by the LASARS partnership (made up of Probation, Lifeline and Oxford Health)

LASARS provide an information and referral service for anyone seeking help. LASARS is new to Oxfordshire and is the single point of access for drug and alcohol treatment. The LASARS partnership started in October 2012 and provides

- Assessment and support for residential rehabilitation placements
- Initial assessments for drug and alcohol treatment services
- A single point of contact drug and alcohol treatment
- Signposting
- Information and advice

Provider Lead: Lou Everatt (Thames Valley Probation)

The Harm Minimisation Service - Provided by Oxford Health Foundation NHS Trust in partnership with OASIS

This service provides:

- Drug and alcohol treatment with specialist drug and alcohol workers, nurses and doctors led by a consultant psychiatrist.
- Support using cognitive behavioural techniques aimed at those people whose alcohol consumption is starting to have an impact on their social, psychological and physical functioning so those showing some signs of dependence.
- Support for chaotic drinkers who are not able or not ready to stop drinking
- Drop in support sessions including Saturday morning sessions
- Detoxification for those addicted to alcohol as well as drugs

Total number of individual alcohol clients April 2012 – March 13	**396**

Provider Leads: Karen Skinner - Clinical Service Manager. Roy Walsh - Manager of the specialist drug and alcohol workers. Dr Alastair Reid - Consultant Psychiatrist (Oxford Health NHS Foundation Trust)

The Recovery Service - Provided by Lifeline

This service is an abstinence based service for those that want to overcome their drug and alcohol addiction. The service provides drug and alcohol detoxification with specialist drug and alcohol workers, nurses and doctors.

- Alcohol detoxification
- Community rehabilitation
- Intensive support groups
- Counselling
- Education, Training and Employment
- Housing support
- Weekend and evening support
- Peer support groups such as NA & AA
- Ongoing aftercare support

This Service is commissioned on a Payment by Results basis as part of a government pilot.

Total number of individual alcohol clients since April 12 to March 13 (Source OTIS)	**400**

Provider Leads: Dee Dee Wallace – Service Manager. Dr Rick Dougal – Clinical Lead (Lifeline)

Howard House - Provided by SMART

Howard House in a ten bed residential detoxification unit aimed at the more complex cases of drug and/or alcohol dependency. The service provides a 12 week programme delivered by specialist drugs and alcohol workers, nurse and weekly on site doctors.

- 24 hours staffing
- Group programmes
- Individual counselling
- Medically assisted detoxification
- Peer support
- Housing support

Provider Lead: Jodie McMinn – Service Manager (SMART)

b. Residential Rehabilitation and Residential Detoxification Framework

A range of approved providers of residential treatment for drug and alcohol addiction are under contract through an Oxfordshire County Council Contract Framework that was tendered for in 2010. Approximately £850k is spent on placements of up to 6 months. There are nine different providers from across the England providing different types of rehabilitation programmes that meet various needs such as Women Only centres, 12 Step (Christianity based) programme which is like AA. This type of service is for more complex cases where community treatment has not worked.

Total number of clients (alcohol, drug, alcohol & drug) 2012/13		102
Number of alcohol only	**28**	**27.45%**
Number of drug only	28	27.45%
Number of drug & alcohol	**46**	**45.10%**

Services Commissioned by DAAT Board for Young People's Drug and Alcohol Misuse

The young people's drug and alcohol service is provided by Young Addaction, This is delivered through the Early Intervention Hub structure throughout the county. There is a specialist drug and alcohol worker within each Early Intervention Hub and the integration enables closer collaborative working. The service provides:

- One to one support for young people who are experiencing difficulties with drugs and alcohol
- One to one support for young people who are affected by their parents/familial drug and alcohol addiction

Provider Lead: Anna Penn – Service Manager, Young Addaction

6. Oxfordshire Recovery Network

The Recovery Network is a social enterprise that has grown from Oxfordshire User Team, aimed at providing those with a history of drug or alcohol addiction and offending with opportunities to overcome social exclusion. This is achieved by creating opportunities for volunteering, supporting people with education, training and employment and enabling people to develop positive lifestyles and friendships. The Refresh Café situated on the Cowley Road is a focal point for this initiative and provides:

- Volunteering and work placement opportunities for prisoners on day release from Springhill prison
- Food Hygiene qualifications
- Volunteering opportunities in the café
- Access to the information hub and internet Café
- Access to education, training and employment opportunities
- Information, advice and support
- Access to leisure activities to build new relationships
- The annual Walk for Recovery event to raise awareness about recovery

Provider lead: Glenda Daniels (Oxfordshire User Team)

7. Medical Treatment

Services Commissioned by Oxfordshire Clinical Commissioning Group (OCCG)

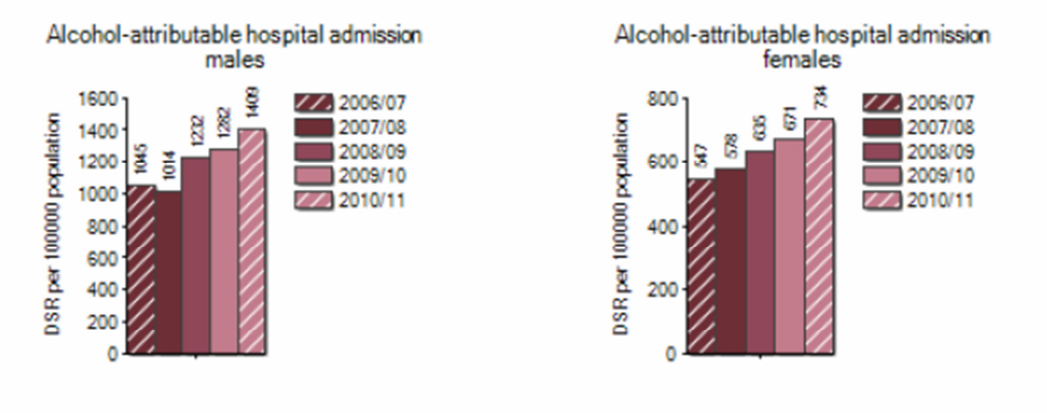
Emergency Department Provided by Oxford University Hospitals Trust

Oxford Emergency Department at the John Radcliffe Hospital is a busy emergency department with a significant amount of admission on a weekend being alcohol related. At present Public Health fund one community safety practitioner (a nurse). This postholder works with staff within the department and follows up individuals whose illness or injury is related to alcohol consumption. Some of these people are offered brief advice about their alcohol consumption or referred to other services. This is shown to reduce the number of alcohol related readmissions to the emergency department.

Provider Lead: Dr Phil Hormbrey – Emergency Department Consultant (OUH)

Hospital in-patient services commissioned by Oxfordshire Clinical Commissioning Group (OCCG)

Hospital admissions for conditions directly related to alcohol consumption or other illnesses that are exacerbated by alcohol are increasing, as shown in the table below. A range of medical services is commissioned by the CCG so that appropriate treatment can be provided. Some examples are given below.



Gastroenterology - Oxford University Hospitals Trust

The liver breaks down alcohol so it can be removed from the body. The liver can become injured or seriously damaged if an individual drinks more alcohol than it can process. There are three main types of alcohol-related liver disease: fatty liver disease, alcoholic hepatitis, and alcoholic cirrhosis.

Fatty liver disease

Fatty liver disease is the build up of extra fat in liver cells. It is the earliest stage of alcohol-related liver disease. There are usually no symptoms. If symptoms do occur, they may include fatigue, weakness, and weight loss. Almost all heavy drinkers have fatty liver disease. However, if they stop drinking, fatty liver disease will usually go away.

Alcoholic hepatitis

Alcoholic hepatitis causes the liver to swell and become damaged. Symptoms may include loss of appetite, nausea, vomiting, abdominal pain, fever and jaundice. Up to 35 percent of heavy drinkers develop alcoholic hepatitis.

Alcoholic hepatitis can be mild or severe. If it is mild, liver damage may be reversed. If it is severe, it may occur suddenly and quickly lead to serious complications including liver failure and death.

Alcoholic cirrhosis

Alcoholic cirrhosis is the scarring of the liver -- hard scar tissue replaces soft healthy tissue. It is the most serious type of alcohol-related liver disease. Symptoms of cirrhosis are similar to those of alcoholic hepatitis. Between 10 and 20 percent of heavy drinkers develop cirrhosis. The damage from cirrhosis cannot be reversed and can cause liver failure. Not drinking alcohol can help prevent further damage. Source: The Liver Foundation

The Gastroenterology department situated at the John Radcliffe Hospital provides treatment for chronic alcohol related liver disease. Gastrointestinal Services (often referred to as GI Services), is concerned with the treatment of the digestive tract (or gut) and associated organs.

Provider Lead: Dr Jane Collier – Gastroenterology Consultant

Commissioning and Partnership Arrangements in Oxfordshire

The Alcohol Strategy Group is a sub group of the Oxfordshire Community Safety Partnership. The group oversees the implementation of the wider partnership alcohol strategy which includes primary prevention of harm to health and some screening and brief interventions. Most of the work is achieved through collaboration or by individual partners commissioning specific pieces of work from their own budgets. The strategy also aims to reduce alcohol related community safety issues and the supply and demand of alcohol to young people.

Oxfordshire Clinical Commissioning Group commissions services related to the medical treatment of alcohol related conditions in secondary care and the Emergency Department.

The DAAT (Drug and Alcohol Action Team) Board is a partnership that oversees the commissioning of services for alcohol dependency for adults and alcohol services for young people. Until recently the budget available to the DAAT board from government was restricted to its primary focus being on commissioning services for illicit drug addiction, this restriction has now been relaxed and services were redeveloped and expanded, with new services starting in April 2012. As part of a national pilot, two of the main services (described on page 6), the Recovery Service and the Harm Minimisation service are commissioned of a payment against outcome basis

Last year all the drug and alcohol treatment services that were commissioned by the DAAT were remodelled and re-commissioned to embed the treatment of alcohol dependency within them. During 2013/2014 further investment will be made to increase the capacity in provision of alcohol treatment. This includes:

- Doubling the number of alcohol workers within the Harm Minimisation Service and having a dedicated alcohol nurse working with the hostels for the homeless.
- Commissioning dedicated alcohol education, for a full three year cycle, for every secondary school in Oxfordshire.
- Reviewing care pathways to ensure that GP practices can access to specialist alcohol workers for their patients.
- Ensuring that the work of the Alcohol Strategy Group and the other commissioners is more closely linked.

Jackie Wilderspin and Jo Melling, Public Health, Oxfordshire County Council