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NHS Oxfordshire Clinical Commissioning Group | OXFORDSHIRE COUNTY COUNCIL | healthwatch Oxfordshire

To: Members of the Health Improvement Partnership Board

Notice of a Meeting of the Health Improvement Partnership Board

Monday, 6 July 2015 at 2.00 pm

Town Hall, Oxford

Peter G. Clark
County Solicitor

26/06/2015

Contact Officer: ***Katie Read, Policy & Partnership Officer***
Tel: (01865) 328272; Email: katie.read@oxfordshire.gov.uk

Membership

Chairman – City Councillor Ed Turner
Vice Chairman - Councillor Anna Badcock

Board Members:

Ian Davies	Cherwell & South Northants District Council
Cllr John Donaldson	Cherwell District Council
Laura Epton	Healthwatch Ambassador
Emma Henrion	Healthwatch Ambassador
Cllr Hilary Hibbert-Biles	OCC – Cabinet Member for Public Health & Voluntary Sector
Dr Jonathan McWilliam	Director of Public Health
Cllr James F. Mills	West Oxfordshire District Council
Dr Paul Park	Oxfordshire Clinical Commissioning Group
Cllr Monica Lovatt	Vale of White Horse District Council
Jackie Wilderspin	Public Health Specialist

Notes:

- ***Date of next meeting: 27 October 2015***

Declarations of Interest

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

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

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

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

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

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

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

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

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

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

For a full list of Disclosable Pecuniary Interests and further Guidance on this matter please see the Guide to the New Code of Conduct and Register of Interests at Members' conduct guidelines. http://intranet.oxfordshire.gov.uk/wps/wcm/connect/occ/Insite/Elected+members/ or contact Glenn Watson on (01865) 815270 or glenn.watson@oxfordshire.gov.uk for a hard copy of the document.

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

AGENDA

1. Welcome by Chairman

2. Apologies for Absence and Temporary Appointments

3. Declaration of Interest - see guidance note opposite

4. Petitions and Public Address

5. Minutes of last meeting (Pages 1 - 6)

2:05pm
5 minutes

To approve the minutes of the meeting held on 23 April 2015 and to receive information arising from them.

6. Performance Report (Pages 7 - 18)

2:10pm
20 minutes

People responsible: Members of the Health Improvement Board

Report presented by: Jonathan McWilliam, Oxfordshire County Council

A report on progress against the targets of the Health Improvement Board.

7. Draft Health and Wellbeing Strategy 2015-2019 (Pages 19 - 48)

2:30pm
20 minutes

Report presented by: Jonathan McWilliam, Oxfordshire County Council

The draft revision of the Health and Wellbeing Strategy 2015-2019, including proposed performance measures for 2015 for the health improvement priorities 8-11, as recommended by the Health Improvement Board.

8. Housing Related Support update

2:50pm
10 minutes

Verbal update from: Natalia Lachkou, Oxfordshire County Council

A verbal update to the Health Improvement Board on the implementation of housing related support services.

9. **Young People's Supported Housing** (Pages 49 - 54)

3:00pm
20 minutes

Report presented by: Eleanor Stone, Oxfordshire County Council

A report on the homelessness and housing need among young people in Oxfordshire and the work of the Joint Housing Steering Group.

The Health Improvement Board is recommended to:

- Provide oversight of the Joint Housing Steering Group and the supported housing pathway for young people.
- Agree the outcome measure for supporting vulnerable young people in appropriate housing that will be monitored by the Health Improvement Board under priority 10.

10. **Health Protection Forum Annual Report** (Pages 55 - 60)

3:20pm
20 minutes

Report presented by: Eunan O'Neill, Oxfordshire County Council

A report on the activity of the Public Health, Health Protection Forum over 2014-15.

11. **Forward Plan** (Pages 61 - 62)

3:40pm
5 minutes

Presented by: Councillor Ed Turner, Chairman

A discussion of the forward plan for the Health Improvement Board.

NHS Oxfordshire Clinical Commissioning Group

OXFORDSHIRE COUNTY COUNCIL

healthwatch Oxfordshire

HEALTH IMPROVEMENT PARTNERSHIP BOARD

OUTCOMES of the meeting held on Thursday 23 April commencing at 2.00 pm and finishing at 4.00 pm.

Present:

Board Members:	Councillor Ed Turner (Vice Chairman), Oxford City Council – in the chair
	Councillor Hilary Hibbert-Biles, Oxfordshire County Council, Cabinet Member for Public Health & Voluntary Sector Councillor Judith-Nimmo Smith, South Oxfordshire District Council Councillor Alison Thomson, Vale of White Horse District Council Councillor George Reynolds, Cherwell District Council Jackie Wilderspin, Public Health Specialist Dr Jonathan McWilliam, Director of Public Health Dr Paul Park, Oxfordshire Clinical Commissioning Group Ian Davies, Cherwell and South Northants District Council Aziza Shafique, Public Involvement Network Paul McGough, Public Involvement Network
Officers:	
Whole of meeting:	Val Johnson, Oxford City Council Katie Read, Oxfordshire County Council
Part of meeting:	
Agenda item 6	Rachel Coney, Healthwatch Oxfordshire
Agenda item 7	Sally Bradshaw, NHS England
Agenda item 9	Kate Terroni, Oxfordshire County Council Natalia Lachkou, Oxfordshire County Council
Agenda item 10	Val Messenger, Oxfordshire County Council Stephen Pinel, Oxfordshire County Council
Agenda item 11	Andrew Stevens, Oxford University Hospitals NHS Trust Behrooz Behbod, Oxford University Hospitals NHS Trust

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

If you have a query please contact Katie Read (Tel 01865 328272; Email: katie.read@oxfordshire.gov.uk)

DRAFT

ITEM	ACTION
1. Welcome The Vice-Chairman, City Councillor Ed Turner, welcomed all to the meeting. The Vice-Chairman shared with members that Councillor Mark Booty would no longer be chairing the Health Improvement Board, as he is not standing for re-election in May. The Board thanked Mark in his absence, for the work he had done in his role as Chairman and wished him well for the future.	
2. Apologies for Absence and Temporary Appointments Apologies have been received from: Councillor Mark Booty	
3. Declaration of Interest No declarations were received.	
4. Petitions and Public Address No petitions or public addresses were received.	
5. Minutes of Last Meeting The minutes of the February meeting were approved. There was one point of clarification; the breastfeeding report is intended to enable sharing of good practice between the districts, city and county councils.	
6. Public Involvement Network Final Report The Vice-chairman, Cllr Ed Turner, thanked Paul McGough and Aziza Shafique for their commitment to the Board and their enthusiasm in working with Oxfordshire communities on health issues that mean the public voice is heard in Board meetings. The Board wished Paul and Aziza well in their future endeavours. Paul McGough and Aziza Shafique presented the final PIN report, which summarised their perspective of the role of lay representatives and their activities in support of the Board during their tenure. The Board was thanked for its support of the PIN and for encouraging the independence of lay representatives, so that they could constructively contribute to and challenge the work of the Board. It was recognised that not all of their hopes and expectations were met during their tenure, but these actions are still being taken forward by the Board. Paul and Aziza expressed their hope that the future role of lay representatives on the Board will evolve from public involvement and	

engagement to public empowerment. Paul acknowledged that this process has already started with the joint Oxford University Hospitals Trust and Oxfordshire County Council Public Health Strategy. Rachel Coney provided a verbal update on the recruitment of a Healthwatch Ambassador to be the lay representative on the Board. The role and responsibilities of the Ambassador have been agreed and the County Council will be involved in the recruitment process; a newly appointed Ambassador will be at the next Board meeting. Filling the role as a job share may be considered. Many of the recommendations in the final PIN report are part of Healthwatch's core business. **It was agreed that a report on the breadth of Healthwatch's work would come to the next meeting, including an explanation of the organisation's relationship to the Board**.	**Rachel Coney / Katie Read**
7. Performance Report Jonathan McWilliam introduced the performance report and discussion was focused on the report cards. It was clarified that localities used for measuring rates of breastfeeding differ from other accepted local authority areas and are organised around GP surgeries; this can lead to skewed results because of the number of surgeries covered by a particular locality. <u>Report card 1 – Immunisation</u> Sally Bradshaw presented the report card and emphasised that immunisation is a priority for NHS England. They are looking to recruit a specialist nurse to sit in a provider organisation and deal with immunisation issues directly. The Board was pleased with this approach and practical support for the recruitment to this post was offered by Public Health colleagues. The reasons for non-vaccination were queried. It was thought that the first dose of the MMR vaccine is easier to gain because children are younger and parents are keen to protect them. The second dose can be harder to achieve because of negative past experiences and an older age, but it often depends on individual circumstances. It is hoped that the specialist nursing post will tackle this issue, providing individual answers to individual questions on the ground. No specific characteristics among under-performing practices have been identified, although migrant population figures and practices with high traveller numbers were considered possible factors. <u>Report card 2 – Treatment of opiate and non-opiate users</u>	

Jackie Wilderspin presented the report and attributed service improvement to implementation of the recovery plan over the last year. Further improvement is hoped for with the appointment of a new contractor, Turning Point, who have been delivering the service from 1st April 2015. Data after October 2014 on opiate and non-opiate users is currently unavailable due to Public Health England's systems being down. More up-to-date data will be available in the performance report for the Board's next meeting. The transition to the service being provided by Turning Point was praised by the Board and the importance of joint working with primary care agencies going forward was emphasised. <u>Basket of housing and health indicators annual report</u> Dave Scholes presented the report. There were no recommendations from the Housing Support Advisory Group to expand the housing and health indicators for 2015-16, but it was proposed that reports could be brought by exception, as the Group develop key contract monitoring measures for the new housing support arrangements.	
The Board agreed the proposal for reporting by exception and asked that a framework be developed outside the meeting to enable meaningful reporting to the Board.	**Dave Scholes**
It was reported that the joint housing steering group for young people has requested that the Health Improvement Board oversees progress on the supported housing pathway for young people. **It was proposed that an indicator for young people's supported housing is included in regular performance monitoring, which the Board agreed.**	**Jackie Wilderspin / Eleanor Stone**
8. Health Improvement Board Priorities 2015-16 Jackie Wilderspin presented the paper on the Board's future priorities to put forward suggestions for the Joint Health and Wellbeing Strategy refresh in July. The addition of an indicator on the percentage of women smoking in pregnancy was proposed. It is considered an area where a real difference can be made, as these women would have more motivation to stop smoking. **The Board agreed to add the indicator on women smoking during pregnancy.**	**Jackie Wilderspin**
9. Domestic Abuse Services Review Kate Terroni and Natalia Lachkou provided a verbal update on the progress of the review.	

The County Council is committed to providing a leadership role that will join up work on domestic abuse services across the county. Funding has been provided for this role, therefore the forecast reduction of domestic abuse services will not be so great. The review will continue once this role has been recruited to. More immediate pressures on domestic abuse services will be tackled before the review, namely access to the helpline not being 24/7, as it is staffed by volunteers. **It was agreed that the scoping document for the review would be brought back to the Board when prepared.** Reporting lines for domestic abuse services were clarified: the Oxfordshire Safer Communities Partnership will lead on the domestic abuse review, but the Health Improvement Board will monitor the health and housing elements of the service to report to the Health and Wellbeing Board.	**Kate Terroni/ Natalia Lachkou**
10. Oral Health Promotion update Val Messenger presented the report. The relevance of the data on 5 year olds was questioned due to it being out of date (based on data from 2011-12). The Public Health England team who are responsible for the survey is limited by data in national mandatory surveys, which are very prescriptive, alternate data collection across years, and focus on a small sample. The lowest level of geographical data that can be obtained is by district/city area. Emphasis was put on the connection between poor oral health and deprivation – it would be useful to have oral health data to inform other work around deprivation and child poverty. Currently data on local oral health can only be extrapolated from national databases. Flexibility has been built into new contracts for oral health promotion to offer training to front line staff in a range of services, e.g. Reablement services.	
11. Oxford University Hospitals Trust and Oxfordshire County Council Joint Public Health Strategy Andrew Stevens and Behrooz Behbod provided an update on the Strategy. The Strategy is causing Oxford University Hospitals Trust (OUHT) to look at how services are provided in a different way, e.g. The “Here for Health” Clinic sited in the hospital has made consultants reconsider the patient pathway and build in health improvement interventions.	

Various initiatives connected to the Strategy's three key aims were expanded upon. The Board discussed the benefits of having a Strategy that encourages hospitals to promote Public Health and welcomed the proposal to appoint a dedicated Public Health consultant based within the hospital. **The Vice-chairman will write to the OUHT Chief Executive, Sir Jonathan Michael, about the importance of this post.** The Board asked whether the Strategy is being expanded to community hospitals and voluntary groups. Community hospitals already run their own Public Health activities, with which the Strategy can align. OUHT is also looking at its catering contracts to promote healthier meal options at its sites; this could present opportunities for voluntary organisations. It was thought that Public Health champions are needed to engage with the public as part of the Strategy. A link with patient experts on the Oxford Health steering group could also be useful.	**Cllr Ed Turner**
12. Health Improvement Board Terms of Reference Jackie Wilderspin shared minor amendments to the terms of reference for the Board, namely around membership. **It was suggested that a stronger link should be made with the Oxfordshire Safer Communities Partnership in the terms of reference.**	**Jackie Wilderspin/ Katie Read**
13. Forward Plan No items on the forward plan were discussed. **The next scheduled meeting of the Board will be rearranged due to availability of Board members.** From the meeting, the following items will be added: • **Healthwatch update** • **Young People's supported Housing pathway** • **Scoping of domestic abuse services review**	**Katie Read**
The meeting closed at 4.00pm	

.... in the Chair

Date of signing ....

Health Improvement Board
23rd June 2015

Q4 Performance Report

Background

1. The Health Improvement Board is expected to have oversight and of performance on four priorities within Oxfordshire's Joint Health and Wellbeing Strategy 2012-2016, and ensure appropriate action is taken by partner organisations to deliver the priorities and measures, on behalf of the Health and Wellbeing Board.

2. The four priorities the Board has responsibility for are:

   Priority 8: Preventing early death and improving quality of life in later years
   Priority 9: Preventing chronic disease through tackling obesity
   Priority 10: Tackling the broader determinants of health through better housing and preventing homelessness
   Priority 11: Preventing infectious disease through immunisation

Current Performance

3. A table showing the agreed measures under each priority, expected performance and current performance is attached as appendix A.

4. There are 18 indicators that are reported to this board. Data is not yet available for 2 annual indicators or the Q4 data for 1 indicator. These will be reported to the next Health & Wellbeing Board.

5. For the 15 indicators that can currently be reported on, current performance can be summarised as follows:

   7 indicators are Green.
   3 indicators are Amber (defined as within 5% of target).
   6 indicators are Red
   2 indicators do not yet have information

6. Four of the indicators rated Red at the end of Q4 are within Priority 8 - Preventing early death and improving quality of life in later years.
   These are:
   a. 53% of people aged 40-74 invited for an NHS Health Checks attended, against a target of 66% (Indicator 8.3)
   b. A target was set for 3800 people to quit smoking for at least 4 weeks but the final figure was only half of this (1955). (Indicator 8.4)
   c. 6.7% of opiate users successfully left treatment by the end of 14/15, roughly in line with the previous year (6.5%) and below the target of 8.6%. (Indicator 8.5).
   d. 20.2% of non-opiate users successfully left treatment by the end of 14/15. This was an increase on 2013/14 performance (15.5%) but noticeably below the target of 38.2%. (Indicator 8.6).

e. For indicators 8.5 and 8.6, current performance is being addressed with a comprehensive recovery plan, with Public Health England supporting the development and implementation of system wide action plans. In addition, a new Integrated Drug and Alcohol Treatment Service has been commissioned and commenced delivery on 1 April 2015.

7. Annual data from the Active People survey shows that the target for Indicator 9.2 was not met. The proportion of people who are NOT physically active for at least 30 minutes a week increased from 22.2% to 23%.

8. All the indicators in Priority 10 – Tackling the broader determinants of health through better housing and preventing homelessness met or exceeded the target.
   In particular:
   - 87% of people receiving housing related support departed services to take up independent living against a target of 75%. (Indicator 10.2)
   - 86% of households presenting at risk of being homeless and known to District Housing services or District funded advice agencies were prevented from becoming homeless against a target of 80%.(Indicator 10.3). There is a degree of variation between districts though from 59% in West Oxfordshire to 89% in Oxford City.

9. 21% of people aged 40-74 who are eligible for health checks once every 5 years, were invited to attend during the year against a target of 15% (Indicator 8.2). This indicator was green throughout the year.

10. 95% of children received dose 1 of MMR (measles, mumps, rubella) vaccination by the age 2, meeting the annual target (Indicator 11.1). This was an increase after a slight dip earlier in the year.

Alison Wallis
Performance & Information Manager, Joint Commissioning
23/06/2015

Oxfordshire Health and Wellbeing Board
Performance Report

No	Indicator	Q1 Apr-Jun	RAG	Q2 Jul-Sept	RAG	Q3 Oct-Dec	RAG	Q4 Jan-Mar	RAG	Locality spread	Notes
Priority 8: Preventing early death and improving quality of life in later years											
8.1 NHS England	At least 60% of those sent bowel screening packs will complete and return them (ages 60-74 years)	**Expected** 60% **Actual**	R	**Expected** 60% **Actual** 57.3%	A	**Expected** 60% **Actual** **57.0%**	A	**Expected** 60% **Actual**			Indicator was previously separated into 60-69 and 70-74 age groups, however from Q2 these are no longer reported separately.
8.2	Of people aged 40-74 who are eligible for health checks once every 5 years, at least 15% are invited to attend during the year. No CCG locality should record less than 15% and all should aspire to 20%	**Expected** 3.75% **Actual** 5.4%	G	**Expected** 7.5% **Actual** 11.6%	G	**Expected** 11.25% **Actual** 16.9%	G	**Expected** 15% **Actual** **21.2%**	G	Q3 - All localities on target to achieve 15%. Only Oxford City and West localities at risk of not achieving the aspired 20%.	
8.3 OCC	At least 66% of those invited for NHS Health Checks will attend (ages 40-74) and no CCG locality should record less than 50% with all aspiring to 66% (Baseline 46% Apr 2014)	**Expected** 46% **Actual** 41.5%	R	**Expected** 50% **Actual** 43.1%	R	**Expected** 58% **Actual** 48.3%	R	**Expected** 66% **Actual** **53.3%**	R	Q3 - Two CCG localities currently over 50% (West and North). All others below 50%. Lowest South East at 40.6%.	
8.4	At least 3800 people will quit smoking for at least 4 weeks (Baseline 3622 in 13/14) Baseline women smoking in	**Expected** 868	R	**Expected** 1672	R	**Expected** 2574	R	**Expected** 3800	R		Women smoking in pregnancy – 8%

No	Indicator	Q1 Apr-Jun	RAG	Q2 Jul-Sept	RAG	Q3 Oct-Dec	RAG	Q4 Jan-Mar	RAG	Locality spread	Notes
OCC	pregnancy (%) – 9% (Q4 1314)	**Actual** 626		**Actual** 1133		**Actual** 1633		**Actual** **1955**			
8.5 OCC	8.6% of opiate users successfully leaving treatment by the end of 14/15 (baseline 6.5% 2013/14)	**Expected** 7.0% **Actual** 7.1%	G	**Expected** 7.5% **Actual** 6.9%	R	**Expected** 8.0% **Actual** 7.2%	R	**Expected** 8.6% **Actual** **6.7%**	R		The number of non-opiates users successfully completing treatment is below the set target. Through the introduction of the Public Health Outcome Framework the performance measure has changed from counting drug users safely supported in services to counting those who successfully complete treatment. Current performance is being addressed with a comprehensive recovery plan with Public Health England support to develop and implement system wide action plans. In addition, a new Integrated Drug and Alcohol Treatment Service has been commissioned and commenced delivery on 1 April 2015.
8.6 OCC	38.2% of non-opiate users successfully leaving treatment by the end of 14/15 (baseline 15.5% 2013/14)	**Expected** **21.2%** **Actual** 14.5%	R	**Expected** **26.9%** **Actual** 17.7%	R	**Expected** **32.6%** **Actual** 17.7%	R	**Expected** **38.2%** **Actual** **20.2%**	R		

Priority 9: Preventing chronic disease through tackling obesity

No	Indicator	Q1 Apr-Jun	RAG	Q2 Jul-Sept	RAG	Q3 Oct-Dec	RAG	Q4 Jan-Mar	RAG	Locality spread	Notes
9.1 OCC	Ensure that the obesity level in Year 6 children is held at no more than 15% and no district population should record more than 19% (Baseline 15.2% in 2013)			**Expected** 14.9% or less **Actual** **16.9%**	**R**					Oxford City – 21% Is the only locality above 19%. South Oxfordshire has the lowest obesity level – 15.2%	
9.2 District council	Reduce by 1% the proportion of people who are NOT physically active for at least 30 minutes a week (Baseline for Oxfordshire 22.2% against 28.5% nationally, 2013-14 Active People Survey)							**Expected** **21.2%** **Actual** **23%**	**R**		Report from the Active People Survey 2014-15
9.3 NHS England & CCG	63% of babies are breastfed at 6-8 weeks of age (currently 60.4%) and no individual health visitor locality should have a rate of less than 50%	**Expected** 63% **Actual** 60.3%	**A**	**Expected** 63% **Actual** 60.5%	**A**	**Expected** 63% **Actual** 59.7%	**A**	**Expected** 63% **Actual** **60.4%**	**A**	Q3. Banbury locality is 45.3%	

No	Indicator	Q1 Apr-Jun	RAG	Q2 Jul-Sept	RAG	Q3 Oct-Dec	RAG	Q4 Jan-Mar	RAG	Locality spread	Notes
Priority 10: Tackling the broader determinants of health through better housing and preventing homelessness											
10.1 District Councils	The number of households in temporary accommodation as at 31 March 2015 should be no greater than the level reported in March 2014 (baseline 197 households in Oxfordshire)							**Expected** 197 or less **Actual** **192**	G	56% (107) are in Oxford City 18% (34) in Cherwell 11% (21) in South 9% (18) in Vale 6% (12) in West Oxon.	
10.2 OCC	At least 75% of people receiving housing related support will depart services to take up independent living (baseline 83.9% in 13/14)	**Expected** 75% **Actual** 87%	G	**Expected** 75% **Actual** 86%	G	**Expected** 75% **Actual** 87%	G	**Expected** 75% **Actual** **88%**	G	The majority of people receive a service from a county wide service which means it isn't possible to accurately provide data on a locality basis	Data has been revised due to the removal of domestic violence cases. Overall figure for the year – 87%
10.3 District Councils	At least 80% of households presenting at risk of being homeless and known to District Housing services or District funded advice agencies will be prevented from becoming homeless (baseline 81% in 2013- 2014 when there were 2837 households known to services)	**Expected** 80% **Actual** 82%	G	**Expected** 80% **Actual** 86%	G	**Expected** 80% **Actual** 84%	G	**Expected** 80% **Actual** **86%**	G	Varies from 59% in West Oxfordshire to 89% in Oxford City.	
10.4	Establish a baseline of the number of households in Oxfordshire who have received significant increases in the			**Actual** 712	G	**Actual** 328	G	**Actual** **428**	G		Total for the year = 1,468 against a target of 550

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No	Indicator	Q1 Apr-Jun	RAG	Q2 Jul-Sept	RAG	Q3 Oct-Dec	RAG	Q4 Jan-Mar	RAG	Locality spread	Notes
Affordable Warmth Network	energy efficiency of their homes or their ability to afford adequate heating, as a result of the activity of the Affordable Warmth Network and their partners. It is hoped that an aspirational baseline target of 550 households will be reached			(Q1&Q2)							
10.5	Ensure that the number of people estimated to be sleeping rough in Oxfordshire does not exceed the baseline figure of 74 in 2013-14							**Target** < 74	**G**		
								Actual **68**			

No	Indicator	Q1 Apr-Jun	RAG	Q2 Jul-Sept	RAG	Q3 Oct-Dec	RAG	Q4 Jan-Mar	RAG	Locality spread	Notes
Priority 11: **Preventing infectious disease through immunisation**											
11.1 NHS England	At least 95% children receive dose 1 of MMR (measles, mumps, rubella) vaccination by age 2 (currently 95.8%) and no CCG locality should perform below 94%	**Expected** 95% **Actual** 95.2%	G	**Expected** 95% **Actual** 94.6%	A	**Expected** 95% **Actual** 92.5%	A	**Expected** 95% **Actual** **95.0%**	G	Oxford City falls below the 94% target (93.8%). Highest performing locality – North East – 98.1%	
11.2 NHS England	At least 95% children receive dose 2 of MMR vaccination by age 5 (currently 93.7%) and no CCG locality should perform below 94%	**Expected** 95% **Actual** 92.6%	R	**Expected** 95% **Actual** 91.9	R	**Expected** 95% **Actual** 95.2%	A	**Expected** 95% **Actual** **92.1%**	A	At Q4 North Oxfordshire = 91.7%, Oxford City = 92.1%, South West = 93.3% Others 3 are at or over 94%	
11.3 NHS England	At least 60% of people aged under 65 in "risk groups" receive flu vaccination (baseline 55% 13/14)							**Expected** 55% **Actual**			
11.4 NHS England	At least 90% of young women will receive both doses of HPV vaccination. (baseline to be confirmed)							**Expected** Over 90% **Actual**			6 month delay in data being reported

Housing data collection, for performance reporting to Health Improvement Board in 2014-15

Regular Performance reporting – outcomes for 2014-15 on priority 10 in the Joint Health and Wellbeing Strategy 2014-16:
Tackling the broader determinants of health through better housing and preventing homelessness

Data collection (Housing Support Advisory Group Chairman):

Collecting	Lena Haapalahti, Oxford City Council Dave Scholes, Oxford City Council	lhaapalahti@oxford.gov.uk dscholes@oxford.gov.uk
Coordinating	Katie Read, Oxfordshire County Council	Katie.Read@oxfordshire.gov.uk
For performance report written by:	Alison Wallis	Alison.Wallis@oxfordshire.gov.uk

District contact to provide data:

District	*Name*	*Email*
Cherwell	Chris Weight	Chris.weight@cherwell-dc.gov.uk
City	Lena Haapalahti	lhaapalahti@oxford.gov.uk
South	Jaffa Holland or Melissa Cripps	Jaffa.holland@southandvale.gov.uk or Melissa.cripps@southandvale.gov.uk
Vale	Jaffa Holland or Melissa Cripps	Jaffa.holland@southandvale.gov.uk or Melissa.cripps@southandvale.gov.uk
West	Sarah Whitcombe	Sarah.Whitcombe@westoxon.gov.uk

Please send your data to Lena Haapalahti: lhaapalahti@oxford.gov.uk

Measure 10.1

10.1	The number of households in temporary accommodation on 31 March 2015 should be no greater than the level reported in March 2014 (baseline 197 households in Oxfordshire in 2013-14) ***Responsible Organisation: District Councils*** **Proposal agreed:** **Separate out the number in bed and breakfast accommodation** **Six monthly instead of annually**	6-monthly Quarter 2 Quarter 4	Housing Support Advisory Group District representatives Collated by the Chairman of the Housing Support Advisory Group (rotates amongst Districts each year) Dave Scholes, Oxford City Council (via Katie Read)

Quarter: 4 Jan – March 15

Data:

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		Cherwell	**City**	**South**	**Vale**	**West**	**Total**
1	The number of households in temporary accommodation	34	107	21	18	12	**192**
2	The number of households in temporary accommodation, housed in bed and breakfast accommodation	0	1	3	2	2	**8**

For 10.1 - bed and breakfast figures cover accommodation with shared facilities; therefore the figures would not include “nightly charged” temporary accommodation.

Measure 10.3

10.3	At least **80% of households** presenting at risk of being homeless and known to District Housing services or District funded advice agencies will be prevented from becoming homeless (baseline 81% in 2013 - 2014 when there were 2837 households known to services). ***Responsible Organisation: District Councils***	Quarterly	Housing Support Advisory Group District representatives Collated by the Chairman of HSAG Dave Scholes, Oxford City Council (via Katie Read)

Quarter: 4 Jan - March 15

Data:

			Cherwell	**City**	**South**	**Vale**	**West**	**Total**
1 (E1)	Total number of applicant households who were homeless as defined by the Housing Act 1996, comprising the following categories	**A**	37	47	10	12	14	120
1a (E1,1)	Eligible, unintentionally homeless and in priority need		18	30	7	8	11	74
1b (E1,2)	Eligible, homeless and in priority need but intentionally so		10	9	3	1	3	26
1c (E1,3)	Eligible, homeless and not in priority need		9	8	0	2	0	19
2 (E,10,1)	Total number of cases where positive action was successful in preventing homelessness of which	**B**	190	368	65	94	20	737
	The Measure		83.7%	88.7%	87%	87%	58.8%	**86%**

References are to P1E return
Outcome indicator is calculated by expressing B as a percentage of A + B

Measure 10.5

10.5	Ensure that the number of people estimated to be sleeping rough in Oxfordshire does not exceed the baseline figure from 2013-14 (baseline: 74) ***Responsible Organisation: District Councils***	Annually Quarter 3 (November)	Housing Support Advisory Group District representatives Collated by the Chairman of HSAG Dave Scholes, Oxford City Council (via Katie Read)

Quarter: 3

Data:

		Cherwell	City	South	Vale	West	Total
1	The number of people estimated to be sleeping rough	14	Estimate 43 Count 26	3	5	3	68

For 10.5 - from November 2014, all Districts will report their November estimate (according to the methodology set out by Homeless Link – so Oxford City will do an estimate according to this methodology, as well as their count).

Oxfordshire's Joint Health & Wellbeing Strategy

2015 - 2019

v.4

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

Oxfordshire Clinical Commissioning Group

healthwatch Oxfordshire

OXFORDSHIRE COUNTY COUNCIL

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

To be added

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

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

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2. Introduction

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

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

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

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

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

3. Vision

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

By 2016 in Oxfordshire:

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

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

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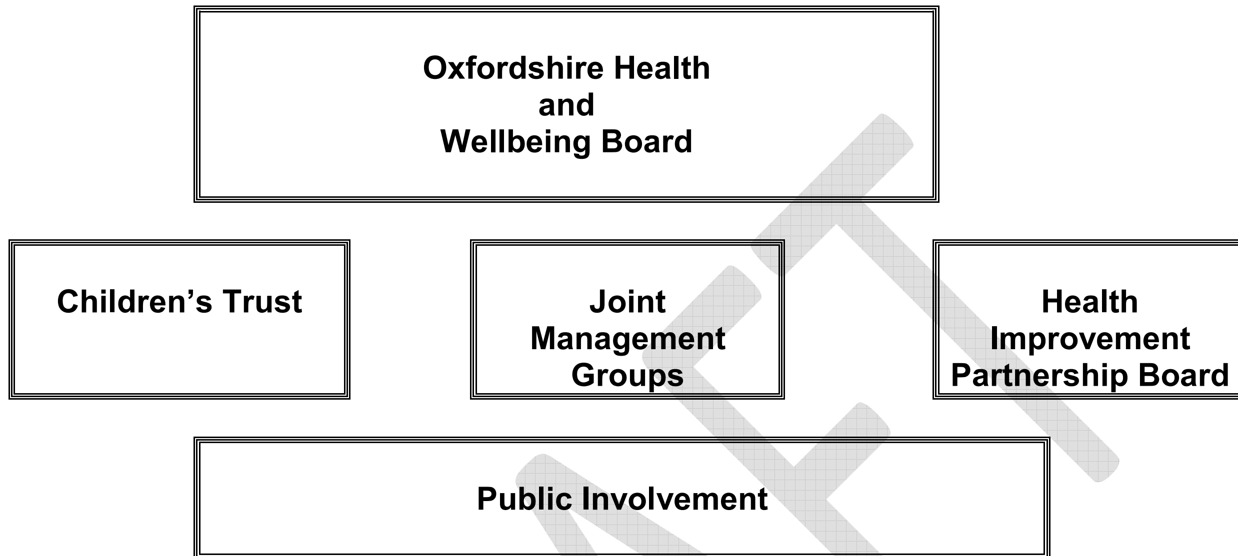
4. The structure of the Health and Wellbeing Board

4.1 What does the Health and Wellbeing Board look like?

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



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

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

4.2 How do decisions get made?

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

In turn, the Partnership Boards and Joint Management Groups are committed to working with a wide range of health and social care providers, voluntary agencies, carers, faith groups, members of the public and advocacy groups. We invite these partners to formal

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meetings as 'expert witnesses' and to workshops during the year as a means of engagement. In this way, the decisions of the Health and Wellbeing Board aim to be truly inclusive.

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

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

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

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

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4.3 The Work of Other Partnerships and Cross-Cutting themes

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

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

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

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

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

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

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

5. A strategic focus on Quality.

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

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

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

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

5.1 Whole system quality priorities for 2015/16

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

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

5.2 The statement

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

All services

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

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

- Oxford Health Foundation Trust will continue to work to make patient care safer through reducing harm through falls, patients going missing, aggression and violence and avoidable pressure ulcers and through the prevention of suicide.

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- Oxford University Hospitals Trust will focus on providing high quality, individualised care, while meeting NHS Constitution pledges on A&E waiting times, cancer treatment times and 18 week referral to treatment targets.
- Oxfordshire County Council will work to improve the timeliness of social care assessments and access to care packages and re-ablement services.
- South Central Ambulance Service will improve ambulance rural response times.
- Oxfordshire Clinical Commissioning Group will work to address the issues of access to GPs and GP retention and recruitment.

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

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

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

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

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

6.2 What are the specific challenges?

1. **Demographic pressures** in the population, Oxfordshire's population is growing, and growing older. In mid-2013 the population was estimated to be 666,100, having risen by about 10% since 2001. There is an increasing number of older people, many of whom need care and may be isolated or lonely. This is markedly higher in our more **rural districts** than in the City.
2. The **proportion of older people** in the population also continues to increase which means that every pound spent from the public purse has further to go.
3. Oxfordshire remains the most rural county in the South East of England. Meanwhile, its population is becoming more diverse
4. There are a growing number of people with **dementia** in the County who require access to new emerging treatments.
5. The persistence of small geographical areas of **social disadvantage containing high levels of child poverty**, especially in Banbury and Oxford but also in parts of our market towns. These areas are also the most culturally diverse in the County **containing ethnic minority groups who have specific needs.**
6. The increase in **'unhealthy' lifestyles which leads to preventable disease**.
7. The need to ensure that services for the **mentally ill and those with learning disabilities and physical disabilities** are prioritised.

8. **Increasing demand** for services.
9. The need to support **families and carers of all ages to care.**
10. The need to encourage and support **volunteering**.
11. An awareness that the **'supply side'** of what we provide does not 'mesh' together as smoothly as we would like - (e.g. hospital beds, discharge arrangements, care at home and nursing home care).
12. The recent **tightening of the public purse** which has knock-on effects for voluntary organisations.
13. The need to work with and through a **wide patchwork of organisations** to have any chance of making a real difference in Oxfordshire.
14. The changing face and **roles of public sector organisations.**

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

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

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

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

6.4 What criteria have been followed in selecting priorities?

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

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

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

A summary of the priorities can be found in Annex 1

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

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

Priorities for Children's Trust

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

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

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

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

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

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

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

Where are we now?

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

Outcomes for 2015-16

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

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

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

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

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

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

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

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and young people eligible for free school meals; children and young people with autistic spectrum disorder and children and young people 'looked after' by the County Council.

Where are we now?

- The number of eligible 2 year olds taking up free early education (2,112) has been much higher than the target of 1,800. This follows significant work by the Early Years workers and children's centres in promoting this funding.
- 86% of 2 year old Looked After Children have taken up the free early education, this is above the target of 80%.
- During the academic year 2013/14, 15% of Children in Need (defined as those with a current Children in Need plan) in Oxfordshire were classed as persistently absent from school (i.e. missing 15% of sessions throughout the year). This is a reduction from the previous year when it was 19.8%. This rate remains higher than the national persistent absence rate for Children in Need, 13.8%. The overall persistent absence rate for all pupils in Oxfordshire in 2013/14 was 3.8%.
- All of the 810 families in Oxfordshire meeting the national Troubled Families criteria have been turned around, and families are now being identified for phase 2 of the national programme.
- At Key Stage 2 the gap in attainment between those with free school meals and their peers has widened to 23 percentage points in Oxfordshire, whereas nationally this has remained at 19 percentage points. The council has recently taken new steps to address this by providing overarching strategy and specific support for individual cases to ensure improved outcomes for this group of young people. This work is overseen and monitored on a continual basis by the Improvement and Development Manager for Vulnerable Learners and we expect to see improvement this year (2015/16)

Outcomes for 2015-16

2.1 Reducing inequalities as measured by Public Health measure (number 1.01i) - Children in poverty (all dependent children under 20) - such that the gap between the wards with most poverty and least poverty is reduced.
2.2 Reduce the number of children and young people placed out of county and not in neighbouring authorities from 74 to 50.
2.3 Reduce the level of care leavers not in employment, education or training from 50%
2.4 Increase the number of young carers identified and worked with by 20% from 1,825 at 1st April 2015 to 2,190.
2.5 Reduce the number of children with Special Educational Needs who are have at least one fixed term exclusion in the academic year from 5.1% in the academic year 2013/14.
2.6 Increase the proportion of children with a disability and are eligible for free school meals who are accessing short breaks services from 24% in 2014/15.

Priority 3: Keeping all children and young people safe

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

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

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

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

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

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

Keeping children safe is a key priority for all agencies.

Where are we now?

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

Outcomes for 2015 -16

3.1 Set a baseline for and then increase the amount of times the Independent Chair is satisfied that the core group minutes show that the objectives of the CP Plan are being progressed by the Core Group
3.2 Set a baseline for and then increase the proportion of specified outcomes that have been achieved in the child protection plan

For Neglect cases only :

3.3 Establish a benchmark and then Increase the proportion of neglect cases where the neglect tool is used
3.4 Reduce the number of hospital admissions caused by unintentional and deliberate injuries in young people aged 15-24 (Public Health measure number 2.07ii) (baseline to be reported).
3.5 More than 70 schools receive direct support to implement effective Anti-Bullying strategies as evidenced by school action plans to tackle and reduce bullying through increased membership of Anti-Bullying Ambassador scheme, individual support from Anti-Bullying Co-ordinator and provision of training.

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Priority 4: **Raising achievement for all children and young people**

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

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

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

Where are we now?

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

Outcomes for 2015-16

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

a) KS2: 19% points

b) KS4: 27% points

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

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

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

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

B. Priorities for Joint Management Groups

Priority 5: Living and working well: Adults with long-term conditions, physical disabilities, learning disabilities or mental health problems living independently and achieving their full potential

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

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

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

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

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

Where are we now?

- Over 25,000 people had information and advice about areas of support through the Community Information Networks, against a target for the contract year of 6800.
- More people moved to recovery having completed psychological therapies with at least two treatment contacts (61% against a target of 50%)

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- People with Learning Disabilities still do not have good enough access to physical health checks. We have kept the target for next year and are working on developing a 'Reasonable Adjustments' team to make sure people have the access to health care they need and are treated fairly.
- Emergency hospital admissions for acute conditions have reduced, although are still more than the target of 951.4 per 100,000 population at 964.6. Nationally the figure is higher.
- There have been fewer unplanned admissions for chronic conditions which can be actively managed (such as diabetes and asthma). The target was 565.4 per 100,000 population and the actual figure was better at 536.4.

Outcomes for 2015-16

5.1 20,000 people to receive information and advice about areas of support as part of community information networks
5.2 15% of patients with common mental health disorders, primarily anxiety and depression will access treatment
5.3 Improve access to psychological therapies so that more than 50% of people who have completed treatment having attended at least 2 treatment contacts are moving to recovery
5.4 At least 60% of people with learning disabilities will have an annual physical health check by their GP
5.5 Reduce the number of emergency admissions for acute conditions that should not usually require hospital admission for people of all ages (2013/14 baseline: 951.4 per 100,000 population)
5.6 Increase the employment rate amongst people with mental illness from a baseline of 9.9% in 2013/14
New 5.7 Reduce the number of assessment and treatment hospital admissions for adults with a learning disability to 8 in 2015/16 from 20 in 2014/15
New 5.8 Reduce the length of stay of hospital episodes for adults with a learning disability so that by March 2016 no one has been in a NHS Assessment & Treatment Unit for more than 2 years.

Priority 6: <u>Support older people to live independently with dignity whilst reducing the need for care and support</u>

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

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

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

For all these reasons our priority is to support older people to live at home whilst reducing the need for care and support. To achieve this we are focusing together on better use of reablement; reducing emergency admissions to hospital for acute conditions; reducing the number of people permanently admitted to care homes; developing more integrated

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community services; improved diagnosis of people with dementia; providing additional extra-care housing units as well as ensuring there is a range of housing options for older people and that people can find the information they need. We have also continue to set a challenging target for reducing the number of people admitted to a care home, because this is the ultimate test of whether these alternative services and options are working.

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

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

Where are we now?

- Delayed transfers of care remain a priority issue for organisations involved in health and social care across Oxfordshire.
- The rate of permanent admissions to care homes has dropped, though the overall number exceeded the target set for the year
- The proportion of older people (65 and over) with on-going care supported to live at home has increased
- A new national tool has been introduced for estimating the number of people with dementia and this has increased the estimate for Oxfordshire. A number of initiatives have been put in place to increase the number of diagnoses made. The percentage of the expected population with dementia with a recorded diagnosis has increased
- There have been increasing numbers of people starting reablement each month but the total remained below the target for the year
- High numbers of people reported that they had been treated with dignity and respect and were involved in planning their care at home
- The growth in supply of Extra Care Housing continues and is on track to deliver more units in 2015/16
- Service users report high levels of satisfaction with access to information and that they receive support and care in a timely way
- Carers breaks jointly funded and accessed via GPs increased through the year and have now been replaced with meeting assessed support needs in line with the Care Act.

Outcomes for 2015 - 16

6.1 Reduce the number of people delayed in hospital from an average of 147 per day in 2014/15.

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

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

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

6.5 Increase the number of people accessing the reablement pathway including
Increasing the number of people accessing the reablement pathway from a hospital pathway to at least the national average
Increasing the number of people accessing reablement from the community

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

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

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

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

Priority 7: <u>Working together to improve quality and value for money in the Health and Social Care System</u>

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

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

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

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

Where are we now?

- Progress is being made in the integration of services, with a number of further initiatives and plans underway to improve outcomes and make services more accessible for people.
- Patient Outcome measures show high levels of satisfaction with care and support received from social care, hospital care and GP surgeries.
- Over 16,000 carers are now known and supported by adult social care which is an increase of almost 1,000 over last year
- 1027 carers received Carer Breaks accessed through their GP and jointly funded

Outcomes for 2015-16

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

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

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

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

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

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

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

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

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

7.6 New: Increase the percentage of people waiting a total time of less than 4 hours in A&E. Target 95%

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

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

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C. Priorities for Health Improvement

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

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

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

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

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

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

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

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

Where are we now?

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

- Smoking quit rates in the county failed to meet the target in the last year. Reports of quit rates in pregnancy have been received but there is still concern that some women are continuing to smoke.
- The Health Improvement Board has been monitoring the rates of successful completion of alcohol and drugs treatment in the last year. There have been some improvements and the Recovery Plan is making a difference, but Oxfordshire still lags behind national averages.

Outcomes for 2015-16

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

8.2 Of people aged 40-74 who are eligible for health checks once every 5 years, at least 15% are invited to attend during the year. No CCG locality should record less than 15% and all should aspire to 20%. ***Responsible Organisation: Oxfordshire County Council***

8.3 At least 66% of those invited for NHS Health Checks will attend (ages 40-74) and no CCG locality should record less than 55% with all aspiring to 66%.(baseline 53% 2014-15) ***Responsible Organisation: Oxfordshire County Council***

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

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

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

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

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

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

Surveillance of these issues in the last year show that

- Rates of obesity in the county continue to rise. Data from surveys show a cause for concern.
- The percentage of people diagnosed with diabetes by their GP continues to rise across the county.
- The rates for breastfeeding initiation soon after birth and continuation to at least 6-8 weeks are good in Oxfordshire. These higher rates need to be maintained.

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- Measurement of children shows the numbers who are deemed to be overweight or obese at both Reception Class and Year 6 are generally lower than England rates, but show over 15% obesity at year 6. These are year on year snap shot measures so trends cannot be identified.

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

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

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

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

Where are we now?

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

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

9.2 Reduce by 1% the proportion of people who are NOT physically active for at least 30 minutes a week (Baseline for Oxfordshire 23% against 28.9% nationally, 2014-15 Active

People Survey). ***Responsible Organisation: District Councils through Oxfordshire Sports Partnership***

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

Priority 10: Tackling the broader determinants of health through better housing and preventing homelessness

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

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

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

These housing issues all have to be tackled in partnership.

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

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

Where are we now?

- District councils have reported similar success rates as last year in preventing homelessness and have taken positive action to prevent a higher number of households from becoming homeless. This reflects more activity as changes in the welfare system have been introduced.

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- The number of households in temporary accommodation has remained at similar levels to last year with 192 households reported (197 last year).
- A large proportion of people who had received housing related support services were able to leave the services and live independently. A review of the impact of changes in the levels of support available will be carried out in the year ahead.
- High numbers of contacts were reported by the Affordable Warmth Network who have disseminated information but there is little evidence of whether this has been translated into improved energy efficiency of homes
- The number of people estimated to be sleeping rough in the county has remained high.

Outcomes for 2015-16
10.1 The number of households in temporary accommodation on 31 March 2016 should be no greater than the level reported in March 2015 (baseline192 households in Oxfordshire in 2014-15) ***Responsible Organisation: District Councils***

10.2 At least 75% of people receiving housing related support will depart services to take up independent living (baseline 91% in 2014-15). ***Responsible Organisation: Oxfordshire County Council***

10.3 At least 80% of households presenting at risk of being homeless and known to District Housing services or District funded advice agencies will be prevented from becoming homeless (baseline 83% in 2014-15 there were 2454 households known to services). This can now be reported 6 monthly. ***Responsible Organisation: District Councils***

10.4 More than 700 households in Oxfordshire will receive information or services to enable significant increases in the energy efficiency of their homes or their ability to afford adequate heating, as a result of the activity of the Affordable Warmth Network and their partners. ***Responsible Organisation: Affordable Warmth Network.***

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

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

Priority 11: <u>**Preventing infectious disease through immunisation**</u>

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

It is important that immunisation rates remain high throughout the population to maintain "herd immunity". Responsibility for commissioning immunisation services sits with NHS

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England. High levels of coverage need to be maintained in order to continue to achieve the goal of protection for the population.

New immunisations were introduced in 2013-14. From July 2013, a rotavirus vaccination was offered at 2 months and at 3 months, flu immunisation is being given to children, (starting with 2-3 year olds and adding more ages each year), and Shingles vaccinations are offered to people aged 70 and 79.

The Oxfordshire Joint Strategic Needs Assessment shows high levels of coverage but some targets are still not being met and there are signs that our high rates have begun to slip a little. The leadership for these services has changed profoundly during the last two years and maintaining our current position will be a real challenge.

We are proposing priorities for improving immunisation levels across the board, focussing on childhood immunisation, immunisation of teenage girls to protect against cervical cancer and flu vaccinations in the elderly and vulnerable.

Where are we now?

- High coverage rates for most childhood immunisations were achieved across the county. This included the number of children receiving their first dose of MMR vaccine which remained above the 95% target, though parts some districts remained below 94%.
- Rates of flu immunisations for people aged under 65 who are at risk of illness did not meet targets last year. It remains important to keep these indicators under surveillance and for the Public Health Protection Forum to ensure that good performance in Oxfordshire is continued.

Outcomes for 2015-16

11.1 At least 95% children receive dose 1 of MMR (measles, mumps, rubella) vaccination by age 2 (currently 95.2%) and no CCG locality should perform below 94% ***Responsible Organisation: NHS England***

11.2 At least 95% children receive dose 2 of MMR (measles, mumps, rubella) vaccination by age 2 (currently 92.5%) and no CCG locality should perform below 94% ***Responsible Organisation: NHS England***

11.3 – At least 60% of people aged under 65 in “risk groups” receive flu vaccination (baseline from 2014-15 to be confirmed) ***Responsible Organisation: NHS England***

11.4 At least 90% of young women to receive both doses of HPV vaccination. ***Responsible Organisation: NHS England***

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Annex 1: Summary of Priorities for the Oxfordshire Health and Wellbeing Strategy

Children's Trust

Priority 1: All children have a healthy start in life and stay healthy into adulthood
Priority 2: Narrowing the gap for our most disadvantaged and vulnerable groups
Priority 3: Keeping all children and young people safe
Priority 4: Raising achievement for all children and young people

Joint Management Groups (for Older People, Mental Health etc)

Priority 5: Living and working well: Adults with long term conditions, physical or learning disability or mental health problems living independently and achieving their full potential

Priority 6: Support older people to live independently with dignity whilst reducing the need for care and support

Priority 7: Working together to improve quality and value for money in the Health and Social Care System

Health Improvement

Priority 8: Preventing early death and improving quality of life in later years
Priority 9: Preventing chronic disease through tackling obesity
Priority 10: Tackling the broader determinants of health through better housing and preventing homelessness
Priority 11: Preventing infectious disease through immunisation

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Annex 2: Glossary of Key Terms

Terms

Carer	Someone of any age who looks after a relative, partner, friend or neighbour who has an illness, disability, frailty, or addiction. The help they provide is not paid for as part of their employment.
Child Poverty	Children are said to be living in relative income poverty if their household's income is less than 60 per cent of the median national income.
Child Protection Plan	The plan details how a child will be protected and their health and development promoted.
Commissioning	The process by which the health and social care needs of local people are identified, priorities determined and appropriate services purchased.
Delayed Transfer of Care	The national definition of a delayed transfer of care is that it occurs when a patient is medically fit for transfer from a hospital bed, but is still occupying a hospital bed.
Director of Public Health Annual Report	http://www.oxfordshirepct.nhs.uk/about-us/publications/public-health-annual-report.aspx
Extra Care Housing	A self-contained housing option for older people that has care support on site 24 hours a day.
Fuel Poverty	Households are considered by the Government to be in 'fuel poverty' if they would have to spend more than 10% of their household income on fuel to maintain an adequate level of warmth.
Healthwatch Oxfordshire	Healthwatch is the independent 'Consumer Champion' for health and social care for people of all ages
Joint Health and Wellbeing Strategy	The strategy is the way of addressing the needs identified in the Joint Strategic Needs Assessment and to set out agreed priorities for action.
Joint Strategic Needs Assessment (JSNA)	A tool to identify the health and wellbeing needs and inequalities of the local population to create a shared evidence base for planning.
Not in Education, Employment or Training (NEET)	Young people aged 16 to 18 who are not in education, employment or training are referred to as NEETs.

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Oxfordshire Clinical Commissioning Group	The Oxfordshire Clinical Commissioning Group is the new organisation in Oxfordshire that has the responsibility to plan and buy (commission) health care services for the people in the County. It is currently in shadow form until it takes over from Oxfordshire Primary Care Trust in April 2013.
Oxfordshire's Safeguarding Children Board	Representatives from the main statutory agencies who ensure there are suitable robust arrangements for protecting children in Oxfordshire.
Pooled budget	A mechanism by which the partners to the agreement bring money to form a discrete 'fund'. The purpose and scope of the fund is agreed at the outset and then used to pay for the services and activities for the relevant client group.
Quality Assurance Audit	A process that helps to ensure an organisation's systems are in place and are being followed.
Reablement	A service for people to learn or relearn the skills necessary for daily living.
Secondary Mental Health Service	Services for adults with more severe mental health problems and needs requiring the specialist skills and facilities of mental health services.
Section 75 agreement	An agreement made under section 75 of National Health Services Act 2006 between a local authority and PCT(s), NHS trusts or NHS foundation trusts. This can include arrangements for pooling resources and delegating certain functions to the other partners if it would lead to an improvement in the way those functions are exercised.
Thriving Families Programme	A national programme which aims to turn around the lives of 'Troubled' families by 2015.
Transition	This is the process through which a person with special needs transfers from children's services to adult's services.

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Health Improvement Board briefing paper

Governance of the Joint Housing Steering Group for Young People's Supported Housing

Recommendation

The Health Improvement Board is recommended to:

- Provide oversight of the Joint Housing Steering Group and the Supported Housing Pathway for Young People.

- Agree the outcome measure for supporting vulnerable young people in appropriate housing that will be monitored by the Health Improvement Board under priority 10.

Overview of the Joint Housing Steering Group

The Joint Housing Steering Group is a strategic development and decision-making group comprising representatives from the County Council - including Children's Social Care, the Youth Offending Service, Early Intervention Service and Joint Commissioning - and representatives from the Housing department within each of Oxfordshire's District and City Councils. The aim of the group is to address the strategic issues presented by vulnerable young people aged 16 to 24 years presenting as homeless or in significant housing need.

This group oversees the work of the Joint Housing Team, an operational team made up of front line Social Workers and Housing Options officers working across the County and District/City Councils. The aim of this group is to undertake case work directly with young people and to work as part of front line services to prevent and address housing and homelessness issues among this group of young people.

The Joint Housing Steering Group meets quarterly unless factors are identified which indicate more frequent meetings are required.

Homelessness and housing need among young people in Oxfordshire

National legislative policy changes around Welfare Reform, local implementation of national legislative changes around the Localism Act, new policy changes around social sector property ownership and the local context of a highly buoyant and competitive private rented sector combine in Oxfordshire to create a highly challenging environment for young people in terms of both short-term and long-term housing options.

In practice this means, unless you are able to remain at home with your family you must be financially self-sustaining in one of the most expensive area of housing in the country.

Groups of young people particularly affected are those who struggle to maintain (or are removed from) their family environments and/or those who struggle to compete on an equal basis with their peers:

- Young people who are Looked After and Leaving Care.
- Young people who are Children In Need.
- Young people who are aged 18+ and homeless but to whom no statutory duty is owed by any agency.
- Young people open to Probation or YOS.
- Young people open to Adult Services as 'best fit'. For example those with Autistic Spectrum Disorder.
- Young parents in any of the categories above who have support needs of their own as well as those around their parenting.

As an illustration of the level of need, since the 1st of April 2015, 92 referrals have been received requesting access to the Young People's Supported Housing Pathway. Referrals have been submitted from a range of agencies working with young people including Children's Social Care, CAMHS, Adult Learning Disability, Probation, YOS, District Councils, Thriving Families and the Early Intervention Service.

Case studies illustrating some of the issues facing these young people and the services which support them can be found at the end of this document.

Supported Housing Services

The Joint Housing Steering Group has a commissioning role and oversaw the recent outcome focused re-commissioning of supported housing services for young people in Oxfordshire.

The new services commenced on the 1st of April and collectively deliver 230 bed spaces across 5 service packages to 16 to 24 year olds across the county. From April 2015 there are 5 supported housing providers delivering services within the Pathway as follows:

- Sanctuary
- Home Group
- St Mungo's Broadway
- Key 2
- Stonewater

The service packages these services span are as follows:

- Package 1: Family provision - for young parents.
- Package 2: Singles Shared provision - for single young people and provided in hostel accommodation and/or smaller shared houses. This package includes emergency accommodation and 'step-down' accommodation.
- Package 3: Self-contained dispersed provision - for single young people who cannot safely be managed living with other young people. This is provided in self-contained flats within the community.

- Package 4: Specialist provision - this includes provision for newly arrived Unaccompanied Asylum Seeking young people (UASC), provided in small shared houses; and a small number of bespoke packages for those with additional and complex needs which are jointly funded by other agencies. This accommodation will vary depending on the need of the young person.
- Package 5: Supported Lodgings - for single young people needing to live within a family environment. This is provided by individuals within their own homes. This service is not commissioned externally, but is delivered in-house the Fostering and Adoption Service.

All services are based on robust, timely and multi-agency assessment of risk, vulnerability and need informing effective intervention to deliver positive long-term housing outcomes and improved life chances for these young people.

These services do not replace Social Sector accommodation provided by Registered Providers (social landlords): this accommodation would be a potential exit route from the Pathway. Nor do they replace Statutory Duty owed to young people under Children's legislation or Housing legislation.

Challenges for the future

The current services were re-commissioned based on a model designed to recognise and address the following issues:

- An increasingly complex cohort of young people entering the Pathway:
    - When previous contracts commenced in 2010, 75% of young people entering the Pathway had housing as their primary need.
    - Just 3 years later, at review of these services to inform re-commissioning, this had dropped to 25% with the large majority of those entering services having other issues as their primary, secondary and even tertiary needs e.g. substance misuse, mental health issues, domestic abuse.
- Reducing and extremely challenging long-term housing options for young people meaning that exit from supported housing is very difficult.
- The need for an emphasis on prevention and early intervention in a time of reducing resources and focus on statutory duty.

Outcome measures

A proposed outcome measure for monitoring by the Health Improvement Board is as follows:

Priority 10: Tackling the broader determinants of health through better housing and preventing homelessness.

- 95% of young people receiving housing related support within the Pathway depart to a planned and positive accommodation option. ***Responsible organisation: Oxfordshire County Council***

This aligns with one of the key outcome measures for the commissioned supported housing services within the Pathway and could sit alongside indicator 2 within priority 10.

Links with the Housing Support Advisory Group and the Health Improvement Board

It is likely that the Joint Housing Steering Group will seek to join with HSAG in the future as the groups perform parallel functions with overlapping membership. A decision has been made for the next year however to maintain the JHSG as a discrete entity, given the recent re-commissioning of services and their implementation.

The Health Improvement Board was identified by JHSG partners as a good fit for governance, as it has representation from all five District Councils. This is significant given that many operational and strategic decisions need all-District sign-up, as they will have reciprocal and interdependent impact.

In addition, since April 2015, 51% of referrals into the Pathway have been for young people aged 18 and over. Referrals span a range of adult partners including Probation, District Councils, Adult Social Care and Disability services. The long-term impact of poor outcomes for young people experiencing these issues will be directly felt by the outcomes reported to the HIB. 40% of those referred to the Pathway already aged over 18 were not Care Leavers and therefore had presented directly to services with homelessness issues as adults, not children.

Case studies - young people and the Supported Housing Pathway

Prevention

Poppy is a 16 year old whose relationship with her family has broken down to the point that she is unable to live at home currently. Despite current difficulties, both Poppy and her mother would like her to return home in the future. The young person has been accepted into the Pathway for up to 3 months to enable intensive work with both the family and the young person to repair the relationship and facilitate a successful and sustainable return home.

Inclusion

Siobhan is a 19 year old Care Leaver who became Looked After when she was 13 years old. Following a transition from residential care at 18 into semi-independent supported housing within the Pathway, she has had a turbulent accommodation history. She has moved in and out of four different housing projects within the services over a period of 18 months due to behavioural issues as a result of historical trauma and current vulnerabilities and risky behaviours. Siobhan began to settle within her accommodation towards the end of last year and made sufficient progress to be nominated for move-on with her District Council for a social sector tenancy. However, historical issues resurfaced, impacting on her behaviour and her nomination was withdrawn. Having subsequently spent some time outside the Pathway, Siobhan has now re-entered the services and has stabilised again. She is

working successfully towards regaining her nomination for social sector housing and is hoping to begin bidding for properties soon.

Progression

Jamal arrived in the UK when he was 16 years old having fled trauma in Afghanistan. He moved briefly into foster care but was unable to sustain the family environment in the wake of his recent trauma. He was suffering with post-traumatic stress and moved into supported housing within the Pathway. Unrelated to this move, Jamal became the victim of two violent attacks committed in the community resulting in significant injuries and hospitalisation leaving him very frightened to leave the house. Around this time he was also refused asylum and went into depression. His asylum claim was later reviewed and he was granted indefinite leave to remain in the UK which entitled him to be nominated for move-on to social sector housing. He was housed in permanent accommodation by the Local Housing Authority at 18 years old but experienced a period of highly chaotic behaviour as a result of his experiences. A multi-agency package of support delivered across Social Care, Education, Health and Housing Support services have supported Jamal to successfully maintain his permanent accommodation. He has been living in this accommodation for two years now, has successfully completed a vocational qualification and is working full-time.

Eleanor Stone
Placement Service Manager
23 June 2015

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A Report to the Health Improvement Partnership Board 6 July 2015

Public Health Protection Forum business 2014/15

Purpose
This document will report on the activity of the Health Protection Forum for 2014/15

1. Introduction

1.1 Oxfordshire County Council (and the director of public health (DPH) who acts on behalf of the local authority) has a critical role in protecting the health of its population. This role is to act as a watchdog, ensuring that all organisations working within Oxfordshire coordinate their activities and provide high quality services to protect the population.

1.2 If organisations fall short of the required standards the DPH has a duty to help them ameliorate the situation. It is therefore a leadership role rather than a managerial role.

1.3 In order to carry out this role the DPH works in partnership with the relevant organisations via the Public Health Protection Forum which reports to the Health improvement board and hence to the health and wellbeing board.

1.4 Most problems are dealt with directly by the Public Health Protection Forum, but should persistent difficulties arise these will be escalated to the Health Improvement Board and Health and Wellbeing Board as required.

1.5 The Public Health Protection forum therefore facilitates the DPH in fulfilling the statutory function of protecting the health of the population of Oxfordshire.

2. Role of the Health Protection Forum

The group report on the following issues

- Prevention
- Planning and preparedness
- Relationships and accountabilities
- Monitoring of local data
- Reporting of local issues which may affect the health of the local population

3. Membership of the forum

Membership of the forum includes;

- Director of Public Health, Oxfordshire County Council (Chair)
- Oxfordshire County Council Portfolio Holder for Public Health
- Consultant in Public Health/Public Health Medicine with responsibility for Public Health Protection/emergency planning – Oxfordshire (Deputy Chair)
- Director of Public Health England Centre – Thames Valley (or nominated deputy)
- District representation of Environmental Health colleagues
- Associate Director Medicines Management, Quality and Innovation, Oxfordshire Clinical Commissioning Group
- Head of Public Health Commissioning, NHS England Thames Valley
- Consultant in Public Health Screening and Immunisation, NHS England Thames Valley
- Consultant in Health Protection/CCDC with responsibility for Health Protection in Oxfordshire – Public Health England

- Specialist advisors will be invited as necessary

4. Meetings
The forum met three times in the financial year 2014/15. There were no extraordinary meetings held in this time.

5. Activity Reporting
The following activity was reported to the forum during the year 2014/15

6. Topical Infections (Lead Role Public Health England)

6.1 This year 2014/15 saw a major outbreak of Ebola in Western Africa. This had a local impact as returning aid workers landed in RAF Brize Norton. The local PHE centre was involved in the monitoring of all aid workers and others who were returning from high risk countries who entered England through Brize Norton and also London airports. The local centre also followed up on monitoring those residing in the local area.

6.1.2 Local stakeholders were involved in an exercise in November 2014 to test their preparedness in the event of a case arising in Thames Valley. At the time of writing this report, whilst the numbers of cases in West Africa are declining the outbreak has not ended. PHE are still in a state of heightened preparedness.

6.1.3 This outbreak event has benefited health protection as all local organisations have looked closely at their mass outbreak preparedness plans to ensure that they are still appropriate following the changes to NHS organisational structures in 2013.

<u>Influenza in care homes</u>

6.4 There were a total of 14 outbreaks of influenza in care homes in Oxon in the last season. Eleven of these outbreaks were sampled and 8 tested positive, 7 were Inf. A & Inf. B. There was a genetic drift in the actual strain that was in the community compared to the predicted strain used in vaccinations for the season. This had an impact in that the vaccine was not as effective as it should be, which can have a detrimental impact on public perception of the effectiveness of vaccination.

7. Healthcare Acquired Infections (Lead Role Oxfordshire CCG)

<u>Clostridium Difficile (C. Diff)</u>

7.1 In 2014/15 there were 134 reported cases of C. Diff which is an improvement on the previous year (171). This reflects the concerted efforts taken by the health care providers to reduce the incidence of C. Diff infections.

<u>Methicillin Resistant Staphylococcus Aureus (MRSA)</u>

7.2 In 2014/15 there were 9 reported cases of MRSA which is an improvement on the previous year (15). All cases are investigated to see how they could have been prevented and two of the 9 cases were considered preventable.

8. Environmental Health Issues (Lead Role District Councils)

8.1 The forum has engaged with the District Councils and has a regular representation from environmental health.

8.2 During the year there have been discussions about local Air Quality Management Areas (AQMA). An AQMA is declared if the levels of NO_2 exceed 40µg/m^3. In Oxfordshire the following areas are declared AQMAs:

- Henley on Thames
- Wallingford
- Watlington
- Abingdon
- Botley
- City of Oxford
- Chipping Norton
- Witney
- Banbury
- Kidlington

8.2.1 It is acknowledged that environmental health does monitor air quality and propose action plans in the AQMA areas, however there is no one single solution to resolve the levels of pollution in AQMA areas and it will require a multifaceted, multi-organisational approach to resolve.

8.3 The forum will be developing a dashboard for environmental health activity in the planned activity for 2015/16.

9. Immunisation Programmes (Lead Role NHS England)

Influenza Vaccine

9.1 At time of writing the Public Health Directorate are awaiting the final data for flu vaccination activity for 2014/15 season. Current available data showed the following activity.

Children's vaccinations 2014/15 Season

9.1.2 Latest sentinel data to 31 January 2015
2 year old children in Oxfordshire vaccinated 44.81% (last year 47.1%)
3 year old children in Oxfordshire vaccinated 48.5% (last year 43.2%)
4 year old children in Oxfordshire vaccinated 37.1%
The offer of immunisations will be extended to children aged 5 & 6 years old will occur in the next flu season.

Adult vaccinations 2014/15 Season

9.1.3 Adults aged >65 in Oxfordshire vaccinated 75.6% (last year 72.7%)
Adults aged < 65 at risk in Oxfordshire vaccinated 51.9% (last year 50.2%)
Pregnant Women in Oxfordshire vaccinated 49.6% (last year 44.3%)

9.1.4 There has been mixed performance in vaccinations for the past season, despite concerted efforts there is still poor uptake for individuals aged under 65 at risk. In the next flu season adults suffering from liver disease, neurological conditions and learning difficulties will be priority groups for vaccination.

9.1.5 The commissioning of vaccinations for 5-6 year old children has been completed and will be delivered through GP surgeries and pharmacies. Work is on-going to ensure that children on the borders of Bucks and Berks are appropriately cared

for as these neighbouring areas deliver vaccinations for this age group through the school system.

10. Other Childhood vaccination programmes (Lead Role NHS England)

10.1 The performance of other childhood vaccinations is still generally achieving the 95% national targets and performance is better than other areas in Thames Valley. The DPH and forum maintain vigilance to ensure that this good performance does not drop. However, vaccinations of note that do not meet targets include

Measles

10.1.2 There has been another slight uptake in MMR vaccine in children aged 2 years. Oxfordshire has now hit the 95.0% uptake target exactly. There has been a loss of momentum at a National and local level. However the vaccination rate for MMR vaccination at 5 years is 92.1% (last year 92.7%). The numbers that are not taking up the vaccine at 5 years are small. The area team are continuing to work on addressing this with local GP practices.

In 2014 there were no reported cases of Measles in Oxfordshire.

Rotovirus

10.1.3 This is a relatively new programme only 2 years in place Q4 uptake date was 93.8%. Several issues which are of a national nature are affecting activity. An action plan is being developed to improve programme. NHSE Area Team working with GPs to improve the performance on immunisation activity.

11. Adult Vaccinations (Lead Role NHS England)

Shingles

11.1 Cohort for vaccination is now 70, 78 & 79 year old adults. Oxfordshire CCG 95.1% of GP practices are participating.

	% of practices responding	% of patients immunised aged 70	% of patients immunised aged 79	% of patients immunised aged 78
OXFORDSHIRE	**95.1**	**52.7**	**56.5**	**55.6**
Thames Valley Total	**97.9**	**53.1**	**56.2**	**55.8**

The NHS Area Team is currently looking at how they can improve on the uptake of the shingles vaccination and will report their action plan to the forum later this year.

12. Screening Programmes (Lead Role NHS England)

Antenatal Screening Programmes

12.1 Programme activity continues to meet targets, except for avoidable repeats for blood spot test. The avoidable repeat of blood spots continues to be an issue as different matters arise. Due to a change in lab policy the repeat screening has not

been improved. The Area Team are working with the lab and providers to reduce repeat screens.

Bowel Screening

12.2 Screening is offered to people aged 60-74 years of age. Uptake for 2014/15 is shown below; performance is above the national minimum target of 52%

	Q1	Q2	Q3
Percentage uptake of offer	55.0%	57.0%	56.0%

12.2.1 The Area Team is working collaboratively with the programme and Cancer Research UK to raise awareness of bowel cancer screening in Oxfordshire with health promotion activities in July 2015.

12.2.2 The Area Team has agreed a health inequalities grant with the local authority for £15,000 funding to support increase uptake by implementing a new national PEARL initiative.

Breast Screening

12.3 This programme is available to women aged 50-70 every three years. Latest data was that 76.4% of women in Q1 and 78.3% in Q2 took the offer of a screening. This is below the nationally set target of 80%.

12.3.1 In June 2014 an incident was identified involving the misdiagnosis of mammograms in the local screening unit. This triggered a look back exercise and further screening of some women. The process was successfully managed by OUHT and the area team and the incident has been resolved.

12.3.2 The incident had an impact on the three week waiting times for further assessment in Q1 and Q2 but activity is nearly to the levels prior to the look back exercise.

Year	2013/14	2014/15		
Quarter	Q4	Q1	Q2	Q3
% seen within 3 weeks of screening for further assessment	92.6%	70.7%	59.9%	88.3%

Cervical Screening

12.4 This programme is available to women aged 25-64. The percentage of those that take up the offer continues to just fall short of the national 80% target, despite continued efforts over the years.

	Q1	Q2	Q3
% uptake of the programme	76.7%	76.5%	76.2%

12.4.1 However, quarter 1- 3 data shows that the colposcopy waiting time targets continue to be met.

	Q1	Q2	Q3
Number of referrals seen within 8 weeks	100.0%	99.8%	100.0%

Aortic Abdominal Aneurism Screening

12.5 This programme is available to men aged 65 to 74 over 10 years. Locally the programme is performing well with uptake meeting the 75% target for Q2 and Q3.

	Q1	Q2	Q3
Percentage uptake of offer of screening	62.9%	79.1%	78.8%

13. HIV and Sexually Transmitted Infections NHSE (Lead Role NHS England & Oxfordshire County Council)

HIV

13.1 The rate of HIV in Oxfordshire continues to increase in line with the improved survival rates for HIV which has become a more chronic condition with the improved effectiveness of treatment. Currently there are 524 people diagnosed with the infection living in Oxfordshire. Of these 524 people, 279 live in Oxford City. It is estimated that there are an additional 115 people undiagnosed with HIV in the County.

13.1.2 Early diagnosis of HIV is important as it improves the prognosis of treatment, reduces the cost of treatment and lowers the risk of transmission. Latest data for 2011-13 reveals that 40 cases of late diagnosis occurred in Oxfordshire.

Sexually Transmitted Infections (STIs)

13.2 The diagnosis for all STIs which had increased in 2012 has levelled off in 2013. The detection rates in Gonorrhoea have had a particular impact on this activity.

Gonorrhoea

13.2.1 An audit to look at diagnoses of Gonorrhoea was agreed with local stakeholders. This was implemented in December and is still on going. The agreed six month period should end in June and reviewing data for presentation to stakeholders in July.
The Sexual Health Action Partnership (SHAP) will discuss the findings of the audit and the best course of action in July/ August.

Chlamydia

13.2.2 The current detection rates are still less than the projected levels that are determined by PHE and we are RAG rated red because of this. OCC will be working with the PHE SE England area lead for Chlamydia on a “deep dive” look at the data to elucidate a cause for the current activity data and how we can improve on the local activity and diagnoses.

14. Blood Bourne Viruses

There were no major incidents to report.

15. Recommendations

The Board is requested to consider the contents of this report on the health protection activity in the year 2014/15.

Eunan O’Neill, Consultant in Public Health

June 2015

Agenda Item 11

Health Improvement Partnership Board
Forward Plan 2015-16

Date	Item
Thu 27 Oct 2015 2-4pm Oxford Town Hall	• Re-commissioning of housing related support • Healthwatch Oxfordshire update report • Children and Young People's Plan 2015-18 • Revised Health and Wellbeing Strategy • Domestic Abuse review
Thu 18 Feb 2015 2-4pm Oxford Town Hall	
May 2016 (tbc)	• Annual Basket of Housing Indicators • Health Improvement Board Priorities 2016-17
July 2016 (tbc)	• Health Protection Forum Annual Report
Standing items:	
• Minutes of the last meeting and any matters arising • Healthwatch Ambassadors' Report • Performance Report (including any report cards) • Forward Plan	
Proposals/periodically:	
To be kept under regular review: • Re-commissioning of housing-related support • Welfare reform • Oral Health Needs Assessment • Healthy Weight Action Plan • Oxfordshire Sports Partnership	

25 June 2015

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