Notice of Meeting Public Document Pack

Oxfordshire Joint Health Overview & Scrutiny Committee

Thursday, 30 June 2016 at 10.00 am
Meeting Rooms 1 & 2, County Hall

Membership

Councillors:	Kevin Bulmer	Surinder Dhesi	Laura Price
	Yvonne Constance OBE	Tim Hallchurch MBE	Alison Rooke
			Les Sibley
District Councillors:	Nigel Champken-Woods	Monica Lovatt	Nigel Randall
	Jane Doughty	Susanna Pressel	
Co-optees:	Moira Logie	Dr Keith Ruddle	Mrs A. Wilkinson

Notes: ***Date of next meeting:*** *15 September 2016*

What does this Committee review or scrutinise?

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

How can I have my say?

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

For more information about this Committee please contact:

Chairman	-	
Policy & Performance Officer	-	*Katie Read Tel: 07584 909530*
		Email: katie.read@oxfordshire.gov.uk
Committee Officer	-	*Julie Dean Tel: (01865) 815322*
		Email: julie.dean@oxfordshire.gov.uk

Peter G. Clark
County Director

June 2016

About the Oxfordshire Joint Health Overview & Scrutiny Committee

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

About Health Scrutiny

Health Scrutiny is about:

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

Health Scrutiny is NOT about:

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

What does this Committee do?

The Committee meets up to 5 times a year or more. It develops a work programme, which lists the issues it plans to investigate. These investigations can include whole committee investigations undertaken during the meeting, or reviews by a panel of members doing research and talking to lots of people outside of the meeting. Once an investigation is completed the Committee provides its advice to the relevant part of the Oxfordshire (or wider) NHS system and/or to the Cabinet, the full Councils or scrutiny committees of the relevant local authorities. Meetings are open to the public and all reports are available to the public unless exempt or confidential, when the items would be considered in closed session.

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

A hearing loop is available at County Hall.

AGENDA

1. Election of Chairman 2016/2017

To elect a Chairman for the municipal year 2016/17.

2. Election of Deputy Chairman - 2016/2017

To elect a Deputy Chairman for the municipal year 2016/17.

3. Apologies for Absence and Temporary Appointments

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

5. Minutes (Pages 1 - 18)

To approve the minutes of the meeting held on 21 April 2016 (**JHO5**) and to receive information arising from them.

6. Speaking to or Petitioning the Committee

7. Forward Plan (Pages 19 - 20)

10:10

A draft Forward Plan is attached for consideration **(JHO7).**

8. Health & Care Transformation in Oxfordshire Update

10:15

Stuart Bell, Chief Executive of Oxford Health and Chair of Oxfordshire's Transformation Board, will give a presentation **(JHO8 – TO FOLLOW)** on the development of system-wide Transformation Plans that will cover:

- The case for health and care transformation in Oxfordshire;
- Key messages from the Oxfordshire, West Berkshire and Buckinghamshire five year Sustainability & Transformation Plan;
- Emerging work streams in the Transformation Programme;
- Plans for public consultation and engagement on the proposed future models of health and care in Oxfordshire.

9. Healthcare Commissioning in Oxfordshire Prisons and Immigration Removal Centres in the County (Pages 21 - 26)

11:45

A presentation will be given by representatives from NHS England on Representatives from NHS England on healthcare in prisons and Immigation Removal Centres (IRC) in the county. A report is also attached entitled 'Health & Justice Commissioning for Oxfordshire Prisons and IRC in Oxford **(JHO9).**

10. Health & Wellbeing Board - Strategy and Priorities for 2016/2017 (Pages 27 - 58)

12:45

Officer representatives from the Health & Wellbeing Board will attend to provide an overview of their Strategy for 2016/2017 **(JHO10).**

11. Healthwatch Oxfordshire - Update (Pages 59 - 62)

13:15

An update report on Healthwatch Oxfordshire activities is attached at **JHO11.**

12. Chairman's Report (Pages 63 - 68)

13:25

The Chairman will update the Committee on meetings attended since the last meeting **(JHO12).**

13. FOR INFORMATION ONLY (Pages 69 - 80)

The Committee is briefed on the following **(JHO13):**

- Health Inequalities Commission – briefing – there will be a substantive item on the November meeting's Agenda;

- Oxford Health NHS Foundation Trust: Striving to Improve Care - briefing.

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.

OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 21 April 2016 commencing at 10.00 am and finishing at 4.15 pm

Present:

Voting Members:	Councillor Yvonne Constance OBE – in the Chair
	Councillor Kevin Bulmer Councillor Surinder Dhesi Councillor Tim Hallchurch MBE Councillor Laura Price Councillor Alison Rooke Councillor Les Sibley District Councillor Monica Lovatt District Councillor Susanna Pressel District Councillor Nigel Randall
Co-opted Members:	Moira Logie and Mrs Anne Wilkinson
Officers:	
Whole of meeting	Hannah Iqbal and Julie Dean (Corporate Services); Director of Public Health

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

17/16 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 1)

Apologies for absence were received from District Councillors Martin Barrett and Nigel Champken-Woods and from Keith Ruddle.

18/16 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 2)

There were no declarations of interest submitted.

19/16 MINUTES

(Agenda No. 3)

The Minutes of the last meeting held on 4 February 2016 were approved and signed subject to the following amendments:

- Minute 8/16 'Closer to Home – Health & Care Strategy' – penultimate sentence in paragraph 5, to read as follows (amendments in bold/italics):

  'Dr McManners asked if the Committee wanted engagement with the public to be 'joined up' in one local area about everything – or would it want it to be repeated in ***each locality?'***

- Minute 12/16 – South Central Ambulance Service NHS Foundation Trust (SCAS) – third sentence, paragraph 2:

  'The Trust was working ***with the Department of Health to consider how*** £1m ***could be reinvested*** into the ***service*** to cover the fines and to address the reasons behind the penalty.'

  There were no Matters Arising.

20/16 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 4)

The Chairman had agreed to the following people addressing the Committee. All had requested to speak at the start of the item concerned:

Agenda Item 7 – Councillor Hilary Hibbert-Biles, (Local Member) and Dr Jonathan Moore (Chipping Norton Health Centre);

Agenda Item 8 – Councillor David Nimmo – Smith (Local Member); and Cllr Ian Reissman (Chair, Townlands Steering Group); and

Agenda Item 12 – Councillor Jenny Hannaby (Local Member).

21/16 OXFORDSHIRE'S HEALTH & SOCIAL CARE TRANSFORMATION PLANS

(Agenda No. 5)

A Panel attended to update the Committee on the development of system-wide Transformation Plans and also to respond to questions from members of the Committee. It comprised of Stuart Bell, Chief Executive, Oxford Health (OH): Andrew Stevens, Director of Planning & Information, Oxford University Hospitals NHS Foundation Trust (OUFT): Dr Joe McManners, Clinical Chair, Oxfordshire Clinical Commissioning Group (OCCG): and John Jackson, Director of Adult Social Services, Oxfordshire County Council (OCC) and member of the Transformation Board. A presentation was given by Stuart Bell.

Stuart Bell, responding to a question about whether there was a sufficiency of trained people to provide health care, agreed that there was a need for more trained personnel and support staff, for example, volunteer drivers. He stated the Board's belief in the importance of creating career structures and the development of apprenticeships. John Jackson added that the practical issues inherent in finding a sufficient workforce to do the job had been recognised at the onset of the Project – and there had been some success in attracting more social care providers into the county – but he had warned that the introduction of the living wage was viewed as a potential problem for the future.

A member asked whether there was sufficient money for the technology required for the project. Stuart Bell responded that much of the technology was about people purchasing their own Health apps to download onto their mobile phone. To this end the Board were working with the Oxford Academic Health Scientists Network on attracting investment into the capability of linking information into the system. He added that the Board was holding discussions with a number of partners and investors in this field with a view to linking into and developing this field. Mr Bell accepted that not everybody accepted new technology, but it was surprising how many older people did – and this acceptance could make the difference between people staying in their own home or having to leave it. An important thread of the project was the concept that care needed to be made much more personal and adapted to people's own circumstances.

A member of the Committee expressed the view that more work needed to be done in the sphere of sharing information on patients between different healthcare professionals or departments to avoid conflicting, and therefore confusing advice. Dr McManners responded that the system needed to be sufficiently flexible to offer a grade of different interventions to assist patients, adding it was more about partnership between the patient and the professional than patient responsibility. The new proposals allowed the patient to self - report and to observe and take action if required.

A member expressed the view that issues in the national agenda such as the scrapping of nurses' bursaries by 2020 and the issues currently in the media regarding GPs contracts could all have an impact on the local workforce and attract funding problems in the future. Mr Bell agreed that any issues of this kind could not be ignored, but there were always opportunities to attract funding and get the best out of a situation, for example, nurses training could be supported by Trusts in return for an agreement that they will work for the Trust for a set number of years.

A question was asked about how robust this Plan for Oxfordshire was in the midst of discussion about the overall structure of local government within Oxfordshire. Dr McWilliam stated that it would be important to design the best systems whose principles did not depend on organisational structures within the NHS or local government, but would be robust.

Mr Bell was asked if there would be sufficient time for the public to be allowed the opportunity to influence plans, given that there would be a consultation at the end of the summer. He responded that there had already been some work with service

users at local level, adding however that more discussion and planning would need to take place on this.

The Chairman thanked all attendees for the excellent presentation. On behalf of the Committee she asked for more information to be given by the OCCG on what would be delivered locally in relation to home/bed based care. – and gave permission for details of this Committee to be included on the Transformation Board's website.

22/16 REBALANCING THE SYSTEM - UPDATE

(Agenda No. 6)

The Chairman welcomed the following representatives from Oxford University Hospitals Foundation Trust (OUH) and Oxfordshire County Council to the meeting:

- Pau Brennan and Lily O'Connor – OUHFT
- John Jackson and Karen Fuller - OCC

Paul Brennan gave a presentation on the pilot to tackle Delayed Transfers of Care (DTOC). He reported, to date, there had been a 30% reduction in delays against an expectation of 25%.

Challenges highlighted in the presentation were:

- Workforce recruitment and retention – some staff tended to find a combination of high cost housing, the cost of living, transport movement around the City a disincentive and move away;
- The 4 hour standard in Accident & Emergency – reaching the desired level of 70% was moving in the right direction, but not as quickly as was hoped;
- Re-ablement care was still posing a challenge, demand being greater than capacity;
- Readmissions had been higher than expected.

Lily O'Connor gave a flavour of how the Hub staff (comprising Occupational Health, Physiotherapy, Social Workers, Contracting, Financial Assessment, Nursing staff, Administration, Medical staff) were working interactively – and were meeting on a formal basis once a week. The Hub was staffed at weekends by nursing staff and Oxford Health Medical Assessment staff. She reported also that there had been a number of readmissions at the start of the project. However, as the Hub had gained in confidence, communication with the Care Homes had improved, and many patients had either been placed in Homes close to their own homes, or been given rehabilitation enabling them to go back home with reduced packages of care.

Karen Fuller spoke of issues which were being dealt with by staff at the Hub, including assistance with obtaining legal power of attorney consent. From an Adult Social Care point of view, there had been a number of key benefits to working at the Hub, such as staff being able to conduct daily tele-conferences to discuss clients, to which key organisations would contribute. This enabled the flow of patients to be managed better. There were good, positive outcomes owing to a robust multi-disciplinary team assessment. Intensive rehabilitation, in conjunction with social workers, enabled patient pathways to change. There was also good communication between organisations which enabled staff to focus resources to the most appropriate point.

In response to a question, it was confirmed that there had been a sufficient number therapists recruited.

In response to a question about funding of the project, John Jackson reported that funding had been via the OCCG, who were currently looking at continuing the project beyond April 2016 at a reduced level.

A member asked how nursing staff in care homes coped with patients with very complex conditions. Lily O'Connor explained that Hub staff went out to homes to support this category of patient when required, and worked alongside staff. There was also a care home support service who worked with other staff in the Home to aid the management of such conditions on a long term basis. Any problems with patients' medication were dealt with on an individual basis via liaison with this service if more support is needed. In all, Lily O'Connor stated that staff in care homes were gaining in confidence, given that they had never been exposed to this situation before. A sense of trust between the Hub and the care homes was more apparent and there were signs that they were working with a problem rather than contacting the emergency services to send the patient into hospital.

In response to discussion around patient deaths, the Committee was informed that patient deaths were automatically reviewed. They were also informed that this patient group were usually more frail and older. It was the view of the speakers that death in a home environment was invariably more dignified.

In response to a question concerning the number of acute beds that had been released to date, Paul Brennan reported that 76 beds that were not in use, had been released, but not closed, as it had been agreed that this would be a consultation issue, as referred to earlier by Stuart Bell. The intention was to maintain the released beds, though it would be highly likely that there would be a recommendation that they be permanently closed at the consultation stage.

A member asked if the released, acute beds had been made available for winter pressure use. Paul Brennan responded that beds often did not require acute care and that a focus was needed on patients who were on an ambulatory pathway, who only needed them for a few short hours before going back home. John Jackson added that if more capacity was taken for the purpose of winter pressures then this would have an impact on funding. With regard to the funding of beds, Karen Fuller added that working together with the social care placement officer had been beneficial, giving an opportunity to negotiate a price when necessary and not pay higher prices. Paul Brennan added also that overall, the cost of support was less than the cost of running an acute bed, thus the cost of running 76 beds had been less.

Paul Brennan, in response to a question, reported that 17 nursing homes had been used across the county and the number of beds used had been just over 70. Every effort had been made to cite a nursing home close to the patients' own town/village and there had been no issues reported over choice.

In response to a question concerning notification to the regulator of clinical incidents, Lily O'Connor explained that the rules and procedures had remained the same and had not been undermined in any way to suit the circumstances.

Lily O'Connor gave her assurance that lessons would be learned as part of the final evaluation.

John Jackson clarified the position with regard to the impact on Health & Social Care of people working in retail, for example, being paid above the living wage. He stated that there was a need to look further at the impact of this if a negative situation was to occur, adding that 2% had been set aside in the County Council's budget to meet the costs of the national living wage.

The Chairman thanked Paul Brennan, Lily O'Connor, John Jackson and Karen Fuller for their attendance and Paul Brennan for the presentation.

23/16 IMPLEMENTATION UPDATE - HENRY CORNISH CENTRE, CHIPPING NORTON

(Agenda No. 7)

Prior to consideration of this item, the Committee was addressed by Cllr Hilary Hibbert-Biles, in her capacity as Local Member for Chipping Norton, and Dr Jonathan Moore, GP at the Chipping Norton Health Centre. The major points of their addresses were as follows:

Cllr Hilary Hibbert-Biles

- The 2011 contract had made clear that the beds were defined as 'sub-acute' and did not have intermediate care status. The change constitutes a down-grade;
- In her view, this Committee had not supported the residents of Chipping Norton in relation to this issue;
- Nursing staff did not wish to TUPE over to the Orders of St. John;
- There was concern that the Unit was not accepting referrals for people who had known clinical needs during the transition. This constituted a waste of staff expertise;

Cllr Hibbert-Biles called for the Committee to consider this as a substantial change in service, consultation for which had not occurred, and asked that it refer it to the Secretary of State for Health as a consequence. She also called for the Unit to be included in the forthcoming community hospital review.

Dr Jonathan Moore

- Expressed his appreciation for the large investment made in 2011 when the old hospital centre had closed down. The Hospital now had a Maternity Unit, a Minor Injuries Unit, Physiotherapy services, Outpatients and X ray facilities.. To complement these facilities, a sub-acute unit had always been expected and it had been disappointing to GP staff, in particular to a new GP with an interest in hospital care, to find that the Community Hospital had been downgraded without sufficient consultation;
- There had always been a need for sub-acute beds and there had been no alternative model of care provided; and

- The numbers of beds were shrinking and as a result there was an inadequate background provision of care in the community.

The Committee had before them a briefing on the implementation of the new arrangements at the Henry Cornish Care Centre ICU. On 26 January 2016, the County Council's Cabinet had approved Option A for the ICU which involved the ICU continuing, the full 14 bed service being provided by the Orders of St John Care Trust (OSJCT). The paper addressed the staffing issues, including the TUPE transferred staff, implications for service users and the plan moving forward.

Due to difficulties in recruiting staff in the west Oxfordshire area, a transition plan had been put in place that involved staffing the ICU with a combination of transferred nursing staff and Health Care Assistants, agency nursing staff and OSJCT care staff. All community and urgent care services would be available as usual during the transition period and there would continue to be medical and therapy cover available to the Unit at the same level as currently provided. The transition plan would focus on providing the service to those predominantly with rehabilitation needs. The service would therefore not be accepting referrals of people during the transition period who had known clinical needs, as it was essential that safe care was provided. The timescale for achieving these aims depended on the recruitment of nursing staff and it was envisaged that it would take approximately 3 months to recruit staff and a further period of 1 – 2 months to fully mobilise the nursing led service.

The Chairman welcomes Sara Livadeas, Strategy Director and Patsy Just, Assistant Operations Director, OSJCT; and John Jackson, Director for Adult Social Services, OCC.

John Jackson introduced the report about an issue which had been discussed on a number of occasions at this meeting and the Committee had previously asked for an update report on implementation. Mr Jackson asked to respond to a number of points made by Cllr Hibbert-Biles and Dr Moore. These were as follows:

- OCC Cabinet had already made the decision on 26 January 2016 on the process of implementation;
- Points had been made during the consultation which had directly addressed the allegation made by Cllr Biles and the Steering Group that the service had been down-graded. No person had written to his department specifically concerning the allegations. He invited a response to it, stating that the consultation information was still in place on the OCC website;
- Improvements to the Intermediate Care Unit had been made by OCC alongside considerable investment made by the NHS into the other facilities offered, as set out above. He paid credit to the efforts made by OSJCT to provide a full complement of nurses in the implementation time-scale.

Sara Livadeas stated that the Unit had only been open for just over 2 weeks and thus it was only very early days. The OSJCT had not been able to begin the recruitment process until after the consultation had ended and the decision made. She pointed out that 3 part-time nurses had transferred from Oxford Health to OSJ and 80 hours of cover would be provided from Health Care Assistants. Whilst she understood any concerns, the nurses on duty would provide a stable staff group, aided by an agency

nurse, to give cover at all times to those patients reliant on services available other than clinical nursing care.

A member of the Committee asked why OSJCT had not started a dialogue with OCC regarding staffing during the course of the consultation. Sara Livadeas responded that it had been decided not to do this in a bid not to want to pre-empt the outcome of the consultation.

Points made and views expressed by members during debate were as follows:

- The people of Chipping Norton had been promised a 'sub-acute' service which would be run by the NHS. Now it was not the case and recruitment had proved difficult. There should have been a plan put in place for what may happen and then contracts could be adjusted accordingly if necessary;
- The mapping of the ICU facility, staffed by OSJ nurses, should be mapped against other provision to ensure transparency.

John Jackson responded that, as part of the communications about the new service, OCC had published a large amount of information on the OCC website. Detailed information had also been given on the specifications of both NHS and OSJ provision, and had been compared with each other. He added that it had proved particularly difficult to recruit nurses in the west oxfordshire area due to it being predominantly rural and housing prices and rents being relatively high. He referred to a crisis in the recruitment of nurses which, he warned, might become an emergency in the future, if something is not implemented nationally.

Committee accepted the need to recruit additional permanent nursing staff for the 3 month transition period.

In addition, Members received confirmation from the Director of Adult Social Services that the Intermediate Care commissioned beds would be included within the county-wide Transformation consultation to be undertaken in the autumn of this year, as set out on page 3 of the Transformation Plans report.

24/16 TOWNLANDS HOSPITAL, HENLEY ON THAMES - UPDATE

(Agenda No. 8)

Prior to consideration of this item the Committee received an address by Cllr Ian Reissman of the Townlands Steering Group, and by Cllr David Nimmo-Smith, local member.

Cllr Ian Reissman

Cllr Reissman began by congratulating all who had been involved in work on the new Townlands Hospital, saying that it was a major achievement in securing local delivery of these much needed services. He expressed the concern, however, of the Townlands Steering Group that the OCCG decision, which was made in September 2015, not to provide the beds as originally planned but to operate the Ambulatory Care Model, had not been shared with the Group sufficiently to provide reassurance that the health needs of patients who had been using the bedded service in the Peppard ward were being met. Cllr Reissman commented also that he believed that

the closure of beds would lead to higher DTOC statistics. He stated that the community were keen to see an effective process of monitoring and scrutiny of the new model of care. He added that the paper presented by the OCCG to this Committee provided an overview of many of the key issues but asked that the Committee ensure that details were provided by the OCCG in the following areas:

- Details and location of the Integrated Locality Team which would be based at Townlands as key components of the RACU and the Multidisciplinary Team;
- Provision of a clear plan for the Rapid Access Clinical Unit (RACU) including the opening dates and staffing arrangements;
- Evidence that home care packages were available both now and when the RACU opened with the inevitable increased demand;
- Details of the operation of the beds leased from the Care Home including levels and qualifications of staffing, co-location of the beds and spot purchasing arrangements;
- Provision of a clear, specific, measurable set of Key Performance Indicators to include an explanation of how these had been arrived at , and the dialogue with the community; and
- To request the OCCG to engage properly with the Townlands Stakeholder Resource Group (TSRG) and co-operate with the OCCG to reconfigure the TSRG and have clear and constructive Terms of Reference. The CCG was asked to respond to the proposals and adopt as many of the proposed Terms of Reference as possible.

Cllr David Nimmo-Smith

Cllr Nimmo-Smith supported the comments made by the previous speaker address. He too congratulated all involved in getting the new hospital opened and looked forward to the care home opening soon. He hoped that the Henley experience would be taken into account as plans were developed, and consultations held, as part of the County's Transformation Plan, which in turn fitted into the national health agenda.

He stressed that the new facilities were, in his view, a great improvement, but the OCCG report accompanying this Agenda gave the impression that all teething problems had been resolved. He pointed out that this was not the case, the community required answers to their questions about integration with Adult Social Care and home care packages.

Cllr Nimmo-Smith added that the Henley and district community did not see the newly formed stakeholder group as being the answer and made a plea to the OCCG for sufficient local community involvement. He commented that getting things right in health care was important to the users of the new facility and for the Oxfordshire model.

The Chairman invited Cllr Lorraine Hillier, Mayor of Henley, to state her views. She commented that the OCCG had pledged in September 2015 to work with the community. The three, two hour meetings which had been held to date, had, in the Stakeholder Group's view, little value. She added that the media coverage had been negative because of the failure of the OCCG to address the communication

problems; and asked therefore for clear Terms of Reference for the proposals from the OCCG.

The Chairman welcomed Dr Andrew Burnett, Clinical Locality Director for SE Oxfordshire and a local GP, and Peter McGraine, Clinical Director of Older People's Directorate, Oxford Health to the table. Andrew Burnett stated that the hospital was now open with excellent facilities. The expanded Minor Injuries Unit, the Physiotherapy service and the Out of Hours service were now in place, adding however that there were still issues with regard to the re - provision of the full X Ray service because the wiring had proved unavailable (it had been ordered in 2014). In addition the RACU was not yet in place, but the plan was always that this Unit would open later. He further reported that consultants were keen to come along to work in the new hospital.

Dr Burnett added that the consultant-led Unit providing rapid access via a combination of doctors and the community teams was a respected and well-established model, which would serve to keep people in their own homes as much as possible. He refuted the issue that the closure of beds would lead to greater DTOC statistics, stating that, conversely, having more beds increased DTOC figures. The modern approach was to close beds and to help patients to go home or out into the community for rehabilitation care.

Pete McGraine reiterated Andrew Burnett's views stating that the facilities were excellent offering a podiatry service, a speech and language service, a therapy service and Out of Hours care. He reported that the public had been invited to visit the site when it opened and feedback had been very positive. Now that the older hospital had been removed, the full visual impact was being appreciated. He further reported that he had met with the media and talked through the benefits, advantages and challenges still faced, for example with the X ray facilities. Oxford Health were working very closely with colleagues at the Royal Berkshire Hospital. It was both difficult and a challenge recruiting suitable staff with suitable expertise for the RACU, adding that it was an emergency discipline providing preventative care in a responsible way. He supported the fact that the RACU was always going to be established after the other facilities. Staff groups were working in the community and those who were focusing on ambulatory care were currently being trained ready for the RACU's opening. He reported also that locality teams were not to be placed at Townlands now. He recognised the issue of timely availability of home care across the county and acknowledged that KPI's had not yet reached the agenda at meetings.

The Chairman, speaking on behalf of the Committee, thanked Dr Andrew Burnett and Pete McGraine for the update. She stated that this new model of health care was to become the norm, but the message did not appear to be being communicated sufficiently well. She added that engagement with the stakeholders and the town about the new model of care and the facilities offered was not strong enough and needed to improve.

25/16 HEALTHWATCH OXFORDSHIRE - UPDATE

(Agenda No. 9)

Eddie Duller, Chair of Healthwatch Oxfordshire (HWO), was invited up to the table to deliver his update on the activities of HWO. He reported that the restructuring of the organisation was now complete and HWO were relocating during the following month. He also stated that they may be able to continue the Hearsay! programme later in the year.

A member suggested that the NHS response to HWO's recommendation (a) on the Discharge Report which stated that 'the discharge summary was being redesigned with input from clinical staff including GPs, pharmacists' should also include summaries from carers and patients.

A Committee member asked for more information in the section on 'what we have heard', page 37, mental health services – first bullet point – 'widespread concerns have been expressed about how difficult it is for people to access mental health services when needed in a timely and effective manner. They report seeing increasingly unwell people who are turned away from services as the threshold to access mental health services rises ever higher.' Mr Duller agreed to send more information with regard to this.

Members asked if it would be possible for HWO to be a little less anecdotal and to give more concrete evidential information, It was agreed, however, that it was useful for the Committee to see a picture emerging from the community of any problems .Mr Duller agreed to this.

Mr Duller was thanked for the report.

26/16 LEARNING DISABILITY UPDATE

(Agenda No. 10)

The Chairman welcomed:

Ian Winter CBE – Independent Chair, Transforming Care Partnership Board;
Ian Bottomley – Head of Mental Health Services & Joint Commissioning – Oxfordshire Clinical Commissioning Group (OCCG)
Sula Wiltshire – Director of Quality & Chief Nurse – OCCG
Helen Ward – Senior Quality Manager, OCCG
Lesley Stevens – Medical Director, Southern Health NHS Financial Trust (SH)
Kate Terroni – Deputy Director for Adult Social Care (Joint Commissioning) – Oxfordshire County Council

Ian Winter CBE addressed the meeting prior to the presentation. It was his view that successive governments had often failed in their quest to find a successful strategy for Learning Disability policy over the years. However, the latest Transformation Care Plan was a positive initiative in that it did not separate patients across the age ranges or by condition. He spoke about the importance of the Transforming Care Plan being underpinned by the Transforming Care Partnership Board. One of the issues for Oxfordshire was about the successful transfer of services to other providers. The role

of the Board was to ensure the safe and effective transfer and transformation of services by means of challenge, championing and collaboration. He hoped the Committee would reach some level of confidence in the action that was being taken.

Kate Terroni and Ian Bottomley then gave a presentation on the current arrangement with Southern Health and how the transition to other providers would be managed. Ian Bottomley referred members to Appendix 1 'Oxfordshire's Health & Social Care Transformation Plans' which was set out in the Addenda to the Committee.

A member asked if the general community health services, as health care providers, would have the appropriate expertise to deal with people with conditions such as autism. Ian Bottomley responded that resources were already in place to provide a service, in the form of the existing contract which would be rolled over. He stated that there was no imposed solution – all had to be fully engaged and inform the OCCG of general risks and of financial risks. Moreover, the OCCG needed to be satisfied that providers were able to do the job. The contract was already provided by the existing community services located at the John Radcliffe Hospital. Here there was a good liaison service in place for people with a learning disability because staff and ward teams had a familiarity with the patients.

In response to a question asking how would intelligence be collected in order to access data, Ian Bottomley stated that the OCCG's working approach would be to identify the outcomes for meeting the health needs for a person with autism or a learning disability, and then to monitor how well the patient had done against those outcomes. Moreover, there was also a need to monitor how well the OCCG was picking up this condition generally, by asking the question of how the organisation might assess whether somebody had got autism. Sula Wiltshire explained further that the commission had made recommendations in relation to the investigation of deaths. She explained that there was an acceptance that good data on people with a learning disability was not apparent and there was therefore a need to know how to secure intelligence in order to determine how robust professionals were, for example, on how incidents were interrogated.

A member stated that it was reassuring to hear that the OCCG aimed to keep staff engaged as a priority, asking if anybody would be monitoring engagement criteria with patients – and would the criteria be set locally or nationally? Ian Bottomley responded that learning disability was not an exact, scientific diagnosis. In general it was known what future demand would be for adult and children's services but mental health, and particularly autism assessments were more difficult. The big challenge was to design a way of assessing which related to professionals looking for signs under the principle 'behaviour always means something'. The specialist aspiration was that everybody would go through the front door of Health. Dr McWilliam commented also that learning disability and autism were not concepts that could be nailed down using socially constructed, imposed definitions. To try to apply to very strict quality standards was 'slippery', and then to be asked to measure it, 'difficult'. At some time the Panel would try to transform services making it routine care rather than specialist care. He added that it was difficult to define what they were going measure, and then to put into contracts at this time, as there were legal contracts to unpick.

A member asked the Panel to expand a little more on what the vision was for the future of in-patient support within Oxfordshire and how spot-purchasing would go forward. Kate Terroni explained that originally there were 8 spot purchases which had reduced to 6. These were managed by a multi-disciplinary team of nurses and clinicians to enable staff to be supported and to keep a person in that environment. Now that there was a move to fewer beds, some patients would be placed as near to home as possible, and with a consistency of staff for in-reach and support, with a view to re-integrating the person into the community. She added that there would only be a small number of circumstances when beds would be required. Ian Bottomley added that in circumstances when there was a need for crisis provision, it would be managed by nationally imposed targets. The aim was to end with a model which only used beds when required, and for as short a time as possible. He added that the OCCG would be monitored on a reduced number of beds during the lifetime of this contract.

A member asked if there would be a point of contact with a member of staff for patients. Kate Terroni explained that professionals would look at the individual to assess whether they would suit that particular placement.

When asked what the CCG was expecting out of mainstreaming, Ian Winter stated that the aim was that people with a learning disability and autism should receive the same access to broad health care as a person without the condition.

Sula Wiltshire then gave a presentation the Commissioners' response to Mazars report into Mental Health and Learning Disabilities deaths in Southern Health NHS Foundation Trust.

The Chairman thanked Sula Wiltshire for the presentation.

Lesley Stevens explained that one challenge was that this was the first real examination of deaths in the community. In the past there had no clarity of guidance about who should investigate and no criteria to apply in particular settings. It is a huge amount of work as there are no tools to apply in the community sector. The data for 50% of the cases was required for the work.

A member asked who was doing the work – and would it have been undertaken if Oxfordshire had not teased out the data. Sula Wiltshire responded that it would not have been undertaken and it was the Health Economy Group who were doing the work. They were due to be trained very soon. She explained that the Group would pick up the recommendations from the thematic review and compile a number of questions to be explored. For example, was the liaison good for that person? Was there a delay in diagnosis?

A Committee member asked if a change in Board leadership had been considered, given the need for a dispassionate eye for how things needed to change. Lesley Stevens responded that it had been considered, in fact much scrutiny around the leadership had taken place, however, Monitor was the body to take such a decision and an Improvement Director would be working with the Trust. She added that there was confidence in both the Director and the Board and a wish that they should stay. She added further that the Trust had been the subject of a significant amount of

external scrutiny to date and had received reassurance about improvements made and the safety of services.

The representatives were thanked for their attendance and for allowing a frank, open discussion.

27/16 QUALITY REPORTS

(Agenda No. 11)

Oxford Health Financial Trust (OH)

The Chairman welcomed Ros Alsted, Director of Nursing & Clinical Standards and Jane Kershaw, Acting Head of Quality & Safety, Oxford Health Financial Trust (OH).

The Committee had before them a summary version of the Quality report. A finalised, detailed report had been circulated to members that day. Ros Alsted reported that the summary had focused on prioritisations. She pointed out that representatives had recently attended Committee to discuss the findings from the Care Quality Commission (CQC). Eleven were evaluated as good, one was outstanding and four required improvement.

Jane Kershaw reported that the Trust had identified for priority areas in 2015/16 and were also keeping the same ones for next year. The four priority areas were as set out in the report.

A Committee member asked about the problems being experienced both nationally and locally regarding the recruitment of nursing staff. Jane Kershaw responded that the overall majority of staff in lower paid work were not clinical members of staff. She added that that there were multifactoral reasons why the problems were unique to Oxfordshire, such as high property and rental costs, but the Trust remained very focused in trying to attract people into the workforce. It had achieved relative success, particularly in respect of the recruitment of nursing staff. She added that in one year's time the bursary system would change, but any problems would not emerge for 4 years. In the meantime, efforts were being made to recruit and retain staff by working together to ensure career pathways were in place, for example. This was an important priority for the Quality account.

The Committee **AGREED** to note the priorities and objectives proposed for the Quality Account in 2016/17.

Oxford University Hospitals Foundation Trust (OUH)

The Chairman welcomed Dr Tony Berendt, Director of Quality, and Claire Dollery, Deputy Director of Quality, OUH.

Dr Berendt gave his apologies for the full Quality report arriving too late to be despatched with the papers for this meeting, but stated that he was pleased to be given the opportunity to discuss the report.

Dr Berendt, during his report to Committee, commented that discharges to GP care had more than doubled. He also stated that the work put into the DTOC programme could not have taken place without all the input that Health and Social Care colleagues had put into the system.

He reported that a public engagement event, to which both governors and staff had attended, had been held on the Quality account, when an overview of the previous year's account and a reflection on outcomes had taken place. A session had also been held on intended priorities for the coming year. The Trust was doing a piece of work on improving the discharge process as part of DTOC work. Part of this was to empower patients and families to ask the right questions. He added that he would be happy to give an update in progress. He undertook to let the Committee know of future patient and public dates in respect of the Quality account process. The Committee welcomed this, commenting that this would ensure a much smoother process for major programmes and their implementation.

Dr Berendt referred to a one day training programme for staff on Compassionate Care which had been arranged and delivered by the Chief Nurse and the HR Department. Patient participants would be encouraged to relate their own experiences, with the aim of helping staff to more consciously empathise with what is occurring. He added that the plan was to broaden this out still further in the future to pick up other medical staff.

In response to questions about incidents of maladministration, Claire Dollery reported that she had worked this year to identify those which were of high risk. For example, a programme to identify any time-critical medication and means by which staff could learn about these and put them into practice. Dr Berendt added that errors in prescribing medication via different kinds of nursing error.

A member of the Committee asked how many cases of sepsis was occurring via hospital acquired infection. Dr Berendt responded that the majority of the cases were community acquired cases. Claire Dollery added that there were two principal streams of work with the sepsis group, one was ensuring that the appropriate antibiotics were given in one hour; and use of data to identify the correct antibiotic.

A member commented that it was difficult for the Committee members to effectively undertake the job of scrutiny if documents were not received in time, particularly in view of their size. Dr Berendt responded that Quality priorities were set nationally and that the Trust's Quality priorities linked into those of lead organisations on patient safety, mortality etc and national priorities had to be met.

The Committee **AGREED** to note the priorities and objectives for the Quality Account in 2016/17.

28/16 CHAIRMAN'S REPORT
(Agenda No. 12)

Prior to discussion, the Committee were addressed by local member, Cllr Jenny Hannaby, in relation to the report of the confidential meeting held with representatives from Oxford Health with regard to Wantage Community Hospital on

14 April. The report informed the Committee of a briefing meeting attended by 10 members of the Committee regarding the imminent closure of Wantage Community Hospital on safety grounds, given the persistent recurrence of legionella in the hot water system of the hospital. This was being treated and there was no immediate risk to health. However, the treatment was not a long term solution and the whole system required re-plumbing in order to permanently eradicate the risk. The purpose of the confidential meeting was for Oxford Health to ask this Committee whether the proposed extension of the temporary closure of Wantage Hospital (to allow public consultation outcomes to shape the nature of capital works undertaken) constituted a substantial variation or not. The outcome of the meeting was that HOSC members recognised the closure of Wantage Hospital as a substantial change in service and noted the commitment by OCCG, OH and other organisations to a full Transformation consultation later this year.

Cllr Jenny Hannaby

Cllr Jenny Hannaby began her address by regretting that local members had not been invited to the confidential meeting with HOSC members. However, she had attended a briefing yesterday, in her capacity as local member. She stated that on making inquiries about the issues prior to the briefing, she had been informed that the hospital would close for 2 weeks, and later told it would be closed for 3 months. The staff had been very shocked when given the full facts. She added that this was the third time in 10 years that she had attended meetings to defend the hospital against closure. She informed the Committee that the problem had been prevalent for 4 years. It had been flushed out in the past and maintenance work had taken place. Friends of Wantage Hospital had given donations for some of this work. She reported that there had been 63 babies born this year at hospital, adding her view that OH should have corrected the problem permanently if it was a danger to patients. She further commented that purdah prevented a consultation on the closure which would have enabled members of the public to have their say. She requested the Committee to encourage OH to do a temporary closure of the hospital until a consultation was held – and to support the fight against permanent closure.

The Chairman responded to Cllr Hannaby on behalf of the Committee stating that, following their meeting with OH on 14 April, members were of the view that a proposal to close the Hospital permanently would constitute a substantial change of service and would require a full public consultation. Members had recognised the Legionella made it unsafe for the health of patients and therefore needed to be flushed out. She added that they were informed that the temporary closure would take place at the end of June.

Cllr Hannaby disputed that it was a temporary closure, informing the Committee that staff had been informed that the outcome of the consultation could be permanent closure. Hannah Iqbal responded that the HOSC members who had attended the meeting had been told that the outcome would not be decided until the consultation outcome.

Hannah Iqbal agreed that clarification on these issues would be sought in the form of a letter, adding that it was her understanding that Oxford Health had wanted to close

it temporarily in a planned, gradual manner and did not wish to be in a position where it would have to be closed as a sudden emergency closure.

Dr McWilliam advised that the Committee needed to make a judgement about whether they had been put fully in the picture. He suggested that the Committee should write a follow-up briefing to the Trust asking the appropriate questions.

It was **AGREED**:

(a) that the Policy Officer should write to the Trust seeking clarification of the issues raised; and

(b) to note the remainder of the Chairman's report.

29/16 FORWARD PLAN
(Agenda No. 13)

The Committee considered the draft Forward Plan.

With regard to a possible review into private nursing care homes, John Jackson advised that the Committee ask for a quality and monitoring report on private care homes.

It was **AGREED** that the Forward Plan be agreed and that patient transport ***and parking to hospital sites*** be reviewed***.***

30/16 FOR INFORMATION ONLY - BRIEFING REPORT
(Agenda No. 14)

The briefing report was noted.

..... in the Chair

Date of signing .....

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HOSC Forward Plan – June 2016			
Meeting Date	**Item Title**	**Details and Purpose**	**Organisation**
September 2016	Rebalancing the System – Pilot Evaluation	• End of pilot review and next steps	Whole System – (Paul Brennan, OH)
September 2016	Transformation Update	• Consultation Outline and Next Steps	Whole System – (Stuart Bell, OH)
September 2016	Travel and Access to Hospitals	• Overview of current issues, actions being taken and broader transformation plans regarding travel and access.	OCCG, OUH, OHFT
November 2016	Health Inequalities Commission Report	• Report of the Health Inequalities Commission – ready Autumn 2016	OCCG
Future Items			
	Director of Public Health's Annual Report	• Annual Report • Impact of cuts on public health	PH
	Better Care Fund Update	• Implementation Update on the Better Care Fund	OCCG
	NHS Workforce – Recruitment and Retention	• Raised as a potential area – most likely has been covered through Transformation work stream updates	Whole System
	Obesity prevention	• In July 2015, the HWB recommended that HOSC scrutinise the prevention of obesity, districts and public health	PH
	Care in Private Care Homes	• Raised in June	CQC, ASC contracts

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NHS England

Health and Justice Commissioning for Prisons and IRC in Oxford

Document Title: Health and Justice Commissioning for prisons and IRC in Oxfordshire

Version number: 1

First published: June 2016

Prepared by: Sue Staddon, Head of health and Justice Commissioning for NHS England South (South Central)

Classification: OFFICIAL

The NHS Commissioning Board (NHS CB) was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.

Health and Justice Commissioning

1. Context

Section 15 of the **Health and Social Care Act 2012** gives the Secretary of State for Health the power to require NHS England to commission certain services instead of Clinical Commissioning Groups (CCGs). These include 'services or facilities for persons who are detained in a prison or other accommodation of a prescribed description'. NHS England assumed these powers from **1 April 2013.** The responsibilities of NHS England cover both public and contracted prisons and Immigration Removal Centres (IRCs).

NHS England is responsible for ensuring that services are commissioned to consistently high standards of quality across the country, promote the NHS Constitution and deliver the requirements of the Secretary of State's (SoS) Mandate and the Section 7a agreement with NHS England. NHS England Health and Justice are responsible for commissioning all health services (with the exception of some emergency care, ambulance services, out of-hours services and NHS 111 services). This includes primary care incorporating dentistry and optometry services, preventive and public health services, secondary care, community services, mental health and substance misuse services, in respect of persons detained in prison, or in other secure accommodation.

Commissioning is led by ten teams across four regions (North, South, Midlands and East and London), supported by a small national Health and Justice team.

2. Health and Offending

Offenders are more likely to smoke, misuse drugs and/or alcohol, suffer mental health problems, report having a disability, self-harm, attempt suicide and die prematurely compared to the general population. The links between poor health and reoffending have been long understood. For example, evidence suggests:

- Drug users are estimated to be responsible for between a third and a half of acquisitive crime and treatment can cut the level of crime they commit by about half;
- Alcohol is a factor in an estimated 53% of violent crime[3] and Accident and Emergency (A&E) data sharing and targeted interventions have been shown to reduce overall A&E violence related attendances in one study by 40%.

The clear links between the wider determinants of health and factors affecting reoffending such as sustainable housing or employment create a potentially vicious circle. For example, offenders with addiction or mental health problems are more likely to need support with housing, education or employment to change their lives and prevent future victims, yet at the same time research shows these offenders will find it more difficult to access mainstream help than the general population. Increased health inequalities are therefore compounded by greater barriers to accessing services to meet those needs.

Just as the evidence base shows both the links between health and crime and the disproportionate levels of health inequalities experienced by those in contact with the criminal justice system, so too there is clear evidence of the efficacy of interventions to improve the health needs of this group, on reductions in crime and better health outcomes. There is also emerging international evidence of the benefits of recognising prison health as a public health issue and the wider 'community dividend' which may be realised by addressing some of the disproportionate levels of illness identified within the prison population, in particular with respect to issues such as communicable disease control.

The World Health Organisation's Health in Prisons Programme and the Council of Europe at a meeting of prison health experts held in Strasbourg in 2014 endorsed the position that there can be 'no health without justice and no justice without health' by which it was meant that health and justice organisations cannot achieve their respective aims in isolation. It is therefore essential that health and justice organisations with responsibilities for commissioning and delivering services in prisons work together in partnership. Further, wider public health objectives around reducing health inequalities can be achieved through addressing the health needs of people detained in prison as they often return to communities experiencing significant levels of disease, poorer health behaviours and less access to health services.

3. Health Needs of Detainees

There has been very little research on the physical health needs of detainees in the UK immigration detention system. However, there is some literature from Europe and Australia on the health of migrant communities that is likely to be relevant to this population group. This research suggests that the most likely health problems for detainees will be communicable diseases such as TB, Chicken Pox and HIV. There is also evidence to suggest that certain ethnic groups including those most likely to be detained have higher prevalence rates for particular conditions including Asthma, Diabetes and Cardiovascular diseases. Certain conditions, including anaemia, dental caries, intestinal parasites, nutritional deficiencies and immunisation irregularities, appear more commonly in newly arrived refugees from developing countries. Also, people with darker skins and those whose mothers lacked adequate nutrition during pregnancy and breast-feeding are known to be at risk of Vitamin D deficiency.

Migrant populations from less developed countries are known to be less likely to have been immunised against common diseases. Some ethic groups are known to have higher prevalence rates of certain chronic conditions e.g. Diabetes. Also some ethnic groups are known to have higher rates of cardiovascular disease.

There are no known prevalence figures for mental health problems amongst detainee populations. However, certain common mental health conditions, especially those that are stress related and depression would be expected to be high due to a variety of factors that are pertinent to these populations e.g. experience of trauma, stress related to immigration status and likely return to a home country where conditions and circumstances may be challenging. There are also known differential rates of mental illness diagnosis amongst certain ethnic

populations. Mental health is reported as being one of the most significant health problems for detainees.

Commissioning in Oxfordshire

4. Establishments

There are three secure establishments in Oxfordshire: HMP Bullingdon, IRC Campsfield and HMP Huntercombe.

HMP Bullingdon is a local prison for adult males and Young Offenders with the operational capacity of 1114 prisoners and is a Category B, C and YOI. It holds prisoners from 18 years of age, but predominantly those aged 21 years and over. The population mainly comprises of remand prisoners and newly sentenced prisoners, received from courts in the Thames Valley area - particularly Reading and Oxford but also from the Wessex area.

Bullingdon is a national treatment centre providing Sex Offender Treatment Programmes, including an adapted programme for prisoners with learning difficulties.

IRC Campsfield is a privately run Immigration Removal Centre based in Kidlington. The centre is run by contractor MITIE Care and Custody. The centre accommodates up to 292 detainees pending their case resolution and subsequent removal from the UK and receives detainees at any time during the day or night.

HMP Huntercome is a Category C establishment holding solely adult male foreign national prisoners who have been identified by the Home Office as meeting relevant deportation criteria. It has an operational capacity of 430 prisoners. Its population is drawn from a large number of different countries. For example, in recent times, it has held a significant proportion of prisoners from Albania, Ghana, Holland India, Jamaica, Poland and Somalia.

5. Commissioning process

The Service Procurement of healthcare in the three establishments took place over 2015 with a new contract for all three starting on 1st April 2016 following the expiry of existing contracts. The procurement fell within the scope of “Part B Services” as defined in the Public Contracts Regulations 2006 (as amended) and Directive 2004/18/EC. Therefore the 2006 Regulations and the 2004 Directive were only applicable to the Service Procurement to the extent required for Part B Services.

NHS England decided to follow a tendering procedure for the Service Procurement which is akin to the Open procedure, as provided for under the 2006 regulations and the 2004 Directive.

The procurement was carried out in partnership with the National Offender Management Service (NOMS) and the Home Office as well Public Health England.

NHS England promotes a Prime Provider or consortium model to encourage an integrated service. Care UK was the successful bidder for the Lot that comprised of the three establishments in Oxfordshire.

6. Healthcare provision

Health care provision in each of the prisons and the IRC includes primary care and secondary mental health services equivalent to that provided in the community. Services include:

- GP
- Healthcare Nursing
- Mental Health and Learning Disability
- Integrated Substance Misuse
- Dental
- Optometry
- Pharmacy
- Sexual Health
- Therapies
- Health Promotion
- Audiology

7. Governance

NHS England works in partnership with NOMS, Home Office and Public Health England through National and regional partnership boards and National Assurance Groups. This is replicated locally through a partnership board that meets quarterly and includes representation from Oxfordshire CC, Oxfordshire CCG and the IMB. It receives performance reports from the provider and considers strategic issues across all three establishments. An action plan is produced from recommendations emanating from Her Majesty's Inspectorate of Prisons (HMIP), IMB Annual Report, Death in Custody Reviews from the Prison and Probation Ombudsman and any Quality Inspection reports.

Her Majesty's Inspectorate of Prisons for England and Wales (HMI Prisons) is an independent inspectorate which reports on conditions for and treatment of those in prison, young offender institutions and immigration detention facilities. All inspections of prisons, young offender institutions and immigration removal centres are conducted jointly with the Care Quality Commission and the General Pharmaceutical Council (GPhC).

Oxfordshire's Joint Health & Wellbeing Strategy

2015 - 2019

Version 5, July 2016

**(First Version July 2012,
Revised July 2013, June 2014, June 2015, June 2016)**

CONTENTS

1. Foreword to the Revised Version of this strategy, June 2016

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

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, Healthwatch 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 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.

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 2019 in Oxfordshire:

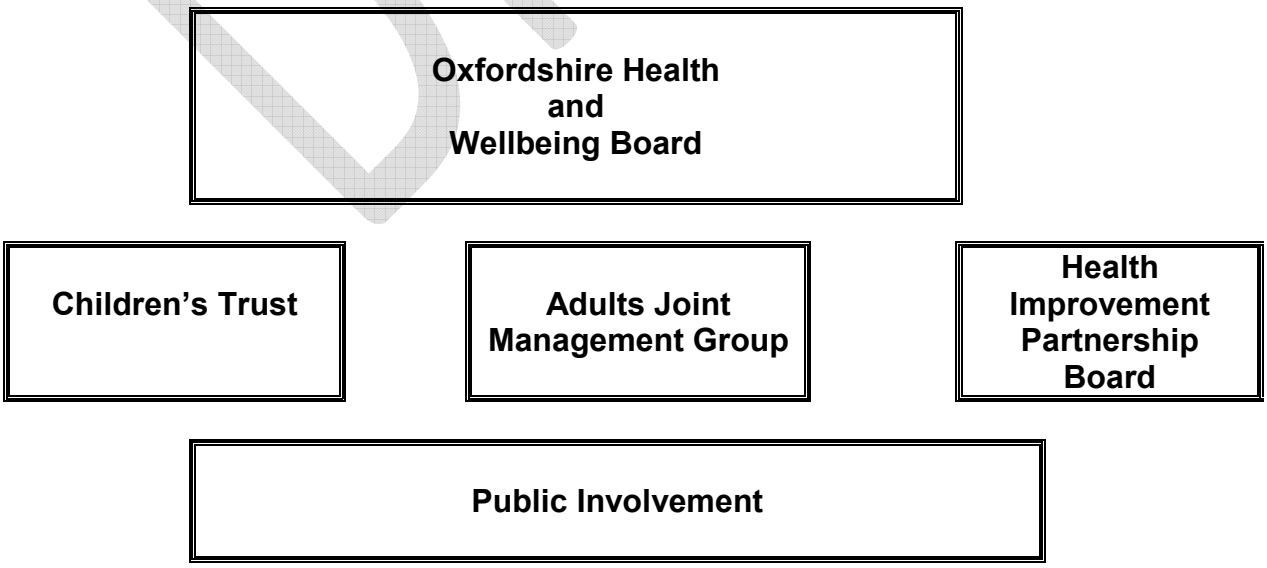
- more children and young people will lead healthy, safe lives and will be given the opportunity to develop the skills, confidence and opportunities they need to achieve their full potential;
- more adults will have the support they need to live their lives as healthily, successfully, independently and 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 will continue to run for the medium term (2015-19), while the measures and targets set out within each priority are for the financial year 2015-16.

4. The structure of the Health and Wellbeing Board

4.1 What does the Health and Wellbeing Board look like?

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



The purpose of each of the Boards, Joint Management Group and for Public Involvement are outlined below:

Adult Joint Management Group	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.	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 Public Involvement bodies to agree that direction. They are also accountable to their constituent organisations – the Oxfordshire Clinical Commissioning Group, County, District and City Councils and Healthwatch Oxfordshire.

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

The Health and Wellbeing Board meets in public three times a year and the Health Improvement Board meets in public. There are 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, can be found through the link below-
http://www.oxfordshire.gov.uk/cms/content/about-health-and-wellbeing-board

4.3 The Work of Other Partnerships and Cross-Cutting themes

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

- Better Care Programme Board
- Transformation Board and System Leadership Group
- Better Mental Health in Oxfordshire
- Urgent Care Programme Board that covers the A&E Recovery Plan
- Civilian Military Partnership
- Corporate Parenting Panel
- Alcohol and Drugs Partnership
- End of Life Care Strategy
- Oxfordshire Children's and Adults Safeguarding Boards
- Oxfordshire Domestic Violence Strategy Group
- Safer Oxfordshire Partnership
- Oxfordshire Stronger Communities Alliance
- Oxfordshire Sport and Physical Activity
- Joint commissioning strategies for people with Physical Disability, Learning Disability, mental health issues, dementia or autism, and for older people
- Schools Strategic Partnership Education Commissioning Board
- Young People's Lifestyles and Behaviours Steering Group
- 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 outcome 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 are embedded in our performance framework. The development of Healthwatch Oxfordshire has brought independent and informed views to the Board.

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

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 2015-16 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 2016 which provided a comprehensive overview of the county. It can be found here:
http://insight.oxfordshire.gov.uk/cms/joint-strategic-needs-assessment-report-2016

In addition an in-depth needs assessment of older people was completed. This formed the third part of a suite of documents covering the whole population which can be found here:
http://insight.oxfordshire.gov.uk/cms/joint-strategic-needs-assessment

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 continuing **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 person's journey through all services smoother and more efficient.
- The need to improve the quality and safety of services.
- The need to streamline financial systems, especially those pooled between organisations, and to align all budgets more closely.

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

6.4 What criteria have been followed in selecting priorities?

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

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

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

A summary of the priorities can be found in Annex 1

Each of the priorities set out in this strategy has associated outcomes to be achieved in the current year. The Board examines progress against all of these outcomes at each meeting along with any associated areas of concern which are identified 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: <u>All children have a healthy start in life and stay healthy into adulthood</u>

The health and wellbeing of women before, during and after pregnancy is crucial in giving children a healthy start in life and laying the groundwork for good health and wellbeing later on.

There is increasing evidence that demonstrates that children's outcomes for physical and emotional health are determined from very early on in life. For this reason we will look at areas that focus on a healthy pregnancy and continued health and wellbeing in the early years.

There are a number of indicators of which the Children's Trust will retain oversight, but which will be monitored by the Health Improvement Board. These relate to breast feeding; smoking in pregnancy; childhood obesity; preventing disease through immunisation; and tackling homelessness and the number of households in temporary accommodation. All of these significantly impact the health and wellbeing of children.

The number of children in Oxfordshire aged 5 and under was 41,545 in December 2015 and had grown by 1.19% since the last census in 2011. 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 prioritising these children as a focus for our services in the community.

The Healthy Child programme delivers a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, supplemented by advice around health, wellbeing and parenting. The transfer of responsibility for commissioning the Healthy Child Programme delivered by the Health Visiting Service, which includes the Family Nurse Partnership Programme, from the NHS to the County Council Public Health team in the last year occurred smoothly.

We are also keen to focus not only on the transition into parenthood, but also the transitions that many of our more vulnerable children will face at different life stages and ensuring that all services are working together to prepare children for adulthood.

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 will be a focus for us in the next year.

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 and will continue to do so in this coming year. During the last year there has been a new service developed for children who have experienced sexual abuse, a new pathway for Autism Spectrum Disorder and Children and Adolescent Mental Health Services (CAMHS) in-reach has been piloted in schools. The CAMHS Transformation Plan will continue to remodel services, working with third sector partnerships and developing new specialist pathways.

We welcome a strong focus on promoting wellbeing and developing resilience, particularly in children and young people and having increasing awareness of mental health and access to support via schools, in partnership with school nurses and CAMHS, is crucial to this work.

Where are we now?

- There are a number of measures relating to a healthy start in life, such as rates of breastfeeding, obesity levels and immunisations that are reported under the Health Improvement Board's priorities 7-9.
- The overall rate for breastfeeding at 6-8 weeks is still higher than the national average and the aspirational target of 63% has been met. This very high level of success needs to be maintained.
- 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%.
- We have had an increase in referrals to CAMHS by 34% from April 2015 to February 2016 and we have not been able to meet our target for waiting times. However, our urgent referrals continue to be seen promptly and we are performing better than national waiting times.
- All secondary schools have a school health improvement plan which is submitted on an annual basis and 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 and Oxfordshire began its Troubled Families programme named Thriving Families in 2012. This first programme was focused on working with children not attending school, young people committing crime or families involved in anti-social behaviour and adults who were out of work. The programme has expanded and aims to effect service transformation with partner services by embedding a whole family approach. Oxfordshire has been provided with a target of 2890 families which it needs to work with in order to achieve "Significant and Sustained Progress" by 2020. Within Oxfordshire we are in the midst of integrating Children's Services, the Troubled Families methodology and Think Family approach will be a key feature of this integration. This continues to be a vital strand in the on-going work locally to 'narrow the gap'.

The Family Nurse Partnership is an intensive home visiting service for first time teenage mothers, their partners and their children that starts in pregnancy and continues until the child is two years old. The programme provides 200 places a year to families throughout Oxfordshire that meet the eligibility criteria. Family nurses are trained to provide support on a broad range of issues including parenting, attachment, child development, maternal mental health and makes an important contribution to the Council's aim of 'narrowing the gap' for our most vulnerable children.

The attainment gaps for many vulnerable groups of pupils in Oxfordshire continues to be wider than the attainment gap nationally and remains a focus 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 continue to be amongst the highest in the country. The number of permanent exclusions from Oxfordshire schools has risen considerably over the last two years. The attainment gap at all key stages of education and the number of school exclusions are greater for specific pupil groups, so there is a particular need to focus on specialist groups of vulnerable learners, in particular, children and young people eligible for free school meals; children and young people with autistic spectrum disorder and children and young people Looked After by the County Council.

Where are we now?

- The percentage of children in poverty has reduced and continues to be significantly better than the England average.
- Although our number of children looked after children (LAC) placed out of county is just above our target the number of children looked after has increased in the last year so the proportion of children placed out of county has decreased.
- During the academic year 2014/15, 17% of Children in Need (defined as those with a current Children in Need plan) and 18% of those subject to a Child Protection Plan in Oxfordshire were classed as persistently absent from school (i.e. missing 15% of sessions throughout the year). This is an increase from the previous year and remain higher than from the same cohorts nationally. The overall persistent absence rate for all pupils in Oxfordshire in 2013/14 was 4%.
- We have increased our number of young carers identified and worked with substantially in the last year.
- We have reduced the proportion of children with Special Educational Needs and disability (SEND) with at least one fixed term exclusion in the academic year.
- We have increased the proportion of children with a disability who are accessing short breaks who are eligible for free school meals.
- The disadvantaged attainment gap in Oxfordshire remains a priority at all key stags with the gap continuing to be wider than that nationally. A Strategy for Equity and Excellence in Education has been launched which takes 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).
    - At the end of the Early Years Foundation Stage the disadvantaged gap narrowed from 25 %points in 2014 to 22 %points in 2015. The national gap is 18 %points.
    - At key stage 2 the disadvantaged attainment gap widened slightly from 18 %points to 19 %points in 2015 and remains noticeably wider than the

national gap of 15 %points.
- At key stage 4 the disadvantaged gap narrowed from 34%points to 30%points in 2015.

Outcomes for 2016-17

2.1. Reduce the number of children and young people placed out of county and not in neighbouring authorities
Baseline: 77

2.2 Reduce the care leavers not in employment, education or training.
Baseline:
Baseline:
Target in Care Leavers Strategy for 2016 is 18%

2.3 Reduce the proportion of children with Special Educational Needs and Disability (SEND) with at least one fixed term exclusion in the academic year.
Baseline: 6.7%

2.4 Increase the proportion of children with a disability who are accessing short breaks services who are eligible for free school meals.
Baseline: 42%

2.5 Reduce the persistence absence of children subject to Child In Need and a Child Protection plan.
Baseline: Child in Need 18%
Child Protection Plan 17%
Compared to 4% of all children

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”.

Young people have previously told us that the five big safeguarding issues they face are:

- Fear of speaking up
- Feeling safe at home
- Boundaries and safe relationships
- Mental Health and Suicide
- Drugs

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 by having better joined up services. We know that we need to ‘Think Family’ and support the network of support around the child.

In the last year increased levels of child protection activity have been seen across all organisations in Oxfordshire and all are working to ensure that children and young people are kept as safe as possible despite the increased pressures and reduced budgets. Seventeen organisations have completed impact assessments at a senior level regarding the increased child protection activity and the three overarching themes were managing demand in a collaborative manner, supporting the workforce as they hold potentially more complicated cases and identifying the impact of changes in housing support and how these can be mitigated.

Child Sexual Exploitation, neglect, domestic abuse and transitions for vulnerable children have been highlighted in recent Serious Case Reviews in Oxfordshire and we will continue to look at what is happening to improve work in these areas.

Child Sexual Exploitation continues to be a priority and there has been much work to ensure that there is increased recognition, detection, prevention and protection for children who may be at risk of Child Sexual Exploitation. We have also developed more support services for those children, young people and adults that have been subjected to Child Sexual Exploitation.

A Joint Thematic Area Inspection took place during March 2016 which concluded that Oxfordshire is working well together across all agencies to tackle Child Sexual Exploitation. A significant strength was the ability to learn from previous investigations and work closely with children and young people to help keep them safe.

We know that going missing is a key indicator that a child might be in great danger and missing children are at very serious risk of physical and sexual abuse, and sexual exploitation. We have developed robust processes across the county to identify and respond to children that go missing.

Domestic abuse continues to be a concern in Oxfordshire with increasing numbers of domestic abuse reports to police including children resident in the house in Oxfordshire in the last year. A strategic review of domestic abuse in Oxfordshire will continue this year and

hearing from children will be central to this review, so we can make sure we provide the right services to help keep children safe.

Where are we now?

- A new domestic abuse pathway for young people has been developed and is being implemented in Oxfordshire.
- The number of hospital admissions caused by unintentional and deliberate injuries in young people aged 15-25 has decreased.
- More than 146 schools have received direct support to implement Anti-Bullying strategies.
- Child Protection activity across all agencies including police, children's social care and health has increased.

Outcomes for 2016 -17

All partners are currently being consulted to incorporate the OSCB Data set and Children's Trust into one data set and the performance measures that go forward under this priority into the Health and Wellbeing Strategy will be decided once this dataset is agreed.

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

The Performance Audit Quality Assurance Group is a sub group of the Safeguarding Children Board and the Children's Trust and reports to both, highlighting pressure points and related actions, as well as reporting on performance.

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 in line or better than the national average and this can be built upon. At key stage 4 the proportion of young people in Oxfordshire reaching key threshold measures continued to be above the national average. There continues to be a wide variation in performance between schools at all key stages and also of specific groups of pupils. 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 educational needs.

There have been improvements in inspection outcomes, in particular the proportion of schools judged by Ofsted as requiring improvements has decreased from 20% in August 2013 to 10% in March 2016. The proportion of outstanding schools remains below the national average. 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 3.9% 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 Hub area.
- 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%.
- At the end of March, 87% of Oxfordshire schools were judged by Ofsted to be good or outstanding, slightly above the national average of 86%. There are over 76,500 young people attending schools that are good or outstanding, an increase of 9,000 since August 2013.

Outcomes for 2016-17

The Education Strategy monitors the levels of attainment and quality across all primary and secondary schools in Oxfordshire. The ambition for the county is to be in the top quartile of local authorities on all performance measures by the end of the 2017/18 academic year.

4.1 Improve the disadvantaged attainment gap at all key stages and aim to be in line with the national average by 2018 and in the top 25% of local authorities. Key stage 2 and key stage 4 are new national performance indicators.

a) Early Years
b) Key stage 2
b) Key stage 4

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

4.3 Early Years - 69% of children in early years & foundation stage reaching a good level of development, Early Years Foundation Stage Profile placing Oxfordshire in the top quartile of local authorities

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 Adults

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

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

- Improved access to, experience of, and satisfaction with, health and social care services;
- 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 development of integrated health and social care teams in local areas. The Five Year Oxfordshire's Sustainability and Transformation Plan is developing and will describe how to achieve the aims of the Five Year Forward View for the NHS.

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.
- Better Care Fund national requirements for closer working of health and social care are all continuing in 2016/17.
- We are continue to monitor the number of avoidable emergency admissions to hospital for older people per 100,000 population as in the last year the number has exceeded our baseline from 2013/14 continuing to rise
- Over 17,000 carers are now known to adult social care which is an increase of 968 over last year
- Our figures for the number of carers receiving a service was below target due to unforeseen consequences of the Care Act. Only carers with a personal budget or direct payment can be counted as receiving a service. Our figures exclude over 4000 people who receive the alert service which a recent review showed that such services reduce carers levels of stress and anxiety levels by 88 %.
- We will continue to monitor the percentage of people waiting a total time of less than 4 hours in A&E as the target of 95% was only met in one quarter
- The target of increasing the percentage of people waiting less than 18 weeks for treatment following a referral was not met due to pressures in a number of specialities and we will continue to monitor this closely.

Outcomes for 2016-17
These outcomes link to the Quality Statements agreed with commissioners, partners and Healthwatch outlined earlier in this document, namely joining up people's care when it is being delivered by a range of health and/or social care providers, improving communication between different organisations and with people and their carers, and involving carers in care planning and delivery.

5.1. Deliver the six 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 people 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 National Guidance.
5. Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?
6. Is an agreement on the consequential impact of changes in the acute sector in place?

5.2. Reduce the number of avoidable emergency admissions for acute conditions that should not usually require hospital admission for people of all ages (2015/16 baseline 996.6)

5.3. Increase the number of carers receiving a social care assessment from 7,036 in 2015/16 to 7,500 in 2016/17.

5.4. Increase % carers, as reported in the 2016 Carers Survey who are extremely satisfied or very satisfied with support or services received from a baseline of 43.8% from the 2014 Carers Survey.

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

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

- Admitted patients target 90%
- Non-admitted patients target 95%
- Incomplete pathway target 92%

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

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 will also continue to measure access to psychological therapies and we know that this makes a difference for people to move towards recovery.

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 2016/17. Partners recognise that the system needs to provide better treatment of patients with physical and mental health needs, and to improve how it recognises and addresses the psychological component of all healthcare. This is reflected in the measures below which address access to treatment for mental health problems and access to psychological therapies

Where are we now?

- Over 30,000 people had information and advice about areas of support through the Community Information Networks, against a target for the contract year of 20,000
- We will continue to monitor from last year the target of improving access to psychological treatment as the target was not met in every quarter.
- People with Learning Disabilities still do not have good enough access to physical health checks.
- We have continued to reduce the number of assessment and treatment hospital admissions for adults with learning disabilities.
- Emergency hospital admissions for acute conditions are higher than the target of 951.4 per 100,000 population although Oxfordshire continues to develop its Ambulatory Care Pathways and we will continue to monitor this closely.

Outcomes for 2016-17

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

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

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

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

6.5. Increase the employment rate amongst people with mental illness from 2015/16. (baseline to be confirmed).

6.6. Reduce the number of assessment and treatment hospital admissions for adults with a learning disability. (baseline data to be confirmed).

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

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

In Oxfordshire we know that the proportion of older people in the population continues to increase and that the number of referrals for support is also increasing along with the cost of caring for older people which increases markedly with age. This is true for both health and social care.
Oxfordshire has one of the highest levels of delayed transfers of care from hospital in the country. All organisations continue to be committed to working together to improve the situation. One of the best ways of doing this is to provide services which help people to learn or re-learn the skills they need to live more independently and to prevent ill health. These services are called “reablement services”. We are committed to offer these services to more people, and will be re-commissioning the reablement services in 2016 to increase capacity.

For all these reasons our priority is to support older people to live at home whilst reducing the need for care and support. The Closer to Home Health and Care Strategy has the aim of enabling people in Oxfordshire to access more care at/or closer to home, achieving a step change in developing community services by

- Increasing their ability for self-care
- Building on the successful UK General Practice model
- Delivering more integrated primary, community, acute and social care
- Managing population health to improve outcomes
- Increasing the capacity of the out of hospital care workforce to provide more care.
- Bringing together organisations to develop a ‘whole Oxfordshire’
- Delivering outcomes based commissioning

In the next year we are focusing together on better use of reablement; reducing emergency admissions to hospital for acute conditions; reducing the number of people permanently admitted to care homes; developing more integrated community services; improved diagnosis of people with dementia; providing additional Extra Care housing units as well as ensuring there is a range of housing options for older people and that people can find the information they need. We 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 2016/17 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 however in the last month delays averaged 112 patients compared to last year where there were 155 patients delayed on average.
- The rate of permanent admissions to care homes has dropped, though the overall number exceeded the target set for the year which is due to the capacity issue within the market for home care provision as care homes are used as an alternative to home care.
- The proportion of older people (65 and over) with on-going care supported to live at home has not reached the target set for the year of 63.0%. We will continue to monitor this closely.
- The percentage of the expected population with dementia with a recorded diagnosis has increased.
- The targets for the number of people accessing the reablement pathway have not been reached due to lack of referrals and service capacity. A new strategic care pathway for non-bed based short term care services has been agreed for 2016/17.
- The number of people supposed through home care by social care in extra care housing has continued to rise.

Outcomes for 2016 - 17

7.1. Reduce the number of people delayed in hospital from 136 in April 2016 to 102 by December 2016 and 73 by March 2017.

7.2. Reduce the number of older people placed in a care home from 12 per week in 2015/16 to 11 per week for 2016/17.

7.3. Increase the proportion of older people with an on-going care package supported to live at home from 60 %in April 2016 to 62% in April 2017.

7.4. Over 67% of the expected population with dementia (5081 out of 7641) with dementia will have a recorded diagnosis (provisional baseline of 66% or 5244 people).

7.5. Increasing the number of reablement service hours delivered to a target of 110,000 hours per year (2115 hours per week) by April 2017.

7.6. 70% of people who receive reablement need no ongoing support (defined as no Council-funded long term service excluding low level preventative service).

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

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, though the gap between women and men is narrowing as life expectancy for women seems to be reaching a plateau while that for men is still increasing. People living in more deprived areas are likely to die sooner and be ill or disabled for longer before death.

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

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?

- The uptake of bowel screening by people aged 60-74 has improved steadily over the last year but the target of 60% has still not been achieved.
- Uptake of invitations to attend NHS Health Checks has remained steady during the year and all Oxfordshire GPs are working hard to invite 40-74 year olds.
- Smoking quit rates in the county failed to meet the target in the last year by quite a large margin. The Health Improvement Board has considered the potential impact of e-cigarettes on this area of work.
- Smoking rates in pregnancy are lower than the national figures but 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 and there is still cause for concern as Oxfordshire still lags behind national averages.

Outcomes for 2016-17

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 Oxfordshire performance for those taking up the invitation for NHS Health Checks should exceed the national average (baseline 2015-16 was 51.7% nationally). No CCG locality should record less than 50% ***Responsible Organisation: Oxfordshire County Council***

8.4 Oxfordshire performance for the number of people quitting smoking for at least 4 weeks should exceed 2015-16 baseline by at least 10% (baseline 1562 quitters 2015-16) ***Responsible Organisation: Oxfordshire County Council***

8.5 The number of women smoking in pregnancy should remain below 8% recorded at time of delivery (baseline 2015-16 was 7%). ***Responsible Organisation: Oxfordshire Clinical Commissioning Group***

8.6 Oxfordshire performance for the proportion of opiate users who successfully complete treatment should improve on the local baseline in 2015-16 (4.5%) with a longer term aspiration to reach the national average (6.8% in 2015-16) ***Responsible Organisation: Oxfordshire County Council***

8.7 Oxfordshire performance for the proportion of non-opiate users who successfully complete treatment should improve on the local baseline in 2015-16 (26.2%) with a longer term aspiration to reach the national average (37.3% in 2015-16) ***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. This is also an inequalities issue, as some vulnerable groups, such as those with learning disability or mental health issues, may have poor diets which lead to,or worsen, diabetes and cardiovascular disease.

Surveillance of these issues in the last year show that

- Rates of obesity in the county continue to rise. Data from surveys show a cause for concern.

- The percentage of people diagnosed with diabetes by their GP continues to rise across the county.
- The rates for breastfeeding initiation soon after birth and continuation to at least 6-8 weeks are good in Oxfordshire. These higher rates need to be maintained.
- Measurement of children shows the numbers who are deemed to be overweight or obese at both Reception Class and Year 6 are generally lower than England rates, but show over 16% 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. The national figure for breastfeeding prevalence at 6-8 weeks is just under 44% 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 along with some ethnic groups, 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. This needs to be set alongside healthy eating and diet advice in adulthood and could also include lobbying for policy change on advertising of junk food and alcohol, or presentation of food in shops. However, the survey showed that almost 22% 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?
- The percentage of children who were overweight or obese in Year 6 last year was lower than in the previous year, helping us towards the target of stalling the general rise in obesity rates and going against the national trend.
- The target for reducing the number of inactive people has been met this year.
- The overall rate for breastfeeding at 6-8 weeks is still higher than the national average but the aspirational target of 63% has not been met. This very high level of success needs to be maintained.

Outcomes for 2016-17
9.1 Ensure that the obesity level in Year 6 children is held at no more than 16% (in 2015 this was 16.2%) No district population should record more than 19% ***Data provided by Oxfordshire County Council***

9.2 Reduce by 0.5% the proportion of people who are NOT physically active for at least 30 minutes a week (Oxfordshire baseline 2015-16 of ???% - to be reported in Q2). ***Responsible Organisation: District Councils through Oxfordshire Sport and Physical Activity***

9.3 At least 63% of babies are breastfed at 6-8 weeks of age (currently 52.2%) and no individual health visitor locality should have a rate of less than 50% ***Responsible Organisation: Oxfordshire County Council and Oxfordshire Clinical Commissioning Group***

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

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

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

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

These housing issues all have to be tackled in partnership.

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

Concerns remain including

- Changes to local funding and arrangements for commissioning housing related support.
- Changes to the welfare benefit system which have potential to put more households at risk of homelessness
- 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.
- 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.

- The number of households in temporary accommodation has remained at similar levels to last year with 190 such households reported (192 last year).
- A large proportion of people who had received housing related support services were able to leave the services and live independently. New contracts were awarded during the year and monitoring of outcomes under these new arrangements will continue to be an area of focus.
- The Affordable Warmth Network has reported full take up of grant aided schemes and also a growth in referrals from health services for people whose poor heating or insulation in their homes was affecting their health. This has been possible due to grant funding in 2015 for the Better Homes Better Health programme.
- The number of people estimated to be sleeping rough in the county has increased.
- Contracts for housing related support are showing high levels of positive move-on for vulnerable young people.

Outcomes for 2016-2017

10.1 The number of households in temporary accommodation on 31 March 2017 should be no greater than the level reported in March 2016 (baseline190 households in Oxfordshire in 2015-16). ***Responsible Organisation: District Councils***

10.2 At least 75% of people receiving housing related support will depart services to take up independent living (baseline 87.2% in 2015-16). ***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 85% in 2015-16). ***Responsible Organisation: District Councils***

10.4 Outcome measure to be confirmed. ***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 2015-16 (baseline 90) ***Responsible Organisation: District Councils***

10.6 Measure on young people's housing related support to be confirmed at the HIB in July 2016. Proposed measure is "at least 70% of young people leaving supported housing services will have positive outcomes in 16-17, aspiring to 95%". **Responsible Organisation: Oxfordshire County Council Children, Education and Families Directorate.**

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

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 70 and 78 yr olds.

The Oxfordshire Joint Strategic Needs Assessment shows high levels of coverage but some targets are still not being met. The leadership for these services has changed during the last few 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 and Oxfordshire compares very well with other areas. This included the number of children receiving their first dose of MMR vaccine which remained above the 95% target.
- NHS England has introduced local outreach to improve the coverage of childhood immunisations. It is hoped that this will lead to improvement in the percentage of children receiving the second dose of MMR which is still below the 95% target.
- Rates of flu immunisations for people aged under 65 who are at risk of illness was still well below targets last year. This has been a national trend but still requires local improvement. The national target has now been set at 55%.
- Coverage of the HPV vaccination for teenage girls remained high.

Outcomes for 2016-17

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 55%% of people aged under 65 in “risk groups” receive flu vaccination (baseline from 2015-16 45.9%) ***Responsible Organisation: NHS England***

11.4 At least 90% of young women to receive both doses of HPV vaccination. (Baseline in 2015-16 tbc) ***Responsible Organisation: NHS England***

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

Children's Trust

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

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

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

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

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

Health Improvement

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

Annex 2: Glossary of Key Terms

Terms

Carer	Someone of any age who looks after a relative, partner, friend or neighbour who has an illness, disability, frailty, or addiction. The help they provide is not paid for as part of their employment, and they do not provide the care as a voluntary member of staff.
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://mycouncil.oxfordshire.gov.uk/ieListDocuments.aspx?CId=116&MId=4398
Extra Care Housing	A self-contained housing option for older people that has care and 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	Young people aged 16 to 18 who are not in

Training (NEET)	education, employment or training are referred to as NEETs.
Oxfordshire Clinical Commissioning Group	The Oxfordshire Clinical Commissioning Group has the responsibility to plan and buy (commission) health care services for the people in the County.
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 young person with special needs moves to having adults services.

healthwatch Oxfordshire

1. Introduction

1. The key areas of work for the Healthwatch Oxfordshire team since the last HOSC meeting in April 2016 have been:
   i. Publishing seAp's report into the experiences of Oxfordshire's Gypsy and Traveller Populations' experiences of health services.
   ii. Fieldwork and reporting for our study into people's use and experiences of minor injuries units.
   iii. Fieldwork and reporting for our pilot 'young healthwatch' project at Icknield School, Watlington.
   iv. Reporting for our work looking into themes across CQC inspection reports of care homes requiring improvement.
   v. Publishing our 'this month we heard' feature on our website, which is a precis of all of the feedback we heard in the preceding month.
   vi. Contributing to the Transformation Board's work, particularly supporting communication and engagement.
   vii. Working with OCCG Locality forum chairs to initiate a project looking at administrative problems reported to us at the OUH eye hospital.
   viii. Publication of our own annual report, which can be found here: http://healthwatchoxfordshire.co.uk/annual-report-2015-16

2. Grant aided projects

a) Healthwatch is currently supporting the following groups to produce reports on their service user experience through the final tranche of its grant programme. The majority of these reports will be published between now and October:
   a. **Oxford Parent and Infant Project (OXPIP)** is reviewing the experiences of parents in the period from conception to 2 years of age.
   b. **Refugee Resource** is looking at access to primary care services of refugee and asylum seeker populations.
   c. **Oxford Against Cutting** is looking to evaluate people's experiences of current support services for women who have experienced FGM and identifying any gaps in current services.
   d. **Cruse Oxfordshire** is working on a project assessing experiences of bereavement services in the north of Oxfordshire.

b) **seAp's report into Gypsy and Traveller experiences:**
seAp was awarded a grant from Healthwatch Oxfordshire to carry out a project looking into how members of the Gypsy and Traveller community in Oxfordshire access health services, and their experiences of the NHS. The project also looked

at the experiences of the health professionals who treat and support the travellers to understand better the issues from their perspective.

The findings show that on the whole the Gypsy and Traveller population have a similar experience to the general population, with much of their comments focusing on access and waiting times. It also shows that local GP practices have been working hard to meet the needs of their patients from the Gypsy and Traveller Communities. However, it also shows the importance that the key worker and health advocate have in building relationships and explaining the health system and in facilitating their access to health services. The report made four key recommendations:

1. **Outreach keyworker** – the role was seen as critical in facilitating access and trust in the system and ultimately in reducing health inequalities; it was recommended that this role be strengthened.
2. **Access to GPs** – there are a few ways which access could be facilitated for the Gypsy and traveller community, such as phone back services and information sessions about services like health checks.
3. **Dental services** – further work could be done to encourage registration with dental practices.
4. **Further research into mental health** – further work could be done to better understand travellers' experiences and concerns about mental health.

The full report, and responses from local services can be found here: http://healthwatchoxfordshire.co.uk/reporting-back

3. **Supporting Voluntary Sector groups to report their work:**
Following the loss of our project fund, we looked to find another way of hearing from members of seldom heard groups. We are providing support to voluntary sector organisations working with such groups in a number of ways, from advising on designing a project or methodology, to assisting with fieldwork, where possible / necessary, to simply helping with reporting and editing reports. At present we are supporting 2 groups with their reports:

a) **Clean Slate** – they are looking into whether there is a gap in provision of mental health support to people who have been victims of sexual abuse, this seems particularly prevalent for male survivors.
b) **Oxfordshire Advocacy's Cancer Advocates** – They have a number of concrete recommendations from their work supporting cancer patients in Oxfordshire. We are working with them to publish these as a report.

4. **Outreach programme**

a) The outreach programme scheduled or attended in the summer months includes:

Date	Event
Fri 6/5	Boots (Cornmarket Street Oxford)
Wed 11/5	Templar Square
Fri 20/5	Kidlington Market

Sat 11/6	Play and Activity Day - Barton (recreation ground)
Sat 18/6	Vauxhall Barracks (Didcot)
Sat 25/6	RAF Brize Norton
Sat 2/7	Play and Activity Day - Bicester Garrison
Sat 9/7	RAF Benson
Sun 10/7	Cowley Road Carnival
Sat 16/7	Play and Activity Day – Abingdon
Fri 22/7	Play and Activity Day – Eynsham
Sat 23/7	Riverside Festival
Fri 29/7	Play and Activity Day - Dalton Barracks
Sat 30/7	Play and Activity Day - Grandpont, Oxford
Wed 3/8	Play and Activity Day – Bicester
Tues 16/8	Thame Community Day
Sat 20/8	Elder Stubbs Festival
Sun 4/9	Abingdon Dragon Boat Festival
Sat 17/9	Wantage PPG Event
Sun 2/10	Banbury Canal Festival

5. **"This month we heard"**
   In order to feedback what we're hearing more regularly with providers and commissioners we have created a new, 'This month we've heard' feature on our website. It is a thematic review of all of the information we've received through our outreach work, phone calls and email. We aim to publish feedback from each month no later than the 15th of the following month. Where we name individual services we write to our lead contact at those organisations to make them aware and offer them an opportunity to respond to the feedback. This feature can be found at http://www.healthwatchoxfordshire.co.uk/hot-topics.

6. **Healthwatch Oxfordshire projects**
   We are currently finalising three Healthwatch initiated projects, which are in final review before publication:

   a) CQC Care Home inspection project:
   We reviewed the CQC inspection reports of care homes in Oxfordshire to see if there were any themes in those rated as 'requiring improvement'. We followed up with conversations with 4 care home managers including some who had 'Good' inspection ratings to understand their perspective. This report will be published in July.

   b) Use and experiences of MIU project:
   We spoke to 62 people across 5 sessions in the county's minor injuries units about their pathway to attending the minor injuries unit, following up with a questionnaire on their experiences after they had been seen. Preliminary results show overall people have good experiences, and use the service appropriately. The full report will be published in July.

c) Icknield school / Young Healthwatch pilot:
We conducted focus groups with students at Icknield School about their experiences of primary care. We believe working with schools will be a good model for future engagement with young people. This report will be published over the summer.

HOSC Chairman's Report - June 2016

Liaison Meetings Attended since last HOSC:

The Chairman attended the following meetings with representatives from health and social care organisations between April-June 2016:

- Transformation Event, Kassam Stadium, 6th June
- Southern Health – Future of the Ridgeway Centre briefing, 24th May
- Strategic Review of the Horton Hospital, 9th June, Horton Hospital
- Chairman's discussion on the Strategic Review of the Horton Hospital, 15th June
- Transformation Discussion with System partners, CCG, 20th June.

Letters sent:

1. **Wantage Community Hospital, Oxford Health Foundation Trust**

Following the discussion at February HOSC regarding Wantage Community Hospital, the Chair of HOSC wrote to Oxford Health seeking clarification on a number areas. The letter, Oxford Health's reply and their subsequent press release are printed below:

OJHOSC

Oxfordshire Joint Health
Overview & Scrutiny Committee

26th April 2016

Dear Dominic Hardisty and Anne Brierley,

I am writing to you following the recent meeting of Oxfordshire Joint Health Overview & Scrutiny Committee (HOSC) on Thursday 21st April, regarding the closure of Wantage Community Hospital. This letter provides a summary of HOSC's engagement with this issue so far and some outstanding questions that have been raised by Committee members.

Informal Meeting – 14th April

As the Chairman's report stated, on 14th April HOSC members were informed at a confidential meeting of the planned closure of Wantage Community Hospital due to safety reasons. Oxford Health representatives sought the views of HOSC members

about their proposal to delay commencement of the repair works until early 2017, when the public consultation would be completed. The purpose of this confidential meeting was for Oxford Health to ask HOSC to consider whether the proposed extension of the closure until conclusion of the county-wide public consultation constitutes a 'substantive variation' or not.

HOSC members regarded closure of Wantage Community Hospital as a substantial change and stated that a full consultation with the community would be required. However, members agreed that Oxford Health could delay consultation until the county-wide Transformation consultation, providing that the future of Wantage community hospital was considered within this consultation. HOSC accepted that purdah (for local and PCC elections and then for the referendum) will delay that consultation until September/October.

Public Meeting – 21st April

At the HOSC meeting on 21st April, the public were informed of HOSC's dialogue with Oxford Health. In the following discussion, Cllr Jenny Hannaby (local member) raised members raised questions over why Wantage Community Hospital needs to close now (as she understood that the building had has problems for several years) and why it could not remain open until after the consultation. HOSC members also queried whether the hospital will be kept in working condition during the closure, to keep open the possibility for it to be repaired and reopened in the future. Since these questions did not form the focus of Oxford Health's earlier discussion with HOSC, HOSC members are keen for their concerns to be fed back to Oxford Health.

Outstanding Questions

The committee will be taking a keen interest in discussions surrounding the future of Wantage Community Hospital as part of the wider Transformation Consultation. In the meantime, the Committee is keen to receive clarification on the following questions:

- Why does the hospital need to close in June 2016 and could closure not have been extended until after the Transformation Consultation?
- Will the hospital be kept in working order during the closure period?
- What assurances can Oxford Health give the Committee that the closure of WCH now will not pre-empt permanent closure?
- Is there scope for any informal public engagement/listening events in Wantage in the meantime before a more formal consultation can be conducted?

Yours Sincerely

Cllr Yvonne Constance

HOSC Chairman

Oxford Health Reply

Dear Hannah,

Wantage Community Hospital

Thank you for your letter of 27 April in which you asked the following questions:

- Why does the hospital need to close in June 2016 and could closure not have been extended until after the Transformation Consultation?
- Will the hospital be kept in working order during the closure period?
- What assurances can Oxford Health give the Committee that the closure of WCH now will not pre-empt permanent closure?
- Is there scope for any informal public engagement/listening events in Wantage in the meantime before a more formal consultation can be conducted?

Please find answers below.

Why does the hospital need to close now? As discussed when we met, we detected legionella at the hospital in January 2015. Whilst a number of remedial actions were taken through 2015, these are only temporary in nature. In January 2016 significantly raised levels of legionella were detected and more aggressive actions taken. However, again, these are only temporary in nature: the pipework is old, poorly designed to meet modern requirements and a potential breeding ground for legionella. It therefore determined to be inevitable that we would have to close the hospital for major remedial works - the only question was when. Our judgement was and is to put safety first. We would rather close the hospital in a planned way, now that winter pressures are abating, than have to undertake an emergency closure and decant if and when legionella re-occurs. The longer we keep the hospital open the greater the risk of this occurring, and our first duty always has to be to the safety of patients, visitors and the public.

Will the hospital be kept in working order? Organisations such as ours regularly 'mothball' wards and sites for various reasons: witness what we did in Witney last year which included closing a ward which has now successfully re-opened. Wantage will remain largely in the same state as it is now until the outcome of the consultation. We would not, however, invest in the site until this point for reasons previously explained.

What assurances can we give re permanent closure? As discussed when we met, the future configuration of community hospitals will be the subject of a formal public consultation. It is clear that there is a need for investment in health care facilities in South Oxfordshire. What is less clear is the nature and type of these facilities, although there are some fairly obvious options. We hold the existing hospitals 'on trust' and sites may only be released for other uses once a plan has been agreed and published by the local health economy. This would inevitably

include formal public consultation, which is already planned. Any funds released must then, also, be reinvested for the benefit of the local health economy.

However, we must be realistic that this might not be for bedded facilities in Wantage, since the catchment is probably of insufficient scale to enable the provision of safe and sustainable services. However, we do not detect any appetite for the provision of additional beds at the JR (indeed the opposite is true) and our informal soundings suggest a real groundswell of support for a large, modern healthcare facility - including significant bedded capacity - on or very near the southern A34. It is our intention to include these in the options appraisal upon which we will consult, and we already know the clinical and economic case to be strong. What we cannot weigh fully at this point is the weight and nuance of public opinion, hence the need and desire to consult.

Listening events. I have emailed St John Dickson, Mayor of Wantage, to suggest a meeting to discuss how we might best engage with the public, but have not yet heard back: it would be helpful if you could forward his phone contacts if possible? As you know, I am myself a resident of the Wantage catchment, and three generations of my family live in the vicinity. I would be delighted personally to hold some public meetings prior to the formal consultation as well as to respond to members of the public directly via correspondence, social media and so on.

I trust that this answers your questions fully and provides necessary assurances. Please do not hesitate to contact me if you have further questions or require additional clarification on any points.

Yours sincerely,

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Oxford Health Press release

15th June 2016

We've listened to local concerns and offered Wantage Town Council a compromise option. We've offered to continue running services where there is the least Legionella risk to patients, the Oxford University Hospitals midwifery-led unit and our physiotherapy service, until the conclusion of the major public consultation into bed-based and ambulatory care which begins in the autumn.

The trust has offered to continue with the short term solution for managing the existing risk of Legionella bacteria in the hospital's old, corroded plumbing system

with the understanding these services may need to cease at short notice if Legionella, or works to address it, necessitate an emergency shutdown.

It remains necessary to close the 12 bed in-patient service to protect those people more exposed to Legionella risk and who are typically the most vulnerable in the event of an outbreak. The inpatient service must be closed since it would be impossible to relocate these patients quickly if an emergency shutdown is required.

No decision has been made about the long term future of Wantage Community Hospital.

A major public consultation involving health and social care organisations in Oxfordshire is planned for this autumn to determine the future of bed-based and ambulatory care for older people and adults with multiple long term conditions in the county.

Our immediate aim is to protect patients at Wantage Community Hospital from the risk posed by Legionella in the pipes of the water system. Repeated high counts of legionella bacteria have been found in the hot water system requiring extensive engineering work to remove and replace the pipework. A closely managed regime of monitoring and testing is currently in place and the hot water system is being dosed with hydrogen peroxide which kills the free floating bacteria. However this is only an interim measure because pipework at the hospital is old, corroded and the hot water circulation is poor. Legionella will recur unless the plumbing for the whole site is replaced.

We have set aside funds to carry out the necessary plumbing works once the outcome of that consultation is known.

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NHS
Oxfordshire
Clinical Commissioning Group

Oxfordshire Health Inequalities Commission

Briefing June 2016

Background

The Oxfordshire Health Inequalities was set up at the end of 2015 by the Oxfordshire Health and Wellbeing Board to:

- review health inequalities in the county across the whole life course
- gauge what programmes are working well
- identify gaps across the spectrum of influences
- make suggestions for reducing inequalities in the future

The objective of the Commission is to identify health inequalities and identify what can be done to reduce them, including improving the delivery of health and social care in Oxfordshire over the next five years.

The commission is chaired by Professor Sian Griffiths. A full list of members and information about their backgrounds can be found here http://www.oxfordshireccg.nhs.uk/about-us/work-programmes/health-inequalities-commission/members-biographies/

The commission will produce a report and make recommendations to the Health and Wellbeing board in the autumn of 2016.

The report and its recommendations will be informed by the evidence being gathered in writing from members of the public and interested parties, and at four sessions held in public at venues across the county, as well as analysis of existing data.

Perinatal and early years health

The first session took place on Friday 26 February at Exeter Hall in Kidlington.

It welcomed representatives of: Oxfordshire Perinatal Mental Health Network; the Brighter Futures Partnership in Banbury; Oxford Academy; Banbury children's centres; Oxfordshire Sport and Physical Activity (OXSPA); and Oxford community paediatrician Mandy Rose.

The perinatal mental health network highlighted the gaps in provision of specialist care for women with severe mental health illness during pregnancy and immediately after giving birth.

The Brighter Futures Partnership, based in Banbury, works to ensure opportunities and quality of life are accessible to everyone in the area, through training and education, family support and safe communities. They identified the importance of multi-agency working to support families in talking responsibility for their own health and wellbeing through prioritising early years health education and prevention.

Representatives from the Oxford Academy School emphasised the importance of a joined up approach to health and social care to tackle health inequalities and suggested that schools in the county were well placed to become health and social care hubs for young people.

The Banbury children's centre spokesperson expressed concerns about how proposed funding cuts and consequent closure of some centres could increase gaps in access to health and social care for disadvantaged families.

OXSPA outlined the importance of physical activity in the promotion of healthy living. It submitted evidence on the success of martial arts programmes for children, but the expansion of these activities is being hampered by a lack of suitable venues.

Mandy Rose highlighted the role of the community paediatrics team, emphasising the need for joined up working and a proactive creative approach to identifying and addressing support needs.

Living well

The second session took place on Monday 7 March at the John Paul II Centre in Bicester.

Those submitting evidence were: Ian Davies from the Bicester Healthy New Town project; the Luther Street Medical Centre in Oxford; The Terence Higgins Trust; West Oxfordshire District Council; OXSPA; and Unipart.

The objectives of the healthy new towns initiative are to make healthy lifestyles the norm and to ensure digital technology, health innovations and adaptations make independent living and care at home the norm for older people.

The Luther Street Medical Centre outlined its work with Oxford city's homeless people to enable them to access health and social care.

The Terence Higgins Trust expressed its concern at cuts in HIV support services in Oxfordshire and across the UK.

West Oxfordshire District Council and OXSPA highlighted the importance of physical activity for adults and how it should be integrated into health services, for example in the 'prescribing' of being active as part of tackling health issues.

A health and wellbeing strategy for employees was outlined by the representative from the Unipart Group, which encourages staff to take responsibility for their own health by taking advantage of workplace health checks and other initiatives.

Ageing well

The third session took place on Monday 11 April at the Rose Hill Community Centre in Oxford.

The commission heard from Teresa Young, manager at Eynsham Medical Practice, who spoke about the practical difficulties faced by some older people living in rural communities in getting to health services.

She suggested a more flexible and better funded district nurse service might help solve these issues, together with more investment in rural bus routes.

The Friendleys group of older people living in Blackbird Leys appeared in a video film made with Age UK Oxfordshire and shown to commissioners. Several members of the group came to the session in person to talk about their experiences of health care in Blackbird Leys. They highlighted difficulties in getting GP appointments and a lack of public transport services.

Penny Thewlis from Age UK focused on the work being done by volunteers, health and social care professionals to offer support to people with dementia and their carers, who often feel isolated by their responsibilities.

Alistair Thomas, from the Age UK Generation Games project, spoke about encouraging physical activity among older people, and the barriers to getting more people active. He outlined the importance of engaging with communities to find out what they want, rather than imposing services on them.

Carol Ball, from Healthwatch UK, presented a short video film about dignity in care and the results of a survey among older people in Oxfordshire which revealed the majority of people received these services with dignity, although there were some instances where standards fell short.

Cross cutting themes

The final session in public took place on Monday 23 May at Oxford Town Hall.

Housing, public transport, migrant health and poverty were among the themes discussed.

The commission noted the county did poorly on the indicator which measures school achievement in children receiving free school meals when they enter reception class.

The commission went on to hear from Dr James Porter about the work of Luther Street Medical Practice which looks after homeless people in the centre of Oxford, many of whom suffer from mental health issues, and alcohol and substance misuse.

Dr Porter said the lack of suitable, affordable housing in the city must be addressed by large and small organisations and statutory bodies acting together.

The need for better joined-up working and partnership was a recurrent theme voiced by many of the contributors to the session, together with anxiety about the funding reductions to services.

The Connection Floating Support charity, which offers practical and emotional help to people who want to regain control of their lives, highlighted reduction in the length of time people are supported as funding priorities shift.

Oxford City Council outlined its housing strategy to help people stay in their homes and avoid homelessness. Oxford's housing strategy manager Frances Evans told the commission that a collective strategic review by public sector partners should be carried out to identify assets (properties and land) which could be regenerated to provide more affordable homes in the city and county.

The reduction in supported bus services across the county was outlined by Oxfordshire County Council (OCC), which also explained how steps were being taken to mitigate the effects.

OCC service manager Alexandra Bailey spoke about the launch of the Oxfordshire Comet to allow the council's own fleet of accessible vehicles to be booked by community groups or individuals during 'downtimes' in the middle of the day. This initiative could help people access hospital or health services or help transport them home after discharge from hospital.

The session heard how access to transport is a particularly important issue facing older people living in rural areas, not just for access to health services but for their independence and wellbeing.

Age UK showed a video as part of its 'Getting the picture' project, made at Oxford's Older People Chinese Centre (Happy Place). It emphasised the centre's importance to the community it serves, and how good translators and cultural understanding were key to giving the Chinese community (one per cent of Oxfordshire's population) access to health services.

The same points were made by the Refugee Resource and Asylum Welcome voluntary organisations which have investigated how refugees, migrants and asylum seekers gain access to primary health care services. They described how migrants, particularly those who have recently come to the UK, need specialist help for complex mental and physical health issues. This help is also needed for at the immigration detention centre at Campsfield House, Bicester.

The Citizens Advice Bureau (CAB) told the commission of the increasing numbers of people seeking advice, coupled with reductions in benefits and resources in the

services they are directed to. CAB said increasing incomes of the poorest households was a priority while highlighting how services which provide advice and support such as CAB were under pressure.

OCC presented its vision for older persons' housing schemes, which will continue to build and provide extra care homes in a bid to keep people independent in the community for longer and reduce the numbers needing residential or nursing home care.

Oxford Health NHS Foundation Trust's associate director Daniel Leveson told the commission that Oxfordshire's population of frail older people was increasing faster than the national average, together with the need for specialist services to support them. In addition, there were more older unpaid carers who need respite and support; and it is also important to support those people who work in home care services.

Andy Blackman from the Clockhouse project, which runs dementia clubs in Blackbird Leys, said there were not enough services for carers looking after their loved ones at home, nor for people with dementia who are living on their own.

And the Association for the Blind pointed to the isolation experienced by people with visual impairments, the difficulties they have in getting information about the support and services available to them, the difficulties they face in getting access to health care when they are unable to drive. Technology could offer potential solutions to these issues.

For more information go to http://www.oxfordshireccg.nhs.uk/about-us/work-programmes/health-inequalities-commission/

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09 June 2016

Dear Colleague,

Oxford Health NHS Foundation Trust: striving to improve care briefing June 2016

I wrote to you last summer to tell you about the work we're doing to improve care here at Oxford Health and I wanted to update you on progress. Our Care Quality Commission (CQC) inspection took place in September/October and we hosted a Quality Summit with inspectors and colleagues from Monitor and invited commissioners and other stakeholders to discuss the findings, published in January. We were pleased that there were some very positive messages about our trust and a recognition that we were aware of and working on areas where we needed to improve. One encouraging aspect of this is that the CQC agreed to come back to re-inspect our adult mental health services from the week commencing 13 June. I hope that as a valued partner in our work that you may be involved in that process and that this briefing will bring you up to date on progress since our last briefing.

CQC report findings January 2015

We were rated 'good' in three out of five quality measurements – *caring*, *responsive* and *well-led* and 'requiring improvement' in the remaining two, *effective* and *safe*. This gives us the over-all rating of 'requires improvement' [satisfactory] based on weighted scoring across all services inspected. No enforcement notices were issued and the majority (11 out of 15) of the trust's services were rated 'good' (10) or 'outstanding' (1) at the time. We are very pleased that the 'outstanding' rating was for our children and young people's community service, which includes school health nurses, health visitors and children's community nurses. Subsequently, in recent weeks our Luther Street GP practice for homeless people has been re-inspected and was also rated 'outstanding'.

The CQC found that Oxford Health NHS Foundation Trust was *well-led* with: accessible visible management at all levels and good working governance systems. It was *responsive* to people's needs across services, especially in a crisis, including reducing the need for police involvement in mental health crises, and in providing emotional support and counselling, especially for end of life care and bereavement. Patients and staff knew how to raise concerns and there was

good learning from incidents and complaints. Perhaps most importantly from our view, staff were found to be *caring*, and patients and their carers spoke positively about the care they received and felt they were treated with dignity and respect."

Oxford Health has a strong track record of working in partnership with others and providing integrated services, inspectors recognised this saying: "The trust is clearly committed to services that are multi-agency and multi-disciplinary and this was evident from the board discussions we observed and how staff at the frontline described the care." We stay committed to continuing to work in partnership with other organisations to develop and deliver services.

Improvements are required in *safety* to ensure that across all trust services the same high standards are observed. Inspectors noted: "On the whole services were safe, but the trust received a rating of requires improvement because we found pockets of poor practice." They also noted that some of our older estate, especially inpatient mental health settings at the Warneford Hospital, was outdated for the delivery of modern mental health care. The trust has long been aware of the challenge of operating from Victorian buildings and in recent years has developed the Whiteleaf Centre in Buckinghamshire and the Highfield Adolescent Unit at Warneford Hospital as exemplars of purpose built 21st century mental health care. A working group is currently developing options for future development of the Warneford Hospital site in particular to better address modern health care needs.

Effectiveness was rated as requiring improvement, due to a number issues we recognised and had plans in place to address. The main area is about involving patients and their families in planning and reviewing their care so that all care is person centred. A major piece of work to develop a three year Patient Involvement and Experience Strategy in collaboration with patients and people who care for them has now been completed. This has started to change how we approach and ensure that all care and interactions are person-centred and individualised.

Re-inspection of adult mental health services

During the week commencing 13 June, over three days, sixteen CQC inspectors will visit the adult mental health services in Oxfordshire and Buckinghamshire. These will include our adult acute mental health wards, our rehabilitation ward at Whiteleaf and our adult mental health teams. The inspectors will give verbal feedback on their findings later that week and we expect publication of their findings in a few months' time.

I am very proud of our caring staff for contributing to delivering and improving our services before, during and after these CQC inspections. We began this journey of improvement before the inspection through our Improving Care: Five Questions (IC:5) work on the five CQC domains (*caring*, *safe*, *effective*, *well-led*, *responsive*) and value the insights that our own preparations and the inspection process have given us. All of this helps our learning and is part of our ongoing drive to work together to improve our services to benefit the people we serve.

Quality priorities for 2016/17

Our quality priorities remain focused on four key aspects of quality:

- A safe and effective workforce supported by effective management and leadership, focused on continuous improvement;
- Striving for a positive patient, family and carer experience (and acting when this is not the case);
- Improving quality through service remodeling;
- Increasing harm-free care.

Full details of our quality priorities and objectives are available on the trust's website and shortly on NHS Choices.

Working in partnership

We continue to develop key partnerships as part of our commitment to working closely with others, including other NHS trusts, social care, education and third sector partners. One of the major areas where we are developing this for the future is through contributing to the Sustainability Transformation Programme (STP), described later in this briefing. Some examples include:

Oxford Health and Oxford University Hospitals are working together to develop and deliver an integrated ambulatory and urgent care model of care for frail older people. Over the winter period in 2015, the two trusts piloted some of the proposed joined up working for the future which has had an impact on reducing delayed transfers of care. This work also contributes to the Sustainability Transformation Programme.

Our Oxfordshire Mental Health Partnership with five mental health charities (Connection Floating Support, Elmore Community Services, Oxfordshire Mind, Response, Restore) has begun delivering a new recovery based model of care, which emphasises working with people who need our services to deliver and develop health outcomes that are meaningful to them. This has included the launch of a Recovery College where service users, carers and staff learn together. In Buckinghamshire we are developing a new Recovery College in partnership with Buckinghamshire Mind on the same basis.

Mental health urgent care services in Oxfordshire and Buckinghamshire have continued to improve, reducing numbers of people in mental distress going into police custody and improving responses when they are in distress in public or at hospital emergency departments. Partnerships include: Street Triage (working with Thames Valley Police), Ambulance Triage (working with the South Central Ambulance Service) as well as Liaison Psychiatry (working with acute hospitals in both counties). The Buckinghamshire Street Triage team was launched in Aylesbury in partnership with Thames Valley Police in June 2015. Buckinghamshire Liaison Psychiatry team are working with Connection Floating Support and Elmore Community Services to deliver the Empower service, to offer alternative and appropriate support to patients who most regularly call on emergency services.

In Oxfordshire our Improving Access to Psychological Therapies (IAPT) service Talking Space Plus works closely with Oxfordshire MIND and now also Principle Medical Limited (PML) to support people who are experiencing anxiety and depression. In Buckinghamshire our Healthy Minds IAPT service is already working alongside a number of partners (Relate and the

Richmond Fellowship) to support patients with relationships and employment and we hope to further these partnerships in 2016/17.

Buckinghamshire CAMHS has a new integrated, single point of access service model for Children and Adolescents Mental Health Services (CAMHS) across the county developed in close partnership with Barnardos and BEAT (eating disorder care). Young people and parents were involved in service development, recruitment and testing. We are talking to commissioners about introducing this new evidence based model of care in other counties.

In Bath and North East Somerset (BaNES), following a successful pilot of emotional resilience school hubs to provide emotional and well-being support to young people of secondary school age, commissioners have asked us to work with schools to roll out the hubs across all secondary schools.

We continue to work closely with partners in acute and community health services to improve care pathways for young people with autistic spectrum disorders (ASD). In Swindon and Wiltshire we contribute to the multi-agency monthly meetings for children with complex neurodevelopmental difficulties, ensuring a seamless diagnosis pathway for children and young people. Each CAMHS in Swindon, Wiltshire and BaNES has a neurodevelopmental assessment clinic offering specialist assessment for ASD who are also experiencing mental health difficulties.

Sustainability Transformation Plan

NHS England's *NHS Five Year Forward View* asks for all partners in local health and care systems to set out a Sustainability Transformation Plan (STP) for their region to help ensure that health and care services are built around the needs of local populations that shows how local services will evolve and become sustainable over the next five years. Buckinghamshire, Oxfordshire and West Berkshire form one of these regions 'BOB' and we are contributing to the STP which will act as a single strategic plan for the region.

Clinicians and health and social care professionals from across all organisations are working together to review services in order to improve quality and reduce inequality. This involves developing community services, delivering care closer to home, and reducing the need for inpatient and acute hospital care by meeting patient's needs in better ways.

An Oxfordshire Transformation Board was established last year between NHS trusts, GP federations, and Oxfordshire County Council to look at organising health and care services more efficiently and achieving the best standard of care for everyone. From June to October 2016 patients and the public are being involved in the development of proposals for new models of healthcare in the county. This period of engagement will inform our ideas for the way services might be best provided in the future.

Keeping in touch

Partnership working is essential to our success and it's important that we continue to work together well and to talk to each other to look at ways that we can continue to improve our services. We are always keen to hear from you. If you would like to discuss anything from this

briefing or any other matter please feel free to contact me through the Improving Care team office, by emailing IC5@oxfordhealth.nhs.uk, or by phoning 01865 902103.

Yours sincerely,

Stuart Bell CBE
Chief Executive

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