Notice of Meeting Public Document Pack

Oxfordshire Joint Health Overview & Scrutiny Committee

Thursday, 22 June 2017 at 10.00 am

Rooms 1&2 - County Hall, New Road, Oxford OX1 1ND

Membership

Chairman -

Deputy Chairman -

Councillors:	Kevin Bulmer	Arash Fatemian	Alison Rooke
	Mark Cherry	Mike Fox-Davies	
	Dr Simon Clarke	Laura Price	
District Councillors:	Jane Doughty	Andrew McHugh	Nigel Champken-Woods
	Monica Lovatt	Susanna Pressel	
Co-optees:	Moira Logie	Dr Keith Ruddle	Mrs A. Wilkinson

Notes: ***Date of next meeting:*** *14 September 2017*

What does this Committee review or scrutinise?

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

How can I have my say?

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

For more information about this Committee please contact:

Chairman	-	Councillor Email: *@oxfordshire.gov.uk*
Policy & Performance Officer	-	*Katie Read Tel: 07584 909530* *Email: Katie.read@oxfordshire.gov.uk*
Committee Officer	-	*Julie Dean Tel: 07393 001089* *Email: julie.dean@oxfordshire.gov.uk*

P G Clark

Peter G. Clark
Chief Executive

June 2017

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 - 2017/2018

To elect a Chairman for the municipal year 2017/2018.

2. Election of Deputy Chairman - 2017/2018

To elect a Deputy Chairman for the municipal year 2017/18.

3. Apologies for Absence and Temporary Appointments

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

5. Minutes (Pages 1 - 10)

To approve the minutes of the meeting held on 6 April March 2017 (**JHO5**) and to receive information arising from them.

6. Speaking to or Petitioning the Committee

7. Forward Plan (Pages 11 - 12)

10:15

The previous Committee's Forward Plan is attached at **JHO7** for information. Committee members are asked to consider priority areas for scrutiny in 2017/18.

8. Healthwatch Oxfordshire - Update

10:20

The new Chairman of Healthwatch Oxfordshire (HWO) will be introduced to the Committee and will share his priorities for the organisation during the next year. Rosalind Pearce, Executive Director, will also update the Committee on the activities of HWO since the last meeting and provide information on key messages from the public in relation to items on the Committee's Forward Plan.

9. Oxfordshire Transformation Plan (OTP) - Phase 1 - Consultation Outcomes (Pages 13 - 22)

10:35

The outcomes a 12 week public consultation on changes to a range of health services in Oxfordshire will be shared with the Committee.

The Phase One Big Health and Care Consultation, which took place between 16 January and 19 April, focused on improving the quality of services and making permanent some temporary changes made in 2016. Public views were sought on:

- Changing the use of acute hospital beds across Oxfordshire
- Planned care services at the Horton General Hospital, Banbury
- Stroke services across Oxfordshire
- Critical (intensive) care services at the Horton General Hospital, Banbury
- Maternity services, including obstetrics, special care baby unit and emergency gynaecology services at the Horton General Hospital, Banbury

In November 2016 the Committee reviewed and approved the Clinical Commissioning Group's (OCCG's) plans for consultation, and requested that:

- Information on any proposals relating to obstetric/midwife-led units in the north of the county that impact on surrounding services is included in Phase 1.
- Any proposals relating to the closure of other services at the Horton Hospital are included and considered together, and if they are not, then nothing in Phase 1 should prejudice Phase 2 proposals.
- Proposed delivery of planned care at the Horton would be included in the consultation and the impact of changes in GP delivery would be made clear;
- That the geographical detail be easily identifiable so that the public can be clear about proposed changes to be made to services in their locality; and
- There is clarity on the meaning of 'ambulatory' care.

The Committee scrutinised the detailed proposals in Phase 1 at a dedicated meeting in March 2017, and its formal response and recommendations were submitted in a letter to the OCCG before the end of the consultation period. The Committee's response and OCCG's reply can be read as part of the Chairman's report from 6 April 2017 HOSC meeting (Agenda Item 10). Please find the link below:

http://mycouncil.oxfordshire.gov.uk/ieListDocuments.aspx?CId=148&MId=5104&Ver=4

Representatives from the OCCG will present the feedback from the consultation and explain the further work that is being undertaken before final decisions on Phase 1 are made at a OCCG Board meeting on 10 August 2017. A report is attached at **JHO9.**

10. Dementia Services

12:00

Early diagnosis for people with dementia has been shown to have benefits in terms of patient and carer quality of life and independence. There is also evidence to show that there is a financial benefit as a result of delayed need for care.

Representatives from Oxfordshire County Council Adult Social Care, Oxfordshire Clinical Commissioning Group and the Dementia Support Service will share with the Committee how they are working together to support people with dementia and their families, particularly in the context of recent changes to other services such as daytime support. A presentation to the Committee will provide an overview of dementia diagnosis, the dementia pathway, dementia support services and end of life care for dementia patients.

More information about dementia support services can be found on the website

http://www.dementiaoxfordshire.org.uk/

11. Health & Wellbeing Board and Strategy Priorities 2018/2019 (Pages 23 - 40)

13:00

Representatives from the Oxfordshire Clinical Commissioning Group and Oxfordshire County Council will attend to give an overview of the Health & Wellbeing Board's priorities and respond to questions from the Committee on the work of the Health & Wellbeing Board.

Representatives from Oxfordshire County Council and Oxfordshire Clinical Commissioning Group will present an overview of the performance against targets in the Oxfordshire Joint Health and Wellbeing Strategy 2016-17 and proposals for new outcome measures in the revised 2017-18 Strategy for discussion and comment. A summary list of the proposals is attached at **JHO11.**

Any recommendations from the Committee will be shared with the Oxfordshire Health and Wellbeing Board in July, where the 2017-18 Strategy will be discussed and agreed.

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 **07776 997946** 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, 6 April 2017 commencing at 10.00 am and finishing at 1.40 pm

Present:

Voting Members:	Councillor Yvonne Constance OBE – in the Chair
	Councillor Kevin Bulmer Councillor Surinder Dhesi Councillor Arash Fatemian Councillor Laura Price Councillor Alison Rooke Councillor Les Sibley District Councillor Nigel Champken-Woods (Deputy Chairman) District Councillor Jane Doughty District Councillor Monica Lovatt District Councillor Andrew McHugh District Councillor Susanna Pressel
Co-opted Members:	Dr Keith Ruddle
Officers:	
Whole of meeting	Strategic Director for People, Julie Dean and Katie Read (Resources)
Part of meeting	Director of Law & Governance

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.

16/17 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS
(Agenda No. 1)

Apologies were received from Moira Logie and Anne Wilkinson.

17/17 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE
(Agenda No. 2)

Cllr Alison Rooke declared a personal interest in Agenda Item 7, 'Quality of Care in Care Homes' on account of her role as a Trustee and Director of Vale House,

Littlemore, Oxford. She declared that she received no payment of any kind in the role.

18/17 MINUTES

(Agenda No. 3)

The Minutes of the Meeting held on 2 February were approved and signed subject to the penultimate sentence of bullet point 6 in page 14 being corrected to read as follows (amendments made in bold italics):

'As more patients are discharged from the OUH, there would need to be proper multi-skilled hospital doctors and GPs to provide ***a more holistic*** aspect ***to the work.'***

Matters Arising

With regard to Minute 11/17 'Closure of Deer Park Medical Centre, Witney', page 17, bullet point 8, a member put forward the view that the patients at Deer Park Surgery should have been automatically re-registered to another practice by the CCG, as there were a significant number of patients currently not registered to a practice.

The Minutes of the meeting held on 7 March were approved and signed as a correct record.

Matters Arising

There were no Matters Arising.

19/17 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 4)

The Chairman had agreed to the following speakers. All speakers to give their address prior to the item itself:

Agenda Item 7 - 'Quality of Care in Care Homes'
Jeanne Warren – Keep our NHS public

Agenda Item 8 - 'Townlands Memorial Hospital
Veronica Treacher – 'Keep our NHS public.'

20/17 FORWARD PLAN

(Agenda No. 5)

The Committee considered the Forward Plan attached at JHO5.

In response to concern expressed by a Committee member about the proposed slippage of scrutiny of the Health Inequalities report, Dr McWilliam advised that a longer term with which to prepare the implementation report was to the Committee's advantage as more information would be provided at that point.

The Committee **AGREED** the Forward Plan.

21/17 HEALTHWATCH OXFORDSHIRE - UPDATE

(Agenda No. 6)

Eddie Duller OBE and Rosalind Pearce, Chair and Chief Executive, respectively, of Healthwatch Oxfordshire (HWO) presented their regular update to the Committee.

They highlighted the following issues:

- HWO had found the Health Inequalities Report helpful as it had recorded the views of the public in an unedited manner. It had found the recorded experiences of patients over 100 days particularly interesting;
- Mr Duller reiterated the view of HWO that joint Health and Adult Social Care working was becoming more and more fractured as the Oxfordshire Transformation Plan was being unveiled;

With regard to the Deer Park Surgery closure, and in light of the outline planning permission recently signed by West Oxfordshire District Council for new homes to be built to the on the west side of Witney, a member asked how confident was HWO that the local GP Federation Group would join with the Patient Participation Group in a newly created Stakeholder Group to discuss issues of concern. Rosalind Pearce responded that a date for a meeting had just been agreed. She added that the role of the Stakeholder Group would be to try to learn some lessons from the Deer Park experience and to take a wider view of how new housing developments would be approached by GP sector. She reported also that the OCCG had confirmed that a number of patients had re-registered in the final weeks and that the CCG had also put in place a small number of measures to improve patient re-registration.

Rosalind Pearce confirmed that the approach of HWO was to share any adverse patient/resident experiences which had been personally relayed to them with the CQC and the provider, whilst maintaining anonymity at all times. However care was taken when considering whether to take it forward. She stressed that the quality of the clinical care was not their concern. Eddie Duller referred back to the Dignity of Care report that HWO undertook in 2016 which revealed that patients tended to talk more about their experience with HWO, whom they perceived as independent from the Health system. Moreover, HWO talked to a larger representation of patients over a longer period, during these ‘one-off’ 100 day investigations than CQC normally did during their inspections.

In relation to the issue concerning the re-registration of patients from the Deer Park Surgery, a member of the Committee raised a concern that some Witney surgeries had closed their lists to out of catchment patients. Rosalind Pearce reported that she had raised it with the OCCG who had carried out a check on all surgeries in catchment, and, as far as they were aware, none had closed their lists. She added that surgeries were at liberty to refuse patients if they did not live within catchment. The Chairman added that she would write on behalf of the Committee if there was evidence that surgeries were using catchment areas as an excluder.

Mr Duller and Rosalind Pearce were thanked for their report.

22/17 QUALITY OF CARE IN CARE HOMES

(Agenda No. 7)

Prior to consideration of this item the Committee heard an address from Jean Warren of 'Keep our NHS Public.' She spoke in support of the argument to bring all care homes 'in-house', referring to an extract from 'Private Eye' which warned that a care crisis was coming. It referred to the high cost of care prices in the residential sector, which were being driven by Health business consultancies.

The Chairman welcomed Benedict Leigh, Deputy Director, Joint Commissioning, OCC and Helen Ward, Deputy Director of Quality, OCCG, both of whom gave a presentation on the quality of care in care homes across Oxfordshire. They were also joined by Patricia O'Leary, Manager of the Vale House Care Home, Littlemore, which had been rated as 'Outstanding' by the CQC in two categories 'Caring' and 'Effective'.

Mr Leigh began the presentation in thanking HWO for citing the patient experience in relation to a particular care home and undertook to speak to the Quality Team, who would in turn talk to the care home in question. He stressed that the commissioners worked closely with the CQC, adding also that all homes were signed up to 'enhanced' GP cover in a liaison capacity.

Patricia O'Leary gave a presentation informing the Committee of the following:

- The model by which the home had been set up was very unique and had proved to be a great success. Incorporated into it was specialised dementia care. The Home was a 'Not for Profit' organisation, with 9 trustees, none of whom received a salary or a stipend;
- The Home was run by registered nurses on a day to day basis, which gave a consistency for residents and which also assisted with retaining staff;
- Family perception of the Home was the key factor, as they proved to be very discerning as to whether their relative was well cared for or not;
- A family support worker had been appointed 15 years ago which was the source of great importance to families, friends and staff. This was an element that had not been taken up by others;
- The model also assisted the less wealthy and allowed OCC to address this;
- The Home embraced psychology and emotional health as an important factor for the well-being of the residents and also used it as an audit tool;
- The Home regularly adopted the lines of enquiry contained in the CQC inspection and had built up their documentation to ensure that it was giving safe, well –led, and effective care.

Questions for Patricia O'Leary from members of the Committee, together with responses received, included the following:

- Some care homes were no longer accepting Social Services clients following problems with negotiating payments. In response to follow up on this by members of the Committee, Benedict Leigh stated that whilst some care homes did not accept OCC's rates, OCC was not seeing a significant increase

and was looking to negotiate block contracts to establish more long-term relationships;

- With regard to referrals, there existed a care home support service (which was previously known as the Falls Service), which was commissioned by the OCCG and provided by OCC. It had proved to be very useful for prospective residents, as it included a number of experienced staff who were able to solve issues quickly. Where there were serious concerns, the Team would be involved almost immediately. It also worked with the Quality Management Team to provide general support to more troubled care homes, sharing learning and development;
- With regard to the possible provision of Care Homes on an 'in-house' basis, Benedict Leigh explained that in the past OCC had provided care homes on this basis. Nowadays this was in partnership with the Orders of St. John (OSJ) who ran certain homes on OCC's behalf. Currently OCC was exploring options for providing more home care. He added that both Vale House and OSJ had worked very effectively together, as has private home care. This would be an issue to be explored as part of the Oxfordshire Transformation Plan Consultation - Part 2. The Committee requested further data on the breakdown of care home placements provided by the Orders of St John, private providers and not for profit providers;
- A member of the Committee pointed out that it may be feasible to use GP Federations to provide a surgery-based enhanced service as a multi – disciplinary team model encompassing pharmacy, advanced nurse practitioners etc. A good system of digitally active care plans could be available online, alongside the GP patient care plans. Helen Ward stated that GPs were investigating a number of innovations as part of their case for the OTP Part 2;
- In response to a question regarding the percentage of bed closures in each organisation it was stated that 180 beds had been purchased to support intermediate care. Of these, 131 were Hub beds purchased by the OCCG and operated by the Hub, and the remaining 49 were used as short stay beds for patients;
- Benedict Leigh undertook to look into the number of people in Oxfordshire who funded their own care and the trends around the stage at which people enter care homes. He added that it was a matter of choice for the individual to enter a care home earlier, adding that improvements could be made to support this category of client to live in the community which they had lived in all their lives;
- With regard to a question about the need to know more in the future about sustainability issues, Benedict stated that OCC had a statutory duty to publish the market position statement, which was due soon. He undertook to send it to members of the Committee when available;
- In answer to a question to Patricia O'Leary about how it was ensured that staff remained motivated, she explained that measures included working with the trustees regarding good rates of pay, careful recruitment of nurses and to honour speciality nursing training (for example, in caring for people suffering from dementia);
- In response to a question, Patricia O'Leary confirmed that all bedrooms had en-suite bathrooms and community physiotherapy was accessed via the community Team.

All were thanked for their attendance.

23/17 TOWNLANDS MEMORIAL HOSPITAL

(Agenda No. 8)

Veronica Treacher, speaking on behalf of 'Keep Our NHS Public', recalled her own personal relationship with the hospital when her life was saved by clinicians. She described her experience, which she felt could have easily resulted in death had it not been for the staff at Townlands Hospital. She expressed her concern that the hospital had seen two major reorganisations in recent years and the likelihood of another one soon.

Dr Andrew Burnett, Locality Director for the South East CCG attended for this item. He reported the following:

- Townlands Hospital was now operating and was seeing approximately twice as many out-patients. The Minor Injuries Unit (MIU) and the Out of Hours (OOH) service units were doing well, providing to patients in south Oxfordshire and north Berkshire;
- The Rapid Access Care Unit (RACU) is open initially to the over 65's, but also younger people. The service had been developed in combination with the Royal Berkshire Hospital and provided care on an out-patient basis;
- The principle behind the Unit was that a patient could be treated at the RACU, returned to their own home after a short stay, return for follow - up with the community rehabilitation teams and also for support, if necessary from the Adult Social Care Teams;
- He explained that it had been proved that patients had rapidly become unable to cope if hospitalised; and their independence could be retained if treated in this way. The average length of stay in hospital was 32 days compared with 9 days for those treated via the RACU method. It was his view that this would give a much improved service to older persons for the future.

Questions, concerns and issues voiced by members of the Committee were as follows, together with responses given:

- A member asked that if there were going to be twice as many outpatients, why would there be a need for specialised services. Dr Burnett responded that the Royal Berkshire Hospital was particularly keen on the model of care for highly specialised services. Satellite services would be created, sending consultants out to the community hospitals to run their clinics;
- Dr Burnett was asked about travel to the satellite clinics. He responded that in order for this to work well, units would be encouraging families and friends to drive patients to their appointments;
- In response to a question, Dr Burnett confirmed that patients would be able to choose where they wished to receive clinical services, in order that they received a speedier service;
- Dr Burnett confirmed that patients would not be placed in care homes with an unsatisfactory CQC report. He also confirmed that beds would be situated in a building adjacent to the Townlands RACU and a small number may have to be admitted to another hospital within the Royal Berkshire area;

- In response to a question, Dr Burnett stated that NHS Property Services were dealing with the letting of the second floor area to the Townlands Hospital. Unfortunately the NHS had to charge a rent over and above the private business models;
- With regard to questions about signage and appropriate waiting areas at Townlands, Dr Burnett stated that currently the site was under constant change and maintenance. A stakeholder Reference Group had been formed to receive feedback on how it was operating. He added that there was no single timescale for all the changes that were required in the near future;
- In answer to a question about the kind of care which would be provided at Townlands, Dr Burnett explained that the specification for Intermediate Care beds differed from that which was provided at the Community Hospitals. The Hospital provided 18 beds for medical care, the standard for which was the same as for Intermediate Care Beds. He added that local Henley GP surgeries and the patients themselves had been pleased with the RACU service. Moreover, GPS were pleased with how OSJ was setting up the management and supervision of patients in beds and the standard of accommodation, despite being sceptical at first;
- Dr Burnett confirmed that the new medical specification at Chipping Norton Hospital was the same as the former hospital specification;
- In response to a question, Dr Burnett confirmed at food was not cooked on the premises.

The Chairman thanked Dr Burnett for his attendance, and, on behalf of the Committee, applauded Health for their pioneering work in the delivery of care for patients.

24/17 QUALITY ACCOUNTS

(Agenda No. 9)

The Chairman welcomed Dr Tony Berendt, Medical Director, Clinical Governance & Risk Team, Oxford University Hospitals NHS Foundation Trust (OUH) and Dr Clare Dollery, Deputy Medical Director. She also welcomed Richard McDonald, Head of Operations – Oxfordshire, South Central Ambulance Service NHS Foundation Trust (SCAS) and Simon Holbrook, Head of Compliance.

<u>Oxford University Hospitals NHS Foundation Trust – Quality report</u>

Dr Berendt and Dr Dollery were invited to come up to the table to respond to questions and concerns regarding the covering report provided (JHO9). These included:

- In response to a question about the selection of quality targets, and how they were prioritised for external audit, Dr Dollery stated that they were prioritised by a Council of Governors from a number of proposals provided. The Council selected on how much importance it had to the hospital in terms of disease or aspect of care;
- In response to a request for more information regarding patients requirement for drugs in dosset boxes, Dr Dollery stated that, within a 2 week period, 98% were being discharged within 24 hours;

- Dr Dollery confirmed that RAG traffic light rating (red, orange, green) could be utilised, but it was felt that this was a little too impersonal;
- In relation to the Delayed Transfers of Care (DTOC) issue, Dr Berendt stated that the targets were achieved in accordance with what the Trust set out to do. However, there had been a great deal of volatility since then. There were a multi-factional set of inputs which had driven the final figures for domiciliary/hospital bed care. Where there was a deterioration in the programme, this was linked to availability of domiciliary care;
- The Trust was still in the process of recruiting of the 140 reablement workers;
- In relation to a question about how the Trust managed reductions in incidents of medical harm, Dr Berendt responded that this was via investigation. The general approach was to understand that people were human, then to minimise the impact of error, then to change systems and finally to re-train people, if necessary. Moreover, they had a professional and legal duty of candour to explain what had gone wrong. The vast majority of incidents were without harm but people were asked to report all incidents, including near misses. Thus all could learn from the event and aim to get as close to zero as possible, or at least a reduction;
- A member asked if there were opportunities to look at some of the wider issues such as staffing and recruitment; and was there a roll-over of issues from 1 year to the next, thus having the effect of threading through the blockages to achieve the targets. Dr Berendt responded that sometimes it took time to measure achievement of quality and improvement. If an issue, such as staffing, turned out to be a major impediment, then the Team would have to work out what action should be taken;
- In response to a question about availability of bereavement training at the Horton Hospital, Dr Berendt confirmed that all staff had access to a computer to undertake e - learning and the problem had been that it had taken longer than originally thought to get the design together.

Dr Berendt undertook to report back to the Committee in writing when a quality target had been achieved or partially achieved, stating his assurance that the Board were cited on this aspect and nothing was overlooked.

Dr Berendt and Dr Dollery were thanked for their attendance.

South Central Ambulance Service - Quality Report

Richard McDonald and Simon Holbrook attended for this item.

In response to a question about whether the Trust had been consulted as part of the Sustainability & Transformation Plan (STP) Plan, Simon Holbrook replied that the Trust was one of the health care providers who formed part of the STP. Currently the Trust was waiting to find out how it would be involved in the Plans. He added that the STP would have an impact on the Ambulance Service as any changes would translate into a reconfiguration of service.

Richard McDonald was asked if some journeys to the John Radcliffe Hospital (JR) were beyond inclusion in the performance indicators, due to matters such as heavy traffic, which were beyond control. Mr Mcdonald stated that all statistics were

provided to the JR and published on the NHS England website, with a view to any of concern being a focus for improvement. A member asked why it was not a priority to work with the JR on travel times. Mr McDonald responded that the Service did sign up to safety pledges and was working in collaboration with other healthcare providers. It was not, however, currently a priority to address travel times.

The Committee thanked Mr McDonald and Mr Holbrook for attending and **AGREED** to request the Ambulance Trust to:

(a) inform the Committee in writing where improvements had been significant; and
(b) that priority should be given to the Trust should work with the JR to improve travel times from the Horton and Chipping Norton Hospitals to the JR.

In conclusion, the Committee **AGREED** that members' comments on the Quality Accounts would be collated and sent to providers as this Committee's formal comment on the Accounts.

25/17 CHAIRMAN'S REPORT
(Agenda No. 10)

The Committee had before them the Chairman's update on meetings attended since the last Committee meeting and any letters sent and received on behalf of the Committee.

It was **AGREED** to note the report.

26/17 ITEM FOR INFORMATION ONLY
(Agenda No. 11)

The items were noted.

..... in the Chair

Date of signing .....

This page is intentionally left blank

HOSC Forward Plan – June 2017

Meeting Date	Item Title	Details and Purpose	Organisation
14 September 2017	Health Inequalities Commission Report	• Health and Wellbeing Board's response to the report of the Health Inequalities Commission • Including info on local activities focused on obesity prevention work	Whole system & HWBB
14 September 2017	Air Quality	• How OCC and partners are addressing the issue of air quality.	OCC & Districts
14 September 2017	Health visiting services	• Impact of changes to children's centres on provision of health visiting service • Scrutiny of newly commissioned service • 0-5 health visiting services	PH & OH & CEF
Future Items			
Summer 2017	Health and social care workforce	• Impact of workforce shortages in reablement & domiciliary care on acute services • Impact of ASC precept	OCC
Summer 2017	FOR INFO – GP appointments	• Update on the success of weekend and evening GP appointments – share data on demand and how this is monitored	OCCG
Summer/Autumn 2017	Health and Care Transformation Consultation Plans for Phase 2	• Committee scrutinises the health and care consultation plans for Phase 2	Whole System
Summer/Autumn 2017	Healthcare in Prisons and Immigration Removal Centres	• More in depth information on performance and how success is measured. • New KPIs in place from April 2017	NHS England
2017/2018	Health and Care Transformation Consultation Phase 2	• Committee formally receives and scrutinises the health and care consultation proposals • A deadline for the formal response from the Committee is advised by the CCG	Whole System

Updated: 14 June 2017

	Health and Wellbeing Board	• How effective is the Health and Wellbeing Board at driving forward health, public health and social care integration? • Is there effective governance in place to deliver this? • How well is the Health and Wellbeing Board preparing Oxfordshire's health and care system for greater integration?	Whole System

NHS
Oxfordshire
Clinical Commissioning Group

Oxfordshire Joint Health and Overview Scrutiny Committee

Date of Meeting: Thursday 22 June 2017

Title of Paper: Oxfordshire Clinical Commissioning Group: Report on the outcome of consultation for Phase 1 of the Oxfordshire Transformation Programme

Purpose:
The report on the outcome of the consultation for Phase 1 of the Oxfordshire Transformation Programme has been published on the Oxfordshire Clinical Commissioning Group (OCCG) website and will be formally received at the OCCG Board meeting on 20 June 2017. No decisions will be made at this meeting.

In addition to the consultation report, a covering Board paper has also been published that introduces the report and explains what other work is taking place before the decision-making meeting on 10 August 2017.

The OCCG Board paper and consultation report can be viewed here and follow.

Senior Responsible Officer: David Smith, Chief Executive, Oxfordshire Clinical Commissioning Group

Oxfordshire

Clinical Commissioning Group

Oxfordshire Clinical Commissioning Group Board Meeting

Date of Meeting: 20 June 2017	**Paper No: 17/43**

Title of Paper: Report on Phase 1 of the Oxfordshire Transformation Programme public consultation

Paper is for: (please delete tick as appropriate)	**Discussion**	✓	**Decision**		**Information**	

Purpose and Executive Summary:

The public consultation on proposed changes to some health services in Oxfordshire took place between 16 January and 9 April 2017. The detailed consultation report published alongside this paper describes the process of the consultation and provides an analysis of the responses. An introductory paper that follows sets out the status of the detailed consultation report and other work being undertaken to support the Board in being prepared for the decision-making meeting on 10 August 2017.

Financial Implications of Paper:

This paper is presenting the outcome of the consultation. The Board is not being asked to take any decisions that have financial implications.

Action Required:
The Board is asked to:

- Agree it is assured about the process for the consultation.
- Receive the report on the consultation and note its findings.
- Note the work that has been commissioned to ensure sufficient information will be available for the decision-making meeting on 10 August 2017.
- Identify if there are any further areas where additional information will be

required prior to decision-making

OCCG Priorities Supported (please delete tick as appropriate)	
✓	Operational Delivery
✓	Transforming Health and Care
✓	Devolution and Integration
✓	Empowering Patients
✓	Engaging Communities
✓	System Leadership

Equality Analysis Outcome: An Integrated Impact Assessment is in progress.

Link to Risk:

Author: Ally Green, Head of Communications and Engagement

Clinical / Executive Lead: Catherine Mountford,

Date of Paper: 8 June 2017

Overview of the public consultation and further work being undertaken

1. Introduction

The public consultation on proposed changes to some health services in Oxfordshire took place between 16 January and 9 April 2017. It focussed on improving quality of services and making permanent some temporary changes made in 2016. This Phase One consultation was seeking views on:

- Changing the use of acute hospital beds across Oxfordshire
- Planned care services at the Horton General Hospital, Banbury
- Stroke services across Oxfordshire
- Critical (intensive) care services at the Horton General Hospital, Banbury
- Maternity services, including obstetrics, special care baby unit and emergency gynaecology services at the Horton General Hospital, Banbury

This consultation was phase one of a two phase process. The plan for a split consultation and the plan for delivering the consultation were agreed with Oxfordshire Health Overview and Scrutiny Committee (HOSC) in November 2016.

The consultation plan was delivered in full. More than 10,000 individual responses were received by Oxfordshire Clinical Commissioning Group (OCCG) and more than 1,400 people attended public events to hear about the proposals and to share their views.

2. Consultation report

OCCG commissioned Qa Research to review and analyse the responses received and to draft a report summarising the consultation process and the responses received.

The report describes the approach to the consultation and the significant efforts made to raise awareness of the various ways that members of the public could respond. The combination of paid advertising, media coverage, leaflets, posters and social media ensured people living across Oxfordshire and across the border into neighbouring counties could participate in the consultation.

It was recognised that in addition to people living in Oxfordshire, people living across the border in south Northamptonshire and south Warwickshire would be affected by the proposals. Efforts were made to ensure they were aware of and had opportunities to take part in the consultation. Media advertising and press releases included the newspapers in these areas, two public meetings took place in Brackley and information was made available in community settings including in GP practices.

Initially, 12 public meetings were planned, including two in Banbury and one in Brackley. In response to requests three additional meetings were arranged so that in total 15 public meetings took place between 26 January and 23 March. This meant that two public meetings took place most weeks during this time in venues across Oxfordshire and Brackley. These varied for days of the week and time of day. The slide presentation and supporting videos were made available via the transformation website[1]. The meetings were all recorded and the audio recordings were posted on the OCCG YouTube channel linked to the website. This allowed those who were unable to attend meetings to listen to the presentation and discussion.

Every public meeting was hosted by a panel made up of clinicians and executive managers from OCCG, Oxford University Hospitals NHS Foundation Trust (OUHFT) and, at some meetings, Oxford Health NHS Foundation Trust (OHFT). In addition, other Board members (both clinical and non-clinical) from these organisations attended all meetings to listen to the views being expressed and the questions being asked.

Many other meetings were attended by OCCG to share information about the consultation and to gather views. These are detailed in the report and included attending HOSC; linking with community groups, key leaders and facilitators from seldom heard groups in Banbury; presenting the consultation at Local Strategic Partnerships and in various voluntary sector organisations. Together, they illustrate the scale of the engagement achieved.

A survey was provided to support people responding to the consultation. This was hosted on OCCG website and was translated into Polish, Urdu and Easy Read. Although 646 people completed the survey, many more decided to share their views by writing to OCCG instead; 9,248 letters and emails were received as a result. The majority of these were template letters provided to local people by Keep the Horton General (KTHG) campaign group.

Every letter received by the CCG was read and included in the analysis. Not all of the emails and letters from members of the public included an address or other demographic details and so analysis was restricted to be about the content of the response.

A report summarising the results of a survey run by KTHG was presented to OCCG at its first public meeting in Banbury and this was included in the consultation analysis.

The consultation report provides a summary of the response to the consultation and key themes were identified:

[1] www.oxonhealthtransformation.nhs.uk

- Largely, people want to maintain as many healthcare services as possible close to where they live. In North Oxfordshire, there is strong support for maintaining the Horton General Hospital as a district general hospital with full provision of urgent and emergency care. Although there is support for increased planned care there is a strong feeling that this should not be at the expense of other current hospital services.
- Reasonable levels of agreement exist for the proposals on stroke care. There is also agreement with the principles behind care closer to home, although there is significant concern that the health and social care infrastructure is not sufficiently developed in order to support this proposal at this point in time.
- There are almost universal concerns and a lack of support for the proposal to close the obstetric unit at the Horton General Hospital and replace it with a Midwife Led Unit, because of travel times and safety concerns.
- It was suggested by the public that if the population growth and housing growth expected in the Banbury area was taken into account, the reduction or removal of services would not be necessary. Current, as well as future, capacity at the John Radcliffe Hospital was also questioned, and there was widespread frustration about public transport access to Oxford and hospital parking at both the John Radcliffe Hospital and Horton General Hospital.
- There was considerable criticism of the consultation process and consultation document, including concerns about it being split into two phases, the timing and location of the consultation events. Concerns were raised over OCCG's commitment to listening to people's views and using them to inform their decision-making.

The report on the consultation was shared with all members of OCCG Board in May plus the responses from stakeholders and a wide selection of letters from members of the public.

3. New Patient Care Test

On the 3rd March 2017, Simon Stevens (Chief Executive of NHS England) announced a new 'Patient Care Test for Hospital Bed Closures' for service reconfiguration plans. This test will apply to all future proposals for NHS reconfiguration that involve NHS bed closures.

Given that the assurance process for Phase One had already been completed when this new test was introduced, Phase 1 of the Transformation Programme was not formally subject to the new test. However, the Programme chose to prepare a retrospective assurance document outlining how the proposals comply with the new requirement. This document has been submitted to the Thames Valley Clinical

Senate[2] for retrospective assurance against this new 'Patient Care Test' and it was considered at their meeting on the 6 June 2017. Feedback and retrospective assurance is expected before the decision-making meeting of OCCG on 10 August.

4. Integrated Impact Assessment

OCCG has also commissioned an Integrated Impact Assessment (IIA) from an external company (Mott MacDonald) for both Phase One and Phase Two of the Transformation Programme. The purpose of the IIA is to analyse the potential impact of the proposed changes. The report will enable Oxfordshire's Transformation Programme and the OCCG Board to think through the consequences of transformation proposals on health outcomes and health inequalities and where appropriate revise plans and/or ensure mitigations are in place.

The aim of the Phase One IIA is explore the positive and negative consequences of the Phase One proposals and provide advice on a set of evidence-based practical recommendations that will be used by the clinical workstreams to review and improve the proposed pathways of care. It will also guide the OCCG Board in its decision making by proving better information about how the proposals will promote and protect the wellbeing of the local communities involved. This report will be made available for the decision-making Board meeting in August.

5. Responding to public views

Three significant concerns highlighted during the consultation related to travel, parking and to the lack of options offered for obstetric services at the Horton General Hospital. Rather than delay any further work in these areas, OCCG initiated some additional work to support the Board for its decision-making meeting in August.

5.1 Travel

Concerns relating to journey times from the Banbury area, Chipping Norton area and over the county border to one of the Headington hospitals in Oxford were raised during the consultation. Estimates of the time it would take to make this journey varied and were widely debated. The journey time would inevitably vary depending on time of day, day of the week and traffic conditions. The IIA will include an analysis of the impact of the proposals on travel. In addition to this, OCCG commissioned Healthwatch Oxfordshire to conduct a survey of patients and visitors attending each hospital site in Oxford and Banbury, asking people about their journey, what form of transport they used (including public transport) and how long the journey took. This report will be shared with Board members and will be published so the findings can help support the decision-making meeting in August.

[2] A role of the Thames Valley Clinical Senate is to provide support and help to commissioners and to carry out clinical assurance reviews of reconfiguration proposals. To do this they identify a team of clinical experts to assess whether the proposal is safe, sustainable and based on sound clinical evidence.

5.2 Parking

Concerns about parking related to facilities at both the Horton General and the John Radcliffe Hospitals. Specifically, the time taken by patients and visitors to park vehicles at the sites during busy times, and therefore the impact the reconfiguration of services might have on patients needing to travel to different hospitals. There are times of the day and week when queues build up and it can take extra time to park. This impacts on patients and visitors and causes concern for those trying to meet appointment times.

Following the qualitative exercise undertaken by Healthwatch, OCCG have commissioned Mott McDonald to undertake a specific quantitative exercise to determine the actual time taken to park cars at different times of the day and on each day of the week.

The aim of this exercise is to capture the data by means of deploying video cameras at each site to record and measure the actual time taken. The data will be collected for a 5 day period at the John Radcliffe and Horton Hospital sites and will demonstrate the peak periods and the expected delay to parking vehicles across a given week.

The cameras are portable and will only be installed for the period of the surveys. The survey will start on 12 June, to avoid school half term, Bank Holiday weekends and also the general election.

5.3 Obstetrics

The Maternity workstream is considering the comments received during the course of the public consultation and will set out mitigations or alternative proposals. It was clear during the course of the consultation (and this is highlighted in the report on the consultation), that there was a widely-held view that insufficient consideration had been given to the expected growth in population in the catchment area of the Horton or of alternative options for Maternity services in Banbury.

In order to address this concern, the workstream members are reviewing the options for Obstetric services, taking into account all the options which were considered in 2016 and any alternative options put forward during the consultation. They will re-evaluate the options and provide feedback to OCCG's Board on this work before the decision-making meeting in August.

6. OCCG Board receiving the consultation report

The public consultation is a very important part of the decision-making process; however it is not a referendum. Its purpose is to seek views from the public, answer questions and allow other suggestions to come forward that may not have been considered. This feedback will be considered alongside other relevant information

such as patient-safety factors and clinical best practice; OCCG Board will use this to help them make decisions about the proposed changes.

The principles set out in the consultation plan have been met and every effort has been made to encourage and enable people to take part in the consultation.

However, there are challenges being pursued through judicial review and referral to Secretary of State for Health. These challenges will need to be addressed through the proper processes and this may take time. OCCG will continue to progress with the process of considering the outcome of the consultation and preparing for the decision-making meeting planned in August.

The Board is asked to:

- Agree it is assured about the process for the consultation.
- Receive the report on the consultation and note its findings.
- Note the work that has been commissioned to ensure sufficient information will be available for the decision-making meeting on 10 August 2017.
- Identify if there are any further areas where additional information will be required prior to decision-making

This page is intentionally left blank

Priority One: Ensuring children have a healthy start in life and stay healthy into adulthood

Outcome measure, target and baseline for 2016-17				Performance in 2016-17								Proposed outcome measure for 2017-18
Outcome measure for 2016-17	OSCB	Tgt	Baseline	Q1		Q2		Q3		Q4		
				Fig	RAG	Fig	RAG	Fig	RAG	Fig	RAG	
1.1 Waiting times for first appointment with Child and Adolescent Health Services (CAMHS). 75% of children will receive their first appointment within 12 weeks of referral by the end 2016/17.	Y	75%	54% (15/16)	29	R	47	R	70	A	68	A	Measure to be retained for 17-18. All children's measures revised in Nov 16 as part of the refresh of the Children's Plan

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

Outcome measure, target and baseline for 2016-17				Performance in 2016-17								Proposed outcome measure for 2017-18
Outcome measure for 2016-17	OSCB	Tgt	Baseline	Q1		Q2		Q3		Q4		
				Fig	RAG	Fig	RAG	Fig	RAG	Fig	RAG	
2.1 Reduce the proportion of children with Special Educational Needs and Disability (SEND) with at least one fixed term exclusion in the academic year.		<6.7%	5.1% 14/15	7.1%	R			4%	G	5.2%	G	Measure to be retained for 17-18. All children's measures revised in Nov 16 as part of the refresh of the Children's Plan
2.2 Increase the proportion of children with a disability who are eligible for free school meals who are accessing short breaks services.		>42%	41.9% 15/16	44%	G	44%	G	46%	G	57%	G	
2.3 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. * Key Stage 2 * Key Stage 4		tbc	No baseline					9% KS2 33% KS4	R			
2.4 Reduce the persistent absence of children subject to a Child In Need plan.		<18%	18% 15/16							30%	R	
2.5 Reduce the persistent absence of children subject to a Child Protection plan.		<17%	17% 15/16							30%	R	
2.6 Reduce the number placed out of county and not in a neighbouring authority from 77 to 60	Y	60 (9.8%)	77 12.6%	87 14%	R	80 13%	R	104 16%	R	118 18%	R	
2.7 Increase the % of care leavers who are in employment, education and training	Y	49.1%	49.1%									

Priority Three: Keeping children and young people safe (select measures from the OSCB dataset)

Outcome measure, target and baseline for 2016-17				**Performance in 2016-17**								**Proposed outcome measure for 2017-18**
Outcome measure in 2016-17	OSCB	Tgt	Baseline	Q1		Q2		Q3		Q4		
				Fig	RAG	Fig	RAG	Fig	RAG	Fig	RAG	
3.1 Monitor the number of child victims of crime: baseline 15/16 2,094	Y	Monitor only	2094 15/16	613		1126		1649		2189		
3.2 Number of children missing from home; baseline 817	Y	Monitor only	1933	495		1022		1610		1780		
3.3 Reduce the number of social care referrals to the level of our statistical neighbours	Y	6151	5,612	1626	R	3154	R	4981	R	6658	R	Measure to be retained for 17-18. All children's measures revised in Nov 16 as part of the refresh of the Children's Plan
3.4 Reduce the number of children subject of a child protection plan	Y	500	569	551	A	563	R	605	R	607	R	
3.5 Reduce the number of hospital admissions caused by unintentional and deliberate injuries in young people aged 0-14 (Public Health measure number 2.07i) to the national level	Y	109.6				118.1	R	110.7	A	101.3	G	
3.6 Maintain the current number of looked after children	Y	600	609	622	R	643	R	651	R	675	R	

Priority Four: Raising achievement for all children and young people

Monitoring Education Strategy measures:

Outcome measure, target and baseline for 2016-17				Performance in 2016-17								Proposed outcome measure for 2017-18
Measure	OSCB	Tgt	Baseline	Q1		Q2		Q3		Q4		
				Fig	RAG	Fig	RAG	Fig	RAG	Fig	RAG	
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 * Key Stage 4			New measure					31%	R			Measure to be retained for 17-18. All children's measures revised in Nov 16 as part of the refresh of the Children's Plan
4.2 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. Baseline is 66 % from 2015.		69%	66%			70%	G					

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

Outcome measure, target and baseline for 2016-17		Performance in 2016-17								Proposed outcome measure for 2017-18
Outcome measure for 2016-17	Target	Q1		Q2		Q3		Q4		
		Fig	RAG	Fig	RAG	Fig	RAG	Fig	RAG	
5.1 Deliver the 6 Better Care Fund national requirements for closer working of health and social care			G		G		G		G	Work still in hand to develop 2017/18 measures
5.2 Reduce the number of emergency admissions for acute conditions that should not usually require hospital admission for people of all ages	997		R	1,105	R	1145 (end Nov)	R	1202 (end Feb)	R	
5.3 Increase the number of carers receiving a social care assessment from 7,036 in 2015/16 to 7,500 in 2016/17.	7,500	nya		2,430	A	3205	A	5690	A	
5.4 Increase % carers who are extremely or very satisfied with support or services received. 43.8 % baseline from 2014 Carers survey.	> 44%							39%	A	
5.5 Increase the percentage of people waiting a total time of less than 4 hours in A&E.	95%	83.5%	R	86.6%	R	86.5%	R	86.1%	R	
5.6 Increase the percentage of people waiting less than 18 weeks for treatment following a referral	92%	92.2%	G	81.7%	R	80.5%	R	78.9%	R	

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

Outcome measure, target and baseline for 2016-17		Performance in 2016-17								Proposed outcome measure for 2017-18
Outcome measure for 2016-17	Target	Q1		Q2		Q3		Q4		
		Fig	RAG	Fig	RAG	Fig	RAG	Fig	RAG	
6.1 20,000 people to receive information and advice about areas of support as part of community information networks.	20,000	2801	G	12949	G	27631 to end Oct	G	41273	G	Work still in hand to develop 2017/18 measures
6.2 15 % of patients with common mental health disorders, primarily anxiety and depression with access to treatment.	15%	15.9%	G	16%	G	15.0%	G	15.0% (end of Jan)	G	
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.	50%	50.6%	G	51.1%	G	51%	G	51% (end of Jan)	G	
6.4 At least 60% of people with learning disabilities will have an annual physical health check by their GP.	60%	nya		nya		nya		nya		
6.5 Increase the employment rate amongst people with mental illness.	16.75%	20%	G	19.7%	G	17%	G	20%	G	
6.6 Reduce the number of assessment and treatment hospital admissions for adults with a learning disability to 6 or fewer	6		G							

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

Outcome measure, target and baseline for 2016-17		Performance in 2016-17								Proposed outcome measure for 2017-18
Outcome measure for 2016-17	Target	Q1		Q2		Q3		Jan 2017		
		Fig	RAG	Fig	RAG	Fig	RAG	Fig	RAG	
7.1 Reduce the number of people delayed in hospital from current level of 136 in April 2016 to 102 in December 2016 and 73 in March 2017.	73	110	G	119	R	126	R	192	R	Work still in hand to develop 2017/18 measures
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.	11	13	R	12	A	12	A	11	A	
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	62%	60.4%	A	61.0%	A	59.9%	A	59%	A	
7.4 66.7% of the expected population with dementia will have a recorded diagnosis	66.7%	66.3%	G	67.8%	G	67.4%	G	67.7%	G	
7.5 Increasing the number of hours people are able to access the reablement pathway to 110,000 hours per year (2,115 per week) by April 2017.	2,115	832	R	775	R	950	A	1246	R	
7.6 75% of people who receive reablement need no ongoing support.	75%	67%	A	65%	R	49%	R	68%	A	
7.7 Monitor the number of providers described as outstanding, good, requires improvement and inadequate by CQC.	See below									

Provider CQC Ratings (as reported 10/5/2017) of providers inspected so far

	Care Homes			Social Care at home			Independent Health Care			NHS Healthcare			Primary Medical Services		
	Oxon No	Oxon %	National %	Oxon No	Oxon %	National %	Oxon No	Oxon %	National %	Oxon No	Oxon %	National %	Oxon No	Oxon %	National %
Outstanding	3	3%	1%	1	1%	2%	1	17%	11%	1	14%	6%	3	4%	4%
Good	97	84%	76%	69	85%	81%	4	67%	68%	3	43%	44%	60	85%	86%
Requires Improvement	15	13%	21%	10	12%	16%	1	17%	19%	3	43%	46%	8	11%	8%
Inadequate	1	1%	2%	1	1%	1%	0	0%	2%	0	0%	4%	0	0%	2%

CQC have rated one care home in Oxfordshire as inadequate - this is Stowford House Care Home in Abingdon. Hawthorns in Minster Lovell which was rated inadequate has now closed. Stowford is rated red on the council's own internal monitoring system due to safeguarding concerns.

The Social Care Organisation which has been rated as inadequate is Enable Health Limited based at Unipart House which provides community based adult social services. It was rated inadequate on 28-3-17. They are rated as red on the council's internal monitoring system since February 2017. There is 1 client receiving services from them as at 2-5-17 managed by us. The Contracts unit have offered support to the organisation to improve their services.

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

New Topics to be discussed and developed in 2017-18

1. Health and Wellbeing of Older Adults, including participation in physical activity and access to social networks / preventing loneliness. This work will build on what is already being done in the County including the Oxfordshire Sport and Activity work to increase participation of older people in physical activity and the Loneliness Summit which will be held in July 2017.
2. Promoting Mental wellbeing. An overview of current work to promote mental wellbeing will be presented to the Health Improvement Board in the autumn of 2017. The Board will consider how value can be added to existing work and a plan will be drawn up.

	Outcome measure, target and baseline for 2016-17		**Performance in 2016-17**								**Proposed outcome measure for 2017-18**
			Quarter 1		Quarter 2		Quarter 3		Quarter 4		
	Indicator for 2016-17	Target	Fig.	RAG	Fig.	RAG	Fig.	RAG	Fig.	RAG	
8.1	At least 60% of those sent bowel screening packs will complete and return them (aged 60-74 years) - and be adequately screened	60%	59.1%	A	59.6%	A	58.5%	A	0%		Data at least 6 months in arrears. ***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%.	15%	5.0%	R	10.2%	A	14.4%	G	18%	G	All CCG localities over 15%. ***Responsible Organisation: Oxfordshire County Council***
8.3	Take-up of invitation for NHS Health Checks should exceed national average (2015-16 = 47.9% nationally) and aspire to 55% in year ahead. No CCG locality should record less than 50%.	>47.9% (Aspire 55%)	35.1%	R	40.8%	R	44.7%	G	51.5%	G	Some localities > 50% - North 60%, South West 56.3%, South East 54.2% Some < 50% - West 48.3%, North East 46.2%, Oxford City 45% Some localities above 50% ***Responsible Organisation: Oxfordshire County Council)***

	Outcome measure, target and baseline for 2016-17		Performance in 2016-17								Proposed outcome measure for 2017-18
	Indicator for 2016-17	Target	Quarter 1		Quarter 2		Quarter 3		Quarter 4		
			Fig.	RAG	Fig.	RAG	Fig.	RAG	Fig.	RAG	
8.4	Number of people quitting smoking for at least 4 weeks should exceed 2015-16 baseline by at least 10% (15-16 baseline = 1923)	> 2115 by end year	551	G	978	R	1471	A	2037	A	8.4 Rate of successful quitters per 100,000 smokers aged 18+ should exceed the baseline set in 2017-18 (Baseline: 2016/17 Oxon baseline was 2315 quitters per 100,000 adult smokers. ***Responsible Organisation: Oxfordshire County Council)***
8.5	Mother smoking at time of delivery should decrease to below 8% - Oxfordshire CCG	<8%	7.8%	G	7.2%	G	7.8%	G	8%	G	8.5 The number of women smoking in pregnancy should remain below 8% recorded at time of delivery (baseline 2015-16 was 7.9%). ***Responsible Organisation: Oxfordshire Clinical Commissioning Group***
8.6	Number of users of OPIATES that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6 months as a percentage of the total number of opiate users in treatment.	> 4.5% 5% end year (Aspire 6.8% long term)	4.6%	G	4.3%	A	6.1%	G	7%	G	**Indicator to be kept under surveillance in 2017-18** 8.6 Oxfordshire performance for the proportion of opiate users who successfully complete treatment ***Responsible Organisation: Oxfordshire County Council***
8.7	Number of users on NON-OPIATES that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6 months as a percentage of the total number of non-opiate users in treatment.	> 26.2% 30% end year (Aspire 37.3% long term)	20.8%	R	20.0%	R	31.6%	G	44.3%	G	**Indicator to be kept under surveillance in 2017-18** 8.7 Oxfordshire performance for the proportion of non-opiate users who successfully complete treatment ***Responsible Organisation: Oxfordshire County Council***

Priority 9: Preventing chronic disease through tackling obesity

Topics to be discussed and developed in 2017-18

1. Addressing inequalities issues in preventing chronic disease by tackling obesity and improving participation in physical activity. In order to implement the recommendations of the Health Inequalities Commission, all of the work to tackle this priority area will include a focus on reducing inequality of outcome.

	Outcome measure, target and baseline for 2016-17		**Performance in 2016-17**								**Proposed outcome measure for 2017-18**
			Quarter 1		Quarter 2		Quarter 3		Quarter 4		
	Indicator for 2016-17	Target	Fig.	RAG	Fig.	RAG	Fig.	RAG	Fig.	RAG	
9.1	National Childhood Measurement Programme (NCMP) - obesity prevalence in Year 6.	<=16%					16%	G			9.1 Ensure that the obesity level in Year 6 children is held at below 16% (in 2016 this was 16.0%) 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 (baseline for Oxfordshire 21.9% Jan14-15)	Reduce by 0.5% from baseline (21.9%)	23.4%	A							9.2 Reduce by 0.5% the percentage of adults classified as "inactive" (Oxfordshire baseline Nov 2016 of 17%). ***Responsible Organisation: District Councils supported by Oxfordshire Sport and Physical Activity***
9.3	Babies breastfed at 6-8 weeks of age (County) No individual CCG locality should have a rate of less than 55%)	63%	62.2%	A	61.7%	A	61.8%	A	62.5%	A	**Indicators to be kept under surveillance in 2017-18** 9.3 63% of babies that are breastfed at 6-8 weeks of age Q4 – S W Oxfordshire and West Oxfordshire localities <55%. All others higher – S East and Oxford City localities >70% ***Responsible Organisation: NHS England and Oxfordshire Clinical Commissioning Group***

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

Topics to be discussed and developed in 2017-18

1. *Domestic abuse – strategic approach to joint commissioning. The work to jointly commission high quality services for prevention, early intervention and support for victims of domestic abuse is building on a major review carried out in 2016. The Health Improvement Board will consider its role in governance and strategic leadership for this work.*

	Outcome measure, target and baseline for 2016-17		**Performance in 2016-17**								**Proposed outcome measure for 2017-18**
	Indicator	Target	Quarter 1		Quarter 2		Quarter 3		Quarter 4		
			Fig.	RAG	Fig.	RAG	Fig.	RAG	Fig.	RAG	
10.1	The number of households in temporary accommodation on 31 March 2017 should be no greater than level reported in March 2016 (baseline 190 households)	≥190			192	A			161	G	
10.2	At least 75% of people receiving housing related support will depart services to take up independent living (baseline 87.2% 2015-16)	75%	85.1%	G	84%	G	85.4%	G	87.3%	G	
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.	80%			86.4%	G			80%	G	
10.4	Increase the number of households in Oxfordshire who have received significant increases in energy efficiency of their homes or their ability to afford adequate heating, as a result of the activity of the Affordable Warmth Network and their partners	Needs a new target							0		
10.5	Ensure that the number of people estimated to be sleeping rough in Oxfordshire does not exceed the baseline figure of 90 (2015)	≥90			79	G	79	G			

	Outcome measure, target and baseline for 2016-17		**Performance in 2016-17**								**Proposed outcome measure for 2017-18**
	Indicator	Target	Quarter 1		Quarter 2		Quarter 3		Quarter 4		
			Fig.	RAG	Fig.	RAG	Fig.	RAG	Fig.	RAG	
10.6	At least 70% of young people leaving supported housing services will have positive outcomes in 2016-17, aspiring to 95%	<=70% Aspire 95%					73.2%	G	70.7%	G	

Priority 11: Preventing infectious disease through immunisation

	Outcome measure, target and baseline for 2016-17		Performance in 2016-17								Proposed outcome measure for 2017-18
	Indicator	Target	Quarter 1		Quarter 2		Quarter 3		Quarter 4		
			Fig.	RAG	Fig.	RAG	Fig.	RAG	Fig.	RAG	
11.1	At least 95% children receive dose 1 of MMR (measles, mumps, rubella) vaccination by age 2 years No CCG locality should perform below 94%	95%	95.0%	G	94.5%	A	94.6%	A	94.8%	A	11.1 Oxford City and North Oxfordshire localities are below 94% in Q4 ***Responsible Organisation: NHS England***
11.2	At least 95% children receive dose 2 of MMR vaccination by age 5 years No CCG locality should perform below 94%	95%	93.4%	A	92.5%	A	93.1%	A	92.6%	A	11.2 Oxford City, S E Oxfordshire and West Oxfordshrie localities below 94% in Q4 ***Responsible Organisation: NHS England***
11.3	Seasonal Flu <65 at risk (Oxfordshire CCG)	≥ 55%							52.4%	A	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	HPV 12-13 years (Human papillomavirus) 2 doses	≥ 90%							0%		**Indicators to be kept under surveillance in 2017-18** 11.4 Data available annually for school year Sept-Aug so published after September) ***Responsible Organisation: NHS England***

Annex 2

Education Quality Dashboard Targets 16/17 24/01/17

The ambition of the Education Strategy 2015-18 is that by 2018 Oxfordshire will be amongst the highest performing local authorities (top quartile nationally) for each measure. The annual targets have therefore been set with this ambition in mind.

		Indicator	Trend data		Target 16/17	RAG		Direction of Travel	Comparative data			Comment
			14/15	15/16		2016 target	2018 target		Oxon	National average	SN Average	
Raising Achievement	A1	EYFSP – % good level of development	2nd Q	2nd Q	Top Q 72%	G	G	↑	70%	69%	71% 7th	
	A2	Phonics – % expected standard	3rd Q	3rd Q	2nd Q 83%	R	A	→	80%	81%	80% 6th	
	New indicators from 2016 so no baseline – target to be in top Q											
	A3a	Key Stage 1 - % expect standard reading	New indicators from 2016	3rd Q	2nd Q 75%	R	A		74%	74%	75% 6th	
	A3b	Key Stage 1 - % expected standard writing		4th Q	2nd Q 67%	R	R		62%	65%	64% 9th	
	A3c	Key Stage 1 - % expected standard maths		3rd Q	2nd Q 74%	R	A		71%	73%	72% 7th	
	A4	Key Stage 2 - % expected standard RWM		3rd Q	2nd Q 55%	R	A		52%	54%	54% 9th	
	A5a	Progress KS1-2 Reading		Top Q	Top Q 0.7	G	G		0.6	0	0.1 3rd	
	A5b	Progress KS1-2 Writing		4th Q	3rd Q -0.7	R	R		-1.2	0	-1.0 7th	
	A5c	Progress KS1-2 Maths		3rd Q	2nd Q 0.2	R	A		-0.5	0	-0.8 4th	
	A6a	KS4 – Attainment 8 score		2nd Q	Top Q 51.5	A	G		50.4	50.1	52.0 11th	Note this is average score NOT a %.

	A6b	KS4 – Progress 8 score		2nd Q	Top Q 0.05	A	G		0.01	0	0.04 6th	

	Vulnerable group performance												
Narrowing the Gap	A7a	Free School Meal gap – EYFSP	3rd Q	3rd Q	2nd Q -18	R	A			-23	-21	-22 5th	Gap narrowed slightly this year
	A7b	Disadvantaged gap – KS2		4th Q	3rd Q -26	R	R			-31%	-21%	-28 9th	Only 4 LAs have wider gaps
	A7c	Disadvantaged gap – KS4		4th Q	3rd Q -13.2	R	R			-15.0 pts	-12.3 pts	-13.7 10th	NB these are scores NOT %s
	A8a	SEN Support – KS2 attainment		4th Q	3rd Q 13%	R	R			9%	16%	14% 10th	Only 5 LAs have wider gaps
	A8b	SEN Support – KS4 attainment		4th Q	3rd Q 34.0	R	R			32.8 pts	36.2 pts	38.1 11th	NB these are scores NOT %s

RAG ratings against 2016 target (G=top Q, A=2nd Q, G=3rd/4th Q) and likelihood of reaching 2018 target. SN comparisons (G=top Q, A= 2nd/3rd Q, R=4th Q)

'Disadvantaged pupils' are those who attract pupil premium funding, meaning pupils claiming free school meals at any point in the last six years and pupils in care, or who left care through adoption or another formal route. Evidence shows that the progress and achievement of disadvantaged pupils is normally lower than that of 'other' pupils

The disadvantaged gap is calculated as the difference between the attainment of disadvantaged pupils in the County compared to other pupils nationally.

Statistical Neighbours

Bath & NE Somerset
Bracknell Forest
Buckinghamshire
Cambridgeshire
Gloucestershire
Hampshire
Hertfordshire
West Berkshire
West Sussex
Wiltshire

This page is intentionally left blank