Notice of Meeting Public Document Pack

Oxfordshire Joint Health Overview & Scrutiny Committee

Thursday, 14 September 2017 at 10.00 am

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

Membership

Chairman - Councillor Arash Fatemian
Deputy Chairman - District Councillor Monica Lovatt

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

Notes: ***Date of next meeting:*** *16 November 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 Arash Fatemian Email: arash.fatemian@*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*

Peter G. Clark
Chief Executive

September 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. Apologies for Absence and Temporary Appointments

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

3. Minutes (Pages 1 - 24)

To approve the minutes of the meeting held on 22 June 2017 and the special meeting held on 7 August 2017 **(JHO3**); and to receive information arising from them.

4. Speaking to or Petitioning the Committee

5. Healthwatch Oxfordshire - Update (Pages 25 - 32)

10:15

Professor George Smith, Chairman of Healthwatch Oxfordshire (HWO) and Rosalind Pearce, Executive Director, will update the Committee on the activities of HWO since the last meeting **(HWO5).**

6. Advice from the Independent Reconfiguration Panel (IRP) (Pages 33 - 52)

10:30

The Committee is invited to consider the advice from the IRP in response to the Committee's referral to the Secretary of State of the Oxfordshire Clinical Commissioning Group's (OCCG) decision not to re-procure services at Deer Park Medical Centre **(JHO6).**

As part of this, the Committee will receive an update on the OCCG's progress in developing a plan for primary care in Witney; and consider how to develop and sustain an open, no surprises, productive and effective working relationship with the NHS. This paper is also attached at **JHO6.**

7. Stroke Rehabilitation Services (Pages 53 - 56)

11:20

A briefing is attached on the proposed relocation of stroke rehabilitation beds in Witney to Abingdon Community Hospital **(JHO7).** Consultation with staff is planned for September.

8. Director of Public Health's Annual Report (Pages 57 - 132)

12:20

The Director of Public Health will present his independent Annual Report to the Committee. Members of the Committee are asked to consider the key issues which it would like to see taken forward in the year ahead **(JHO8). TO FOLLOW**

9. Chairman's Report (Pages 133 - 142)

13:15

The Chairman's report is attached at **JHO9**. This includes a copy of the referral letter to the Secretary of State made by the Committee in relation to the maternity services at the Horton General Hospital. Also included will be an update on the assurances agreed at the Board meeting on 10 August**.**

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.

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OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 22 June 2017 commencing at 10.00 am and finishing at 2.10 pm

Present:

Voting Members:

Councillor Kevin Bulmer
Councillor Mark Cherry
Councillor Dr Simon Clarke
Councillor Arash Fatemian
Councillor Mike Fox-Davies
Councillor Laura Price
District Councillor Jane Doughty
District Councillor Monica Lovatt
District Councillor Andrew McHugh
District Councillor Susanna Pressel
Councillor Jenny Hannaby (In place of Councillor Alison Rooke)
District Councillor Lorraine Hillier (In place of District Councillor Nigel Champken-Woods)

Co-opted Members: Mrs Anne Wilkinson

Officers:

Whole of meeting — Strategic Director for People & Director of Public Health; Julie Dean and Katie Read (Resources)

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

27/17 ELECTION OF CHAIRMAN - 2017/2018

(Agenda No. 1)

Councillor Fatemian was elected Chairman for the municipal year 2017/18.

28/17 ELECTION OF DEPUTY CHAIRMAN - 2017/2018

(Agenda No. 2)

District Councillor Monica Lovatt was elected Deputy Chairman for the municipal year 2017/18.

29/17 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 3)

Cllr Jenny Hannaby attended in place of Cllr Alison Rooke; District Cllr Lorraine Hillier for District Cllr Nigel Champken-Woods; and an apology was received from Keith Ruddle, co-opted member.

It was reported that Moira Logie, co-opted member, had tendered her resignation on account of her moving away from Oxfordshire. Members joined in thanking her for all her valuable work for the Committee.

30/17 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 4)

District Councillor Andrew McHugh declared a personal interest on account of his appointment as a short-term locum at West Bar GP Surgery, Banbury; also on account of his recent appointment to the Cherwell Community Partnership Network; and finally on account of his role as a non-voting attendee on the Cherwell Locality Network.

Councillor Jenny Hannaby declared a personal interest on account of her appointment as Chairman of the Wantage Hospital League of Friends.

Dr Simon Clarke declared an interest on account of his appointment as a public governor serving on the Council of Governors of the Oxford University Hospitals NHS Trust.

31/17 MINUTES

(Agenda No. 5)

The Minutes of the meeting held on 6 April 2017 were approved and signed as a correct record.

Matters Arising

In relation to Minute 24/17 ‘Quality Accounts’, page 8, bullet point 2, the Committee asked for an update on the Delayed Transfers of Care situation to include an update on recruitment.

32/17 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 6)

The following addresses from speakers had been agreed. Each speaker had elected to give their address prior to the item itself:

Agenda Item 9 – Oxfordshire Transformation Plan (OTP) Phase 1 – Consultation Outcomes

Joan Stewart – representing ‘Keep our NHS public’

Cllr Mark Ladbrooke – Oxford City Council

33/17 FORWARD PLAN

(Agenda No. 7)

The Committee considered the Forward Plan attached (JHO7).

The Committee **AGREED** the Forward Plan and that Anaesthetist training at the Horton General Hospital be added to the Plan. It was noted however that this would most likely be included within the broad Transformation programme for consideration by the Committee in the near future.

34/17 HEALTHWATCH OXFORDSHIRE - UPDATE

(Agenda No. 8)

The Committee welcomed Professor George Smith, newly appointed Chairman of Healthwatch Oxfordshire (HWO). He was joined by Rosalind Pearce, Executive Director. He spoke of the need for HWO to challenge Health authorities to provide a clear vision on a longer horizon than at present. His major concern was that Health's long term strategic plan was set at 2021 and not at the required 2031. In the current climate patients were being faced with cutbacks, for example, with reductions in bed numbers, thus causing a major mismatch between Health and the needs of the county. He added that the short-term message of the Oxfordshire Transformation Plan - Phase 2 was one of joint working, collaboration, integration was not visible in Oxfordshire. He made a plea, now there was a new County Council, for more partnership working and planning with the NHS. He believed that this was the way forward.

The Chairman asked if it was possible for the Committee to receive an update on HWO's findings in relation to their traffic/parking survey at the John Radcliffe site. Ros Pearce reported that they were in the process of drafting the report and when complete, would be placed on the HWO website. It would be submitted to the OCCG by the end of June. She undertook to send a copy to the Committee when it had been placed in the public domain. Professor Smith added that the Hospital had also authorised some of their employees to undertake some automated counting, to measure how long it took to find a parking space. However, it had also been recognised that the problems often started on the journey to the hospital on busy roads, and therefore it was important where the initial sensors were placed. Here lay the need for a level of engagement with the local authority.

Professor Smith was asked for his view with regard to the rise in population for the over 85's and the problem this would cause for the Health economy. He commented that the profound changes to the demographics in relation to the over 85's were now well known. However, what was less clear were the demographics of people moving into the county as a result of housing growth and its subsequent effect on Health services. These people would be likely to be younger and more economically active and the underlying planning assumption would then be to expect a rise in the birth rate, with respective health needs. This would require better career structures for Health staff and the integration, in the form of hubs, of care workers, of consultants (to provide diagnostic care) and specialist nursing staff, as had happened in the

Netherlands. His view was that community hospitals could best provide the source where services could coalesce.

Professor Smith and Rosalind Pearce were thanked for their attendance.

35/17 OXFORDSHIRE TRANSFORMATION PLAN (OTP) - PHASE 1 - CONSULTATION OUTCOMES

(Agenda No. 9)

Prior to the consideration of this item the Committee was addressed by the following members of the public:

Joan Stewart – 'Keep our NHS public'

Joan Stewart was of the view that there were many more questions that the Committee needed answers to before the OCCG meeting to make their decision on the Oxfordshire Transformation Plan – Phase 1 proposal. She listed her reasons for this as follows:

- The OCCG's response to this Committee's letter was 'evasive, disingenuous and high-handed'. They had ignored the Committee's misgivings about the 'domino effect' that phase 1 decisions would have on phase 2, particularly on services in the north of the county. Also, why 146 acute bed losses formed part of phase 1, but proposals to shift care into the community would not be seen until Phase 2, when the beds would be gone;
- Despite being the statutory, accountable body for the consultation, OCCG had attempted to 'shift responsibility' onto the Oxford University Hospitals NHS Foundation Trust (OUH) for solving access and car parking problems and for investment in the Horton Hospital. How this would be financed was in question;
- OCCG had also 'side stepped the fundamental question of whether proposals were workable and sustainable given the severe underfunding of health and social care, shrinking care home capacity, and chronic workforce shortages' in Oxfordshire;
- The OCCG's response to concerns voiced by this Committee about how inequalities would be tackled was 'the feeblest in their whole response';
- The findings in the full consultation report revealed a catalogue of 'concerns, misgivings and reservations' about the proposals. The findings also include 'strong criticism of the consultation process, not least of which was the decision to split the consultation in the way it was; the lack of options; and the leading nature of many of the questions'.

She concluded by stating that there were many more questions that this Committee required answers to before the OCCG decision – making meeting in August. She asked when this Committee would:

- be able to scrutinise the re-evaluation of the options for Obstetric services at the Horton?
- be able to evaluate the criteria and results of the integrated Impact Assessment, the conclusions of which would be 'critical' to the proposals?

- be able to assess the methodologies and quantitative and qualitative data being collected by Healthwatch and Mott McDonald on travel and parking: and
- how would the revision of these consultation proposals reverse the crisis in health and social care?

'Keep our NHS Public' wished to urge the Committee to schedule a further public meeting with OCCG prior to 10 August when the final decision would be made - or to refer to the Secretary of State for Health that day if it was not satisfied with OCCG's response to its concerns.

Cllr Mark Ladbrooke – Oxford City Council

Cllr Ladbrooke highlighted his concern that the health inequality issues in certain areas of Oxford were not being considered in sufficient proportion by the OCCG. He asked that the whole of Oxfordshire be considered in addition to the north of the county. He explained that he had recently met with people belonging to the Barton Community Association who told him that 36% of people living within that area were living below the poverty line and that fuel poverty was also prevalent in this area. Many were living in cold, damp and overcrowded homes without access to safe and reliable facilities. He expressed his concern that the proposed changes would have an unfavourable impact on people who had the least levels of resilience. Cllr Ladbrooke particularly highlighted the proposal to permanently close 194 beds without testing its impact on patients beforehand. He urged the CCG to do an impact assessment in order for the consequences of the proposals on health outcomes and health inequalities to be thought through, and, where appropriate, plans for mitigation to be proposed and scrutinised by this Committee. He brought the attention of the Committee to the proposal made by Simon Stephens that NHS units should apply a patient care test which would demonstrate sufficient alternative provision. He concluded that there was no evidence of such a test to date and that, on the basis of this, the Oxfordshire Transformation Plan should not be accepted.

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.

This Committee scrutinised the detailed proposals in Phase 1 of the Oxfordshire Transformation Plan at a dedicated meeting on 7 March 2017 and its formal response and recommendations had been submitted to the OCCG before the end of the consultation period. David Smith, Chief Executive, OCCG and Catherine Mountford, Director of Governance, OCCG now attended to present the feedback from the consultation. The report was attached at JHO9.

David Smith stated that the CCG would be pleased to attend another meeting of this Committee prior to their decision-making Board meeting on 10 August. With regard to the points made by Cllr Ladbrooke, it was the responsibility of the Clinical Senate of NHS England to highlight the Patient Care Test. An integrated Impact Assessment was taking place on Phases 1 and 2 of the proposals and added to any of the options as required. Once complete, it would be looked at with the clinicians and then placed in the public domain. They added that if there were any other areas the Committee wanted the CCG to look at, then this would be welcomed. They then proceeded to introduce the paper.

Members of the Committee welcomed the opportunity to have another dedicated meeting to look at and discuss the impact assessments in detail, in order to conduct a meaningful intervention and do service to any issues that had crystalised with regard to, for example, the bed closures.

The Committee also expressed its concern to the OCCG that a number of significant changes had been made to services on a temporary basis and once the decisions were made on 10 August, all would be irreversible. David Smith reminded Members that the CCG had gone out to consultation on Phase 1 of the proposals with the agreement of this Committee, in the light of so much uncertainty around patient safety, as a result of, for example, problems with regard to the recruitment of doctors. He added that the CCG had also sought to make a decision on these issues of great concern as early as it could.

During a lengthy question and answer session, the Committee established the following:

- with regard to maternity services at the John Radcliffe Hospital, the issues highlighted would be addressed when the options for decision were documented. Some were currently undergoing analysis on how to utilise the funding allocations available. Moreover, the CCG's Quality Committee was regularly reviewing the impact on services. In relation to access to car parking, the CCG would continue to work with the local authorities on the transfer of people to the site, either via their own cars or via the Park & Ride services. All options were being looked at;
- The Committee would be provided with a copy of the specification on the Impact Assessments;
- Oxfordshire had a very substantial pooled budget process with the County Council and this meant that solutions to a whole range of issues could be considered on a joint basis. These included issues around health inequalities. It was pointed out that the CCG could not use this consultation as a means of dealing with everything. The Oxfordshire Health &Wellbeing Board also had a role in addressing some issues such as health inequalities and its Strategy

was the mechanism with which to do this. The mantra of the pooled budget arrangement with the CCG was to pool money where it could be demonstrated that the best outcomes could be achieved, such as in relation to the re-design of the reablement service, the purchase of care beds, spending on care homes and equipment;

- The CCG Board would be seeking a level of clarity on decisions, such as the proposal to close the Obstetric Unit at the Horton Hospital. It would be asking for assessment of the knock on effects;
- The importance of hearing what the clinicians had to say about the proposals and what their advice was. This would be shared with the Committee. All responses received from the CCG Board and from the various organisations and the public would be made public;
- The consultation contained a number of 'confusing' comments and references that made some of the proposals unclear, such as mention of 'high risk' births, when 40% of births would take place in an acute hospital because anaesthetics could not be administered at a midwife-led unit;
- What had to be delivered would be delivered at local level. However commissioning of some services, such as cancer care, would be undertaken at a higher, regional level. The Committee was concerned that Oxfordshire's very effective joint working and savings delivered, via pooled budgets, would be derailed by the Sustainability and Transformation Plan (STP) across multi-authorities, all of whom had differing financial profiles. David Smith gave his assurances that the STP was about trying to achieve the right level for some services;
- In answer to a question that if all failed due to outside influences, such as Brexit, who would be liable, David Smith responded that the biggest challenge across the whole of the system was the workforce. He added that collective action would be required across Oxfordshire with other organisations to resolve this issue, for example, looking at low-cost housing for the workforce.

In his summing up, the Chairman raised a concern that there was a substantial amount of work to be completed in a very short space of time which could give rise to the danger of a 'box-ticking' exercise that would show all bases had been covered, rather than exploring alternative options. He further commented that the decision to split the consultation meant that it lacked clarity. It was recognised however that partly this was due to concerns that the Committee had over the Horton Hospital. He referred to a number of points raised during the discussion which the Committee were keen to see addressed within the final CCG report. These were:

- The outcomes of the patient care test;
- Options for the future of the obstetrics service at the Horton Hospital;
- The outcomes of the Mott MacDonald parking analysis and Healthwatch Oxfordshire qualitative travel and parking survey at the Oxford University Hospitals sites. Officers to seek advice as to whether the County Council could assist with this work and the CCG to share information which they had commissioned;
- Inclusion of the outcomes of the Integrated Impact Assessment; and
- Addressing of the points raised by Professor Smith, Chair of Healthwatch Oxfordshire in Agenda Item 8 regarding population growth and a consequential rise in the number of births.

The Committee **AGREED** to request the Officers to seek the specifications for each of the further analyses commissioned by the OCCG to understand their remit; also a timetable from the CCG to ascertain when the final reports would be available; and then to hold a special meeting of the Committee to scrutinise the final proposals before the CCG Board meets to make its final decisions.

36/17 DEMENTIA SERVICES

(Agenda No. 10)

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

The following representatives from Oxfordshire Clinical Commissioning Group, Oxfordshire County Council's Adults Social Care and the Dementia Support Service attended to share with the Committee how they were working together to support people with dementia and their families, with particular reference to recent changes to other services such as daytime support:

- Sonja Janeva – Oxfordshire Clinical Commissioning Group (OCCG)
- Mandy Carey – Dementia Oxfordshire
- Nicola Luxton – Dementia Oxfordshire
- Benedict Leigh – Oxfordshire County Council

A slide presentation was given to the Committee which provided an overview of dementia diagnosis, the dementia pathway, dementia support services and end of life care for dementia patients.

During the question and answer session that followed, the Committee established the following:

- Representatives were unaware of any new drugs on the market except for ones which allowed the slowing down of the degeneration process, which had appeared in recent years;

- In recent years there had been a significant emphasis put on research and funding;

- All care homes specialising in dementia came under Sonja's remit;

- There were benefits from the early diagnosis of dementia. It was important to know who had been diagnosed with dementia within a locality, so that need could be planned and support given. Furthermore early diagnosis also presented circumstances where personal preference would be taken into consideration alongside support;

- There were two types of mental health services, one for older people, which largely focused on dementia, and one for working age people suffering from illnesses such as depression or psychosis. Those of a younger age diagnosed

with dementia were automatically referred to the working age team. The cut-off age from one to the other was 65. Currently Oxford Health was exploring all age mental health teams and more teams focused on the frail elderly;

- There was no strong evidence to suggest that a person's existing mental health condition could be masking dementia, even though they could be suffering from other mental health problems. However, there was an increased prevalence for people with a learning disability to develop dementia at a younger age than the norm. Ideally they should be offered an annual GP health check;

- Many people suffering from dementia lived alone. This was dependent on how the person felt about that. Services such as 'Phone Friends' were available to them and there were other means of support given, such as dementia friendly aisles in Sainsbury's. The Alzheimer's Society also ran a 'dementia friends' service and Carers Oxfordshire, which came under the auspices of Age UK, also ran a 'Guideposts' service;

- In response to a question about how we can prevent people with dementia being placed out of county, Benedict Leigh explained that the Orders of St John and other partners were exploring the possibility of building specialist dementia care homes in Oxfordshire. A key challenge was sourcing an organisation equipped to run a good care home for specialist placements. They were also looking at existing provision in Oxfordshire, with a view to it becoming more specialised in favour of dementia patients. He agreed to return to a future meeting of this Committee with the case for investment in specialist units;

- Dementia funding was a challenge that was increasingly being picked up by local authorities and Oxfordshire was one of the lowest funded authorities per individual. This was a significant issue that had not however been picked up as part of the discussions around the Oxfordshire Transformation Plan. More funding was needed particularly around the County Council's ability to provide community support. Oxfordshire was very fortunate in having a large pooled budget which met the majority of patient needs. Sonja reminded the Committee that Continuing Health Care funding was available for dementia patients. She also informed the Committee that some work on the dementia pathway and diagnostics had been undertaken as part of the Phase 2 proposals of the Oxfordshire Transformation Plan. Health were at a stage where testing was required to ascertain if further work was needed. A workshop with users was being held in July to look at how the pathway was working for them;

- Health were keen to enable other services to care for people with dementia, rather than develop dementia specialist services. District nurses were being trained in giving support to dementia patients living in the community, with the support of a dementia adviser (of which there were 9 fte in Oxfordshire) should a person require a clinical input. A large number of sessions had already taken place on raising awareness of dementia. Advisers, who each had background in casework and were trained to NVQ level, had been assigned GP surgeries

and follow-up clinics from which to work. They were also happy to post information out to people via their computer;

- With regard to a question about the extent to which people could be supported in their own home and what the tipping points were for a family when coping with a relative's dementia, Benedict Leigh recognised the importance of respite care. Respite could be accessed through nursing and care homes nursing home. However, he recognised the difficulties experienced by families of self-funders as care homes tended to favour long-term clients. Furthermore, patients and families did not tend to want bed-based care. He undertook to provide a briefing on respite care.

The Committee recognised the importance in assisting society to better understand the different stages of the illness and the kind of support required for that person. It followed that as society aged then there would be less anxiety and concern about the kind of support that would be given. To this end it was hoped that the 'Dementia Friends' course would become more valued in the years to come. It was also noted that the local Fire Station in Witney had also rolled out this course.

The Committee **AGREED** to thank the representatives for attending, commenting that they looked forward to their return to the Committee at a future date to present on the:

(a) outcomes of work being undertaken with the Orders of St John to explore the use of land within the county to develop dementia specialist units; and
(b) provide a briefing on respite care for patients.

37/17 HEALTH & WELLBEING BOARD (HWB) AND STRATEGY PRIORITIES 2018/2019

(Agenda No. 11)

Tan Lea, Benedict Leigh and Jackie Wilderspin, Oxfordshire County Council, attended to present an overview of the performance against targets in the Oxfordshire Health & Wellbeing Board's Strategy 2016 – 17 and proposals for new outcome measures for new outcome measures in the revised 2017-18 Strategy for discussion and comment. All comments would be shared with the Oxfordshire Health & Wellbeing Board (HWB) at their meeting in July.

The Committee's comments for the HWB are listed below:

Overarching comments

- A graphical representation of the data and trends for these indicators could be helpful – to show how big the issue is and whether it's getting better or worse.
- Ensure the wording of targets makes it clear what is being measured.
- Need a way demonstrate whether performance is improving over time, to show that we are always moving forward – i.e. if we're always using last year's performance as a baseline.
- It was important for the Health & Wellbeing Board to do a regular 'deep dive' on a chosen target in order to ascertain where the issues lie.

Comments on each priority in turn were:

Priority 1

- Child and Adolescent Mental Health Services (CAMHS) – the focus on lead times should continue.
- It would be useful to have some context alongside the data that is presented.
- The targets seem to be very low – should we be more ambitious?

Priority 2

- 2.3 – Educational Attainment – The Committee requested feedback once the baseline had been agreed.
- 2.6 – out of county placements. The target should be reviewed and should be achievable – the numbers have been increasing steadily, rather than reducing as planned.
- Should we be monitoring the rate of care leavers to compare with the number of people entering care and monitor how they fare on leaving care? It seems important to tell the whole story.

Priority 3

- 3.3 and 3.4 – Children in need or on Child Protection Plans. The Committee asked why we would want to reduce the number of children subject to a Child Protection Plan or the number of social care referrals – should the focus instead be on the nature of the circumstances behind the referral and on tackling the factors affecting this at a much earlier stage?

Priority 4

- 4.1 – Narrowing the gap in school attainment. The Committee suggested that the national average be made available when published to see how Oxfordshire compares. If there has been a reduction in the rating, then this needs to be made clearer.

Priority 5

- 5.6 – 18 week waits. The waiting time for treatment following a referral is very long – should we have a more ambitious target? It would be more valuable to look at the number of people where the 18 week deadline has been breached.

Priority 6

- 6.5 – People with mental illness in employment. This seems a very low target, but if we're doing better than the national average, should we display this on the table? Also need to be clear whether the percentage target represents the people in employment or the target rate of increase.

Priority 7

- How do the DTOC figures compare nationally?

Priority 8

- Clarified that OCC is responsible for reporting on 8.2 & 8.3 (NHS Health Checks) because Public Health commission this – perhaps this can be made explicit?

Priority 9

- 9.1 – Childhood obesity. Expand on which districts are good performers and which are below the target. Suggestion that this Committee should hear from district councils on the work of Health Improvement Partnership Board.

Priority 10

- Clarified why the indicator for fuel poverty is still to be decided.

Priority 11

- 11.4 – Immunisation for Human Papilloma Virus. We should be able to see previous year's data, including first dose uptake, on HPV.

..... in the Chair

Date of signing

OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Monday, 7 August 2017 commencing at 10.00 am and finishing at 2.45 pm

Present:

Voting Members:	Councillor Arash Fatemian – in the Chair
	Councillor Kevin Bulmer Councillor Mark Cherry Councillor Dr Simon Clarke Councillor Mike Fox-Davies Councillor Laura Price Councillor Alison Rooke District Councillor Nigel Champken-Woods District Councillor Jane Doughty District Councillor Monica Lovatt (Deputy Chairman) District Councillor Andrew McHugh District Councillor Susanna Pressel
Co-opted Members:	Dr Keith Ruddle Mrs Anne Wilkinson
Officers:	Jonathan McWilliam, Strategic Director for People and 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 an addenda of additional documents: and agreed as set out below. Copies of the agenda, reports and additional documents are attached to the signed Minutes.

38/17 WELCOME BY CHAIRMAN

(Agenda No. 1)

Councillor Fatemian thanked councillors for their attendance at this additional meeting and welcomed the speakers and health representatives.

During his welcome Councillor Fatemian expressed disappointment at the way the process had been approached by the OCCG referring to the lateness of documents, that representatives had only committed to stay until 1.30 pm and that as the Chairman of this Committee he had been given only 3 mins to speak to the Board at its meeting on 10 August. He also made it clear that this Committee had not been in favour of but had reluctantly agreed to a 2 phase consultation.

39/17 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 2)

There were no apologies for absence.

40/17 PETITIONS AND PUBLIC ADDRESS

(Agenda No.)

The Chairman had agreed the following requests to address the meeting:

Victoria Prentis, MP
Robert Courts, MP
The Rt Hon. Sir Tony Baldry
Councillor Kieron Mallon, local member
Councillor Tony Ilott, local member
Councillor Lynn Pratt, local member
Councillor Eddie Reeves, local member
Rosalind Pearce, Healthwatch Oxfordshire
Bishop Colin Fletcher
Dr Peter Fisher, member of the public and retired consultant in General Medicine at the Horton Hospital
Ian Davies, Director of Operational Delivery, Cherwell DC & South Northants Council
Roseanne Edwards, Newspaper Health Journalist, Banbury Guardian
Valerie Ingram, Administrator of 'Save Our Horton' facebook page
Joan Stewart, 'Keep our NHS Public' – a petition was also submitted
Charlotte Bird, Press and PR for 'Keep the Horton General' campaign
Keith Strangwood, Chair of 'Keep the Horton General' campaign
Mrs Sophie Hammond, 'Keep the Horton General' campaign
Kelly Cowley, member of the public
Jenny Jones, member of the public
Councillor Barry Wood, Leader of Cherwell District Council

41/17 OXFORDSHIRE BIG HEALTH AND CARE TRANSFORMATION - PHASE 1

(Agenda No. 4)

David Smith, Chief Executive, Oxfordshire Clinical Commissioning Group (OCCG), Catherine Mountford, Director of Governance, OCCG, Dr Tony Berendt, Medical Director, Oxford University Hospitals Trust, Sarah Adair, Head of Communications and Engagement, OCCG, Simon Angelides, OTP Programme Manager, OCCG and Stuart Bell, Chief Executive, Oxford Health NHS Foundation Trust were in attendance.

David Smith, Chief Executive, Oxfordshire Clinical Commissioning Group (OCCG), Catherine Mountford, Director of Governance, OCCG, Dr Tony Berendt, Medical Director, Oxford University Hospitals Trust, presented final proposals for Phase 1 of the Oxfordshire Big Health & Care Transformation Programme that would go forward for discussion and decision at an extraordinary meeting of the OCCG Board on 10 August 2017. They explained the reasons behind the commissioning of additional work in a number of areas following the consultation; and also how this information would be used to inform the Board's final decisions on 10 August.

The Committee had before them the following OCCG's Board papers:

- The decision-making business case outlining the final proposals for Phase 1 of the Big Health and Care Transformation Programme;
- The draft Minutes of the OCCG Board meeting held on 20 June 2017 at which the Phase 1 consultation outcomes were examined;
- The results of the OCCG commissioned Integrated Impact Assessment for Phase 1, including a travel and access analysis;
- The results of an OCCG commissioned parking survey at the John Radcliffe and Horton General Hospital sites undertaken by Mott McDonald; and
- The results of an OCCG commissioned qualitative survey undertaken by Healthwatch Oxfordshire capturing patient experiences of travelling and parking at Oxford University Hospitals NHS Trust sites hospital sites.

The Committee also had before them for reference the following:

- Minutes of the 7 March 2017 HOSC meeting to scrutinise the Oxfordshire Big Health and Care Consultation – Phase 1;
- HOSC's formal response and recommendations in relation to the Oxfordshire Big Health and Care Consultation - Phase 1; and
- Oxfordshire Clinical Commissioning Group's reply to HOSC's response and recommendations
- Draft unconfirmed Minute of the 22 June 2017 HOSC meeting – Item 9 'Oxfordshire Transformation Plan – Phase 1 consultation outcomes'

In response to questions from members of the Committee on points of clarification health representatives made the following points:

1. Asked about the reduction in income from district general services they stressed that these services were important and that they had a vision for modern hospital service for Banbury which they could not realise whilst the consultation process carried on.
2. They were unable to confirm if they had been able to make use of traffic data from the County Council.
3. They expressed confidence that patient outcomes would be better under the proposals.
4. Asked to explain the validity of the rebalancing the system pilot as a driver for bed closures given lack of evidence that it was effective they refuted that this was the case. The resources released by the pilot had already been redeployed in the system. The accepted that any further bed closures should await the reduction in figures on the delayed transfer of care.

The following speakers addressed the Committee:

Victoria Prentis MP**,** highlighted the housing growth figures in Oxfordshire which were 5 times the national rate. She stressed that residents were anxious about the future of the Horton General Hospital (HGH) which had been under threat for many years. She highlighted the domino effect of losing services and with one anaesthetic rota already gone there was fear for the future of A&E. Residents were also frightened about the safety of mothers and babies particularly those requiring transfer to the

John Radcliffe (JR) either during labour or immediately after. There were concerns about travel times and she expressed the view that there was a lack of real evaluation of travel times. Victoria Prentis,MP referred to her travel survey which she felt had been ignored. Residents were angry about the process. Holding a split consultation was wrong; information was inadequate and timelines confusing.

Robert Courts MP**,** urged the Committee to seek an independent review speaking against the proposals due to the impact on West Oxfordshire. He expressed concerns about process, safety and the future of Chipping Norton Community Hospital. He commented that split consultation had failed to take into account the future of health care as a whole and the consultation ignored the impacts of population growth. On safety he questioned the ambulance journey times to JR which he felt were unrealistic. He highlighted the expected reduction in births at Chipping Norton Midwife Led Unit (MLU) and was concerned for the future of this and other MLUs.

The Rt Hon. Tony Baldry urged referral to the Secretary of State. He stressed that the impact of the proposals would be County wide. They would increase the pressure on the JR and he highlighted a capacity issue. He referred to the IRP judgement in 2008 and suggested that the Committee should have it before them to consider. He commented that nothing had changed since those very clear recommendations against removing maternity services from HGH except that the population had grown.

Councillor Kieron Mallon spoke against the proposals and highlighted the 2008 IRP judgement. He referred to: the lack of choice for pregnant women in Banbury and surrounding areas; the uncertainty over the future of the static ambulance currently provided, the lack of an impact assessment on social care beds as a result of the split consultation which meant meaningful representations were not possible. Councillor Mallon asserted that witness statements had been ignored and that there was a lack of trust by local people caused by poor engagement, lack of forethought and preconceived opinions on behalf of the OCCG.

Councillor Tony Ilott highlighted journey times to JR from his Division in the event of problems. He referred to expected housing growth that would exacerbate travel and access issues to the JR.

Councillor Lynn Pratt**,** as a Town and District Councillor for Bicester, spoke in support of a fully functioning district wide hospital at HGH. She highlighted ramifications for Bicester and surrounding villages of the loss of maternity services. Referring to the figures she believed that the number of births had been underestimated referring to future population growth with Bicester expected to double in size by 2030.

Councillor Eddie Reeves spoke against the proposals in terms of the current downgrade already having a detrimental impact on the ability of residents of Banbury to access high quality health care. He highlighted the dangers of an over reliance on a stretched JR with poor access. Further centralisation was not in patients' best interests. He referred to an historic lack of investment at HGH. He gave some welcome to the investment in a diagnostic centre but not at the expense of a further loss of acute services. He noted the lack of detailed plans or funding to ensure plans came to fruition.

Rosalind Pearce, Healthwatch Oxfordshire stated that they were unable to support the OTP on the following grounds:

- Capacity issues – population growth meant any proposal to close another 36 beds was unsustainable
- Economic growth will bring highly skilled young people in to the Country and will lead to an increase in the birth rate
- In relation to stroke services there was concern that the national agreement to downgrade response times was at odds with the need for a quick response and further review was required.
- Travel and parking would be made worse by more activity on fewer sites.
- The concentration of services was a threat to the resilience of services.
- The split consultation was flawed.

In conclusion she stated that concerns were so great and so deep that the proposals should not go ahead until there was greater understanding and better consultation.

Bishop Colin Fletcher urged the Committee to refer the proposals for further work. He highlighted that in North Oxfordshire and over the County boundaries in that area people looked to HGH. The journey to JR was very difficult and parking was a problem. He expressed concern over the two stage process and the uncertainty for residents and staff at the HGH and the local distrust this had caused.

Dr Peter Fisher, a member of the public and retired consultant at the HGH rejected the idea of a 2 phase consultation stressing that services at the HGH were interdependent and must be considered as a whole. He argued that the basis of clinical urgency for Phase 1 was not valid and urged that it be considered alongside Phase 2. In particular it was perverse to make permanent decisions on maternity services when still trying to recruit and it was unwise to make decisions on bed closures before the community services were in place and before seeing the impact of winter bed needs. He considered the stroke proposals not to be controversial and to make common sense.

Ian Davies, Director of Operational Delivery, Cherwell District Council and South Northants Council expressed concerns about the consultation process. He referred to the 'Better Births' recommendations and to a practicable alternative model proposed by Cherwell DC which they felt had not been given serious consideration. He stated that selective use of the Better Birth recommendations had led to an urban model in a rural area. The loss of obstetric services removed choice with over 50% of women using HGH being transferred. There was a lack of support for a free standing MLU as opposed to an alongside MLU.

Roseanne Edwards, Newspaper Health journalist, Banbury Guardian highlighted population growth and that Census data used in the OTP was out of date. She noted that in the past HGH had been a safety valve for pressures on the JR and queried the impact of this in the future. She stated that information had been kept secret and alleged that at a consultation meeting Tony Berendt had accepted there would be a 5% mortality rate as a result of the OTP. She questioned the process by which training accreditation had been removed from HGH and the commitment to resolve

the problem of recruiting mid-range doctors. Tony Berendt put on record that he did not recognise the comment attributed to him.

Valerie Ingram, administrator of 'Save our Horton' facebook page urged referral and spoke in particular against the proposals for maternity services by reference to the individual experience suffered by a pregnant woman and her family.

Joan Stewart, 'Keep our NHS Public', submitted a petition in the following terms:

> 'We entreat you to reject Phase 1 of the Oxfordshire Transformation Programme because:
> - It entails closing hospitals and health facilities that belong to us
> - It will give the people of Oxfordshire a poorer, cheaper service than they had before
> - It will lead to overcrowding and longer waits at the JR and Churchill
> - It will make things even more difficult for those without transport, and those living alone
> - It is based on the false idea that the government must cut funding to the NHS (funding can be found and taxes for the rich raised).
>
> Please demand that Phases 1 and 2 be consulted together and agreed with West Berkshire and Buckinghamshire across the whole STP population'

Speaking in support of the petition Joan Stewart expressed concern at the inadequate time given to digest the Board papers and prepare questions and at the lack of genuine consultation. The Group found the business case flawed and unconvincing with flimsy mitigation. She raised a number of issues:

- Workforce pressures
- Travel & journey times
- The need for a safe, reliable, sustainable and affordable ambulance service

She stated that there was nothing in the financial plan to assure the Group that issues would be addressed. Millions of pounds of funding would be required to bring about enhanced services.

She commented that improvements to the Delayed Transfer of Care (DToC) figures had failed to materialise and she expressed doubt about other alternative services which had increased costs and whose future were in doubt.

Charlotte Bird, Press & PR for 'Keep the Horton General' campaign expressed her concern at the lack of notice given to views expressed during the consultation. She also queried the information and conclusions of a number of the consultants used for specific pieces of work including the parking survey.

Keith Strangwood, Chair of the 'Keep the Horton General' campaign in supporting referral of the proposals urged local MPs and Rt Hon Tony Baldry to come together in parliament with others to fight for funding for the NHS.

Sophie Hammond, 'Keep the Horton General' campaign queried why if there was a genuine commitment to retaining the training accreditation, which was subsequently lost, consultants had been allowed to neglect their training duties. She spoke against the proposals on maternity services by reference to her own experience when at the

HGH where following a routine birth emergency surgery had been required and which would now require a transfer to the JR. She also referred to other anecdotal evidence of pressures on the JR with mothers being in labour in the waiting room and one mother being sent to Wallingford.

Chrissie Ansel, speaking on behalf of Kelly Cowley, a member of the public informed the Committee that local people did not feel adequately informed or consulted. Consultation meetings had been held at inconvenient times and there had been a lack of information. The literature provided did not explain how the changes would be made nor the impact. Population growth figures were out of date and papers had been designed to produce the required outcome. Local people would suffer financially through the changes due to increased travel costs. She was concerned at the future of the static ambulance. She noted that having friends and relatives able to visit is a part of recovery. The most vulnerable members of society would be affected by the proposals.

Jenny Jones, member of the public expressed disappointment that other options (page 80) had been too readily rejected. She supported an independent review to increase confidence in the solutions. Details of a recruitment agency had been passed to OUHT but she was disappointed at the lack of flexibility shown by OUHT in their processes to allow candidates to work towards registration. She queried the commitment to finding recruits when this would undermine their argument to downgrade the HGH.

Councillor Barry Wood, Chairman of Cherwell District Council requested the Committee to stand up for local people and to refer the proposals to the Secretary of State. He explained why Cherwell DC was continuing with Judicial Review:

- In order to stand up for local people
- To ensure things were done lawfully but to highlight failures:
  - Split consultation
  - Failure to provide information including annexes
  - Failure to comply with NHS Act 2006

He commented that no consideration had been given to their imaginative and innovative plan. He urged the OCCG to contact Cherwell DC with regard to the Capital Programme.

During questions to OCCG from members of the Committee the following points were made

- With regard to free standing MLUs Tony Berendt clarified that the provision of free standing MLUs was evidence based and endorsed by NICE. Free standing MLU's were an option for low risk births.
- Asked about funding David Smith was clear that the reason for the consultation was patient care quality and safety. Funding would be revisited in phase 2 but it was a fact that OCCG was the lowest funded CCG per capita and funding was not keeping pace with demand. He was happy to come back to the Committee with more information with regard to funding.
- Tony Berendt considering the domino effect agreed that it was necessary to look at interdependencies and linkages. It was correct to say that changes in

anaesthetics have to be thought through to ensure it does not impact on other services. They did not see acute medical or A&E services being affected.

- With regard to parking at the JR site Phase 1 would see a net increase in people visiting Banbury which should help parking at the JR. With regard to improvements there would be a focus on flow, access and signage even if as suggested by a questioner it was with the same number of spaces. They would continue to work with partners with regard to public transport
- Asked about the problems to the plan posed by workforce issues it was explained that if anything those pressures were greater under the status quo and would be a threat to health care in the County.
- Asked whether the personal cases referred to today by speakers had been investigated the Committee was assured that all incidents were investigated. Tony Berendt undertook to take back a request that the Committee in future receive anonymised information on such incidents. He would consider what could be provided whilst complying with the duty of confidentiality.
- OCCG would be happy to discuss with them what financial support Cherwell Dc could provide.
- Asked about plans for Witney Community Hospital it was confirmed that there were no plans to close either wards but that they were looking at the best location of beds. In response to further questions about uncertainty over the future of beds at Witney CH Stuart Bell advised that they were not moving stroke beds to the JR. They were looking at how best to organise beds. Community Hospitals often had patients with complex care needs over a longer period. They made use of hub bed arrangements.
- In response to concerns that bus travel times were based on buses that were either not in existence or which ran a very limited service Simon Angelides advised the Committee that travel times had been built on information from the national database and that he was happy to go through the specific concerns raised with him.
- Asked whether the changes to bed numbers would put lives at risk this was refuted. A large amount of work had been put into the ambulatory services with the aim that where people did not need to remain in hospital they did not have to do so.
- An assurance was given that Phase 2 would take place with decision making expected in autumn next year.
- Asked to define 'significant progress' in terms of reducing DToC figures David Smith referred to the 5th test that had been brought in and that they were suggesting a figure of 120 beds (there were currently 170 beds in use). Success would result in further requests to close beds.
- Asked what had changed since 2008 Tony Berendt highlighted:
    - Loss of training recognition
    - Public expectations
    - Changing legislation
    - Changed levels of safety assurance
    - A different financial environment
    - Hugh changes in workforce demographics
    - An expectation of consultant delivered services and greater difficulty with middle grade doctors.

  Pressed further on what had fundamentally changed that no longer required the provision of maternity services in North Oxfordshire Tony Berendt explained that

it was not safe to have an obstetrics service that was not properly staffed and that it is safe to have a MLU endorsed by NICE.

- Asked if the lack of staffing was the only obstacle preventing a standalone obstetrics unit at HGH Tony Berendt stated that their continuing experience was that that middle grade tier had been difficult to recruit and retain.
- Responding to concerns about the length of papers David Smith advised that they had responded to the request for this meeting and following the Board meeting they would expect there to be follow through on the toolkit.
- It was confirmed that the independent body referred to in the papers would not be chosen by the OCCG.

During questioning Committee:

- Discussed concerns that the proposals would lead to the eventual removal or significant downgrade of HGH.
- Considered that underfunding of the NHS was a significant factor in the need for OTP.
- Expressed fears that the OTP was undeliverable due to workforce and funding issues.
- Commented that proper scrutiny of phase 1 was difficult without knowing the full picture to be provided by Phase 2 and STP.
- Were concerned at the domino effect on anaesthetics at the HGH, on other MLUs and on other services such as A&E and paediatrics.
- Raised travel and access issues
- Considered whether there had been any material change since the IRP judgement that there was an absolute requirement to have a maternity unit in North Oxfordshire. It was noted that 7 out of 9 of the obstetrics post had been filled.
- Highlighted the impact that the removal of maternity services would have on South East Oxfordshire with pressure on Wallingford MLU and Stoke Mandeville.

The Committee adjourned at 1.35 pm reconvening at 2.30 pm.

During discussion the Committee:

- noted that they had seen the 2008 IRP judgement;
- was informed by the Chairman that the toolkit referred to by David Smith was not relevant as it was for use to determine if there was a substantial change only when there was doubt;
- expressed some sympathy for the financial constraints the OCCG found themselves working under;
- expressed general agreement to refer maternity services. There was concern that assumptions about extra parking and availability of staff would not materialise and there was no plan to cope with that.
- were concerned about the impact on community based services of bed closures particularly as a means of reducing DToC. More information was needed and concerns were expressed about Phase 2. Recruitment was a problem in Oxfordshire and there were fears that there were no assurances that the additional staff in low paid care jobs would be found.

- Were concerned about the domino effect on services at the HGH and in particular the impact on anaesthetics and A&E services.
- Noted that the responses to concerns raised over the recommendations very often referred to the need to await Phase 2.

Following discussion it was proposed by Councillor Fatemian, seconded by Councillor Rooke and as amended by Councillor Price and Councillor Champken-Woods it was:

AGREED: (a) to support the proposals for critical care subject to assurances that there will be no knock on effect at the Horton General Hospital;

(b) to support proposals for acute stroke services subject to: future guidance on ambulance response times and how it fits with national guidance; and assurances that rehabilitation will be carried out at relevant local sites around the county such as the Horton General Hospital and Witney and Abingdon Community Hospitals;

(c) to support the closure of the 110 beds that has already taken place but that they were unable to support any further closures until they had seen the impact of Phase 2 proposals;

(d) that whilst agreeing to the principle of the planned care services at Horton General Hospital the Committee were unable to support at this stage as no detailed plans were available and the proposals were not fully thought through, costed and the local community fully engaged in the process. The Committee further considered that although this proposal could not be considered as requiring urgent decision under Phase 1 they asked that more detailed proposals be brought back with haste to ensure increasing footfall at the Horton General Hospital to ensure sustainability; and

(e) to strongly oppose the proposals in respect of maternity services and if the decision is to go ahead with the creation of a single specialist obstetric unit at the John Radcliffe Hospital and to establish a permanent Midwife Led Unit at the Horton General Hospital to refer the matter to the Secretary of State on the grounds that

- This committee has not been adequately consulted;
- The decision is not in the best interests of the residents of Oxfordshire due to the concerns expressed to and by the Committee during the meeting and which includes:
    - The arguments set out in the IRP judgement in 2008 still apply;
    - The fundamental need for obstetric services in Banbury and North Oxfordshire have not changed since that IRP judgement;
    - Increases in population since 2008 and expected further increases impacting on the demand for services;
    - Ongoing issues around access and travel times.

The Committee accepted that there were difficulties with staffing, but did not accept that as just cause for the changes when the fundamental needs of mothers had not changed.

.....

..... in the Chair

Date of signing 2017

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healthwatch Oxfordshire

1 Introduction

This report references the HOSC agenda items:

1. Independent Review Panel advice on Deer Park Medical Practice
2. Oxford Health proposals to reorganise stroke rehabilitation services across Abingdon and Witney Community Hospitals

At the time of writing we have not had sight of the Director of Public Health's annual report

2 Independent Review Panel advice on Deer Park Medical Centre, Witney

Since the closure of Deer Park Medical Centre at the end of March 2017, Healthwatch Oxfordshire has not heard directly from patients having trouble in registering with a GP, or the impact on them changing GP surgeries. We have had second-hand information that people were having their preferred chemist changed by their new surgery without their involvement or consent. We also heard that one patient had difficulty in getting repeat prescription "as normal" i.e. in the same time as when registered at Deer Park. The patient was able to "argue" their case and now has the same service as before.

In April, Healthwatch Oxfordshire facilitated a meeting between representatives of Oxfordshire Clinical Commissioning Group and representatives of the Deer Park Patient Participation Group. The outcome was two-fold:

1. The agreement to send a letter to the remaining patients registered with Deer Park urging them to register with another practice. This letter was to be signed by OCCG, Healthwatch Oxfordshire and Deer Park Patient Participation Group (DPPPG). Ultimately the DPPPG withdrew from being associated with the letter as they did not agree with the first draft.
2. Healthwatch agreed to facilitate an initial meeting in Witney – a primary care planning workshop – involving key stakeholders: OCCG, planning, local GPs, Locality representatives, Locality Forum, local PPGS, local politicians, local people (initially the representatives from DPPPG) and voluntary organisations. The agenda was agreed and HWO set a date for mid-July, which unfortunately we had to cancel. The date has now been set for 27th September and invitations have gone out.

Response to IRP

Healthwatch has arranged a meeting with ex-Deer Park patients (still known as Deer Park Patient Participation Group) and OCCG to discuss progress on responses to the IRP. The local MP will also be in attendance. The date for this meeting is Friday 8th September 2017.

Healthwatch Oxfordshire Witney Report

This report will be available at the HOSC meeting. Reference is made to this report as it is pertinent to the planning of primary care services in Witney and surrounds. We made direct contact with more than 1000 people and asked people to "Tell us…" about their experiences of health and social care services, 487 told us about their experiences and told us what was good about these services and what could be improved.

There were 235 responses about GP surgeries and 74% of people who rated their surgery rated it good or very good. The most common comment was about waiting times (29 comments) – waiting for the phone to be answered to make an appointment, waiting for appointments, and waiting in the surgery to see the doctor. Suggestions included more staff / GPs but people did express an understanding that this needs more doctors and more funding and this is not available.

There were concerns expressed about the impact that the closure of Deer Park will have, and for some already has had, on waiting times for appointments with their GP.

Deer Park Medical Practice

In March 2017, when HWO was in Witney, the closure of Deer Park GP Surgery was imminent. This was a closure which was actively campaigned against by the Deer Park Patient Participation Group, who received much local support.

We received 32 responses that named Deer Park Surgery, of which eight made no comment on the service but pleaded to keep Deer Park open. Overall 19 comments related to keeping Deer Park open.

Common comments found the staff as 'caring', the doctors as 'good' and ease of access to the surgery was a positive. Other individual comments included "small and personal", on time (appointments), "constant staff" and "reliable".

Proposed follow-up

Healthwatch Oxfordshire intends to work with the local GP Surgery Patient Participation Groups, West Oxfordshire Locality Forum (PPPWO) and surgeries to understand what impact the closure of Deer Park has had on patients and the surgeries. This will most likely happen early next year.

3 Stroke rehabilitation services

Whatever the proposed changes by Oxford Health NHS Trust to stroke rehabilitation services across Abingdon and Witney Community Hospitals, Healthwatch is concerned that waiting times for physio, speech therapy and other identified support services are not increased as a direct result or increase the numbers of patients affected by delays in transfer to care (DToC).

Our recent short report 'Peoples Experiences of Stroke Services in Oxfordshire[1]' reported on feedback on current services and what a good stroke support service would look like. Since October 2016, Healthwatch Oxfordshire has visited and spoken to the members of four different stroke clubs around Oxfordshire. These were in Wallingford, Banbury, Witney, and Abingdon. In all around 40 people were engaged and listened to. There was agreement that stroke services seemed to have improved in recent years and people who had strokes more recently (2013 onwards) seemed more satisfied with their care then those who had had their stroke more than a decade ago. People told us their experiences and also gave us their thoughts on how they felt services could be improved.

A summary of what people said:

- Good care at John Radcliffe (JR) stroke unit and community hospitals
- Excellent care at the Oxford Centre for Enablement (OCE) though there were delays in accessing the service
- Praise for occupational therapists and social services
- Mixed experiences with GP follow up support
- Lack of support at home following discharge

People also told us what they thought a good stroke support service looks like:

- Prompt access to physiotherapy without delay is critical
- Support at home after discharge
- Regular follow up appointments with GP not just an annual check up
- Good coordination between GPs and other support services

Although the report contains the responses of a relatively small number of people (40), their experiences and suggestions for how a good stroke support service shows that there is a mixture of experiences across a few years and it is assumed that this reflects the experiences of the wider community.

Oxfordshire Clinical Commissioning Group Board meeting 10th August 2017

At this meeting, the OCCG Board agreed the recommendation of changes in acute stroke Acute Stroke Services as follows:

'Secure an improvement in outcomes for stroke patients through direct conveyance of all patients where stroke is suspected from Oxfordshire (and its neighbouring areas) to the Hyper Acute Stroke Unit (HASU) at the John Radcliffe Hospital (JRH) in Oxford. This will be supported by the roll out of countywide Early Supported Discharge (ESD) (already available in two localities) to improve rehabilitation and outcomes.'

[1] Healthwatch Oxfordshire People's Experiences of Stroke Services in Oxfordshire August 2017

However, the potential impact on the demand on the voluntary sector involvement[2] in delivering closer to home services was not referred to in the background papers to the Stroke Early Discharge Scheme.

Healthwatch is concerned that that the roll out of the Early Stroke Discharge Scheme must be timely and involve local specialist voluntary sector organisations which play a vital part in supporting survivors of stroke in the community e.g. stroke and carers' organisations

Summary

Changes in stroke services across Abingdon and Witney Community Hospitals must not result in delays in accessing support services i.e. increased waiting times for physio, speech therapy and other identified support services is not increased as a direct result

The Early Supported Discharge Service, which will be rolled out across the county as a consequence of the OCCG Board's decision on 10th August, must:

1. Be timely and properly resourced.
2. Involve local specialist voluntary sector organisations

4 Voluntary Sector Forum – Health Inequalities

On 13th July 2017, Healthwatch Oxfordshire held a meeting for voluntary sector organisations and community groups with a focus on health inequalities. The forum was held in Abingdon, at the Preston Road Community Centre and 50 people attended the meeting representing 28 different voluntary sector and statutory organisations.

The meeting took as its starting point the report by the Health Inequalities Commission (HIC) on health inequalities in Oxfordshire. Richard Lohman, a commissioner on the HIC, provided attendees with an overview of the process of how the HIC took evidence and the 60 recommendations it made.[3]

Jackie Wilderspin, Public Health Specialist, Public Health, Oxfordshire County Council then spoke about the progress that has been made to date on addressing these inequalities.[4] Jackie started her presentation by stating the established link between deprivation and health inequalities, making the point that people who lived in more deprived communities lived less long and were sicker for longer.

Information was given on the various initiatives around the county to tackle health inequalities such as the Oxford City Council project to tackle homelessness after discharge from hospital or prison, or measures taken to support the 10% of the population in Oxfordshire who are considered to live in fuel poverty.

[2] Healthwatch Oxfordshire Voluntary Sector Forum February 2017 report submitted to OCCG consultation
[3] The slides from Richard Lohman's presentation can be read here: http://bit.ly/2uJgCks
[4] The slides from Jackie Wilderspin's presentation can be read here: http://bit.ly/2uJfa1P

To summarise what the sector had to say:

- The voluntary sector has an important role in tackling health inequalities including:
- Signposting their communities to services
- Prevention and awareness raising
- Developing and delivering social prescribing services / activities
- Challenging the system when it does not work for their community
- They are experts in their communities, have access to the community and often fill the gaps in services where the statutory sector is unable to meet a need

Suggestions made on what needs to be done to tackle health inequalities included:

- Involving the voluntary sector organisation early on in service design and delivery.
- Explore how the sector can be represented on the Health & Wellbeing Board – with a seat reserved for it.

Following the Forum, Healthwatch Oxfordshire reported that in light of the issues raised by attendees, we recognise that we can play an important role in supporting community and voluntary groups, including local, self-help groups to:

- Have their voices and their members' voices heard by decision makers, commissioners and providers of health and social care services in the county.
- Stay informed about upcoming events, meetings, policies, and decisions of significance that have an impact on their role.
- Network with each other on key issues and areas of interest.

Healthwatch Oxfordshire is keen to develop further our mechanisms for ensuring this happens. To this end, we will be holding another Forum later in the year to explore with voluntary sector partners how we can strengthen this aspect of our work.

5 Outreach report May – August 2017

Over four busy months, the Healthwatch Oxfordshire team has attended several events, giving us an excellent opportunity to listen to a wide range of experiences from many different users of Oxfordshire's health and social care services.

We have heard the concerns of people from the many regions of rural Oxfordshire and have noticed some recurring themes and concerns.

Many of the events where we have run the Healthwatch Oxfordshire stall have been the Play and Activity Days organised by Oxfordshire Play Association where

we have been given the opportunity to speak to parents and carers of children and younger people.

A recurring theme that emerged from these days was the impact of the cuts on children's services including:

Loss of children's centre services resulting in feelings of isolation; difficulty in accessing services including health visitors; lack of breast feeding support in the community whilst the support at JR was excellent.

Mental health support for children

- Common concerns regarding the length of time to access the service

Schools

Healthwatch Oxfordshire heard from young people that:

- Drug and alcohol sessions were not useful because the overriding message was just "Don't do it" rather than teaching young people about harm reduction which, they felt would be far more effective.
- Counselling services should be more anonymous and accessible – perhaps using a direct telephone line.
- On Healthy Eating, the students said that it costs £1.80 to buy a salad for lunch in the school canteen compared to 90p for a sausage roll or Cornish pasty. They said that there were posters around school promoting the "Eat Healthy, Eat Well" message but that the school canteen prices did not encourage students to do that.

Hospital Experiences

Good care and praise for nursing staff but concerns included those around hospital food, the use of 'technical language' by staff that is not properly understood, waiting times for physiotherapy that resulted delay in discharge.

Military Families

At the **Carterton** Play and Activity Day we had the opportunity to talk to the Community Fundraising Officer for *Combat Stress, The Veteran's Mental Health Charity*.

He informed us that only eight percent of referrals to the charity came from GPs. He explained the reason, as being that veterans were reluctant to talk about their feelings due to the stigma that still surrounds mental health. This creates a barrier to seeking help and support for those who are finding it difficult to adjust to life as a civilian.

He felt that the solution was at the point of referral so that it is clear on patient's referrals whether they have served in the armed forces, allowing the GP to see this and be aware of the patient's history.

GP Practices

Lots of feedback on lots of practices across the county, and common theme was the wait associated with getting a GP appointment. We spoke to a lady who pointed out the challenge of phoning the GP practice and being made to wait in a queue which eats away at phone credit. She told us that she has previously run out of credit, lost her place in the queue, and had to go to a neighbour to phone again. She felt that there should be a free phone number.

6 Future activity

The next town event will be held in Bicester between 29th September and 14th October 2017. We kick off with two events:

1. A stall in the market square on Friday 29th September and
2. Our voluntary sector / information fair 'Healthwatch Happening' on 29th September 10:00-13:00 to be opened by Bicester Town Mayor, Cllr L Sibley.

From October 2017 Healthwatch Oxfordshire will provide secretariat and development support to all 6 Locality Patient Participation Groups Forum, and will also have resources to support the development of Patient Participation Groups across the county. This is an exciting development supported by the Locality Forum Chairs and delivered under contract from Oxfordshire Clinical Commissioning Group.

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Department of Health

From the Rt Hon Jeremy Hunt MP
Secretary of State for Health

Richmond House
79 Whitehall
London
SW1A 2NS

020 7210 4850

POC_1073014

Councillor Yvonne Constance,
Chairman Oxfordshire Joint Health Overview and Scrutiny Committee,
County Hall,
New Road,
Oxford,
OX1 1ND

- 3 JUL 2017

Dear Cllr Constance,

Review of Oxfordshire Clinical Commissioning Group's decision not to re-procure services at Deer Park Medical Centre, Witney - IRP Advice on Referral by the Oxfordshire Joint Health and Overview Scrutiny Committee

I am responding to your letter of 8 February 2017 referring the decision taken by Oxfordshire Clinical Commissioning Group not to re-procure services at Deer Park Medical Centre to the Secretary of State.

You referred this case on the basis that consultation with the public and patients at Deer Park Medical Centre was inadequate and the closure of the surgery would not be in the interests of residents and patients in the Witney area. As you know, I asked the Independent Reconfiguration Panel (IRP) for its initial advice on receipt of your referral.

The IRP has now completed its initial assessment and shared its advice with me. After careful consideration, the IRP is of the view that your referral does not warrant a full review and I accept the IRP's advice in full.

IRP advice

The IRP has considered the issues you raise in your letter. They recommend that Oxfordshire CCG should immediately commission a time limited project to develop a comprehensive plan for primary care and related services in Witney and surrounds. This strategic vision should not preclude the possibility of providing services from Deer Park Medical Centre.

The IRP have recommended that Joint Health and Oversight Scrutiny Committee should review its relationship with the NHS and work to ensure that this relationship commands public confidence.

A copy of the full advice is appended to this letter and will be published today on the IRP's website at www.irpanel.org.uk.

I am copying this letter to The Lord Ribeiro, Chair of the IRP.

Yours sincerely

Jeremy Hunt

JEREMY HUNT

6th Floor
157 - 197 Buckingham Palace Road
London
SW1W 9SP

The Rt Hon Jeremy Hunt MP
Secretary of State for Health
Richmond House
79 Whitehall
London SW1A 2NS

11 April 2017

Dear Secretary of State

REFERRAL TO SECRETARY OF STATE FOR HEALTH
Referral of Oxfordshire Clinical Commissioning Group's decision not to re-procure services at Deer Park Medical Centre, Witney

Thank you for forwarding copies of the referral letter and supporting documentation from Cllr Yvonne Constance OBE, Chairman Oxfordshire Joint Health Overview and Scrutiny Committee (OJHOSC). NHS England South (South Central) and Oxfordshire Clinical Commissioning Group (CCG) provided initial assessment information. A list of all the documents received is at Appendix 1.

The IRP has undertaken an initial assessment, in accordance with our agreed protocol for handling contested proposals for the reconfiguration of NHS services. In considering any proposal for a substantial development or variation to health services, the Local Authority (Public Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 require NHS bodies and local authorities to fulfil certain requirements before a report to the Secretary of State for Health may be made. The IRP provides the advice below on the basis that the Department of Health is satisfied the referral meets the requirements of the regulations.

The Panel considers each referral on its merits and concludes that **this referral is not suitable for full review because further local action by the NHS with the Committee can address the issues raised.**

Background

Primary medical care services (such as those provided by general practitioners) are commissioned under three main types of core contract - general medical services (GMS), personal medical services (PMS) and alternative provider medical services (APMS). APMS contracts allow the organisations responsible for commissioning primary medical care services to contract with a wide range of providers including those from the independent sector. Added flexibility allows commissioners to tailor

services to local needs. The health service reforms of 2012 placed responsibility for general practice commissioning with NHS England. However, in 2014/15, NHS England invited local CCGs to take on responsibility through one of three models – greater involvement, joint commissioning and delegated commissioning. More recently, new care models such as primary and acute care systems (PAC) and multispecialty community providers (MCP) have offered CCGs further options for developing and supporting general practice at scale, working with partners such as acute, community and mental health trusts. NHS England has stated that it wants national coverage of these two models to grow to 25 per cent in 2017/18 and 50 per cent by 2020.

Deer Park Medical Centre (DPMC) in Witney, Oxfordshire, provided primary medical care services for approximately 4,300 registered patients. There are three other practices in Witney (population approximately 23,000), within two miles of DPMC. The practice closed on 27 March 2017 prior to the end of the provider's contract on 31 March 2017.

In November 2010, the then Oxfordshire Primary Care Trust entered into an APMS contract with Virgin Care for the delivery of primary medical services at DPMC for a term of five years. The contract was extended in November 2015 for one year by NHS England South (South Central) as joint commissioner of primary care services with Oxfordshire CCG. In January 2016, The Oxfordshire Commissioning Board (incorporating the Joint Committee for Commissioning of Primary Care) took the decision to continue commissioning primary care services at DPMC for a further ten years and a procurement process began seeking to have a new contract in place for the provision of services from November 2016.

On 7 March 2016, in accordance with the requirements for tendering exercises, a notice was placed in the Official Journal of the European Union and Invitation to Tender (ITT) documents were published. The contract was offered at a bid price from the current GMS price upward, but with a ceiling of £95 per patient per year for the core costs. On 1 April 2016, Oxfordshire CCG became the fully delegated commissioner of primary care services.

Although five providers initially expressed an interest in tendering, and two retained an interest throughout the tendering period, ultimately only one bid was received by the closing date for submission of 11 April 2016. That bid, from Virgin Care, was based on a clinical model indicating 2.65 whole time equivalent (wte) GPs. At a meeting on 12 April 2016, Virgin Care representatives informed the Deer Park Patient Participation Group (PPG) that a bid for the new contract had been submitted.

The criteria set in the ITT documentation for short listing required bidders to have obtained a score of at least 60 per cent in the quality evaluation. An evaluation panel, comprising members from the NHS South (Central and West) Commissioning Support Unit procurement team, NHS England South (South Central), Oxfordshire CCG and Healthwatch took part in the evaluation process. Despite evaluation of its bid being assessed as slightly below the agreed threshold, Virgin Care was invited to present its bid to the CCG.

In line with its concerns about the financial envelope for the contract, Virgin Care in its presentation on 9 May 2016 confirmed that the level of GP provision offered was 2.0 wte. Further discussions to clarify the nature of the bid took place between May and July 2016 including a meeting between the CCG and Virgin Care on 28 June 2016. In particular, clarification was sought on the level of GP provision being offered and whether the proposed clinical model would deliver services to the expected standards whilst also taking account of anticipated population growth in the west Witney area. A meeting of the evaluation panel on 5 July 2016 concluded that Virgin Care had been unable to provide the necessary assurance on the reduced GP workforce model and covering of long and short term absence. The final score for the bid was revised down accordingly.

The Oxfordshire Primary Care Commissioning Committee (OPCCC) met on 4 August 2016 and, in the confidential session of its meeting, decided that a contract should not be awarded to Virgin Care on the basis that the bidder had failed to provide the necessary assurance about the clinical model and absence cover. It also decided that possible options should be explored and a virtual meeting held to deliberate and decide on the appropriate course of action.

Over the following two weeks, alternative local GP practices were approached to ascertain their capacity to accommodate Deer Park patients should the list be dispersed and also to explore whether any of the other practices would be willing to take on DPMC as a branch. No practice expressed a willingness to do so.

At an informal meeting with the OJHOSC on 11 August 2016, Oxfordshire CCG representatives provided the Committee Chairman with a confidential briefing on the Deer Park situation.

Between 17 and 19 August 2016, members of the OPCCC received and responded to a paper considering options and agreed not to undertake a further procurement on the basis that the previous exercise had resulted in only one bidder despite the

contract having been offered at a higher price than that paid to other practices in Oxfordshire. The decision was taken to disperse DPMC patients to other local primary care lists. Virgin Care was advised of the decision not to award the contract by letter on 19 August 2016.

During August and September 2016, negotiations took place between Oxfordshire CCG and Virgin Care about future arrangements for patients and staff at DPMC. The OJHOSC Chairman was updated on developments by email on 8 September 2016. The Deer Park PPG was informed by a representative of Virgin Care at a meeting on 13 September 2016 that no contract had been awarded following the procurement exercise. The OJHOSC was updated on the situation by a Chairman's report at a meeting on 15 September 2016. A contract extension to 31 March 2017 was agreed between Oxford CCG and Virgin Care on 19 September 2016. Representatives of Oxfordshire CCG, NHS England and Virgin Care met members of the Deer Park PPG on 21 September 2016 to discuss the closure of DPMC and the provision of necessary information to affected patients. The CCG wrote to all DPMC patients in a letter dated 22 September 2016 advising that no contract had been awarded and that having considered the alternatives the CCG, supported by NHS England, had decided to close the practice. The letter further advised that agreement had been reached for Virgin Care to continue providing services until 31 March 2017 to ensure that all patients had time to choose and register with another practice. The letter advised that patients did not need to do anything at that stage. More information on how to register with another local GP practice would be provided in January 2017.

A meeting of the OPCCC on 6 October 2016 was advised that an impact assessment and action plan in respect of the DPMC closure were being prepared. Also on 6 October 2016, representatives of Virgin Care, DPMC and Oxfordshire CCG attended a meeting of the West Oxfordshire District Council Economic and Social Overview and Scrutiny Committee to provide an update. The Deer Park PPG submitted a report outlining its concerns to the district council committee dated 25 October 2016.

In response to patient concerns and those of its members, OJHOSC and Oxfordshire CCG met on 17 November 2016 to discuss the CCG's approach to managing current pressures on general practice. An overview of the changes at DPMC was presented at the meeting and it was agreed to hold an informal meeting to examine a substantial change assessment (known locally as the toolkit) that had been completed by the CCG and which had concluded that the CCG's actions in respect of DPMC did not constitute a substantial change in service. The toolkit meeting was held on 12 December 2016. While the CCG maintained its position that the matter did not constitute a substantial change, the majority of OJHOSC members present concluded that it did.

Also in December 2016, a letter before action was issued on behalf of a local resident to Oxfordshire CCG giving notification of an application for permission to bring a judicial review of the decision to disperse the patient list. Permission to bring a judicial review was refused in early February 2017 and an appeal against the Court's decision was dismissed on 27 February 2017.

At a meeting of the OJHOSC on 2 February 2017, it was agreed to refer the matter to the Secretary of State for Health. A letter of referral was sent on 8 February 2017. The Oxfordshire CCG wrote to DPMC patients on 27 February 2017 advising that the surgery was closing on 24 March 2017 and offering advice on how to register with another practice.

The Secretary of State wrote to the Oxfordshire CCG on 14 March 2017 advising that he was satisfied that, based on the evidence presented to him that *"the option to continue the existing service expired some months ago, and that it is not now a safe or practical option".* The letter continued *"I wish to take this opportunity to reiterate that patient safety is my first and foremost priority and the priority of the NHS. It is therefore vital that all Deer Park Medical Centre patients should register with another surgery nearby, in line with the arrangement you have made, to ensure that, whatever the outcome of the IRP review, they have continued access to the services they need".*

The practice closed on 27 March 2017. It is understood that, as of 6 April 2017, around 1,000 DPMC patients have yet to register with another practice.

Basis for referral

The OJHOSC's letter of 8 February 2017 states:

"On 2 February 2017 the Oxfordshire Joint Health Overview and Scrutiny Committee (OJHOSC) unanimously agreed to refer the Oxfordshire Clinical Commissioning Group's (OCCG) decision not to re-procure services at Deer Park Medical Centre (DPMC), Witney to the Secretary of State for Health. This referral is made pursuant to Regulation 23(9) of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

and

"The Committee and the OCCG have been unable to reach agreement on whether the OCCG's actions regarding DPMC constitute a substantial change in service and no satisfactory local resolution has been found. This referral is therefore made, pursuant to Regulation 23(9)(a) and (c) of the 2013 Regulations, on the basis that consultation with the public and patients at DPMC was inadequate and the closure of the surgery would not be in the interests of residents and patients in the Witney area."

IRP view

With regard to the referral by Oxfordshire Joint Health Overview and Scrutiny Committee, the Panel notes that:

- referral on the grounds of inadequate consultation relates to consultation with the relevant scrutiny body - rather than wider consultation with patients, the public and stakeholders
- OJHOSC and Oxfordshire CCG were unable to reach agreement on whether the actions taken with regard to DPMC constituted a substantial variation in service provision
- the CCG asserts that any "lowering" of the threshold for considering what constitutes substantial would place a significant burden on NHS bodies and paralyse ongoing transformation work
- the use of APMS contracts offers added flexibility to commissioners in meeting local needs – however, attracting bidders for the contract within the financial envelope offered did not live up to expectations
- in the immediate period, Oxfordshire CCG's duty to ensure the safety and continuity of services for the patients affected by the closure is paramount
- there is an urgent need to put in place a comprehensive plan that will ensure safe, accessible and sustainable primary care and related services for the residents of Witney including anticipated population growth in the area
- the OJHOSC and NHS bodies need to review the effectiveness of their working relationship

Advice

The IRP offers its advice on a case-by-case basis taking account of the specific circumstances and issues of each referral. **The Panel does not consider that a full review would add any value. Further local action by the NHS with the Committee can address the issues raised.**

OJHOSC has referred this matter to the Secretary of State on two grounds – that the consultation undertaken was inadequate and that the proposal would not be in the interests of the health service in its area. In considering issues of inadequate consultation, the 2013 Regulations relate to consultation with the scrutinising body rather than wider consultation with patients, the public and stakeholders. The concerns expressed by the OJHOSC about the lack of consultation with interested parties are addressed in this advice on the basis of their not being in the interests of the health service generally.

The 2013 Regulations require NHS bodies to consult a local authority on any proposal under consideration for a substantial development of the health service in its area or a substantial variation in the provision of such a service. Evidence submitted by Oxfordshire CCG indicates that it entered into the tendering exercise in the expectation that a new contract would be awarded. On that basis, there was no reason at that time to believe that a substantial development or variation would take place. Nor is there any indication that, prior to the commencement of the tendering exercise, OJHOSC deemed the matter to be substantial though the extent to which the Committee was aware of the issue at that point is unclear. Nevertheless, when the OJHOSC was notified of the outcome of the tendering exercise, it was reasonable at that point to consider whether the CCG's decision to close DPMC constituted a substantial variation.

The Regulations do not define what constitutes a substantial development or variation. Well established good practice is that joint consideration through protocols agreed locally between HOSCs and the NHS can help in this respect. It is disappointing that in this instance, despite the existence and use of an established toolkit for determining whether or not the matter should be considered substantial, agreement could not be reached. The unilateral determination by the Oxfordshire CCG that the matter was not substantial was not helpful and undermined ongoing dialogue. The IRP considers that determining whether or not a proposal or action is substantial is a matter for joint agreement. In cases where agreement cannot be reached, the parties concerned should reflect on the fact that it is local authorities that were given the powers of scrutiny. The logical conclusion of this is that the local authority's view (or that of its delegated scrutinising body) should prevail.

The evidence submitted to the IRP by the NHS asserts that, were the commissioning arrangements relating to a 4,300 patient practice to be viewed as substantial, this would indicate a significant lowering of the threshold for the need for public consultation. This is misguided on two counts. First, the requirement to consult with a local authority scrutiny body does not automatically mean that a full, three month, public consultation is necessary. This is a matter for discussion depending on the nature of the subject matter and the circumstances pertaining locally. Secondly, where a full public consultation is not deemed necessary, the NHS is still required to

fulfil obligations around public and patient involvement[1]. Evidence prepared by the Deer Park PPG suggests that little, if any, work was undertaken either to inform or to seek the views of Deer Park patients or Witney residents before the tendering exercise began or once the outcome of the exercise was known. The IRP would have expected more to have been done, indeed evidence provided by the Oxfordshire CCG as part of its disclosure documentation for the judicial review application shows a considerable amount of public and patient involvement work undertaken to ascertain the views of residents affected by a parallel exercise in Banbury.

The belief expressed by the Oxfordshire Commissioning Board in January 2016 that the Deer Park tendering exercise would be *"quite a straightforward re-procurement"* can most charitably be described as complacent. Guidance from NHS England exists on managing the end of time limited contracts which sets out the first stage requirements that should inform a decision to recommission, procure or end a service. These include needs assessment, value-for-money, impact assessment and seeking the views of services users, local providers and other interested parties such as the local medical committee and the scrutiny body. It appears that this guidance was not followed. Consequently, when the CCG decided it could not award a contract, it had not done the background preparation for other options or for managing the risks that materialised.

It is unclear whether the financial policy to align the value of APMS contracts with GMS contracts is, in isolation, compatible with securing future services. Whether attracting bidders for this type of contract within the financial envelope offered was ever, or will be in the future, a realistic possibility must be open to question. However, that is not to say such situations will or should end with the closure or merger of affected practices. CCGs play a pivotal role in working with practices to shape and implement changes towards working at scale through hubs and networks as well as exploring alternative models such as PACs and MCPs. In this regard, Oxfordshire CCG, rather than simply accepting a practice closure such as DPMC, needs to be much more proactive, inclusive and forward thinking about the future of general practice and primary care.

That there are many lessons to be learnt from these events has been acknowledged by the Primary Care Commissioning Committee of the Oxfordshire CCG. The more

[1] Continuous engagement should be built into all practice relating to the strategic planning of services. NHS England has published new guidance *Patient and public participation in commissioning health and care: Statutory guidance for clinical commissioning groups and NHS England* "to support staff to involve patients and the public in their work in a meaningful way to improve services, including giving clear advice on the legal duty to involve". https://www.england.nhs.uk/wp-content/uploads/2017/04/ppp-guidance.pdf

pressing issue now, and the one that will be of most interest to Witney residents, is how to proceed for both the immediate and longer term benefit of the local population.

Secretary of State's letter of 14 March 2017 to the Oxfordshire CCG made clear that patient safety must be the priority. There are still some 1,000 DPMC patients who have yet to register with another practice. The CCG has a duty to provide medical care services for these people. The impact assessment and action plan produced in October 2016 set out steps to mitigate the loss of DPMC and it is imperative that plans are implemented as quickly as possible to ensure the continuity of care for the patients affected. The IRP has received mixed messages about the progress of dispersal and experiences of affected patients. The CCG must continue actively to pursue the objective that all former DPMC patients are registered as soon as possible. Healthwatch has been providing informal support and might usefully be more formally engaged in facilitating and evaluating progress.

General practice is one of the great strengths of the NHS and patients rightly expect and deserve high quality care from a familiar team of healthcare professionals they know and trust. Beyond the immediate needs of the patients affected, there is a longer term goal to secure the best primary medical services for the people of Witney and the surrounding area. The CCG should immediately commission a time limited project to develop a comprehensive plan for primary care and related services in Witney and its surrounds. At the heart of this must be the engagement of the public and patients in assessing current and future health needs, understanding what the options are for meeting their needs and co-producing the solutions. This work should seek to produce a strategic vision for future primary care provision in line with national and regional aims and should not preclude the possibility of providing services from the Deer Park Medical Centre in the future. Further, the work should be completed within six months and should be reviewed by a third party identified by NHS England so that residents can see a credible plan for delivering the services they need.

Having fully delegated the commissioning of primary care services to Oxfordshire CCG, it is NHS England's duty to monitor the performance of the CCG to ensure that it is properly executing its responsibilities. This applies both to the duty to provide primary medical services for those Deer Park patients who have yet to register elsewhere and the urgent action required to secure the services needed now and in the future.

Whilst there are many lessons to be learned from this case for the NHS, the Oxfordshire Joint HOSC should also reflect on the part it has played. The

Sustainability and Transformation Plan (STP), Oxfordshire Transformation Plan and self-evident problems of providing primary care in the county present a challenging agenda to be tackled. Involving the public and their elected representatives in a transparent way is critical to moving forward successfully. As part of this, the OJHOSC should review its working practices with the NHS to develop and sustain the open, no surprises, productive and effective working relationship that is required to command public confidence.

Yours sincerely

Lord Ribeiro CBE

Chairman, IRP

APPENDIX 1

LIST OF DOCUMENTS RECEIVED

Oxfordshire Joint Health Overview and Scrutiny Committee

1 Letter from Cllr Yvonne Constance OBE, Chairman OJHOSC, 8 February 2017

Attachments:

2 DPMC substantial change assessment, as completed by the OCCG, 12 December 2016

3 Record of the informal Committee meeting to discuss the OCCG's assessment, 12 December 2016

4 OCCG presentation for HOSC toolkit meeting on DPMC, 12 December 2016

5 Email form the OCCG – availability of appointments at DPMC, 13 December 2016

6 OCCG impact assessment – DPMC closure, 18 October 2016

7 Questions put to the OCCG Board on DPMC, 29 November 2016

8 OCCG report – *Primary Care in Oxfordshire*, presented to OJHOSC, 17 November 2016

9 OJHOSC minutes, 17 November 2016

10 West Oxfordshire District Council DPMC Working Party minutes, 9 November and 26 October 2016

11 West Oxfordshire District Council Economic and Social Overview and Scrutiny Committee minutes, 19 January 2017, 24 November 2016 and 6 October 2016

12 DPMC Patient Participation Group report for West Oxfordshire District Council Economic and Social Overview and scrutiny Committee, 25 October 2016

NHS

1 IRP template for providing initial assessment information

Attachments:

2 Disclosure documents of the defendant in the matter of a proposed application for judicial review between The Queen on the application of Yvonne de Burgo and Oxfordshire Clinical Commissioning Group

3 CQC inspection report, Deer Park Surgery, 21 November 2016

4 Minutes of Oxfordshire Commissioning Board meeting, 5 January 2016

5 Contract award report, SCW CSU/NHS England, 4 August 2016

6 Presentation to Oxfordshire CCG Primary Care Commissioning Committee, 4 August 2016

7 Presentation to Oxfordshire CCG Commissioning Board, 5 January 2016

8 Oxfordshire OCCG report, 23 February 2017

9 Impact assessment, 18 October 2016

10 Emails to IRP from Oxfordshire CCG, 29 March 2017, 3, 4, 6 April 2017 and attachments

11 Letter to Area Directors, Review of PMS contracts, NHS England, 3 February 2014

12 Implementing the 2016/17 GP Contract, NHS England, 6 April 2016

13 Virgin Care ITT submission

14 Q5 DPMC practice structure

15 Virgin Care clarification 30 June 2016

16 Part F, financial model template

17 OPCCOG draft minutes v3, 19 July 2016

18 Deer Park contract value comparisons, 13 December 2016

19 Tabled paper for OPCCOG, 19 July 2016

20 Monthly contract value comparisons for DPMC

Other information

1 Letter to Secretary of State for Health from Robert Courts MP for Witney, 1 March 2017

2 Letter to Secretary of State for Health from Robert Courts MP for Witney, 16 March 2017

3 Emails and attachments to IRP from representative of Deer Park Patient Participation Group, 16, 20, 21, 24 March 2017, 2, 5, 7 April 2017

4 Letter to Cllr B Churchill from Dr Carol Lole-Harris, 3 April 2017

5 Feedback forms from Witney residents, 1 April 2017

6 Submission to IRP and chronology from DPMC Patient Participation Group, 6 April 2017

7 Update from DPMC Patient Participation Group, 20 March 2017

8 Letter before claim re judicial review application, 5 December 2016

9 Correspondence from Witney Town Council, 4 October 2016, 11 November 2016, 9 December 2016

10 Oxfordshire CCG letters to DPMC patients, 26 September 2016, 2 February 2017, 27 February 2017

11 Email from NHS South Central and West CSU, 25 May 2016

12 NHS England Five Year Forward Plan – Next Steps, 31 March 2017

13 Sustainability and Transformation Plan covering Oxfordshire

14 Managing the end of time limited contracts for primary medical services, NHS England, June 2013

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Primary Care in Witney

Deer Park Medical Centre – update following response from Secretary of State

Background

A referral was made to the Secretary of State for Health (SoS) by the Oxfordshire Joint Health Overview & Scrutiny Committee (OJHOSC) in February 2017 relating to the decision by OCCG not to re-procure the Deer Park Medical Centre contract following the failure to award the contract in the first attempt. In March 2017 the referral was passed to the Independent Review Panel for initial assessment in line with the protocol for handling contested proposals for the reconfiguration of NHS services.

In a letter to the SoS, the Panel concluded that the referral was not suitable for full review because further local action by the NHS with the OJHOSC can address the issues raised. The SoS responded to JHOSC on 3 July 2017 with a copy of the IRP review and confirming he had accepted their recommendations in full. This letter was shared with the Oxfordshire Clinical Commissioning Group (OCCG) by OJHOSC, but initially there was no direct communication from the Secretary of State for Health with OCCG.

The full response from the IRP to the SoS is available here. In summary the Panel noted as follows:

- Regulations do not define what constitutes a substantial variation or development and determining this should be a matter for joint agreement. In the absence of agreement the local authority's (HOSC's) view should prevail.
- Requirement to consult with a scrutiny body does not necessarily mean a full 3-month public consultation is necessary and this should be locally agreed. If there is no full consultation, NHS should fulfil its obligations around public & patient involvement.
- OCCG should have carried out more involvement prior to the tendering exercise as per NHS England guidance (needs assessment, VFM, impact assessment and seeking views of patients and stakeholders). More involvement should also have been carried out once the outcome was known. *[NB the service was tendered prior to delegation therefore this would have been the responsibility of NHS England and the CCG under joint commissioning arrangements prevailing at that time].*
- OCCG needs to be much more proactive, inclusive and forward thinking about the future of general practice and primary care, rather than simply accepting a practice closure.

- Impact assessment and action plan was noted. Should be implemented swiftly to ensure continuity of care for patients.
- Healthwatch could be more formally engaged in facilitating and evaluating progress against action plan.

On 25 July 2017 NHS England wrote to the CCG confirming expectations that the CCG would address the recommendations from the IRP and in particular:

- The CCG must continue actively to pursue the objective that all former DPMC patients are registered as soon as possible
- The CCG should immediately commission a time limited project to develop a comprehensive plan for primary care and related services in Witney and its surrounds. This needs to be linked to, and integrated with, the wider CCG and STP plans for the whole of Oxfordshire. This work should seek to produce a strategic vision for future primary care provision in line with national and regional aims and should not preclude the possibility of providing services from the Deer Park Medical Centre in the future.

NHSE confirmed that they would seek to identify a third party to review the plan.

Specific recommendations & OCCG planned action

At its meeting on 5 September 2017 the Oxfordshire Primary Care Commissioning Committee (OPCCC) reviewed and agreed the approach outlined below. OPCCC noted that the approach taken by OCCG to planning engagement in primary care has developed over the past year and now follows a template that has been developed and used consistently following the learning from Deer Park.

1. ***CCG should commission a time limited project to develop a comprehensive plan for primary care and related services in Witney and its surrounds. Engagement with the public and patients is required in assessing current and future health needs, understanding options and co-producing the solutions. This should not preclude the possibility of providing services from DPMC in the future. To be completed in 6 months and reviewed by a third party identified by NHS England so that residents can see a credible plan for delivering the services they need.***

   OCCG is already taking forward analysis, engagement and forward planning for primary care services in and around Witney through the locality group (as part of the overall work being undertaken on development of place based plans for all parts of Oxfordshire) . The West locality plan is already in progress as part of the strategic development of locality place based plans. Patient and stakeholder engagement and involvement is an integral part of this process and plans will be tested with PPGs, local councillors and the HOSC. It is proposed that the Locality Plans will be ready for publication (following engagement and input) in early December 2017.

In addition

- A proposal for wider engagement supported by the Locality Forum Chairs and Healthwatch has been agreed with the locality Forum Chairs. All Locality For a will host events to allow a wider discussion with local people about the developing locality plans. OCCG and Healthwatch would provide support for these events by preparing materials, supporting developing a programme and facilitation at the event. These will allow PPG members to have opportunities to understand the emerging plans and to share their views with OCCG. They could also attract members of the public whose interest in primary care could also lead to an interest in joining their practice PPG. The date for the meeting in the West is not yet agreed but will be in the autumn.
- OCCG are meeting with the West Locality Forum Chair and Healthwatch on 7 September 2017 to consider approaches to ensuring wider patient and public engagement in this work to assess current and future needs. A verbal update will be given to the Committee.
- On 8 September OCCG are meeting with local patient representatives (ex Deer Park Medical Centre Patient and Participation Group members), Healthwatch and Robert Courts MP to discuss the IRP report and OCCG's response to developing a plan for Witney within 6 months. A verbal update will be given to the committee.
- As agreed prior to receipt of the IRP report Healthwatch are working with OCCG to facilitate a workshop with those concerned with planning health and other services in Witney and surrounds. This will take place in September.

2. NHS England to monitor the performance of the CCG, including ensuring provision of primary medical services for Deer Park patients yet to register elsewhere and the urgent action required to secure the services needed now and in the future.

As at 27 July, 400 patients on the Deer Park list had not yet registered elsewhere. This is in line with other practice closures where a proportion of patients do not register in the immediate period following closure. We are satisfied that all patients have been notified of the need to register elsewhere and offered support to do so via a range of different methods and we feel that it is safe to assume that the remaining patients have either moved away from the area or have made an informed choice not to re-register at this point.

All patients have been able to transfer to a practice of their choice within Witney or in the surrounding rural area. All practices were able to maintain open lists throughout the period of transition in order to accommodate the patients. Support in managing the additional pressures on local practices who have taken on the new patients has been provided by the local GP federation, who have provided additional GP and nurse consultations at the Witney GPAF hub and support from emergency care practitioners to carry out urgent home visits. Recent feedback from practices and the federation indicate that the situation is stable in Witney and patients are able to access high quality clinical services. It should be noted

though that pre-existing pressures on services due to recruitment problems are still ongoing in this locality as in other parts of Oxfordshire.

3. NHS England arrangements to review plan

NHS England have approached two companies to get proposal for independent review of the plan to develop primary care in Witney and surrounding areas that OCCG will develop.

The Oxordshire Joint Overview and Scrutiny Committee is asked to note the approach proposed and highlight if there are any other actions they wish to see taken.

Catherine Mountford
Director of Governance
06 September 2017

Oxford Health
NHS Foundation Trust

From the Chief Operating Officer
Warneford Hospital
Warneford Lane
Oxford OX3 7JX
www.oxfordhealth.nhs.uk

4th September 2017

Oxfordshire Joint Health Overview and Scrutiny Committee
Oxfordshire County Council
County Hall
New Road
Oxford OX1 1ND

Dear Committee members,

Proposed Relocation of Stroke Rehabilitation Services from Witney to Abingdon

I am writing to ask HOSC to consider a proposed service change: the relocation of stroke rehabilitation beds from Witney to Abingdon. We do not believe that these changes require consultation or formal HOSC approval, but felt it appropriate to sight HOSC on them in advance of making the proposed changes so that Members have the opportunity to consider and discuss them. I and relevant clinical colleagues have arranged to attend the next session of HOSC on 14th September to discuss the matter further and take questions.

The Proposed Change

Currently, patients who have had a stroke are seen at OUH or Royal Berkshire Hospital for the first, 'hyperacute' phase of their illness. Following a period of stabilisation some patients with on-going intensive rehabilitation requirements are transferred to specialist stroke rehabilitation beds. These are located at the John Radcliffe, our community hospitals in Witney and Abingdon, and a similar unit at the Horton.

Our proposal is to move 10 stroke rehab beds from Witney to Abingdon to create a dedicated, 20-bedded ward. These beds will not close - they will be used instead for general rehabilitation, typically after an acute stay for another medical event. There is therefore no intention to reduce bed numbers in Witney - we will just change what we do with those beds.

It is preferable to do this in Abingdon rather than Witney, since the two Witney wards are each significantly larger than the required 20 beds, meaning that we would be unable to provide a dedicated stroke ward without reducing the overall number of community hospital beds.

Approximately 150 patients will be affected each year: 75 stroke patients currently treated in Witney, and a similar number of general patients currently treated in Abingdon.

Currently approximately 95% of patients that undergo rehabilitation within the Witney stroke unit are from Oxford and areas to the north and west of the county. Under our proposal, these patients (approximately 70 per annum), would be treated in Abingdon.

A similar number of inpatients who would currently be treated in Abingdon will need to use other community hospital facilities. We already offer 'generic' beds at Bicester, Didcot, Oxford City, Wallingford and Witney. We will also continue to run a 'generic' ward at Abingdon next door to the stroke ward. Patients will be offered a bed at these sites, as now, based on the first available bed.

Informal discussions have started with staff at both sites, and there is a joint project group considering the implications of the proposed changes for staff, patients and carers. It is intended that a formal staff consultation will be commenced shortly, in line with normal Trust HR standards. No redundancies will result from these proposed changes.

Oxfordshire CCG, OUH and colleagues from OCC Adult Social Care have all confirmed their support for the proposed changes. We have yet to commence formal engagement with patients/carers, stakeholder groups and HealthWatch, since we felt it appropriate to approach HOSC first. However, our intention is to engage more fully with key stakeholders following the HOSC discussion.

We plan to make these changes from 1st November.

Rationale for the Proposed Change

There are several reasons why we want to make these changes, and why we want to make them now.

- **We believe this will improve flow in the system.** It is much harder to achieve a smooth flow of patients with small patient cohorts. The average course of treatment in stroke rehab is about 30 days. This makes lining up admissions and discharges difficult when, on average, we are discharging one patient every 3 days from each site. A small delay in discharge can prevent an urgent admission, and the lack of a suitable patient on any day may mean a bed going unused. This is true for both stroke and general rehabilitation patients - locating similar patients together in larger cohorts generally makes it easier to manage flow. This is particularly pertinent at a time when there is great pressure on beds in the system due to the decant from the JR Trauma Unit, which is why we are proposing to make these changes now. We certainly need them to be in place prior to winter.
- **Workforce challenges.** Stroke therapy requires a concentration of different specialist disciplines: speech and language therapy, physiotherapy, occupational therapy and others. It also requires expert medical cover. We have been finding it extremely difficult to recruit and retain these staff across two sites. We believe that locating stroke rehab on one site will give us a much better chance of filling our staffing rosters.
- **Quality.** We want to provide high quality clinical supervision and a pathway that conforms fully to national specifications, principally the Royal College of Physicians Stroke Guidelines

(see relevant extract in the attached Appendix). This is much harder to achieve across two sites than one.

The benefits described above will address the following priorities in the Oxfordshire Health & Wellbeing strategy:

- Priority 5: Working together to improve quality and value for money.
- Priority 6: Helping adults with physical disability and long term conditions to live independently and achieve full potential.
- Priority 7: Support older people to live independently with dignity whilst reducing the need for care and support.
- Priority 8: Preventing early death and improving quality of life in later years.

We look forward to discussing our proposal with you on 14th September and very much hope that HOSC will support it.

Thank you and best regards.

Yours sincerely,

Dominic Hardisty, Chief Operating Officer and Deputy Chief Executive

Appendix: Extract from Royal College of Physicians Stroke Guidance 2016

A stroke rehabilitation unit should predominantly care for people with stroke.

A stroke rehabilitation unit should have a single multi-disciplinary team including specialists in:

- *medicine;*
- *nursing;*
- *physiotherapy;*
- *occupational therapy;*
- *speech and language therapy;*
- *dietetics;*
- *clinical neuropsychology/clinical psychology;*
- *social work;*
- *orthoptics;*
- *with easy access to pharmacy, orthotics, specialist seating, assistive technology and information, advice and support for people with stroke and their family/carers.*

A facility that provides treatment for in-patients with stroke should include:

- *a geographically-defined unit;*
- *a co-ordinated multi-disciplinary team that meets at least once a week for the exchange of information about in-patients with stroke;*
- *information, advice and support for people with stroke and their family/carers;*
- *management protocols for common problems, based upon the best available evidence;*
- *close links and protocols for the transfer of care with other in-patient stroke services, early supported discharge teams and community services;*
- *training for healthcare professionals in the specialty of stroke*

DIRECTOR OF PUBLIC HEALTH FOR OXFORDSHIRE

ANNUAL REPORT X

Reporting on 2016/17
Produced: August 2017

Contents

Foreword

Every Director of Public Health must produce an Annual Report on the population's health.

This is my 10th Annual Report for Oxfordshire.

It uses science and fact to describe the health of Oxfordshire and to make recommendations for the future.

It is for all people and all organisations.

I hope you find it interesting, but more than that I hope it is found to be useful in shaping the County's services for the future.

I am responsible for its content, but it draws on the work of many too numerous to name. I thank you all for your help, support and encouragement.

With best wishes,

Dr Jonathan McWilliam
Director of Public Health for Oxfordshire.
August 2017

Chapter 1: The Demographic Challenge

Let's keep this simple.

There are two major challenges facing Oxfordshire:

- How do we cope with the increasing stresses and strains a growing population brings?
- How do we keep children and adults of all ages healthy so that disease is minimised as the population grows?

Of course there are many other problems and issues, but these two are the overwhelming ones, and this report looks at these two issues from many different angles.

This chapter focusses on the first of these two – the demographic challenge.

The demographic challenge is a challenge because of 5 interlocking factors:

1. The population is growing
2. The population is ageing
3. The proportion of older people is increasing
4. Public expectations are high
5. Money is tight

A further problem is rapidly approaching which will further complicate matters – being overweight is the new norm in adults and increasingly prevalent in younger people, and this will inevitably lead to higher levels of disease – but that's for chapter 4.

Disadvantage also acts as a brake to stop people achieving their full potential and this is another confounding factor – you will find that topic in chapter 3.

Population growth means we have to plan our communities better and poor air quality - generated by more people and more activity – is an important issue - covered in chapter 2.

All of these changes put stresses and strains on the mental wellbeing of young people – see chapter 5.

…… and of course, let's never forget the shadow cast by infectious disease – sleeping, but not defeated - chapter 6.

So let's look first at population growth and population ageing.

Population Growth

Between 2000 and 2015, the total population of Oxfordshire increased by 70,700 people (+12%) compared with 11% across England.
Plans for a significant expansion in new housing, following the Oxfordshire Strategic Housing Market Assessment, imply a growth in the population of Oxfordshire over the next 15 years of more than double that of the previous 15-year period.

Oxfordshire County Council population forecasts, based on expected housing growth, predict an increase in the number of Oxfordshire residents of 183,900 people (+27%) between 2015 and 2030.

This is a massive increase by any standards and will put a huge strain on our already stretched infrastructure such as roads and schools- a factor I will pick up in chapter 2.

Will Government funding of statutory services keep pace? No one knows the answer, but we do know that health and social services are already stretched to breaking point.

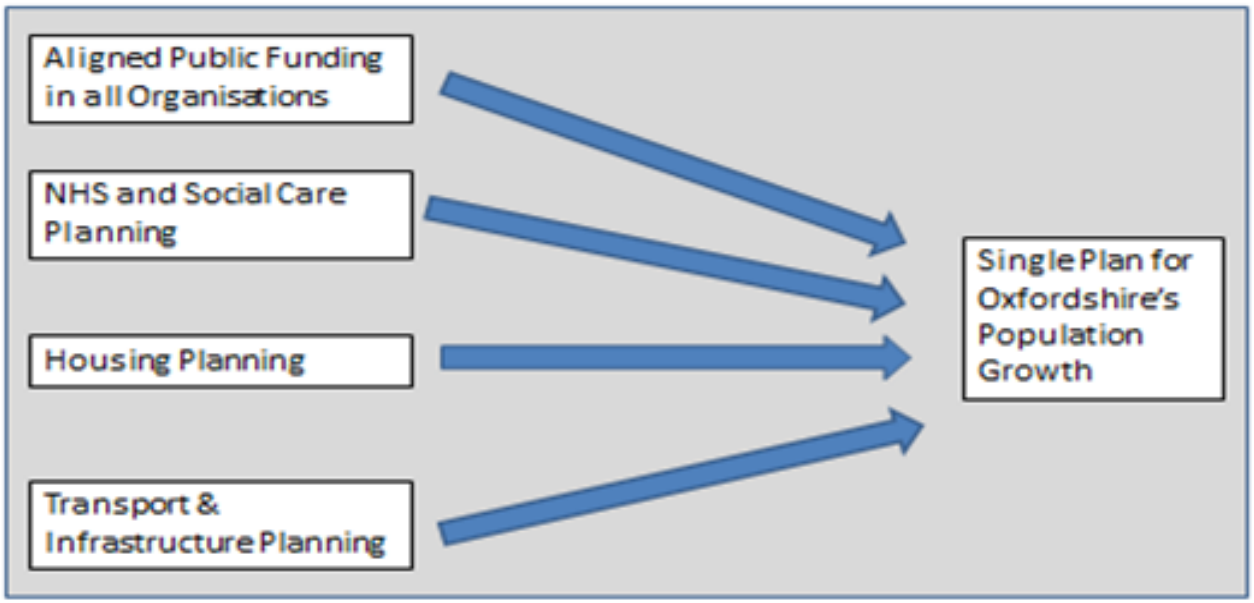
What we also know is that the old ways of doing things aren't likely to cope with such an increase as they stand. Our planning systems need to work far more slickly and intelligently if we are to have the transport systems people will demand. The daily commute will become increasingly tortuous and movement more difficult. Perhaps home working and IT solutions point the way forward.

Of course, people tend not to like change – it's hard-wired into us. During the last year local NHS organisations put forward proposals about radically changing the way hospitals and community services might be changed to cope with this pressure. The response was - to put it mildly - mixed. It's like one of those problems in which you push the problem down in one place but that makes it pop up in another – for example, the NHS proposed increasing the care carried out by people coming to hospitals for the day (ambulatory care), but it is outside the NHS's remit to plan for the increase in journeys and traffic and parking that implies, and so another problem is created.

All of this means that the problem of population growth is too big for any one organisation to cope with alone – we need to harness plans for housing, transport, the NHS and social care to the same yoke so that we can plough a single furrow.

We haven't solved this yet but the problem is staring senior executives and senior Councillors in the face. Necessity will, as always, drive the solution, and the solution we need is to craft a unified planning system.

In simple terms it will need to look something like this:



There are signs that we are closer to this than ever before, and these have occurred during the last 18 months. These are:

- Council Leaders and the NHS, Local Enterprise Partnership and the Universities debating new forms of local Government and Devolution
- The NHS trying to join up the currently fractured system through a single plan
- The Hospital Trusts and Universities reaching out to Local Authority planners to seek a `joined up' approach.

This is good. These are green shoots. They cause much controversy, but they are clear signs that all the big organisations are saying 'we can't go on as we are' and that is always the first step. No one knows where it will lead, but we seem to have begun the journey, and this is to be welcomed, for the problem of population growth is very real and the solution is likely to be radical.

Expected growth in housing

The plans for housing growth recommended for Oxfordshire shed a factual side-light on the scale of future population growth. In April 2014 the Oxfordshire Local Authorities, published the Strategic Housing Market Assessment (SHMA) for Oxfordshire.

The Assessment suggested that the demographic trends and growth of the County economy and the level of affordable housing required would necessitate **100,060** additional new homes in Oxfordshire between 2011 and 2031. More houses mean more people. There are currently over 600,000 people living in Oxfordshire. 100,060 more houses will swell this number considerably.

Up to the end of March 2016, just under 11,700 homes had been built in Oxfordshire and, since 2011, the year with the highest rate of housing completions was 2015/16 with 3,350 homes built. This leaves a remaining requirement of 88,400 new homes to be built by 2031, or just under

6,000 homes per year for each of the next 15 years. This is a contentious topic and is much debated. Where will the houses go? When exactly will they be built? Will they be grouped to make best use of the 'developer contributions' which can fund the sensible road and transport links we need? The risk is that a piecemeal planning system which doesn't take a view of the whole is less likely to help. This is another reason why organisations need to pull together if we are to cope.

The Strategic Housing Market Assessment represents a view of how Oxfordshire 'should' grow in the national context. Of course it's not just about houses. Houses mean people and people mean more roads, more schools and more workplaces….and more diseases. More people also implies a much higher volume of attendances at GP surgeries and hospitals and more need for social care. All of this requires careful planning and, as highlighted in previous annual reports, there is a widely shared view that our current planning processes are fragmented and won't cope well as they stand. Hence the need to move towards a single planning process.

During the year, a useful start has been made on this and the infrastructure requirements of all organisations across the County have been drawn together in one place in a document called Oxfordshire Infrastructure Strategy. This is a start and is to be applauded. The question is, can this be used to make the disparate cogs of the planning process turn as one smooth machine to serve local people? Only time will tell.

Where will the nurses, home care workers and ancillary staff come from?

The very real and tangible effects of population growth, the relative prosperity of Oxfordshire, low unemployment and sluggish housing growth of affordable housing all combine to create a very big problem for services.

It is becoming increasingly difficult to recruit the staff we need to fill nursing, caring and ancillary posts. In the last few weeks, I attended meetings where the hospital and social care services were spelling this out very clearly. Some hospital wards are for example reported to be running with 25% vacancies. This is unlikely to be sustainable. Looking at local house prices sheds light on this and underlines the problems of high house prices in Oxfordshire. The statistics are as follows:

Housing affordability

- In 2016, house prices in Britain were 10 times the annual salary of residents.
- **Oxford was the least affordable city, with house prices being 16.7 times higher than annual earnings** - on a par with London.
- Burnley was the most affordable city, with house prices being 4.1 times the average annual earnings – 4 times more affordable than Oxfordshire.
- All the top 10 least affordable cities were located in the South of England. The majority of the most affordable locations were in the North West and Yorkshire regions.

Here is the relevant table.

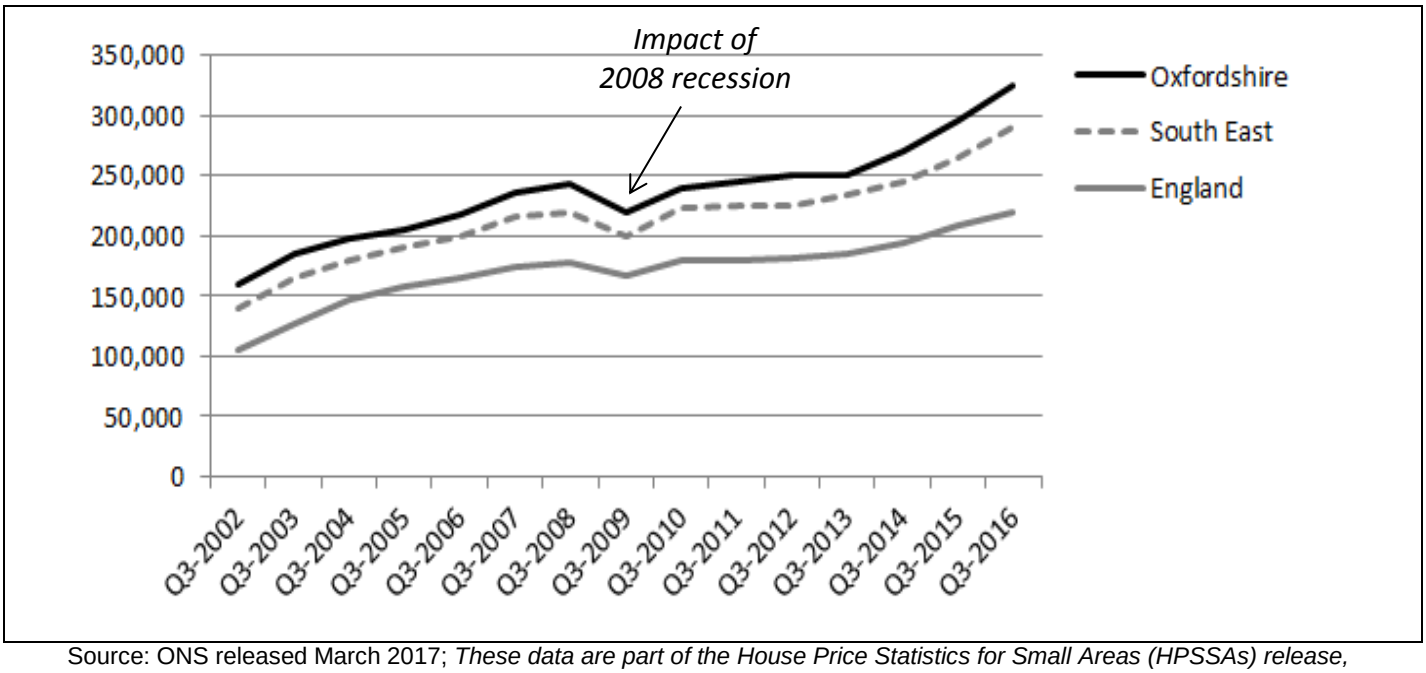
Housing affordability ratio

Rank	City	Affordability ratio	Average house price, 2016 (£)	Yearly wages, 2016 (£)
10 cities with the highest affordability ratio				
1	Oxford	16.7	491,900	29,400
2	London	16.7	561,400	33,700
3	Cambridge	15.8	475,800	30,100
4	Brighton	13.7	367,900	26,800
5	Bournemouth	12.5	309,300	24,700
6	Aldershot	11.6	360,400	31,200
7	Reading	11.3	375,200	33,300
8	Worthing	10.7	279,100	26,100
9	Exeter	10.5	253,500	24,100
10	Bristol	10.4	275,900	26,600

Trends in house prices

Over the past 10 years the increase in the median (mid-point) house price in Oxfordshire has been above the South East region and England. Between 2006 and 2016, the median price of housing in Oxfordshire increased from £218,000 to £325,000, an increase of 49% compared with 46% in the South East and 33% in England. The districts seeing the highest increase were Cherwell (60%) and Oxford (60%). In other words, the local affordability gap is getting worse compared with England.

Median house price 2002 to 2016



Source: ONS released March 2017; *These data are part of the House Price Statistics for Small Areas (HPSSAs) release, produced by ONS. These statistics report the count and median price of all dwellings sold and registered in a given year. They are calculated using open data from the Land Registry, a source of comprehensive record level administrative data on property transactions.*

Median house price 2006 to 2016

	Q3-2006	Q3-2016	Q3-2006 to Q3 2016	
Cherwell	£183,000	£292,250	*£109,250*	*+60%*
Oxford	£235,000	£375,000	*£140,000*	*+60%*
South Oxfordshire	£241,100	£355,000	*£113,900*	*+47%*
Vale of White Horse	£225,000	£325,000	*£100,000*	*+44%*
West Oxfordshire	£212,000	£300,000	*£88,000*	*+42%*
Oxfordshire	**£218,000**	**£325,000**	***£107,000***	***+49%***
South East	£198,950	£290,000	*£91,050*	*+46%*
England	£165,000	£220,000	*£55,000*	*+33%*

Source: ONS, released March 2017

All services are trying to find new ways to address this problem, and we are likely to need to look beyond the county boundary to developments around, say, High Wycombe to find the solution. Other options such as building hostels for workers are also being considered.

I have dwelt on housing prices because they illustrate with crystal clarity why the demographic challenge is real, it is here now, and it our most pressing challenge.

The ageing population

It is a blessing and a great achievement that people are living longer, often into a productive and active old age…… But it brings with it a new raft of issues for society to deal with…….

Growth of the population aged 65+

Between 2015 and 2030, Oxfordshire County Council predicts that the growth of people in the age group 65+ to be, 62,700 or **an increase of 53%.** This takes into account the plans available for new housing.

Growth of the population aged 85+

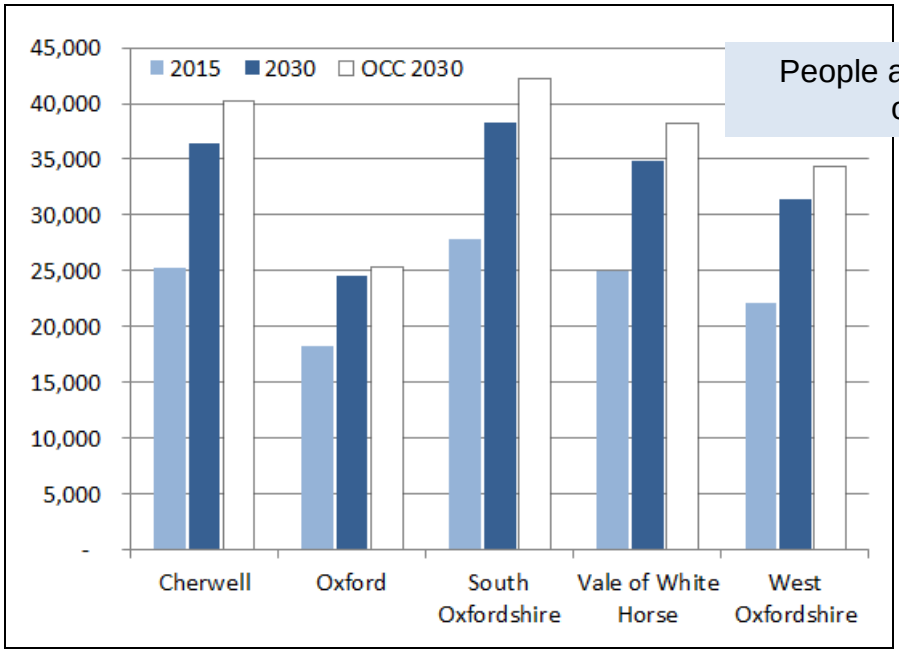
Between 2015 and 2030, Oxfordshire County Council predicts that the increase in people aged 85 and over in Oxfordshire to increase by +15,600 or **an increase of 96%** - a huge percentage increase.

Why does this matter? It is to be welcomed that life expectancy is increasing and in terms of opportunities it has been said that “70 is the new 50”. But in planning terms it presents a serious dilemma. It matters because as well as being simply more people, it means more people in the age group who experience most long term disease and disability, and, with advances in treatment and care that means more expense per head than in previous decades….. and not only that…….

……It matters also because at the same time the proportion of older to younger adults is increasing and this puts a pressure on the tax-base. Every penny going into the exchequer has to be made to go further while the demand on every pound increases.

Looking at this in more detail, different parts of the county are affected differently. The chart below tells the story. It shows the 65 plus population in 2015 and then shows two growth scenarios for 2030. The middle bar in each group shows the growth without house building and the bar on the right of each group takes account of what we know of planned housing growth.

Forecast growth in the number of people aged 65 and over between 2015 and 2030– ONS vs Oxfordshire County Council projections



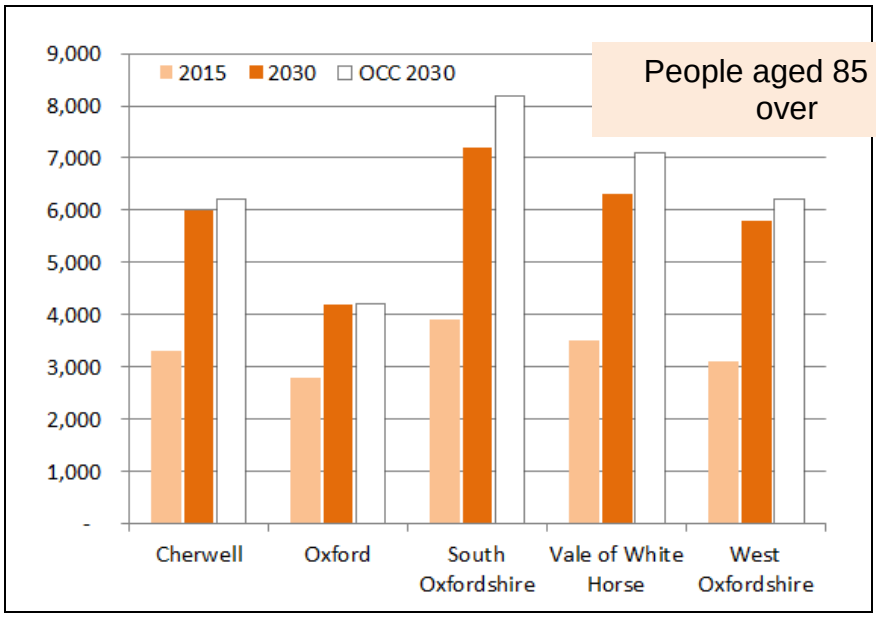
Source: ONS 2014-based sub-national population projections and Oxfordshire County Council released December 2016 including assumptions on expected housing growth

It shows that:

- The rate of growth is pretty evenly spread across all Districts
- Housing increase swells the numbers considerably, apart from in Oxford where housing growth is constrained

Looking at the same data for over 85's using the same format gives the picture below:

Forecast growth in the number of people aged 85 and over between 2015 and 2030
ONS and Oxfordshire County Council projections



Source: ONS 2014-based sub-national population projections and Oxfordshire County Council released December 2016 including assumptions on expected housing growth

It shows that:

- There is uneven growth. The city is the outlier as it has a 'younger' population.
- Housing growth adds to the predicted rise more in South Oxfordshire and Vale of the White Horse than elsewhere.

OK, one might ask, so ***the population is ageing, but is it getting healthier?***

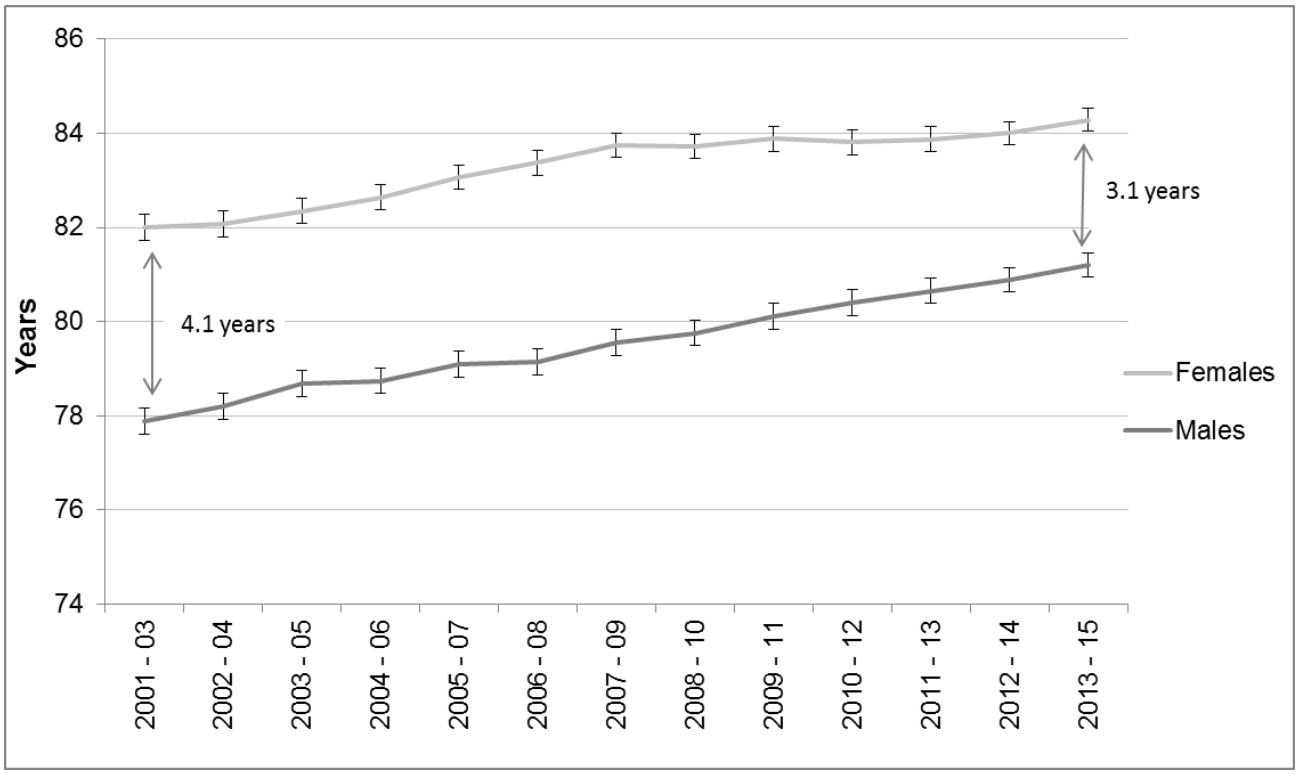
……An interesting question with no easy overall answer.

We can shed light on it by comparing two statistics.

The first is called 'life expectancy at birth' which estimates the average number of years a person born in an area could expect to live if they were to experience that area's mortality rates in the future. It's a best estimate, as no one really knows the exact answer.

It predicts that both males and females will continue to live longer. The gap between male and female life expectancy in Oxfordshire is narrowing. The gap in 2013-15 is the same as it was in 2012-14. A similar narrowing can be seen for England and in the South East region, so this is a national trend.

Male and female life expectancy at birth in Oxfordshire, 3-year rolling data for 2001-03 to 2013-15



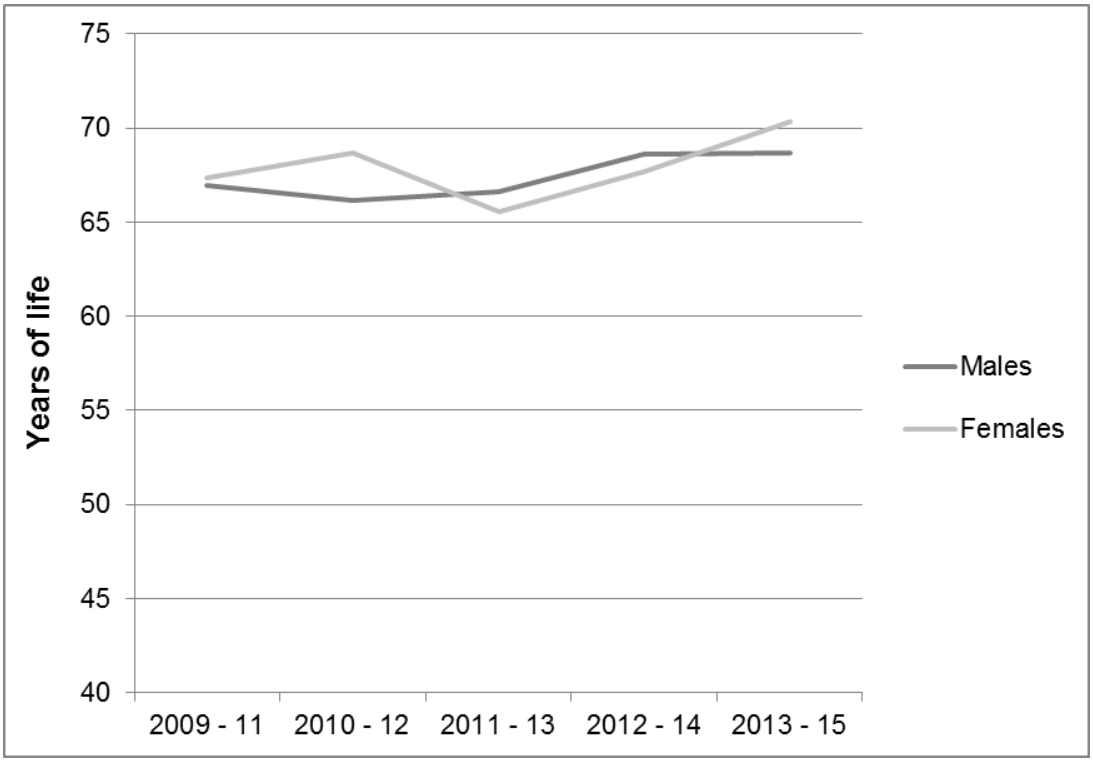
Source: Office for National Statistics (ONS). Vertical axis starts at 74 years, not zero

So far so good – longer life is the engine which drives the demographic challenge with regard to ageing, but the big question is ***are we ageing well or will more older people add to the demand for health and social care?***

A second statistic called 'Healthy Life Expectancy' points towards an answer. This statistic estimates how long we can expect to live in a reasonable state of health.

The picture is shown over the page:

Healthy Life expectancy at birth in Oxfordshire (2009-11 to 2013-15)



It shows that, on average, healthy life expectancy lasts into one's late sixties and the trend is moving slowly upwards – which is a good thing, BUT it isn't increasing as fast as average overall life expectancy……

So we can conclude that ***an ageing population will indeed create a further increase in demand for services because 'good health' isn't increasing as fast as 'long life'.*** This in turn means that services really do need to adapt quickly to demographic change, or, other things being equal, they will simply not cope.

What should we do about it?

Keeping it very simple again, and assuming the exchequer doesn't find a crock of gold any time soon, the answer would seem to contain the following elements:

1. Stay in good health for longer through preventing ill health

2. Coordinate all health and social care services so that they pull together, using new technologies to find new solutions

3. Create a single planning system for Oxfordshire encompassing health, social care, housing, and infrastructure planning

4. Be open to new ways of doing things because……

The demographic challenge means the change is inevitable.

What did we say last year and what progress has been made?

Last year's recommendations have essentially been met. They talked about the need to have a full debate about the NHS's consultation and to scrutinise it thoroughly. The recommendations also proposed that health and social care should be better integrated and more should be done to prevent disease before it starts. So what has been achieved? Looking at the big picture:

- The NHS has put forward significant proposals for change to meet these challenges in a lengthy consultation. Its reception was mixed to say the least. Overall, I think the need for change was broadly accepted, but the specific changes put forward proved controversial. A decision has now been made and is currently being challenged – we await the results.

- Local Government leaders have debated publicly the need to pull together via the many different proposals for reshaping Local Government and through devolution proposals. This has also proved to be very contentious.

- Integration of health and social care has moved forward through the Government's new 'Improved Better Care Fund' and we have a new Director of Adult Social Services in post who is reviewing current arrangements thoroughly so that we can move forward.

- The basics of prevention are in good order (immunisation, screening, maternal health etc.), but organisations have not been able to release funding to make a further step change as tight budgets are swallowed by the immediate service needs of today.

What should we do next?

Again, keeping it very simple, essentially we need to resolve these issues and move on – which is what we are all trying to do. It sounds easy but in practice it is difficult because the precise solutions are not obvious and so debate continues. However, being locked in debate and achieving little is unlikely to suffice for long. Perhaps we need to find a 'good enough' solution that everyone can agree to live with so that we can move on. I understand that this is a re-statement of the obvious, but I am hoping it might help to do just that. The key is that these are interlocking issues that need to solved as a single whole.

Recommendations

1. The NHS, County Council, District Councils, Universities and the Local Enterprise Partnership should pull together to resolve the current debates about 4 topics:

   - What is the best shape for NHS services for Oxfordshire?

   - What is the best way of achieving a sensible integration of health and social care - including local democracy in health care planning?

   - How can all organisations pull together a 'masterplan' to tackle issues such as the future use of NHS sites in Headington and Banbury, including travel and transport issues, so that services are improved and the 'knowledge economy' boosted?
   - How should housing growth be best coordinated so that developments and their supporting infrastructure are planned as one?

2. Local Government organisations should work together to create a single planning framework including 'health and social care planning', housing planning and infrastructure planning as a single whole.

3. All organisations should agree how to fund a step change in preventative services.

Chapter 2: Building Healthy Communities

For the last two years I have concentrated on public health aspects of the built environment. This year I want to combine that topic with a focus on air quality because two are closely connected in terms of solutions. I will look at air quality first.

Air quality

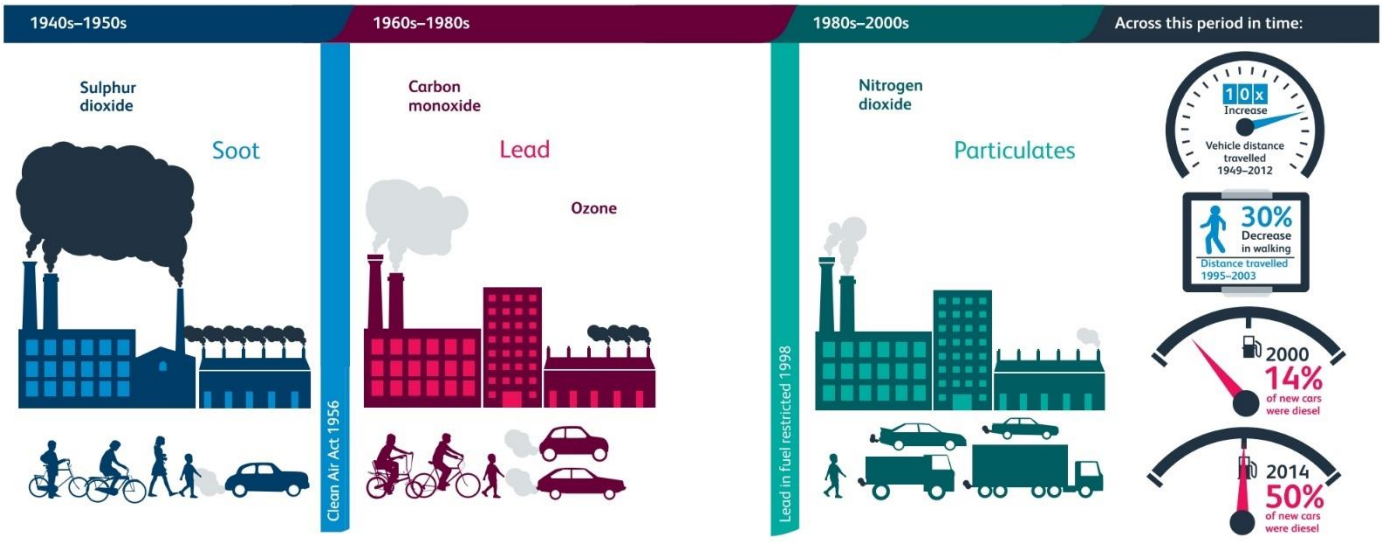
Air quality is a complex topic and I want to approach it from a Public Health point of view. The history of the long term improvement of the air we breathe is a jewel in Public Health's crown.

It's also an interesting topic because it underlines a historical truth of all public health activity – you solve one problem and another rises up to take its place.

Just as beating off many infectious diseases leads to the challenges of long life, and just as improving prosperity and diet leads to the challenges of obesity, so it is with air quality.

In this case it's an issue of scientific advances revealing underlying problems we didn't know were there before – in this case the problems of 'particulates' in the air and their health consequences.

The history of Public health and air quality is summarised in the following schematic:



This shows that in the 19th and 20th centuries the big problem was soot from coal fires and industry – which we solved. In the mid to late 20th century the big problem was lead, mainly from petrol – which we solved.

The new problem is oxides of nitrogen - nitrogen dioxide and its family of gasses – shorthanded as NOx. This has grabbed the headlines recently and is now being grappled with by Government because it is the only atmospheric pollutant where the UK fails to meet EU standards and the Government have been obliged to tackle this by the High Court.

Road transport makes up 38% of all NOx pollution, and it is highly concentrated in towns & cities where people live. Road traffic continues to grow: between 2000 – 2015 the number of licensed

cars increased from 24.4m to 30.3m. Diesel cars, the worst offenders when it comes to nitrogen oxide, have increased their share of the car market from 12.9% to 37.8%. The widely reported controversy over the accuracy of testing vehicles for particulate emissions has helped to push this issue to the top of the agenda.

Historically the problems of air pollution have generally been solved through national and European standards and legislation. There is a huge debate raging as I write about the Government's proposals to tackle NOx. This includes extending initiatives such as clean air zones and whether responsibility should sit at national or local level. Whatever the outcome of that debate, money remains tight and we need to seek out low cost options we can start to do today.

In this report I want to concentrate on what we can do NOW in Oxfordshire and under our own steam as individuals and within current organisational budgets irrespective of Government's deliberations

Let's look in more detail at particulates in the air

In the 1990s it was felt that air pollution was no longer a major health issue in the United Kingdom. Legislation had made the great smogs of the 1950s a thing of the past. But evidence started to emerge that small particles emitted to the air from various sources, such as road transport, industry, agriculture and domestic fires, were still having an effect on health. This type of air pollution is so small that it can't be seen by the naked eye, but can get into our respiratory systems. For example, nitrogen dioxide and sulphur dioxide are produced by burning fuel, whilst ozone is formed by chemical reactions in the air.

The scientific understanding of the health effects of everyday air pollution has changed dramatically in recent years. Population effects of air pollution that were largely unknown in the 1990s and uncertain until recently are now quantifiable.

Studies have shown that long-term exposure **(over several years)** reduces average life-expectancy, mainly due to triggering death from cardiovascular and respiratory causes and from lung cancer. Air pollution is now associated with much greater public health risk than was understood even a decade ago.

In the UK, the Committee on the Medical Effects of Air Pollutants (COMEAP) estimated the burden of particulate air pollution in the UK in 2008 to be equivalent to nearly 29,000 deaths and an associated loss of population life of 340,000 life years lost.

It is important to understand that long-term exposure to air pollution is not thought to be the sole cause of deaths. Rather, it is considered to be a contributory factor – this is an important point.

Impact on deaths

An Air Quality Toolkit for Directors of Public Health was published by Defra in March 2017 and looks at the health impact of air pollution and particulates in particular. According to the toolkit:

> *'Short-term exposure to particulates over a period of a few hours to weeks can cause respiratory effects such as wheezing, coughing and exacerbations of asthma and chronic*

bronchitis. It can trigger CVD-related mortality and non-fatal events including myocardial ischemia and myocardial infarctions (MI), acute decompensated MI, arrhythmias and strokes.'

In plain English, this means that if you are exposed to particulates for a period of time, it may cause breathing problems and in some cases it can trigger underlying heart problems and strokes. These may in turn contribute to one's death. This is, it seems, the mechanism through which particulates impact on health.

Because of the indirect nature of the effect, it is difficult to measure, estimate or be certain about.

The toolkit sets out a method for calculating the rate of mortality 'attributable' to Particulate Matter. We always need to be careful with 'attributable' statistics. It means that a group of experts have looked at the science and have made a best estimate. In Oxfordshire this rate is 12.6 deaths per 100,000 population per year. What does this actually mean? Well, there is a sort of 'league table' of 'attributable' causes of death (all are best estimates) which looks like this for under 75s:

Measure	Mortality rate, per 100,000	
	Oxfordshire	England
Overall preventable mortality	142.6	184.5
Preventable cancer	64.5	81.1
Preventable heart disease and stroke	34.7	48.1
Mortality attributable to Particulate Matter	12.6	39.0
Preventable Liver disease	11.3	15.9
Communicable diseases	9.4	10.5

It is very clear that the number of deaths relating to air quality, preventable cancer, heart disease stroke, preventable liver disease and communicable diseases in Oxfordshire are well below the national averages and this is a good result. However, this does not mean that we should be complacent. We need to act to consolidate this position and strengthen it further.

The figures mean that preventable deaths associated with particulates are estimated to be associated around 1/5th of the number of preventable deaths due to cancer and around 1/3 of the number of preventable deaths associated with preventable heart disease and stroke.

It is important to grasp when particulates contribute to a death they generally act as a trigger. This isn't like smoking or alcohol related deaths where the main cause is the tobacco or the alcohol directly.

Clearly this isn't an exact science. It is easy to build castles on sand using these statistics, but it does give us a guide – enough to say that the experts think that particulates are a real health issue and should be tackled.

The Government's recent consultation on the topic summed it up as follows,

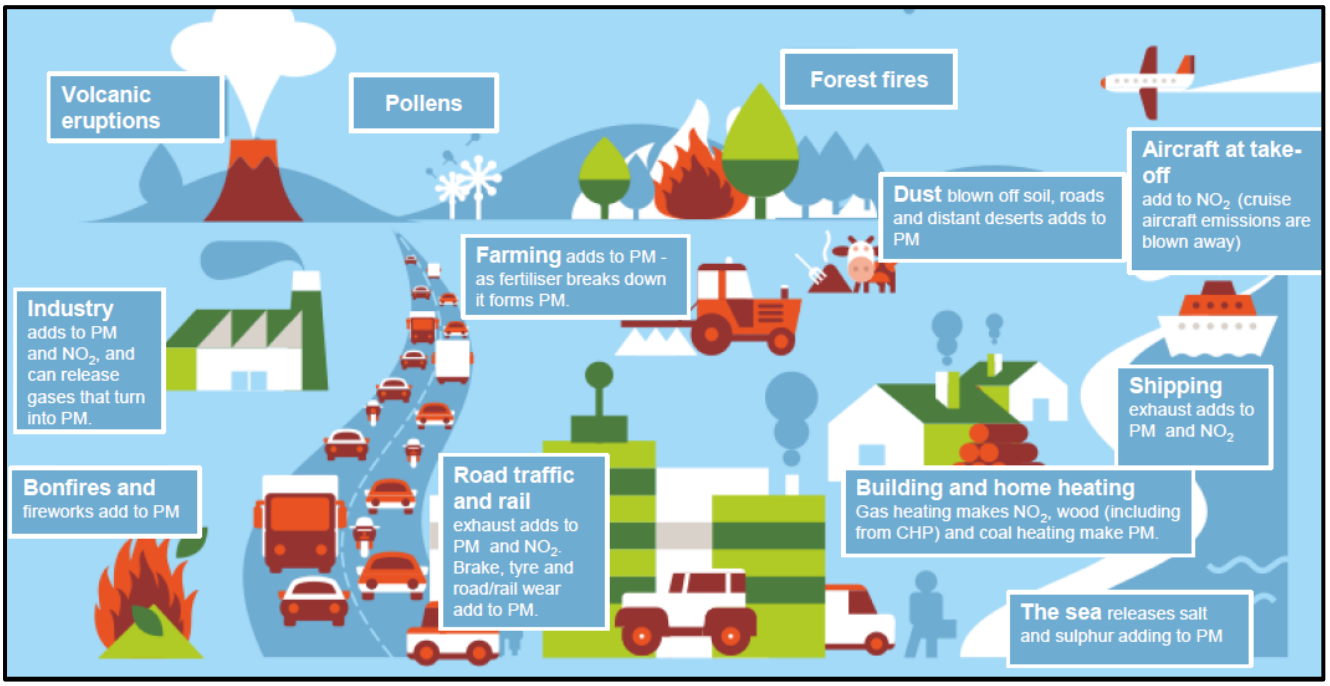
*Poor air quality is the largest **environmental** risk to public health in the UK. It is known to have more severe effects on vulnerable groups, for example the elderly, children and people already suffering from **pre-existing** health conditions such as respiratory and cardiovascular conditions. Studies have suggested that the most deprived areas of Britain bear a disproportionate share of poor air quality.*

I would stress that this isn't the biggest threat to the public's health, but it is judged the most pressing environmental risk.

Much of the action has to come nationally from Government, but there is evidence that people are voting with their feet and sales of diesel cars are reported to have fallen recently.

Where does air pollution come from?

The following schematic paints the picture and shows that the sources of pollution are many and varied from the fire in your hearth, to traffic, to pollen, to aircraft, to industry, to agriculture. There's no escape, but this diversity of sources *does* mean that we can all do something about it. for example, 39% of these tiny particles of dust that lodge in the lungs are caused by coal and wood burning.



Exposure to air pollution in everyday life can come from ordinary activities like being near traffic, sitting in traffic jams, traditional home fires and bonfires.

The effects are localised, so, although they are more concentrated in towns, they also occur at hot spots in rural areas like busy crossroads.

Also, air pollution levels tend to be higher in less well-off areas, this is yet another cause of disadvantage which being less well-off brings. These are analysed in chapter 3.

What can we do about it?

While we wait for Government to decide what to do, there are actions we can take – and the good news is that many of these are already in hand. For example, we can:

- Make it easier for people to cycle and walk more through better planning
- Plan cycle routes through quiet areas
- Build pedestrian areas and green spaces into the design of communities and regeneration schemes
- Shift transport fleets to electric or electric hybrid vehicles
- Choose new cars with more care.
- Encourage fewer car journeys through 'park and ride' and similar schemes
- If you suffer from diseases that high levels of pollution might trigger, you can keep an eye on DEFRA's pollution warnings and adapt your lifestyle to avoid areas with high levels of emissions.
- Consider 'no-idling zones' outside schools and similar areas
- Consider where possible installing gas central heating, or modern wood stoves rather than open fires, smokeless coal rather than house coal or burning dry high quality wood rather than green wood.

Whatever the outcomes of the debate on air pollution, the local actions will all boil down to better local planning, which builds health into community design, and residents making choices which are heathy ones.

All of which leads us nicely into an update on the main featured item from last year's report, namely getting health into local planning and the 2 healthy new towns we have as pilot sites in Oxfordshire in Bicester and in Barton.

What did we say last year and what has been done?

Last year we talked about the benefits of building green spaces, community areas, cycle paths and the like into the design of communities. I want to report on progress in two ways – a report of a workshop we held and an update on the Healthy New Towns.

'Planning For Health' Workshop

In November 2016, the County Council hosted a County-wide Health and Planning learning event for Officers working in areas such as planning, transport planning, health commissioning and health improvement. Officers from County, District and City Councils and the local NHS attended. The idea of the event was to enable us to learn together about best practice for creating healthy environments. We were grateful for the support from our regional colleagues at Public Health England (South East) who helped with guiding the learning themes and sourcing the key note speakers.

We aimed for participants to be able to:

- understand the link between health and the built environment
- understand how the planning system works and how it can contribute to health improvement
- keep abreast of national, regional and local work to improve health through the built environment

- learn about current good practice through case studies
- meet other health and planning colleagues from across Oxfordshire to network and learn more about each other's roles.

A wide range of speakers gave the national, regional and local perspective. Some of our speakers included Public Health England, the Town and Country Planning Association, other Local Authorities and both Healthy New Towns in Oxfordshire.

The event was really 'buzzing' and enthusiastic. The main lessons learned included:

- **Early involvement in the Planning Process** - including the need for early health involvement in planning and for a Health Impact Assessment (HIA) to be completed early on for new developments.

- Working in constructive partnerships is essential.

- Understanding the **roles of stakeholders/organisations** and how they could contribute to health through planning.

- Understanding the specialist 'tools' that help to make sound plans.

- Learning from **examples of good practice** elsewhere.

- **Evidence and statistics** being useful to be able to demonstrate the impact of planning innovation on health

- **Understanding the health Issues** within communities, and that loneliness and isolation are big issues that need to be addressed. There was recognition of the impact of disadvantage on health and the potential of small initiatives to make a big difference.

- **Understanding the economic benefits** of greener and healthier forms of transport and how these can be encouraged - including the long term benefits of investment in walking. Considering and encouraging active travel (i.e. going by bike or walking) at the earliest possible stage in planning new communities.

The event was a real boost to this area of work, and we need to keep this momentum going. We all have a part to play in this. We need to remember though, it's not just about infrastructure. It's about creating a place where people can actually meet and get together, and where it is easy to stroll, cycle and play in safety.

Healthy New Towns – what has happened in the year since my last report?

Last year I highlighted the NHS Healthy New Town Programme and the opportunities that this could bring to Oxfordshire. With two Healthy New Towns, Barton and Bicester, both within our County there is a real chance to make a difference to the health of not only those living in (or who will be living in) those areas to benefit, but momentum to share this benefit and learning wider – and this is perhaps the real added value.

We can see that the builders are on site now, but what else is happening in the actual community, and what does it mean for the people who live in those areas now or who might live there in the future?

I can report that it's been a productive year. Both areas have been:

- Fine-tuning priorities and keeping the dialogue between organisations flowing.

- Engaging the community to pave the way for new residents coming to the area. Various engagement workshops/meetings have taken place. Everyone tells me that getting residents involved early on is the key.

Bicester is taking a whole town approach and similarly Barton a whole area approach as 'One Barton'

We can look at some of the key achievements and successes of each of the Healthy New Towns in more detail.

Barton

- Funding was secured through WREN (a not-for-profit business that awards grants for to communities) for physical improvements to Fettiplace Road linking the 'linear park' to Barton Park via what is now called 'Barton's Park'. This will mean that people can access green space, play areas and socialise and it will join the new community to the existing community.

- Carrying out a **'**Health Impact Assessment' (a device for systematically recording the impact on residents' health when new initiatives are planned) was commissioned which suggested improvements.

- Supporting Bury Knowle's social prescribing pilot (a jargon term for 'prescribing' healthy activities to people instead of pills and powders). This might include joining a group or a club to reduce loneliness and isolation or attending a local exercise class or health walk to become more active.

- Commissioning research to gain a deeper understanding of existing and potential residents' health needs. This can be used by health and other service providers including the voluntary and community sector providers, GPs, leisure and physical activity services, green spaces etc, to help inform the planning of services for the area.

- Providing training for people working in Barton to:

    - understand the link between food, poverty, poor diet and health, and how all that links to the price and availability of fresh fruit and veg and how to avoid the really fatty and salty foods.

    - give people brief advice about stopping smoking, cut down on drinking and tips for staying mentally healthy.

- Supporting the Oxford Brookes University's Healthy Urban Mobility study to look into how access to cycling in Barton can be improved for older people.

- Eight community-led health and wellbeing pilot projects receiving grant-funding to generate learning from practice. The grant scheme was open for applications up to £5,000. Projects included a full independent review of Food Banks to shape the future management of the food bank within the Barton Neighbourhood Centre, ensuring that people needing to access the food bank are best supported. This work then led to the creation of a Barton Community Cupboard - a market-style provision which includes a fridge, recipe cards and a cook book inspired by recipes from local residents' attending a cooking session for all ages. The project has aimed to reduce the stigma attached with using a food bank.

- Another real success story has been the work in Barton to increase the uptake of Healthy Start Vouchers. Healthy Start is a national service through which free vouchers are given to selected families every week to spend on milk, fresh and frozen fruit and vegetables, and infant formula milk. You can also get free vitamins. You qualify for Healthy Start if you're at least 10 weeks pregnant or have a child under four years old and you or your family receive:

    - Income Support, or
    - Income-based Jobseeker's Allowance, or
    - Income-related Employment and Support Allowance, or
    - Child Tax Credit *(with a family income of £16,190 or less per year)*
    - Universal Credit *(with a family take home pay of £408 or less per month)*
    - You also qualify if you are under 18 and pregnant, even if you don't get any of the above benefits.

    This was done by an outfit called Good Food Oxford. They did it by producing:

    - A paper and electronic map of retailers which accept Healthy Start Vouchers
    - Promotion by local retailers their participation in the scheme
    - Use of posters and community newspaper
    - A guidance leaflet for frontline service providers to help individuals to complete the form

Bicester Healthy New Town

Initiatives during the year included:

- Launch of the community activation programme with small grants available up to £1000. Some of the activities funded have included:

    - A Scout Group purchasing equipment to provide adventurous outdoor activities for children aged 6+.

    - A pilot street-play activity delivered by Oxfordshire Play Association.

- Setting up a Bicester meeting for local learning disabled adults through the voluntary organisation My Life My Choice. The programme has encouraged the group to be active and take responsibility for their health as well as offering the usual support of the organisation which promotes volunteering and social activity.

- Bicester and Kidlington Ramblers were funded for the printing of a book of local walks of 5 miles and under. The book aims to encourage people to get out and enjoy their local area more and to become more active.

- Looking at how to improve the care of people with diabetes between primary, secondary and community care. Some of this will involve collaborative working with other Healthy New Town sites to work out the impact of population growth on demand for GP services.

- A Healthy Weight Strategy produced to address childhood obesity in Bicester. The plan outlines life stages, services, key messages and initiatives. The plan aims to provide a co-ordinated approach, with consistent messages which will link to national and local initiatives.

- Engaging all Bicester schools to participate in Walk to School week for May 2017. A springboard to promote a year round walking to school programme.

What else have we done in the past year?

There are many signs that the penny has dropped and that 'getting health into planning' is now a necessity. The Public Health team's work with planners at County and District level has increased remarkably and there is a demand for more – which is a really positive development.
BUT

It doesn't just happen by accident and it needs a sustained and coordinated approach which we are now moving towards – on a shoe-string….

The key is to

- know your topic so you have something positive and easy to offer

- Know the people and get involved in the networks

- concentrate on the economic benefits and the need to cut diseases such as diabetes, heart disease and some cancers off at the source – as well as slowing the progress of dementia….. and avoid preaching and nannying!

- keep selling the message:

'planning is health and health is planning'

Recommendations

1. All Local Authorities should improve air quality at local level under our own steam through keeping up the work to integrate 'public health and planning'.

2. All Local Authorities should continue to monitor and actively engage with the Healthy New Towns programme and use the lessons learnt to improve all local planning across the County

Chapter 3: Breaking the Cycle of Disadvantage

This year I want to achieve 4 things:

1. To keep the issue of disadvantage high on organisations' agendas
2. To describe overall disadvantage in Oxfordshire in a straightforward way
3. To report in detail on the basket of indicators agreed last year to monitor progress
4. To report on the work of the excellent Health Inequalities Commission

Why is this topic important?

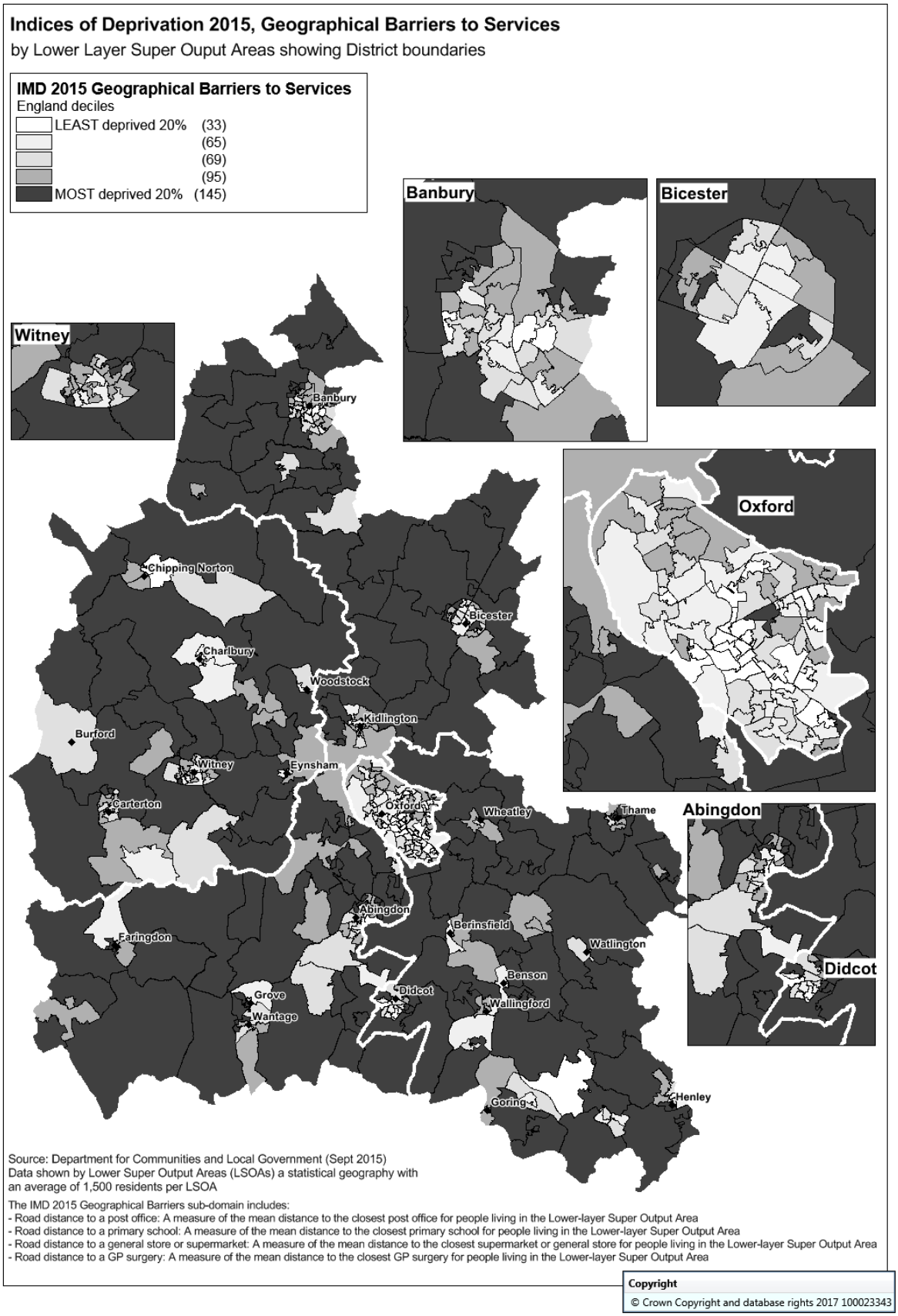
Because disadvantage is one of the factors strongly associated with poor health and poor life chances. Reducing disadvantage will directly improve health and will help people to live lives which are productive and less burdened by disease.

Overall disadvantage in Oxfordshire in two pictures

If I were asked to give a 'helicopter view' of disadvantage in Oxfordshire, I would do it through two pictures, one highlighting rural disadvantage and one urban disadvantage.

Rural Disadvantage

A major cause of disadvantage in the County stems from its rural nature. This means that some areas have more difficulty in accessing services as well as having a high proportion of older people. This is shown in the map below in a measure called 'geographical barriers'. It takes into account the many challenges posed by rurality in terms of accessing services. It was updated in 2015. This index is based on road distances to post offices, primary schools, GP surgeries, and general stores or supermarkets.


Indices of Deprivation 2015, Geographical Barriers to Services
by Lower Layer Super Ouput Areas showing District boundaries
IMD 2015 Geographical Barriers to Services
England deciles
LEAST deprived 20% (33)
(65)
(69)
(95)
MOST deprived 20% (145)
Banbury
Bicester
Witney
Oxford
Abingdon
Didcot
Chipping Norton
Charlbury
Woodstock
Kidlington
Burford
Eynsham
Carterton
Wheatley
Thame
Faringdon
Berinsfield
Watlington
Benson
Grove
Wantage
Wallingford
Goring
Henley
Source: Department for Communities and Local Government (Sept 2015)
Data shown by Lower Super Output Areas (LSOAs) a statistical geography with an average of 1,500 residents per LSOA
The IMD 2015 Geographical Barriers sub-domain includes:
- Road distance to a post office: A measure of the mean distance to the closest post office for people living in the Lower-layer Super Output Area
- Road distance to a primary school: A measure of the mean distance to the closest primary school for people living in the Lower-layer Super Output Area
- Road distance to a general store or supermarket: A measure of the mean distance to the closest supermarket or general store for people living in the Lower-layer Super Output Area
- Road distance to a GP surgery: A measure of the mean distance to the closest GP surgery for people living in the Lower-layer Super Output Area
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The map shows that the majority of Oxfordshire's 407 small areas are more deprived according to this measure than the national average. 85 are among the 10% most deprived nationally and are concentrated outside the main urban centres. A further 60 small areas are in the 10-20% most deprived nationally.

The implications of this mostly fall on older people and we see the results particularly in terms of isolation and loneliness and in terms of difficulty in getting about. This is where the demographic challenge will be felt the most and services will need to be designed to meet the needs of these communities.

This is difficult because:

- modern hi-tech services tend to need centralised kit and centralised specialists
- it gets harder for anyone to do home visits because of the increasing busyness of the roads

The way to square the circle seems to be to use hi-tech aids (like the alarm systems some people wear on their wrists or round their necks) and on-line communication, and to plan the routes of home carers really carefully. The other solution was discussed in the previous chapter – i.e. planning new communities around communal spaces and local facilities. Nonetheless, there are inevitable challenges to come as GP surgeries coalesce, becoming more specialist and less local.

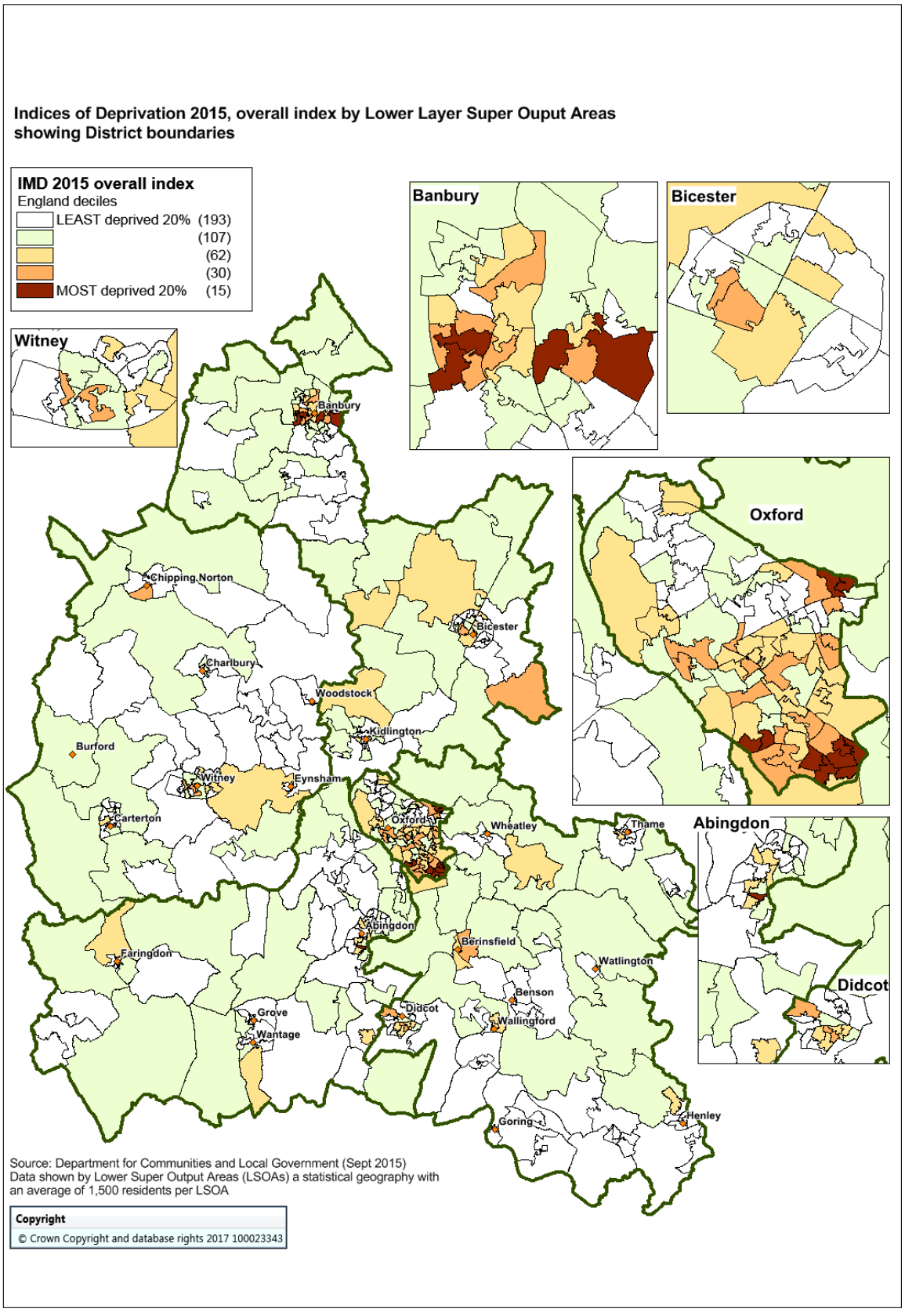
In conclusion, this picture of rural disadvantage presents one side of the coin of disadvantage in Oxfordshire.

Urban Disadvantage – the 'Index of Multiple Deprivation' (IMD)

This is the flip side of the coin and tends to pick out disadvantage in areas of greater population density - which I am loosely calling 'urban'.

This measure uses 37 indicators spanning seven broad types of disadvantage. These indicators are used to calculate an overall Index of Multiple Deprivation (IMD). The indicator looks at 407 small areas within Oxfordshire and compares them with national figures.

Overall, Oxfordshire has relatively low levels of disadvantage. It is the 11th least deprived of 152 upper tier local authorities in England (up from 12th least deprived in 2010). However, as we know, there is significant variation across different parts of the county. The map below tells the story – the areas in Oxfordshire which fall within the 20% most disadvantaged in England are shaded the darkest and the areas which fall within the least disadvantaged 20% of areas are not shaded at all.



The map shows that:

- Most of Oxfordshire's 407 small areas are less disadvantaged than the national average.
- 110 are among the least deprived 10% nationally.
- Overall, nearly half (46%) of the county's population lives in areas that are among the least disadvantaged 20% in England.
- More than four in five residents (82%) live in areas that are less disadvantaged than the national average.
- Of course this does not mean that there is no disadvantage in those areas –Berinsfield is a good example of an area where disadvantage is 'masked' by being included in larger more affluent areas, and many rural communities can tell the same story.
- 13 areas are among the 10-20% most disadvantaged (down from 17 in 2010).
- Two areas are among the 10% most disadvantaged in England. These are in Oxford City, in parts of Rose Hill and Iffley ward and Northfield Brook ward. In 2010 only Northfield Brook was among the 10% most disadvantaged areas in the country

The most disadvantaged areas are concentrated in parts of Oxford City and Banbury with one in Abingdon.

In general, the areas of Oxfordshire that were identified as the most deprived in 2010 remain the most deprived. However, in Oxford City, one area in Holywell ward, and another in Littlemore, have moved out of the 10-20% most deprived. However, one in Rose Hill has moved into the 10-20% category.

In Banbury, one area in Ruscote ward has moved out of the 10-20% most deprived.

In summary, these two 'faces of Oxfordshire' usefully sum up the overall picture when it comes to disadvantage.

Conclusion: Breaking the cycle of disadvantage in Oxfordshire is all about targeting services to level the experience of all up to the best. Disadvantage in small areas of the County remains the biggest challenge, and services need to be designed to focus on them.

Report on the Basket of Indicators

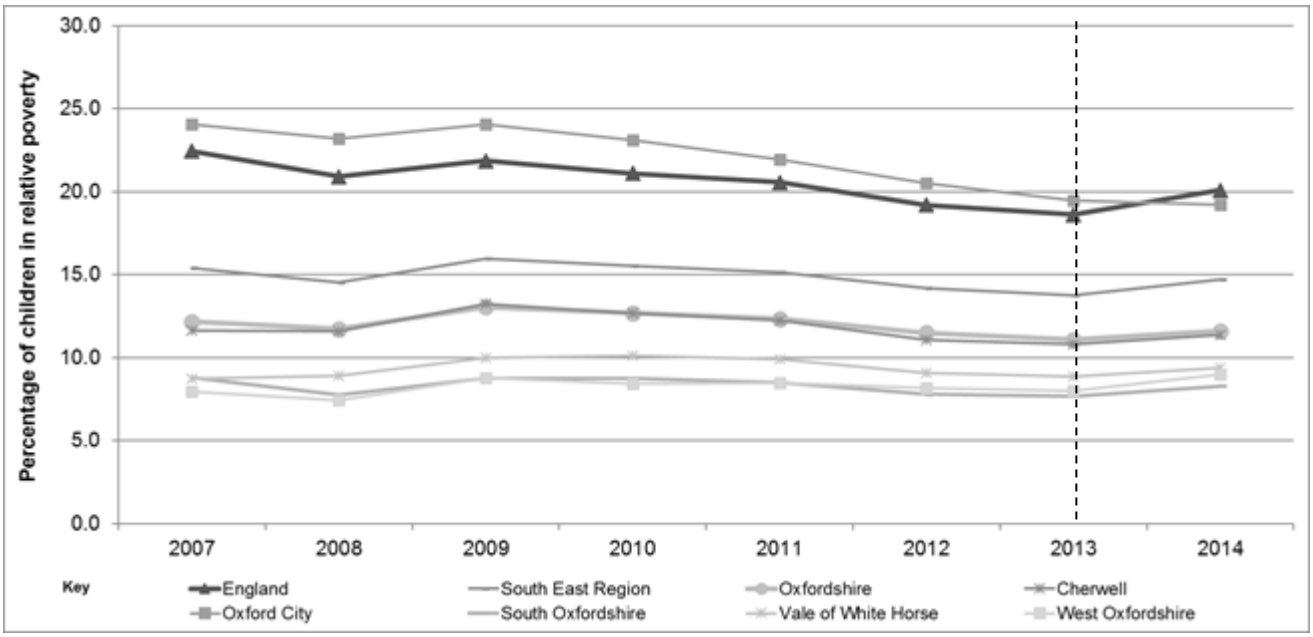
In last year's report I identified a basket of high quality indicators which would help us to measure progress in the fight against disadvantage. I set a baseline figure for comparison and will report on progress against these one by one.

Indicator 1. Child poverty

Percentage of children (under 16 years) in Low-Income Families (2007 to 2014 calendar years)

The proportion of families classed as having 'children in poverty' had fallen for the last few years but has increased slightly across the board according to the latest data from 2014. This is a national trend. The reasons for this are unclear, and a single year's figures need to be treated with caution but it is important that we closely monitor this figure going forward. The correct name for this is indicator is 'relative poverty'. An individual is considered to be living in relative poverty if their household income is less than 60% of median national income. Nationally two-thirds of children in poverty are living in households where at least one adult is in work.

Percentage of children (under 16 years) in Low-Income Families Local Measure (2007 to 2014 calendar years)



Source: Child Poverty Statistics (extracted from Public Health England: Public Health Outcomes Framework)

The chart shows that:

- The proportion of children in poverty has increased slightly since we set the baseline (2013 data) across all geographic areas.
- Oxfordshire has a significantly lower percentage of children in low-income families than England. This is good news.
- Oxford City has higher levels than the rest of the County and is closer to the national average.

Note: this is a national statistic and takes time to collate and so we are still seeing historic data from 2014.

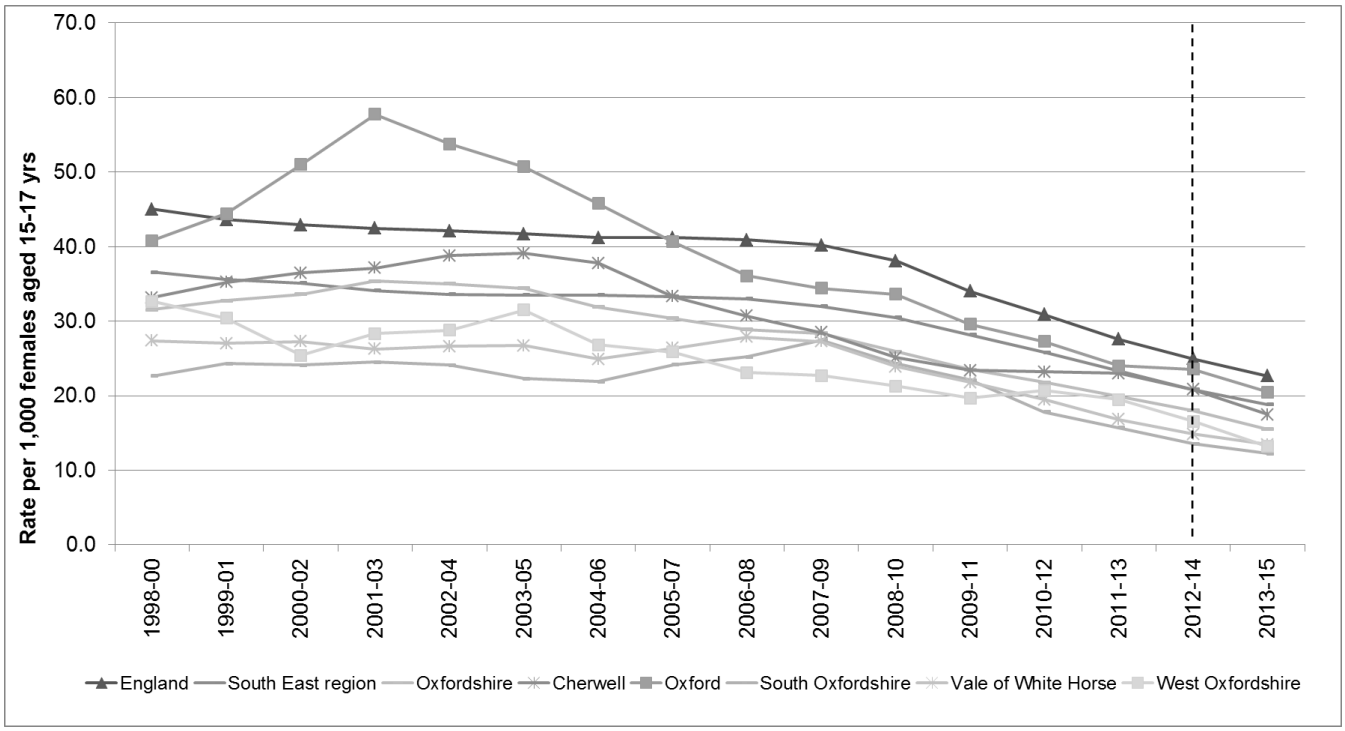
The profound influence and impact of poverty on health needs to be widely recognized and systematically addressed.

Also, as ever, if we drill down into the figures the gaps widen. Whilst Oxfordshire is overall a very 'healthy and wealthy' county, there are significant differences in poverty. For example: children living in Rose Hill & Iffley, Blackbird Leys, Banbury Ruscote, Littlemore, Churchill and Northfield Brook are in the top 10% of children in England aged 0 to 15 living in less wealthy families.

Indicator 2. Teenage pregnancy

This indicator measures all conceptions in females under 18 years of age, no matter whether the pregnancy ends in birth or in a termination.

Under 18 conception rate per 1,000 female population aged 15-17 years 1998-2000 to 2013-15 (3-years combined)



Source: Office for National Statistics (ONS) - combining information from birth registrations and abortion notifications

The chart shows that:

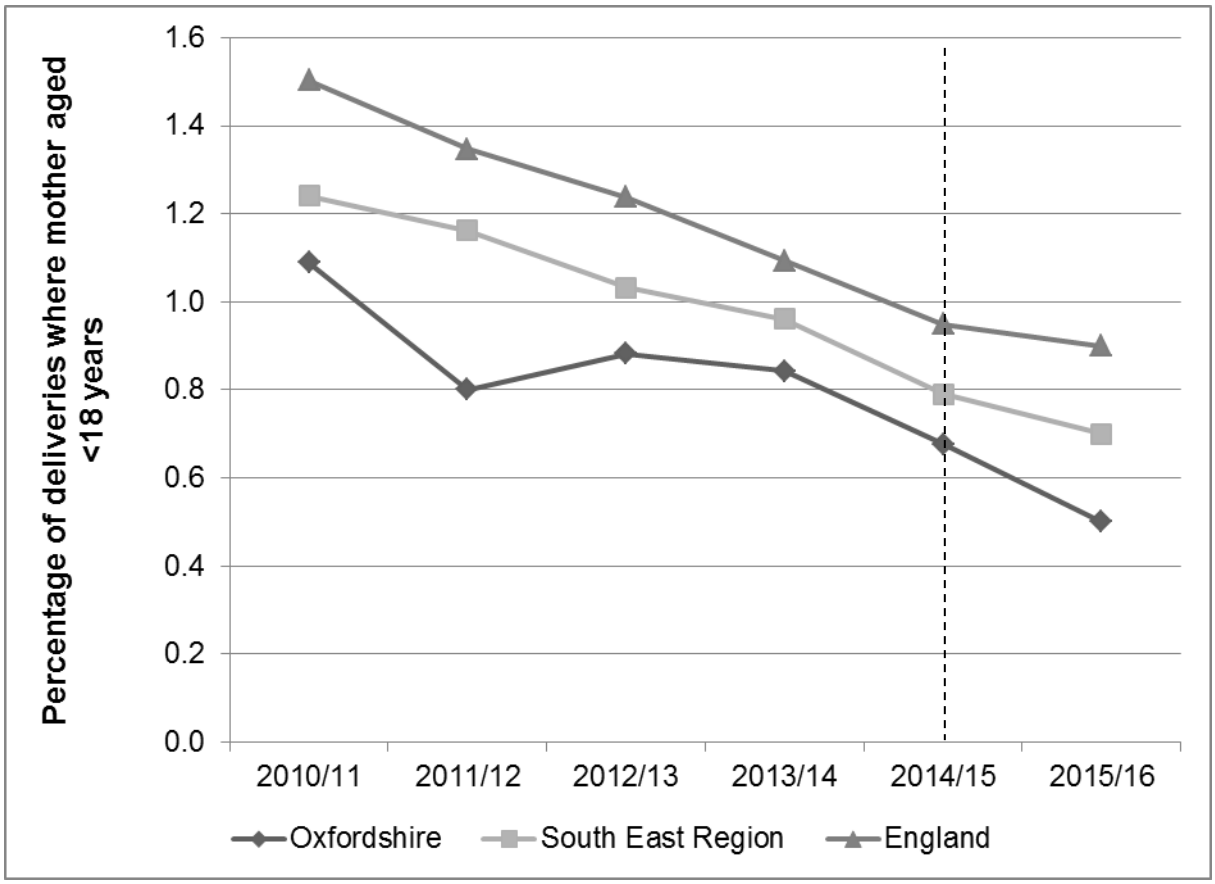
- The teenage conception rate in Oxfordshire is lower than the national average and is decreasing broadly in line with national and regional trends.
- There has been a welcome sharp decline in Oxford City since 2001-03
- Most recent data (2013-15) continues on a downward trend across all geographies.
- This is a good result.

Indicator 3. Percentage of Teenage Mothers

This indicator measures the percentage of babies delivered where the mother was under 18 years of age.

Almost half of teenage conceptions result in termination. This indicator measures the percentage of births to mothers aged under 18.

Under 18 conception rate per 1,000 female population aged 15-17 years 1998-2000 to 2013-15 (3-years combined)



Source: Public Health England: Child Health Profiles: Pregnancy & Birth

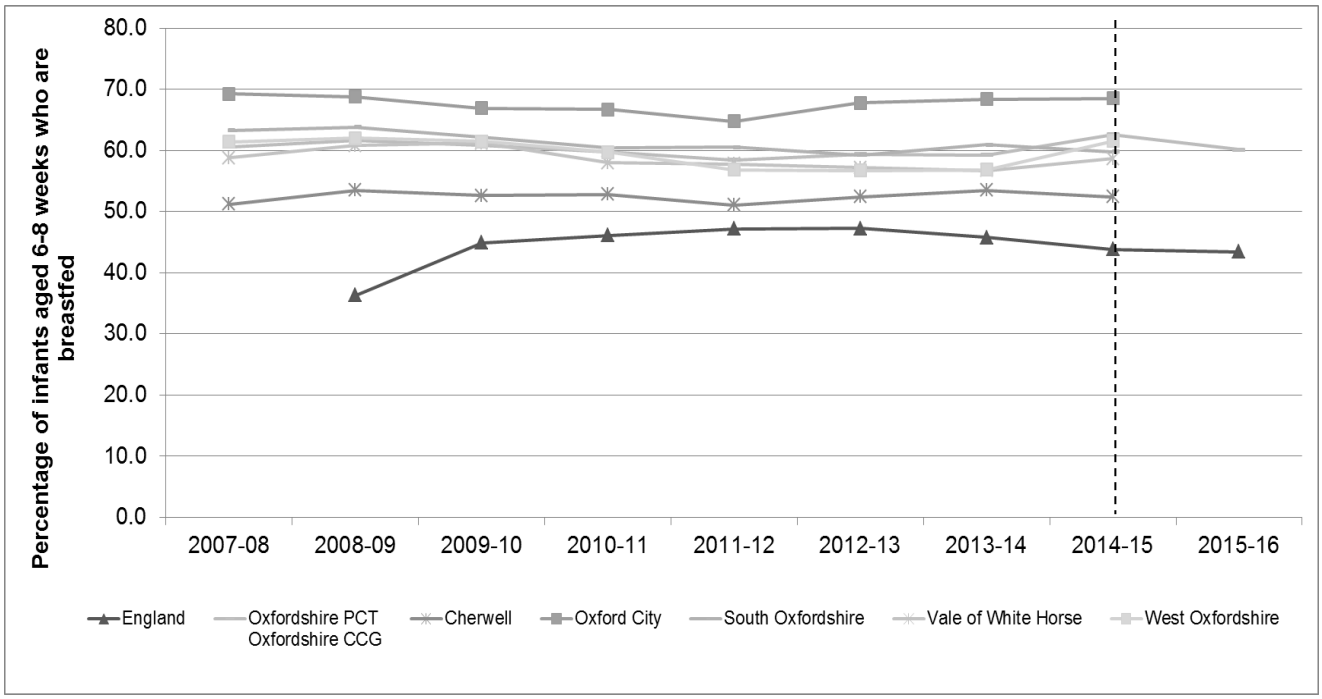
The chart shows that:

- The proportion of births to mothers under 18 years has reduced.
- This is a national trend.
- The proportion in Oxfordshire continues to be lower than the national or regional figures.
- This is another good result, and particularly good in Oxfordshire.

Indicator 4. Breastfeeding at 6-8 weeks

Breastfeeding is important and underpins a healthy life. Its positive effects on health are long-lasting. The breastfeeding rate remains high in Oxfordshire compared to England. The challenge is to get the rates higher in the lowest areas which are historically: Banbury, Bicester, Kidlington, Didcot, Wantage and South East Oxford.

Percentage of infants aged 6-8 weeks who are being breastfed (partially or wholly) – 2007/08 to 2015/16



Source: NHS England

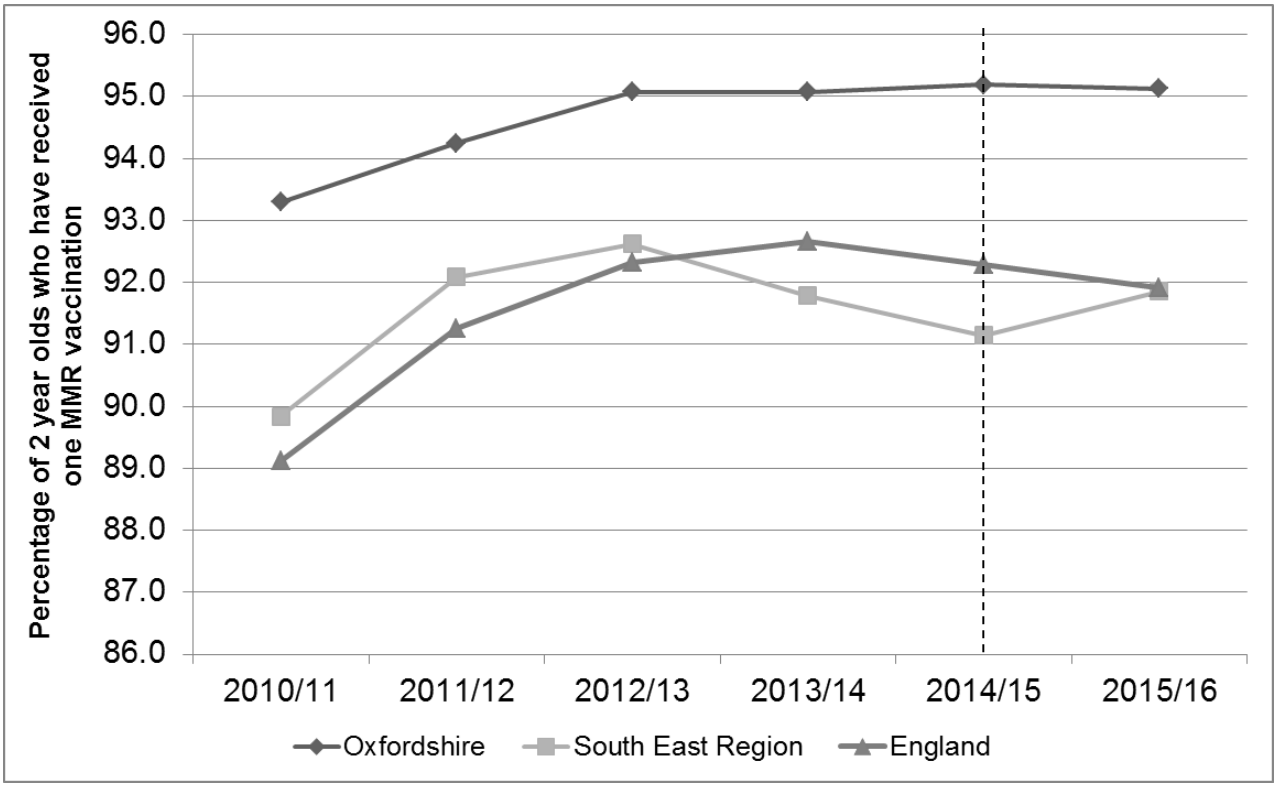
The chart shows that:

- Nationally the prevalence of breastfeeding at 6-8 weeks increased over this time period and now appears to be levelling off at around 43%
- Oxfordshire has a significantly higher rate of breastfeeding at 6-8 weeks than England average at just over 60% This is a good result.
- Locally breast feeding rates remain fairly stable for the county as a whole.
- Data at district level are currently not available for 2015/16

Indicator 5. Childhood Immunisation

Children should receive two Measles, Mumps and Rubella (MMR) vaccinations, one by the time they are 2 years old and the second by 5 years old. We use this as an indicator for the uptake of all immunisations as this is one of many immunisations for children. We monitor all the rates thoroughly through the Public Health Protection Board and through the Health Improvement Board. Oxfordshire's results are very good and NHS England and Public Health England are to be congratulated. An initiative has begun to push the rates higher by tracking down the families who slip through the net individually and offering their children the vaccine.

Percentage of 2 year olds who have received one MMR vaccination



Source: Cover of Vaccination Evaluated Rapidly (COVER) data collected by Public Health England

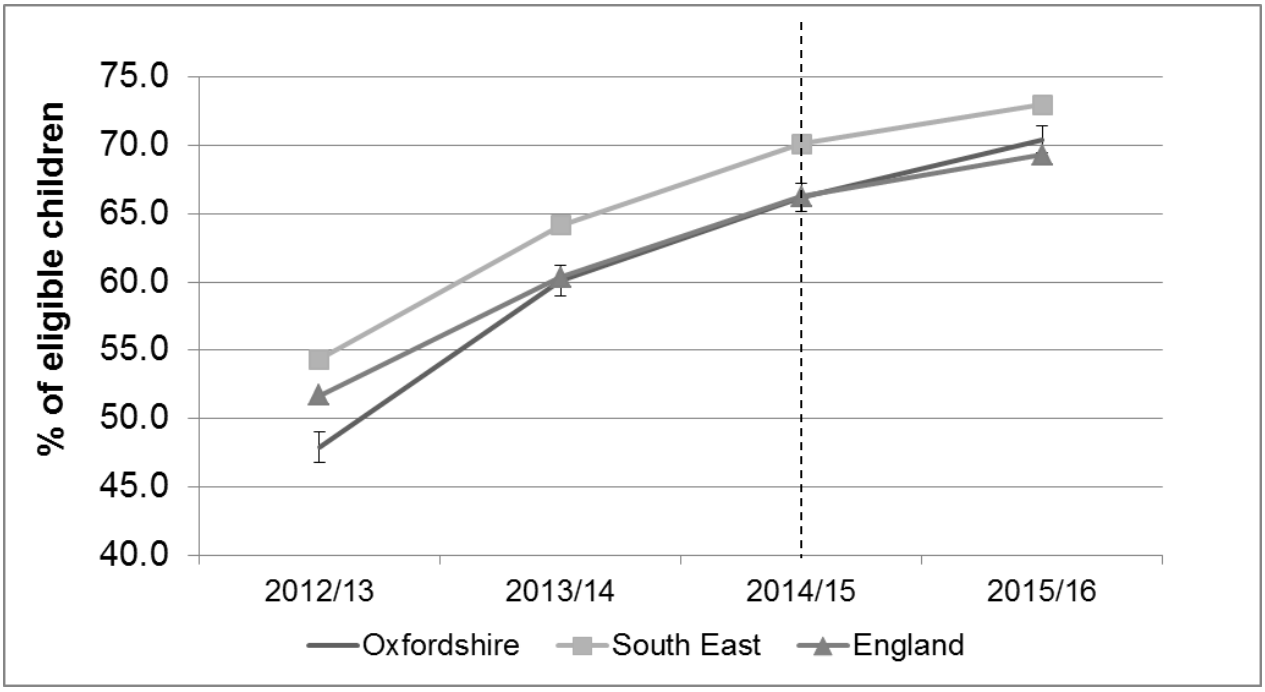
The chart shows that:

- Oxfordshire remains significantly higher than national and regional average. This is an excellent result – our vigilance is paying off.
- Nationally this vaccination coverage is falling and we are bucking this trend.

Indicator 6. School readiness

This indicator measures children defined as having reached a good level of development at the end of the Early Years Foundation Stage (EYFS) as a percentage of all eligible children. Children are defined as having reached a good level of development if they achieve at least the expected level in their 'early learning goals' in the following areas: personal, social and emotional development; physical development and, communication and languages, as well as early tests of mathematics and literacy. This is a useful measure of health in its broadest sense of 'life potential' and a useful marker for disadvantage between different groups of children.

Percentage of children achieving a good level of development at the end of reception year



The data shows that:

- Oxfordshire has a slightly higher percentage of children with a 'good development' compared with the England average but remains below the regional average.
- The proportion of children achieving a good level of development at the end of reception year has increased across all three geographies.
- There is a clear gap between males (63%) and females (78%) in Oxfordshire, similar to national and regional figures.
- The percentages in children with free school meal status is much lower at 51% (43% in males and 59% in females).
- This is reasonable progress but shows the need to focus on disadvantaged groups if performance is to improve.

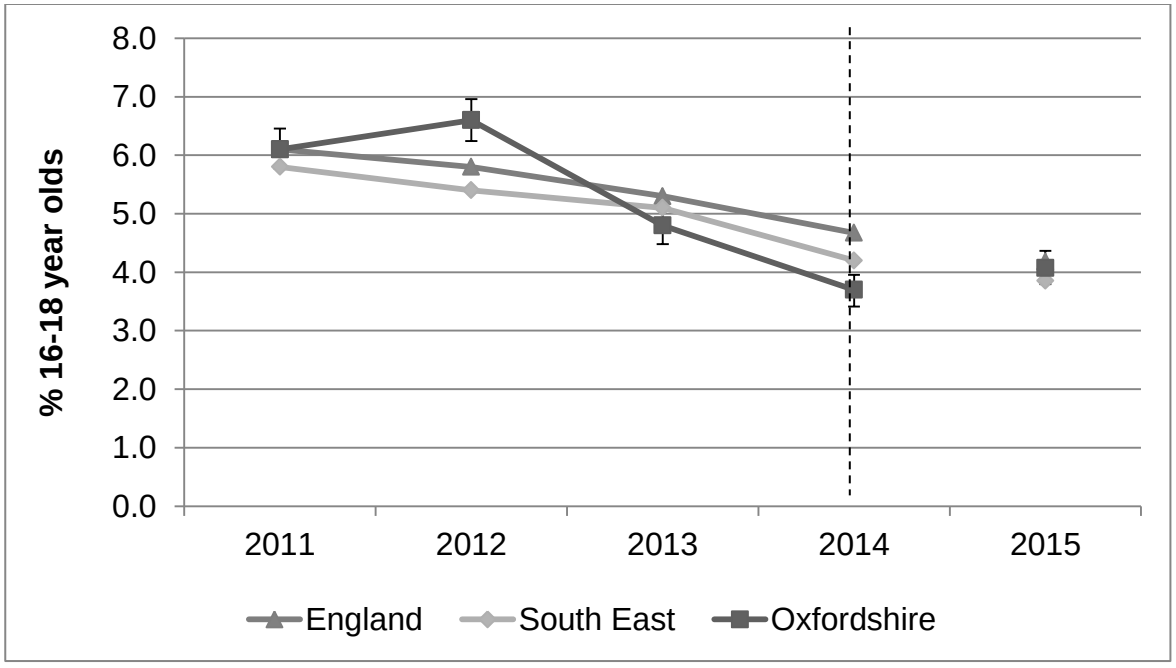
Indicator 7. GCSE results

Unfortunately, the previous indicator which allowed us to measure GCSE performance between different areas and different groups of children in the County has been discontinued by Government. It is unclear whether the new 'performance 8' statistic will be as useful – and there is as yet little data for comparison. Rather than report on this figure prematurely this year, I will need to see how well it is received before I use it to draw conclusions.

Indicator 8. 16-18 year olds not in education, employment or training

This is a useful general indicator of future life chances and prosperity for young people.
The way the data has been counted has also changed since last year to try to make it more accurate, so we can't compare it accurately with previous years. The problem comes because for some young people it is not known what their status is. To try to account for this, the new method takes figures for where it is not known if young people are not in education, employment or training and assumes a proportion of them are not and adds this to the old figure. For that reason, there is a break in the line in the chart below and then new figures are shown as a new 'blob' for 2015.

Percentage of 16-18 year olds not in education, employment or training



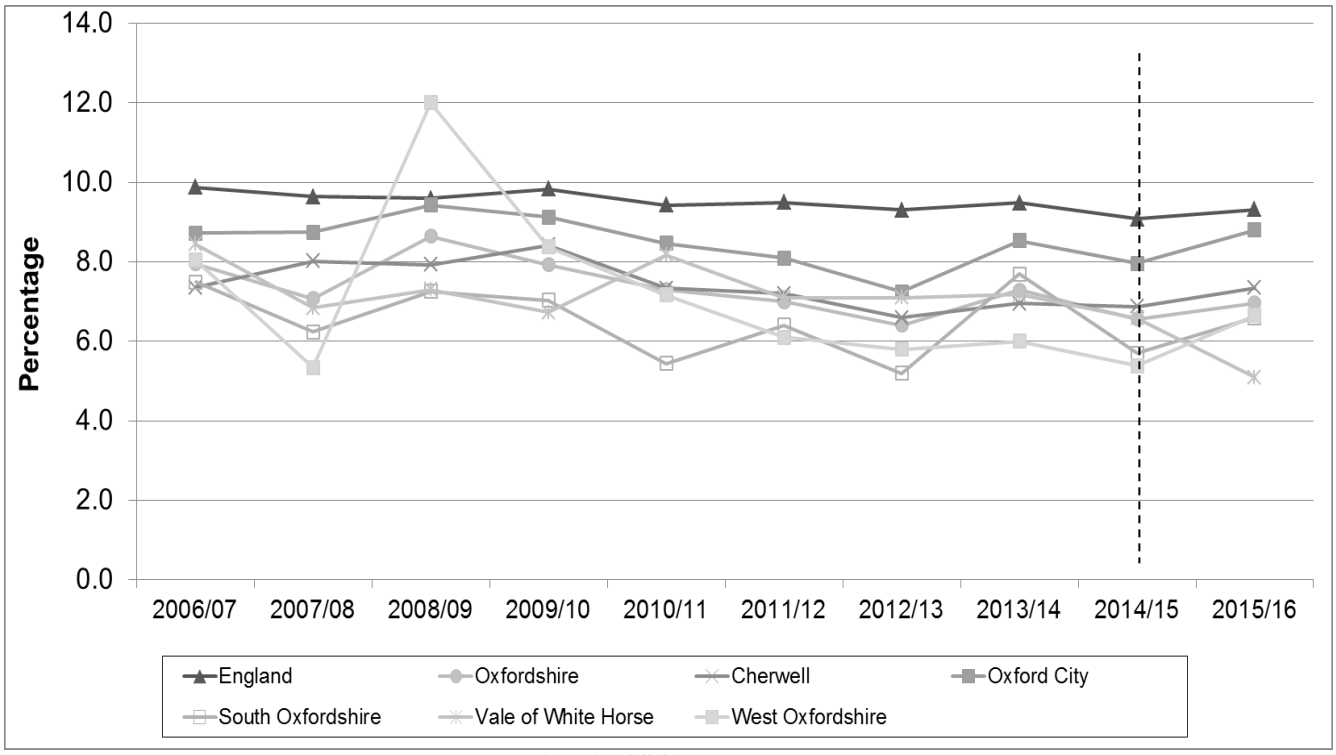
Source: Public Health Outcomes Framework

The data shows that:

- The Oxfordshire figure is comparable to regional and national levels.
- We will monitor this new data in future reports.

Indicator 9. Obesity in children in reception year

Percentage of children in Reception Year (4/5 year olds) who are obese 2006/07 to 2015/16 (Academic years)

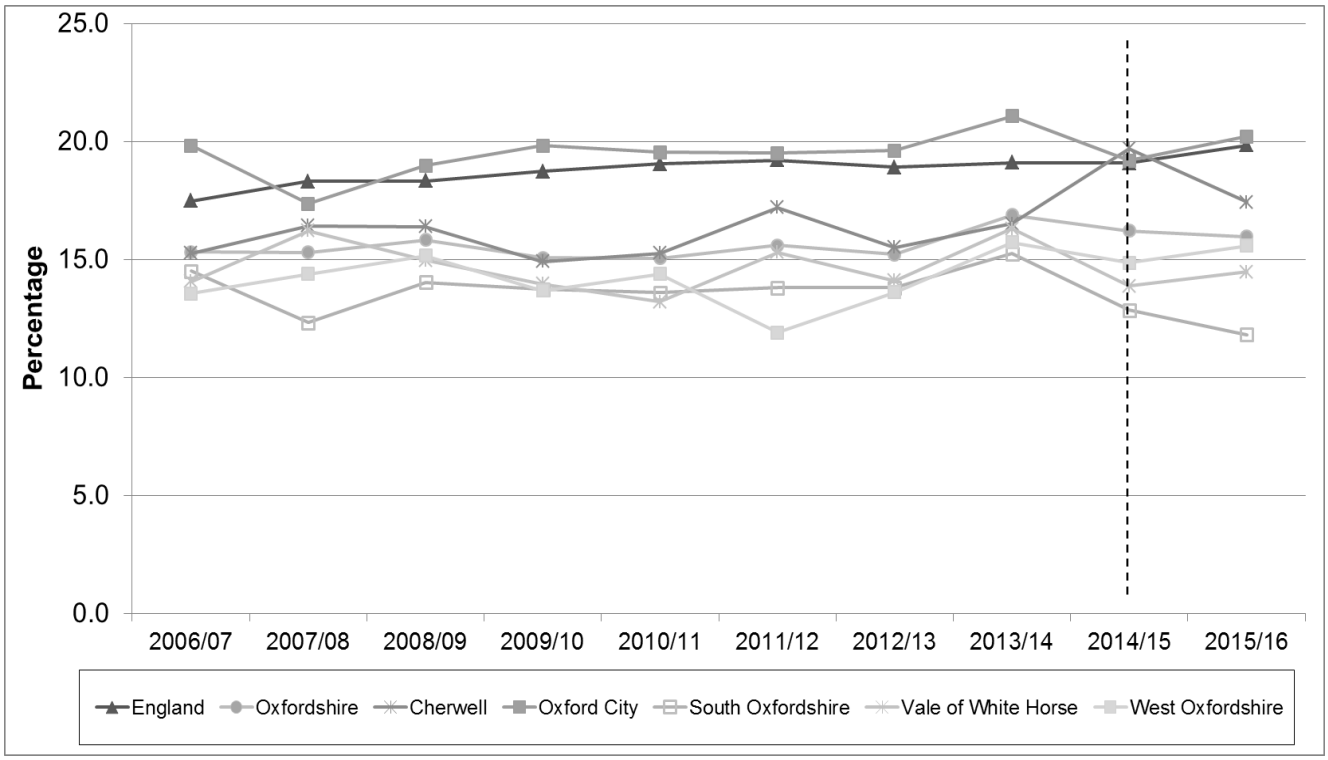


Source: National Child Measurement Programme

- Prevalence of childhood obesity among this age group has remained fairly level at around 7% with some fluctuation at a district level.
- We continue to buck the national trend which is just over 9% and this is a good result.
- Levels of obesity in this age group remain higher in Oxford City, probably reflecting the association between social disadvantage and higher levels of obesity.

Indicator 10. Obesity in Year 6 (10/11 years)

Percentage of year 6 children (10-11 years old) who are obese 2006/07 to 2015/16 (Academic years)

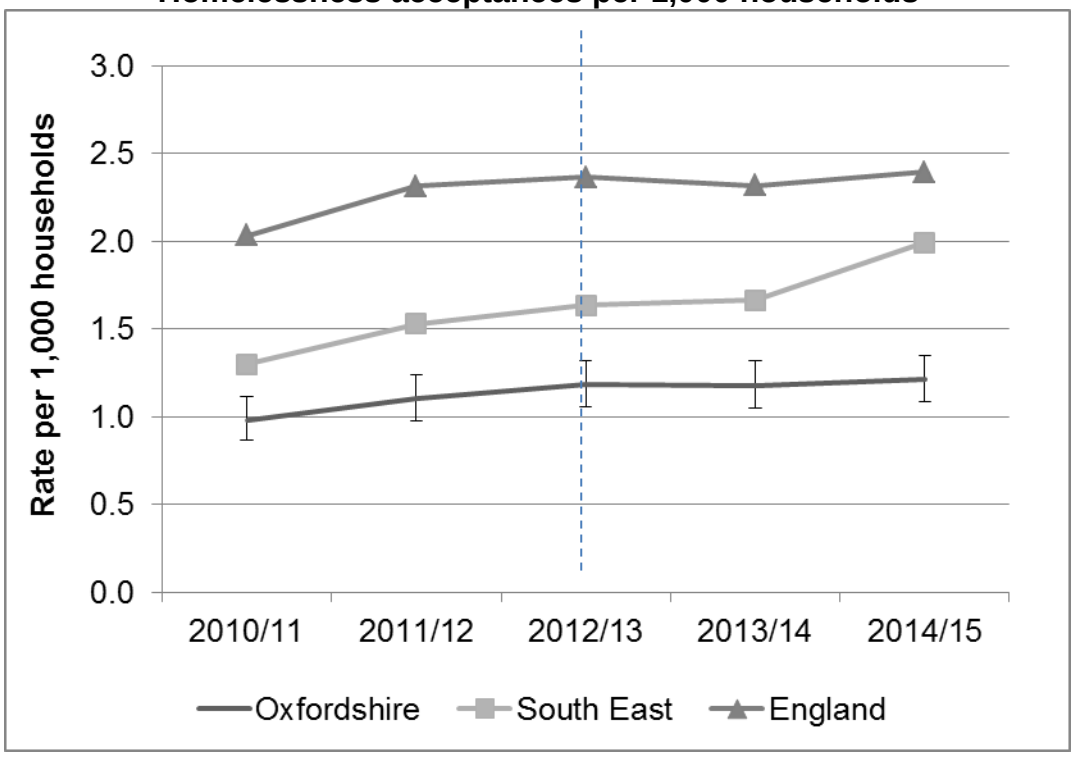


- The county figure has continued to fall and is around 16% - better than the England average by almost 4 percentage points (19.8%). This is a significant achievement.
- Oxford City has a higher rate at 20%, again, probably reflecting higher average rates of social disadvantage.
- After an increase in 2014/15 the rate in Cherwell has decreased to 17% for 2015/16 which is good news.

Indicator 11. Homeless Households

Homelessness is a direct reflection of disadvantage to families and is therefore a useful overall indicator.

Homelessness acceptances per 1,000 households

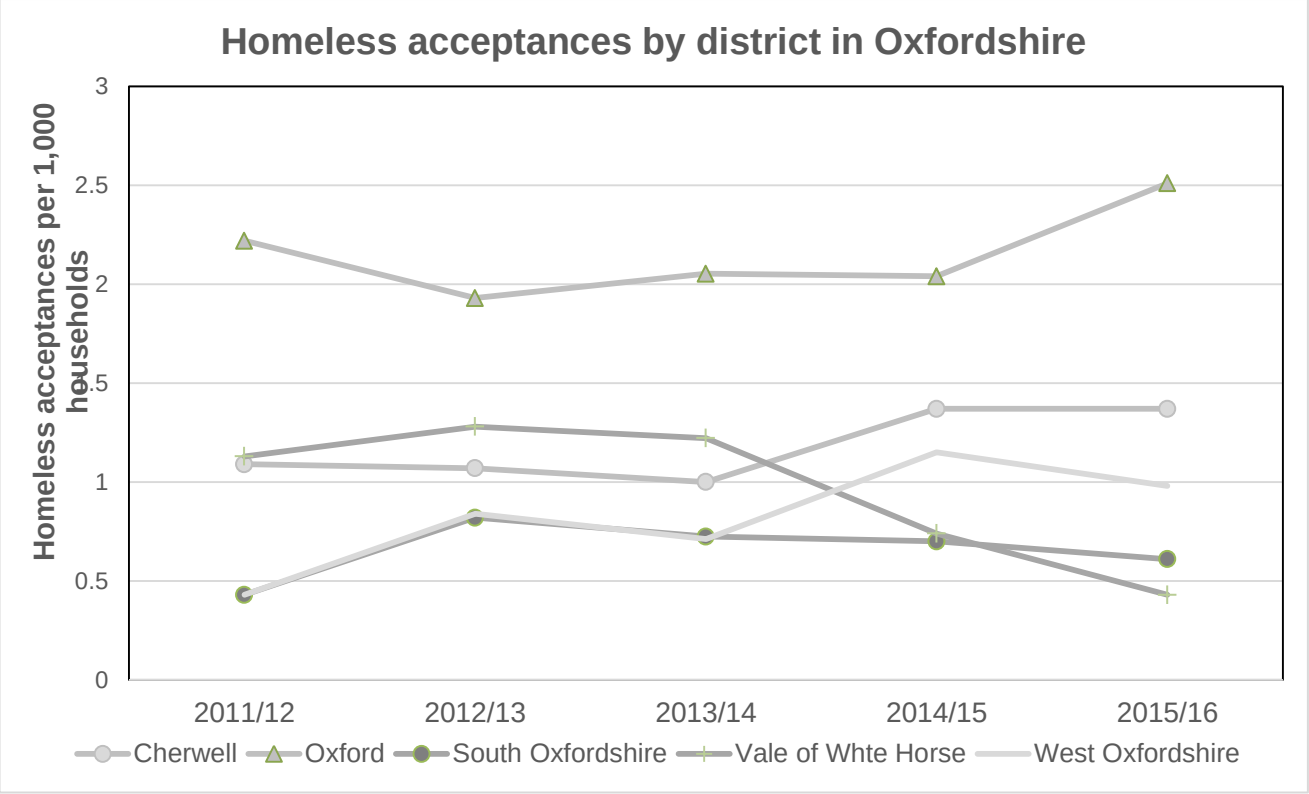


The chart shows that:

- Oxfordshire's results are well below the national average and have remained fairly stable.
- National figures are slightly up and regional figures show a sharp upward trend.
- It is a good result that Oxfordshire's figure is both lower and more stable than our regional neighbours.

Homelessness acceptances per 1000 households by districts in Oxfordshire

We know that homelessness varies widely across the different Districts. As this is an important indicator, it is worth drilling down more into the data to look at the trends at District level.



The chart shows that:

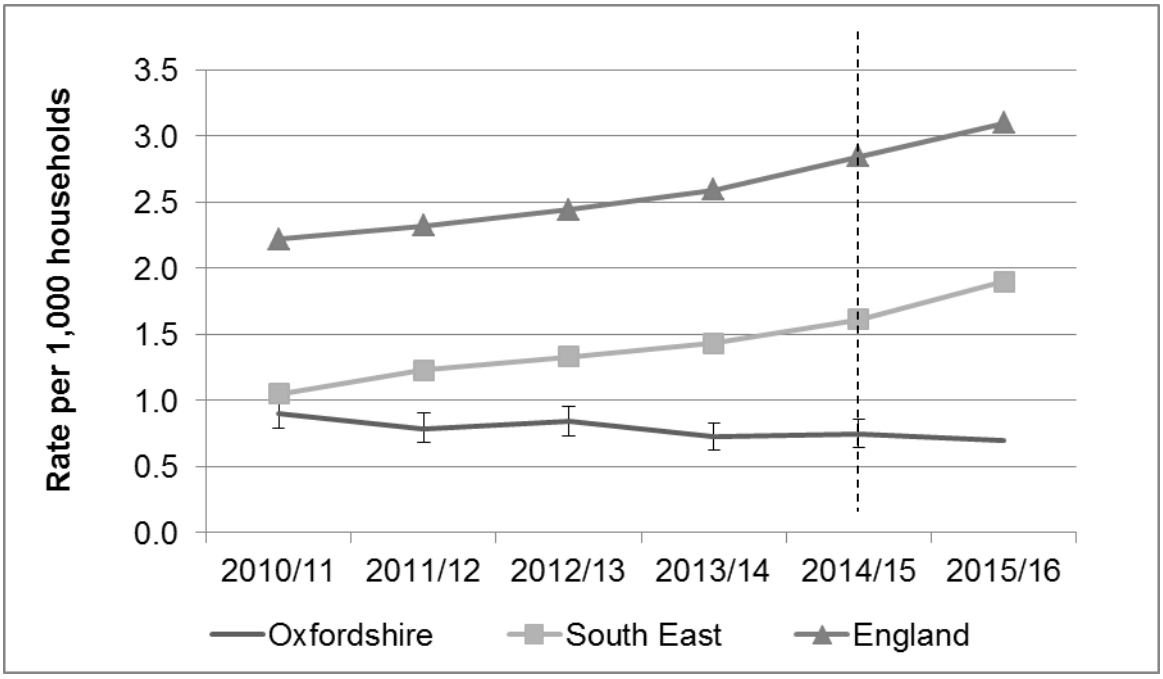
- Oxford City has increased to 2.5 homeless acceptances per 1,000 households (higher than the rate for England), putting the level higher than it has been in recent years. This is concerning and the trend needs to be monitored closely. It is possible for quite wide random fluctuations to occur in this data as the numbers involved are quite small and so a watching brief is appropriate, but the figure is a cause for concern.

- The rates in the other districts have also fluctuated – up slightly in Cherwell and down in South Oxfordshire and West Oxfordshire. Vale of the White Horse continues to show a marked downward trend.

Indicator 12. Households in temporary accommodation

Homelessness is prevented in part by placing families in temporary accommodation. This is not a good option in terms of life-chances, but it is better than facing homelessness.

Households in temporary accommodation per 1,000 households



The chart shows that:

- The rate in Oxfordshire shows a gradual continued reduction while rates nationally and regionally have increased.
- This is a good result and indicates overall success in tackling disadvantage.

Summary from the basket of indicators.

Statistics around teenage pregnancy, teenage mothers, obesity, young people in employment and training, households in temporary accommodation, homelessness overall and breastfeeding show good or reasonable results indicating that progress is being made.

Statistics around child poverty, school readiness and homeless acceptances in the city require a close watching brief.

What we said last year and what we have done about it

Last year's recommendations are set out below with a commentary on progress made:

1. The report of the Commission for Health Inequalities should be studied carefully when it is published and all organisations should use it to challenge current practice and make appropriate changes to services.
   Progress report: Good progress has been made and this is set out immediately below.

2. Trends in disadvantage should continue to be monitored closely in Director of Public Health Annual Reports
   Progress: This has been done through the Joint Strategic Needs Assessment and through this report.

3. The Children's Trust is requested to consider the basket of children's indicators proposed in this report and to drill down into indicators to uncover further inequalities at more local level using data from services.
   Progress: This is scheduled to happen shortly.

4. The NHS's Sustainability and Transformation Plan should target disadvantaged groups and seek to level up inequalities. The NHS 'offer' should not be 'one size fits all'.
   Progress: In the event, the consultation was divided into two parts. Disadvantage featured in the local phase 1 consultation document published by the CCG earlier in the year. However, it is the mooted phase 2 consultation on community services which will probably reflect whether variations between localities have been adequately taken into account to ameliorate health inequalities, so it is too early to form a judgement.

The Work of Oxfordshire's Health Inequalities Commission

I want to report here on the most significant event in tackling health inequalities and disadvantage which happened during the year – a report on the work of Oxfordshire's Health Inequalities Commission.

What is the Health Inequalities Commission?

The independent Health Inequalities Commission for Oxfordshire was commissioned by the Health and Wellbeing Board and carried out its work throughout 2016. It was the brainchild of the Chair of Oxfordshire's Clinical Commissioning Group and took two years of persistent effort to bring about. The Clinical Commissioning Group, the County Council's Public Health team, along with many other partners, including Oxfordshire Healthwatch played a midwife role. The report of the Commission was presented by the independent Chair, Professor Sian Griffiths, to the Health and Wellbeing Board in November 2016 and at a launch event on 1st December, chaired by the Leader of the County Council, attended by the media and a wide range of partners.

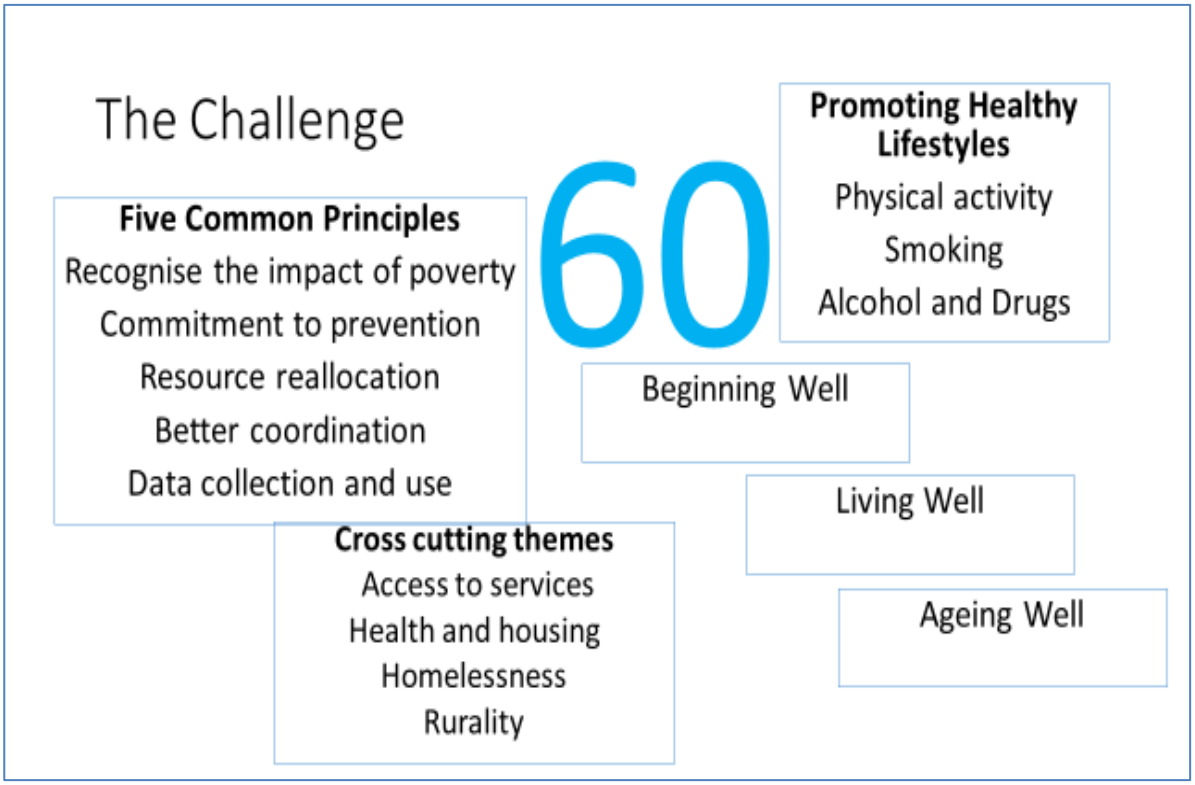
The Health Inequalities Commissioners were independent members selected from statutory and voluntary sector organisations and academia. They received written submissions and verbal presentations from a wide range of people and organisations at four public meetings held around Oxfordshire in the winter and spring of 2016. Local data and information on health inequalities were also presented to the Commissioners supported by access to a wide range of local and national documents, including the Director of Public Health Annual Reports, the Joint Strategic Needs Assessment and data from Public Health England.

What did it say and who signed up to its recommendations?

The Introduction to the report of the commission summarised their remit as follows:

Health inequalities are preventable and unjust differences in health status. People in lower socio-economic groups are more likely to experience chronic ill health and die earlier than those who are more advantaged. But as Sir Michael Marmot has highlighted, health inequalities are not just poor health for poorer people but affect us all – "it is not about them, the poor, and us the non-poor: it is about all of us below the very top who have worse health than we could have. The gradient involves everyone".

There are 60 recommendations in the report which are arranged in a set of themes as follows:



How are we taking it forward and who is involved?

The Health and Wellbeing Board agreed to oversee the implementation of the recommendations and receive regular updates.

The report was discussed by a wide range of organisations who signed up to deliver the recommendations, including:

- Oxfordshire Health and Wellbeing Board and its subgroups - The Children's Trust, The Health Improvement Board and the Joint Management Group for Older People.
- Oxfordshire Clinical Commissioning Group Executive, Board and Localities.
- Oxford University Hospitals Foundation Trust Management Executive and Public Health Steering Group

- Oxford Health Foundation Trust Board
- The Stronger Communities partnership in Oxford and the linked Local health partnerships in Wood Farm and Rose Hill
- Cherwell Local Strategic Partnership and 'Brighter Futures' in Banbury
- Oxford City Council Scrutiny Committee, in their oversight capacity.

In addition, an Implementation Workshop was held in May 2017 attended by a wide range of public and voluntary sector organisations. They began the process of identifying current work and discussing how this can be developed.

It may be impossible to keep a complete overview of the activity that develops as a result of the report, as many groups and organisations have renewed their efforts and energy in addressing health inequalities – that was one of the goals of the Commission, to mainstream the debate about health inequalities. This is good news. In addition, a multi-agency Implementation Steering Group has now been set up and will work together in taking forward the recommendations in a more formal way. Their first tasks include:

- Making sure there is a comprehensive overview of all the recommendations and what is being done in response
- Setting up a workshop to explore social prescribing (prescribing healthy activities) as a means of improving health inequalities and beefing up existing prevention initiatives
- Setting up a (modest) Innovation Fund and determining the criteria by which money pledged by all local authorities and the Clinical Commissioning Group can be used effectively.

How do we keep this initiative going?

It is important to maintain the interest and focus on tackling inequalities and disadvantage that have been stoked by the Health Inequalities Commission. This can be done in several ways:

- Demonstrating the impact of current work and new developments on tackling inequalities will keep the momentum going. Keeping watch over a range of indicators that show the variation in health outcomes will be important and a basket of indicators is being drawn up to help with that.
- Changing systems so that they address inequalities. For example, commissioning new services should consider the needs of people in the population who have worse outcomes or poor access to services. The Joint Strategic Needs Assessment and other sources of information will help with this needs assessment.
- Adopting the "Health in All Policies" approach to developing public policies which looks at the health implications of decisions, tries to join things up and prevents harmful health impacts.

- Making sure major plans, such as the Sustainability and Transformation Plan and Joint Health and Well Being Strategy, include action to address inequalities and deliver results.

- Using the Innovation Fund well and attracting more funding to sustain and develop good practice and make a difference.

This annual report is part of that process, and also aims to help carry the torch lit by this work.

What concrete things have happened as a result?

Individual organisations will of course be taking their own actions, not all of which we will know about, and this is to be welcomed. The report aims to galvanise us all – not just the big organisations. The process of bringing about change in the statutory services will be a long haul and we are still putting the foundations in place - but there are already some encouraging signs that things are happening:

The response to the call to improve prevention initiatives includes:

- Oxfordshire Sport and Physical Activity have begun to prepare plans for improving levels of physical activity in disadvantaged groups. Although an initial bid to Sport England to take the work forward was unsuccessful, other opportunities are being worked through.

- A database of food banks and other free or affordable food suppliers has been drawn up by Good Food Oxford. They are also providing 'food poverty awareness' training for front line services and have developed guidelines on "healthy cooking" for those who are training people in cooking skills.

Challenges to improve inequalities faced by vulnerable groups are being responded to, for example:

- Planning to make Barton a dementia friendly community as part of the Barton Healthy New Town initiative.

- A Trailblazer grant to reduce homelessness on discharge from hospital or prison. This involves a wide range of partners, led by the City Council.

- Programmes that promote personal resilience and positive lifestyle choices are being run for specific vulnerable groups. This includes a programme for people recovering from drugs or alcohol misuse which is called "Get Connected", run by Aspire and Turning Point. A similar programme, "Active Body, Healthy Mind", is run for mental health service users along with access to regular physical health checks.

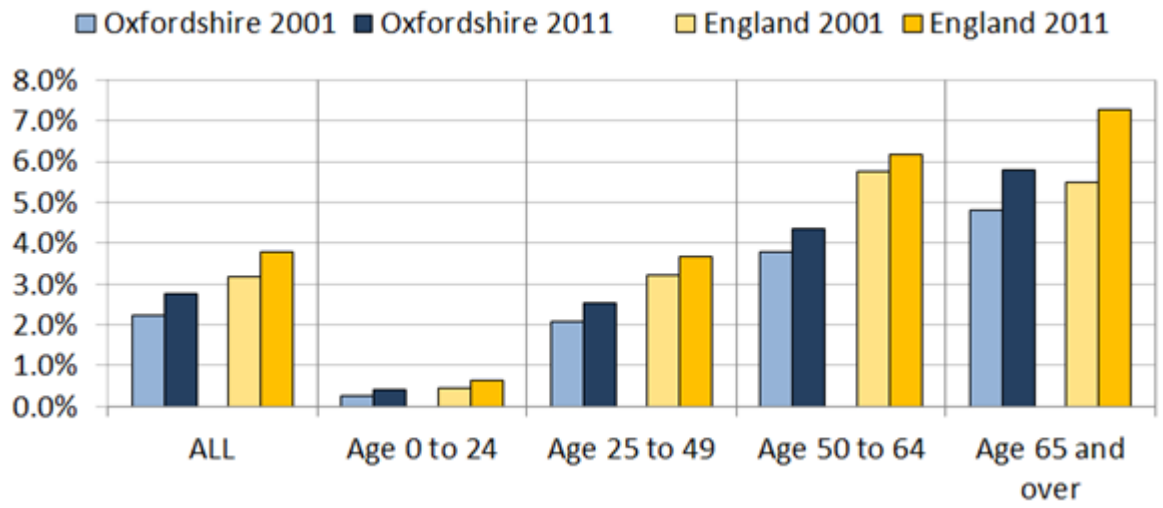
- A pilot project has been set up to provide counselling to children who are asylum seekers or refugees. This is already in place in Oxford Spires Academy and needs more funding to be expanded. This is led by Refugee Resource.

Caring for others as a cause of disadvantage

Previous reports have highlighted caring for others as a factor which can cause disadvantage. Before I close this chapter I am keen to report on the current situation.

Looking at the last two censuses shows the following picture for Oxfordshire compared with national data:

% of people providing 20 or more hours of unpaid care per week by age 2001 to 2011, Oxfordshire and England



The chart shows:

- An increase in the proportion of people providing unpaid care (of 20 or more hours per week) across all age group in Oxfordshire.
- The proportion of carers in each of the broad age groups in Oxfordshire remains below the England average.
- Between 2001 and 2011, the increase in the proportion of carers in the age group 50 to 64 in Oxfordshire was above the increase in that age group nationally.

As highlighted in previous reports, carers do a marvellous job, and organisations should continue to make sure they are well supported and taken into account when planning new services.

Recommendations

1. The Health and Wellbeing Board should ensure that the work of the Health Inequalities Commission continues to be taken forward.
2. The Basket of indicators of inequalities in childhood should be reported in the DPH annual report next year. The Health Improvement board should monitor homeless acceptances closely during the year.
3. The next phase of the Oxfordshire Sustainability and Transformation Plan should target disadvantaged groups and seek to level up inequalities. The service 'offer' should not be 'one size fits all' and the needs of different parts of the county should be recognised.

Chapter 4: Lifestyles and Preventing Disease Before It Starts

We are what we eat, breathe, drink and do: whichever way we look at it, how we live our lives has a huge impact on our health. True, our genetics at birth deal us a basic hand of cards to play, but how well we feel, and how long we live has a lot to do with how we play our hand. What's your game-plan?

This chapter looks at some of the things people in Oxfordshire do that affect their health and looks at some of the actions we are taking to inform them of their choices and give them a helping hand.

This isn't about nannying, it's about giving the people the inside info to help them make the best choices they can.

The Health Survey for England gives us a good place to start – and the picture here will apply pretty well to Oxfordshire. In 2015 a total of 8,034 adults (aged 16 and over) and 5,714 children (aged 0 to 15) were interviewed. 5,378 adults and 1,297 children had a nurse visit as part of the survey.

The headlines (which we will unpack in this chapter) were:

- Smoking in adults fell from 28% in 1998 to 18% in 2015 – this is excellent. However, we know that around 25-30% of manual workers still smoke – this is a serious health inequality

- Alcohol consumption in adults is falling slowly (bringing with it a decline in alcohol related disease) – good news

- Obesity and overweight increased – it is now the new 'norm', with around half of adults overweight or obese – this is bad news for our future health.

- Children reporting smoking and drinking both fell steeply – more good news –though of course new threats like 'new psychoactive substances' (formerly called "legal highs") may be filling some of this gap.

- I would also add that teenage pregnancy continues to fall both locally and nationally – which is also good news.

So, what does this quick overview tell us?

It tells us that the lifestyle challenge that is still on the rise is all about obesity. Let's look at that first.

Obesity, Diet and Exercise

I'm not for a moment minimising other challenges and issues, but the unavoidable fact is that as a society the problem we are storing up for ourselves is all about our weight. Why? Because it leads to heart disease, cancer, mobility and disability problems and costs the economy an estimated £27bn, the NHS £6bn and social care £350m each year.

We also know that it is an inequalities issue and affects women more than men, unskilled workers more than skilled and Black and Asian ethnic groups more than white.

The UK Millennium Cohort Study, published an update in 2017 which illustrates this point beautifully. The following chart from the report shows very clearly that prevalence of children overweight increased by age and by lower maternal academic attainment. Mothers without qualifications (and so with less income and fewer choices) had on average children who were around 75% more likely to be overweight than mothers with degrees. The chart also underlines the steady increase in overweight children with age.

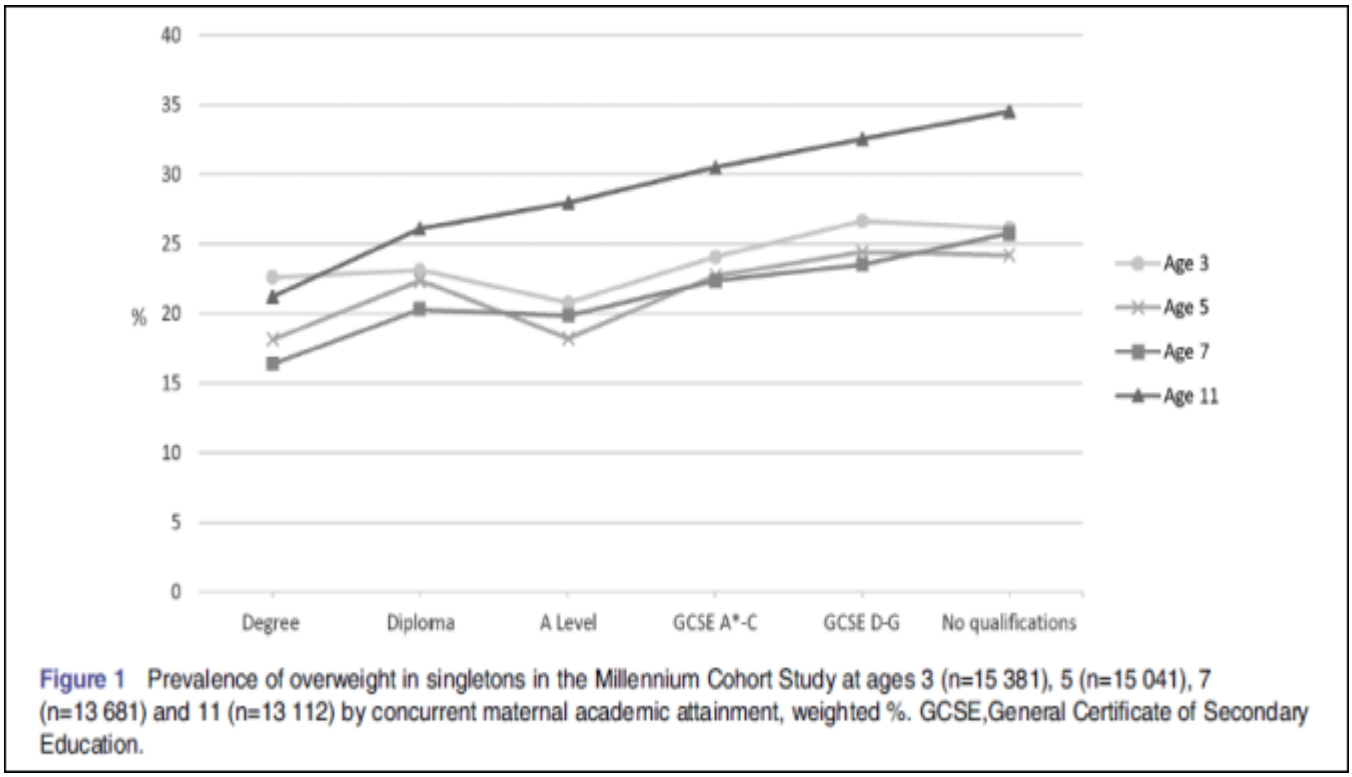


Figure 1 Prevalence of overweight in singletons in the Millennium Cohort Study at ages 3 (n=15 381), 5 (n=15 041), 7 (n=13 681) and 11 (n=13 112) by concurrent maternal academic attainment, weighted %. GCSE,General Certificate of Secondary Education.

We saw again in the previous chapter that obesity begins early – doubling between reception year and year 10, and continues to increase into adulthood.

A recent report from Public Health England sets out the situation with regard to physical inactivity well;

"Put simply, we are not burning off enough of the calories that we consume. People in the UK are around 20% less active now than in the 1960s. If current trends continue, we will be 35% less active by 2030. We are the first generation to need to make a conscious decision to build physical activity into our daily lives. Fewer of us have manual jobs. Technology dominates at home and at work, the 2 places where we spend most of our time. Societal changes have designed physical activity out of our lives."

This won't be news to anyone who has read these reports before as it has featured as an issue in ten out of ten reports. Why? Because it is still a problem and, as a collective, we still haven't cracked it…… although there may be some 'green shoots' of hope emerging.

If it matters so much, and we all know about it, why is it so hard?

I suspect this is for a number of reasons which I have teased out below. This isn't about victim blaming – absolutely not – this is really hard stuff – if it wasn't, it wouldn't be such a problem. In brief, the issues seem to be:

1. What we want regarding our lifestyles short-term works against us long- term when it comes to weight gain. We want comfortable lives, we want to travel by car or public transport, we want to watch TV, we want fast and easy food - and all these things lead to weight gain over time.

2. Our genetic programming may work against us. The evolutionists tell us we are programmed to gobble goodies when we see them to hedge against times of famine from our hunter-gatherer days (e.g. a glut of ripe fruit on a tree) by building up a fat store. That makes sense, but we are fortunate that the famine doesn't come any more, and so the fat builds up.

3. Because weight gain is insidious and we are hard-wired for short term responses. We seem to be programmed to respond to immediate dangers and tend to be blind to longer term issues.

4. Because the problem becomes invisible when the majority have it – I suspect that if you could bring a coach full of time-travellers from the 1950's they would be truly surprised to see us now.

5. Because the answer is multi-facetted. The answer isn't simple and implies change by individuals, families, organisations employers and government. We need a 'team UK' effort – and this is always difficult.

6. Because it isn't fair –Our metabolic rates and our genetic make-up are like hands of cards dealt to us at birth. It means that we put on the pounds in different patterns to one another. Where one loses another gains – it isn't fair. It also means that the answer isn't a one shot deal. The answer will vary from individual to individual and this makes setting a consistent policy harder.

7. Because it changes with age. I think many of us know that if we were to eat now what we ate as twenty-somethings we would put on weight very quickly. We are probably on average also less active than in our younger days. This implies that our eating and exercise patterns need to change with age. It is another challenge of an ageing society – how do we adapt to each decade, because the answers at 25 do not apply to 55.

8. Because it's so easy to put on weight and so hard to get it off. It's a bit like a lobster pot: easy to get into and hard to get out again. Many of us have tried slimming, and I think we all know how difficult it is to keep the pounds off once they have been lost. It does take a lifestyle change- and that can be hard graft.

9. Because we don't like preaching – especially if it makes us feel a bit uncomfortable. The messages are I think clear to us all. But they can get a bit 'preachy' and that tends to make us close our ears.

So what do we do?

The answer has to come through teamwork between the individual, family, government, employers, planners and organisations. It's about 1000 adjustments to 1000 tillers to turn the flotilla we all sail in…….. and there *are* green shoots - for example, in the last year or two:

- The health messages continue to seep home into the public's mind – the '5 a day' message is well embedded and shoppers are demanding healthier prepared foods – and the supermarkets are responding.
- At national level, Government has taken steps to improve food labelling and to reduce the sugar content of drinks.
- The climate in schools is changing – take for example the adoption of the 'daily mile' in schools across the country.
- Health and exercise options are being main-streamed by planners into new developments.
- The inequalities issues are clearer - and our Health Inequalities Commission report helps.
- Front-line health professionals are more willing to consider giving lifestyle advice during routine consultations.

And more locally……

- We have made very good progress in building exercise options into planning through the Healthy New Towns.
- The Health Improvement Board has made useful efforts to begin bringing recreation and leisure services together with the Sports Partnership to update its healthy weight strategy.
- The NHS has taken the topic of 'making every contact count' more seriously so as to get health advice into more face to face consultations.
- More schools are looking at options such as the 'daily mile'.

What Did We Say Last Year and What Have We Done About It?

We said that this topic should become a priority for the NHS's Sustainability and Transformation Plan – this has happened on paper, but there is no spare cash to fund the scale of change needed.

We said that the Health Improvement Board should play its part in partnership activity and this has been more than achieved.

What should we do next?

To keep it brief, this is a long haul, so essentially it is more of the same – more awareness, more coordination and more money are required.

Recommendations regarding obesity, diet and physical activity.

1. The NHS should continue to seek a serious investment fund to take this work forwards.

2. The Health Improvement Board should continue to coordinate the activities of all Local Authorities and the NHS

3. Planners should continue to plan communities that support active lifestyles until this is the norm.

Alcohol

There seems to have been a helpful shift in drinking patterns that will reap benefits in the decades to come.

Previous reports have set out the real health risks of alcohol as a causative factor for a wide range of diseases and its corrosive effects on society when consumed to excess.

I am not saying the problems have gone away altogether because:

- There were over 1 million alcohol related hospital admissions in England in 2015 and over 23,000 deaths related to alcohol.

- Alcohol is a causal factor in many medical conditions including mouth, throat, colon, liver and breast cancers; strokes and heart failure; liver disease and pancreatitis as well as road traffic accidents and injuries due to falls.

- Alcohol affects us all – for example, the highest earners (those earning £40,000 and above annually) are more likely to be frequent drinkers and "binge" on their heaviest drinking day when compared with the lowest earners.

But on the other hand:

- Overall alcohol consumption in the UK has decreased between 2000 and 2014, reducing from over 10 litres of pure alcohol per person aged 15+ to around 9.5 litres per head

- The proportion of the adult population of Great Britain (aged 16 and over) who drink alcohol has fallen from 64% in 2005 to only 60% in 2016).

- Young people aged 16 to 24 years in Great Britain are less likely to drink than any other age group.

- Alcohol consumption in young people in general is falling

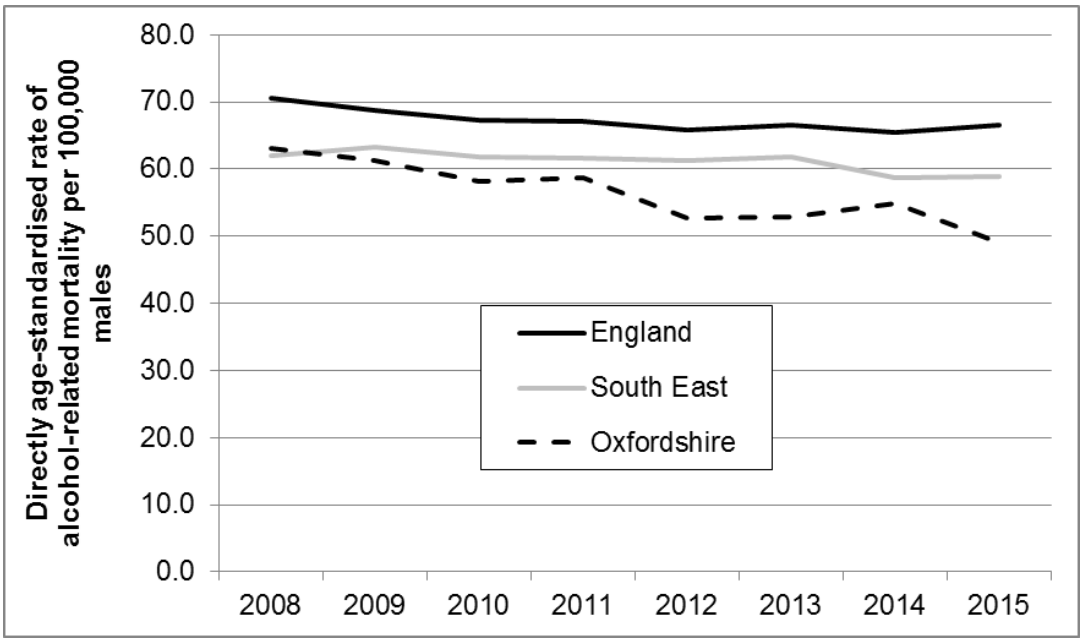
Why should this be?

I'm not sure anyone really knows. It may be that the health messages have hit home, or it may just be one of those complex societal 'fashions'. My money would be on the latter. Looked at over centuries, the average trend in alcohol consumption per capita has always fluctuated. We may have entered a down-turn and, whatever the reason, that is very good long term news.

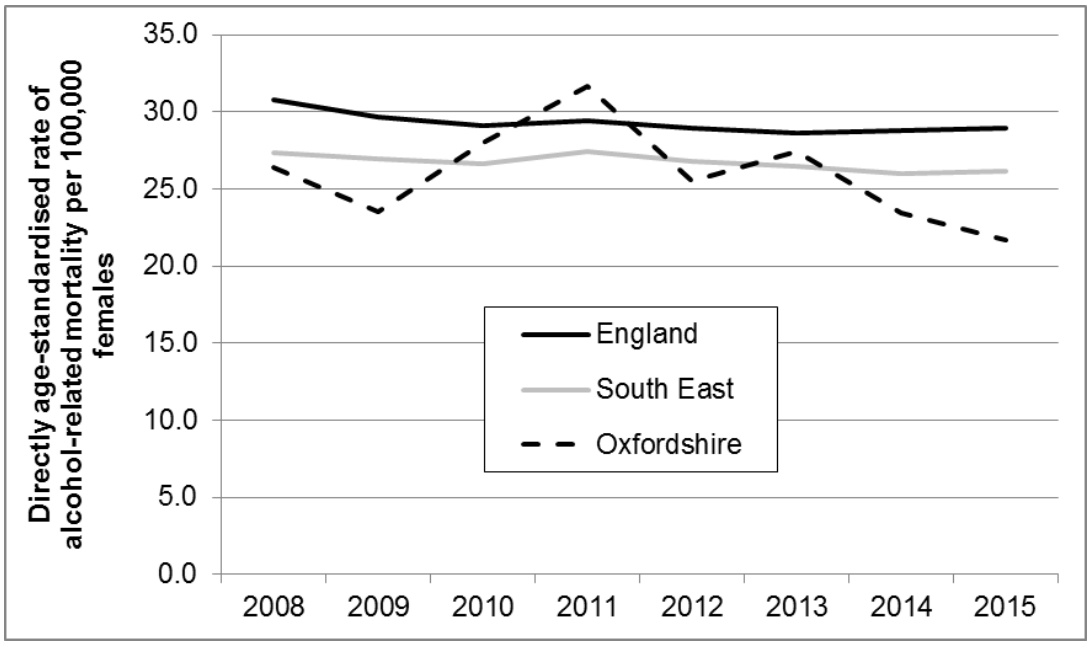
The statistics paint the picture well:

- Alcohol related deaths in males and females have been declining over the last 6 of 7 years and the figures are better for Oxfordshire than nationally. Also, deaths in females are around half of those in men

Alcohol-related mortality – males



Alcohol-related mortality – females

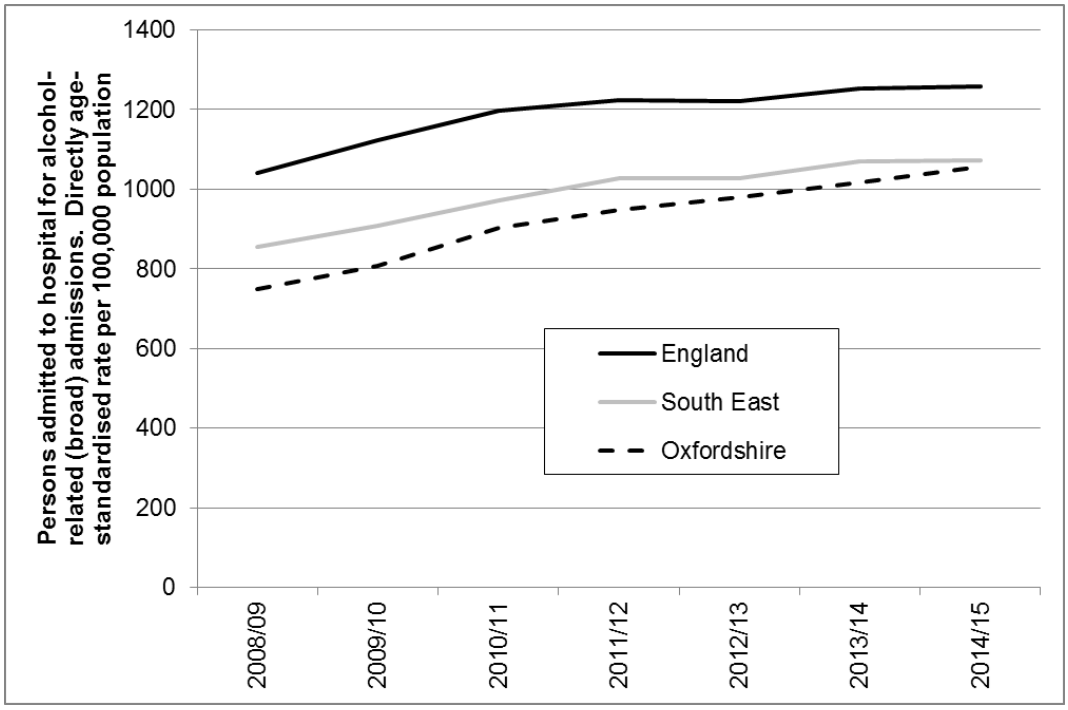


However, we aren't out of the woods yet as the figures for alcohol-related hospital admissions continue to show an upward trend. You can see this in the charts below which show people

admitted to hospital each year per 100,000 population. Because alcohol-related disease is long term, this might be the long term legacy of the drinking habits of previous decades – time will tell.

Whatever the reason, it is good news that the levels in Oxfordshire are well below national levels.

Persons admitted to hospital for alcohol-related conditions) - all ages



What Did We Say Last Year and What Have We Done About It?
Achievements in 2016-17

The Alcohol and Drugs Partnership reports the following progress in partnership work:

1. Identification and Brief Advice (IBA)

   The goal is to equip professionals with the confidence to give brief advice to people who are drinking too much. The partnership's role is to train the professional. This year the training was expanded to include smoking cessation and all sessions have been well attended by a range of professionals including those working in adult social care, early Intervention services, mental health organisations, charities, housing providers, primary care, pharmacies and Oxford University Hospitals Trust.

2. Targeted alcohol campaigns

   This year the Dry January campaign was again supported by the Fire and Rescue Service, and included 'mocktail' sessions run by Alcohol Concern. Advertising for the campaign included social media, the County Council's Yammer pages as well as an article in the Oxford Mail.

3. Improvement in Pathways to treatment.

Oxfordshire treatment services have been working hard to improve pathways between local hospitals and their services. Referral routes from both A&E and ward admissions back into the community have been reviewed as well as barriers to communication and continuation of prescribing. Staff from Turning Point (a drug and alcohol treatment organisation) continue to develop joint-working with the NHS, and a community alcohol detoxification nurse attends the John Radcliffe Hospital weekly to discuss patients and provide on-going community support for patients leaving hospital.

4. Street Pastors

Street Pastor schemes continue to flourish in the City and several market towns across Oxfordshire. Street Pastor schemes work in partnership with organisations such as the Police, Local Authorities, local door staff and licenced premises. They patrol the streets with a remit to 'care, listen and help'. Between April and September 2016 over 577 people were assisted by the street pastors.

What we said last year and progress made

Recommendations for 2016-17 were set out as follows:

1. The NHS should use the Sustainability and Transformation Plan to embed brief advice for people with problem drinking into all consultations. This is a real opportunity to nip alcohol related diseases in the bud.

2. This should be backed up by staff training and support.

Progress report: This work is ongoing and, due to delays in publishing the Transformation Plan for Oxfordshire, it is not yet clear that last year's recommendations have been fully implemented.

Recommendations for 2017-18

1. The NHS should continue use the Sustainability and Transformation Plan to embed brief advice for people with problem drinking into all consultations. This should be backed up by staff training and support.

2. Campaigns should focus on the impact of alcohol on health so that there is increased awareness of the harmful effects of alcohol on cancer and cardiovascular disease in particular.

NHS Health Checks

The NHS Health Check is a national cardiovascular risk assessment and prevention programme which is commissioned by the County Council. It is delivered by local GPs and has been commissioned by the County Council's Public Health team since 2013

NHS Health Checks specifically target the top seven causes of preventable death: high blood pressure, smoking, high cholesterol, obesity, poor diet, physical inactivity and alcohol consumption.

Eligible individuals aged 40-74 years are invited for a Check every five years (191,000 people), which means that 20% of this age group are invited per year and every eligible person is invited at least once every five years. The 40-74 age range is set nationally because it has been determined that this is the group in which detection and prevention of cardiovascular disease is most cost effective.

In Oxfordshire, the Health Improvement Board has set a target of 55% of those invited for a NHS Health Check take up the offer and receive the Check.

In 2016/17 in Oxfordshire 34,667 people were offered NHS Health Checks (18.2% of eligible population) and 17,847 checks were completed (9.3% of the total eligible population and 51.5% of those offered a check). This is an improvement on 2015/16 in terms of uptake (51.2% in 2015/16), but a decrease in percentage offered (20% in 2015/16) and percentage completed.

During 2016/17 of the 17,847 people who had a Health Check:

- **896 people were found at high risk of CVD, with 417 people now taking a statin**
- **275 people diagnosed as having high blood pressure, with 252 now on an antihypertensive drug**
- **63 people were diagnosed with diabetes**
- **1537 people were given brief advice regarding smoking, with 148 people referred/signposted to the local stop smoking service**
- **6310 people were given brief advice regarding physical activity, with 1706 people referred/signposted to the local physical activity services**
- **5821 people were given brief advice regarding weight management, with 283 people referred/signposted to the local weight management services**
- **1574 people completed a screening tool for their alcohol consumption. In addition1658 people were given brief advice regarding alcohol, with 8 people referred to the local alcohol services.**

This is a good result.

What Did We Say Last Year and What Have We Done About It?

Last year we said we would continue to bring the NHS Health Check programme to the public's attention in new and innovative ways to further raise awareness in the local community. This peaked with a month long campaign in January using local radio and advertising on transport links- which is thought to have contributed to the increased uptake in quarter 4.

We also said we would continue to work with GPs to improve the uptake of the offer, including the invitation process. Commissioners are working with GPs to investigate a combined approach of electronic communications from GPs and simultaneous targeted marketing online to improve uptake of the offer.

The commissioning team continue to closely support practices and have visited every practice as part of quality auditing the programme. They provide feedback to GP practices on how to improve on the quality of the programme. The approach to quality auditing taken by the public health team is still considered a national exemplar.

Recommendations for NHS Health Checks

The NHS Health Check programme continues to perform well, is now well embedded in the health system and is well received by the public. However, the concerted efforts to raise the profile of this programme with the public and improve on it must be maintained. In order to achieve this we need to:

1. Continue to market the NHS Health Check programme in new and innovative ways which take advantage of emerging technologies to raise awareness and understanding of the benefits of the programme with the public.

2. Continue to work with GPs to improve on the uptake of the offer of a free NHS Health checks and investigate new ways to best collaborate on improving the invite process.

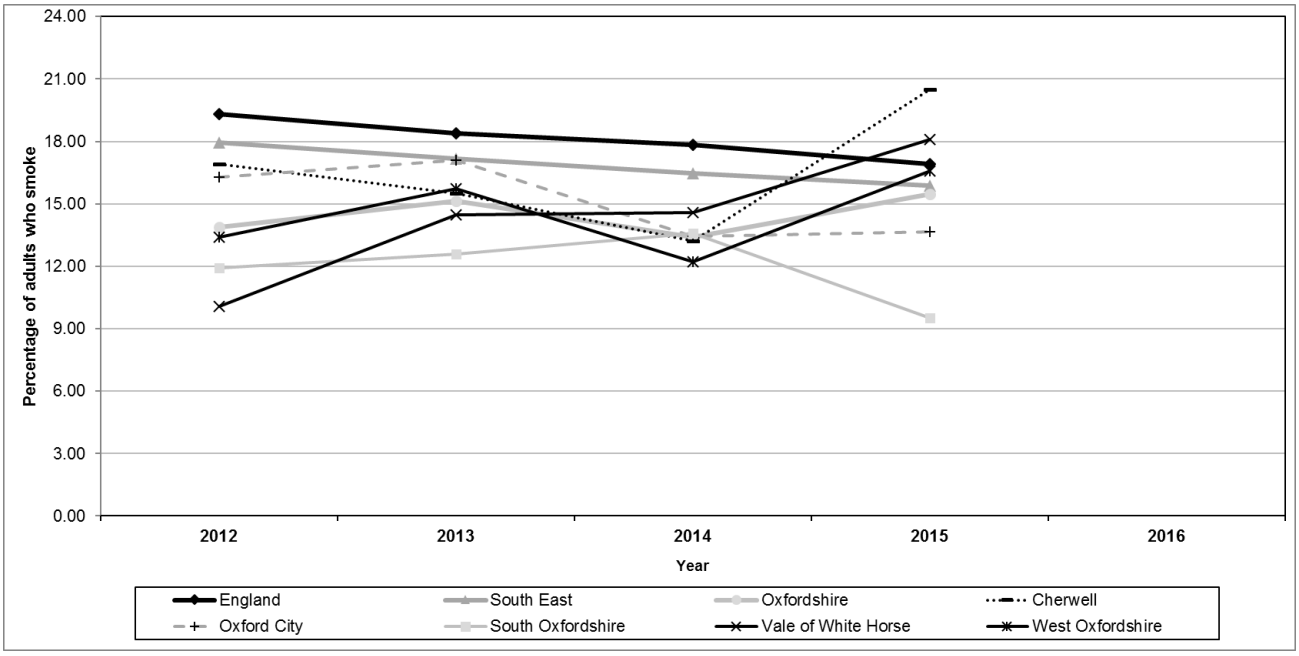
3. Better identify and engage with high risk groups to take up the offer of a free NHS Health Check.

Smoking Tobacco

Smoking Tobacco continues to be the single most harmful thing you can do to damage your health. Smoking causes conditions ranging from cancers, vascular diseases and events such as heart attacks and strokes, and dementia. In Oxfordshire the prevalence of adult smokers has seen a very welcome continued decline in the past few years. This decline is shown in the figure below. The prevalence of adults who smoke in Oxfordshire is currently estimated to be 15.5% (an estimate of 91,892 people) which is better than the national prevalence (16.9%). This is a good result.

The chart below shows the results. Because this is based on a survey of a limited number of people, the national line will be accurate, the County line fairly accurate and the District lines far less accurate and subject to wide fluctuations.

Smoking prevalence in individuals aged 18+ by District in Oxfordshire



(Source PHE)

However, we still cannot be complacent about smoking rates in the County. There is still an inequality in who smokes, with much higher levels of smoking found in more disadvantaged communities. Indeed, in routine and manual workers the level of smoking is as high as 29% - double the County average. To meet this challenge, we need to target services at the groups who need help the most.

Smoking is highly addictive and the best thing for health is not to start. Although the trend for smoking in young people is falling the prevalence of young people aged 15 years who report in the survey that they are current smokers is 10.4%. This is significantly worse than the national average of 8.2%. While this is of concern some caution has to be exercised as the data is estimated based on responses provided to surveys of young people and can be subject to statistical errors (i.e. in plain speak it may be a 'blip'.). We should monitor this trend to see if this is a consistent finding.

Stop Smoking Services

The decline in people accessing traditional stop smoking services seen in recent years was halted in Oxfordshire with 1923 quits recorded for 2015/16 – three less than in the previous year total of 1926. This was against the national decrease of 10% in the recorded number of quits recorded nationally. This is to be applauded but preventing a further decline in recorded quits is becoming increasingly difficult. Why? Because there are fewer smokers 'out there' and there has been a sea-change in the way people choose to quit tobacco – increasingly opting for self-help solutions rather than statutory services.

The impact of the dramatic increase in the use of e-cigarettes in the UK is the most significant contributor to the reduction in people accessing stop smoking services. Latest data estimates:

- An estimated 2.9 million adults in Great Britain currently use e-cigarettes up from 700,000 in 2012

- For the first time there are more ex-smokers (1.5 million) who use e-cigarettes than current smokers (1.3 million).

- Over half (52%) of e-cigarette users are now ex-smokers and 45% continue to smoke as well.

- The main reason given by ex-smokers who are currently vaping is to help them stop while for current smokers the main reason is to reduce the amount they smoke.

- The use of e-cigarettes as a quit aid and their increasing usage has opened a debate in the public health community on a national and international scale. Currently in 2017, public perceptions of harm from e-cigarettes still remains inaccurate with only 13% accurately understanding that e-cigarettes are a lot less harmful than smoking. Among those who smoke, perceptions of e-cigarettes are also getting more negative, with only 20% accurately believing in that e-cigarettes are a lot less harmful than smoking compared with 31% in 2015.

With the increasing amount of conflicting information for and against e-cigarettes becoming available in the public arena there has naturally been confusion for the public and health professionals alike.

Public Health England have helped to clarify the position and published an evidence update which concluded that e-cigarettes are significantly less harmful to health than tobacco and have the potential to help smokers quit smoking.

The report also concluded there is no evidence so far that e-cigarettes are acting as a route into smoking for children or non-smokers. This is further supported by a report from the Royal College of Physicians published in April 2016 which states that e-cigarettes are an effective method for people wanting to quit tobacco and the hazard to health arising from long-term vapour inhalation from the e-cigarettes available today is unlikely to exceed 5% of the harm from smoking tobacco.

How should we move forward?
Our current services are now outdated. We need to move to a service which helps the general public but which also actively seeks out smokers in the most at-risk groups.

The public health team, in line with The National Institute for Health and Care Excellence (NICE) recommendations, are considering the following main areas for future services:

- Mass media and other education campaigns
- General education campaigns aimed at everyone;
- Media campaigns aimed at under 18s.
- Planning evidence based stop smoking services;
- Preventing children and young people from taking up smoking;
- Illegal sales
- Coordinated approach in schools
- Developing services which encourage better uptake in disadvantaged and minority communities who have higher rates of smoking.

Recommendations regarding smoking

1. The Health Improvement Board should continue to monitor activities of local smoking services and wider agencies to help people quit smoking and also not start in the first place.

2. Commissioners should re-commission services to deliver a blend of services to meet the changing attitudes and use of stop smoking services.

Oral Health

The marked improvement in oral health and the number of adults keeping their teeth as a result of better brushing with fluoride toothpaste and more awareness of oral health is welcome. However nationally in England the biggest cause of child hospital admission for general anaesthetic procedure is to provide dental extractions due to severe tooth decay. Tooth decay is one of the most easily preventable diseases and the high level of extractions under general anaesthetic is avoidable.

The picture in children

Local data is based on national surveys whose sample size is really too small to draw firm conclusions at lower than County level. However, looking at the national data, we can see that tooth decay is linked with other measures of general social disadvantage and so is a further source of inequality in the County. Latest available data from the 2015 oral health survey of five-year-old children shows that 77% of 5-year-old children are now free from any dental decay which is higher than the national average of 75% and improved locally from 67% since the 2012 survey. Whilst this is a good result there is room for improvement, the number of children who are decay free is significantly lower in Oxford than the other districts at 67%, probably reflecting social disadvantage.

During the 2016/17 dental teams have been conducting the latest national five-year-old children's survey and we expect to refresh the local data in the next twelve months.

The major sources of sugar which causes decay in children are found in soft drinks and cereals. Locally we will continue the work to educate children and parents about the impact of dietary choices on teeth and also wider health.

The picture in adults

Tooth decay has fallen in adults in England from 46% having active decay in their teeth in 1998 to 28% in 2009. The main sources of sugar in adults' diets come from cereals, soft drinks, jams and sweets.

Older adults are now keeping their own teeth into old age as the norm. The proportion of 65 to 75 year olds with their own teeth increased from just 26% in 1979 to 84% in 2009- a significant change. As the population ages it will be important that the NHS keeps pace with this changing need - particularly as the number of people needing more complex dental work rises steadily with age.

What are we doing and what should we do next?

Since the NHS reorganisation, the responsibility for oral health has been split three ways. The NHS has a responsibility for dentists and more specialised oral surgery, Public Health England

provides dental public health advice while Local Government has an emphasis on prevention and commissioning oral surveys in line with the national programme.

The oral health promotion and dental epidemiology service commissioned by the County Council has been in operation since 1st April 2015. This service aims to work in collaboration with wider dental services to prevent oral health problems in children and adults. The range of activities provided by the service include:

- Accreditation scheme for pre-school settings
- Piloting tooth brushing programme in primary schools. Four primary schools took part in the pilot programme in which children brushed their teeth under supervision of staff. The programme developed better understanding of oral health and improved brushing skills in children, making tooth brushing a routine part of the day which improved attitudes to brushing in the young children involved.
- Training of school health nurses in oral health promotion to promote a 'whole school' approach to oral health in education such as through making plain drinking water freely available, providing a choice of food, drinks and snacks that are sugar-free or low in sugar and form part of a healthier diet (including those offered in vending machines), and displaying and promoting evidence-based, age-appropriate, oral health information for parents, carers and children, including details on how to access local dental services.
- Piloting an accreditation scheme for care homes for elderly residents. The pilot successfully accredited three care homes as oral health promoting environments. The service trained staff to better understand the oral health needs of residents, the causes of oral disease, good oral hygiene for their residents and how to access dental services. The participating care homes also developed policies to better promote oral health for residents.
- Delivering oral health promotion sessions and events throughout the county
- Training health visitors in oral health to better understand the causes of tooth decay, oral development in young children, looking after teeth in young children and accessing dental services.
- Training staff who work in the community with children and adults to promote oral health with their client and user groups including causes of tooth decay, oral hygiene and access to dental services.
- Delivery of oral health promotion in local workplaces including Siemens and Thames Valley Police.
- Promotional events during National Smile Month and Mouth Cancer Awareness Month
- Provision of a lending service of health promotion resources for local stakeholders.

In the next year the oral health promotion service will

- Continue the supervised tooth brushing scheme in primary schools. Two of the schools in the pilot are planning to continue the programme and the service is looking to recruit new schools for the 2017/18 academic year.

- Find ways to reach a wider number of care homes.

- Continue to train staff in healthcare and community settings to become oral health promoters within their workplace with their service users and make every contact count.

- Continue support of oral health promotion development within both school health nurse and health visitor services.

- Continue to participate in oral health promotion events and sessions in the community to directly work with the public on raising the awareness of the importance of good oral health and accessing dental services.

Recommendations for Oral Health

1. The NHS should ensure that improvements in access to NHS dentistry are maintained including complex care and domiciliary care for older people and work continue to work to reduce child admissions for dental extractions under general anaesthetic.

2. Providers of care home facilities should be aware of maintaining good oral health in their clients which can significantly affect their quality of life. Commissioners of the oral health promotion should work with colleagues to develop this programme to increase the number of care homes who sign up to this programme.

3. Continue to work with school health nurse and health visitor services to embed oral health prevention and promotion into children's health from 0-19, allowing for a healthier oral health start to life.

4. Continue to develop the supervised brushing scheme in primary schools, developing on the encouraging work of the pilot programme.

Chapter 5: Mental Health

Mental Health - Children and Young People

I reported last year on mental health in children and young people and I want to keep that focus this year.

Last year I reported on two topics – trends in mental wellbeing in this age group in general and self-harm.

Looking at each of these in turn, we noted that:

- mental wellbeing and mental distress are difficult to define and measure in this age group and that what is classed as a mental health problem changes over time

- however, the indications are that living in the modern world and a digital age puts new stresses and strains on young people

- young people are coming forward to seek help – and we can see this in the work of our school health nurses and through rising referrals to NHS services

- this increase is no bad thing as it also shows young people's awareness of the issues they face and also young people's general self-help attitude.

To recap, the picture of emotional resilience and mental wellbeing can be summed up as being built up in the following ways:

- Positive relationships with caring adults
- Effective caregiving and parenting
- Intelligence and problem-solving skills
- Self-regulation skills
- Perceived efficacy and control
- Achievement / motivation
- Positive friends or romantic partners
- Faith, hope, spirituality
- Beliefs that life has meaning
- Effective teachers and schools

In contrast, when these factors are deficient, the individual's resilience is likely to be lowered and there is a greater vulnerability to stresses and strains.

Regarding more severe mental health problems in Children and Young People, the main facts are:

- 1 in 10 children and young people aged 5-16 suffer from a diagnosable mental health disorder; that is around three in every class at school or 8,000 children across Oxfordshire. According to national prevalence rates about half of these (5.8%) have a 'conduct disorder', whilst others have an emotional disorder (anxiety, depression) and Attention

Deficit Hyperactivity Disorder (ADHD). The prevalence increases with age and rises to 20% for the 16-24 age groups.

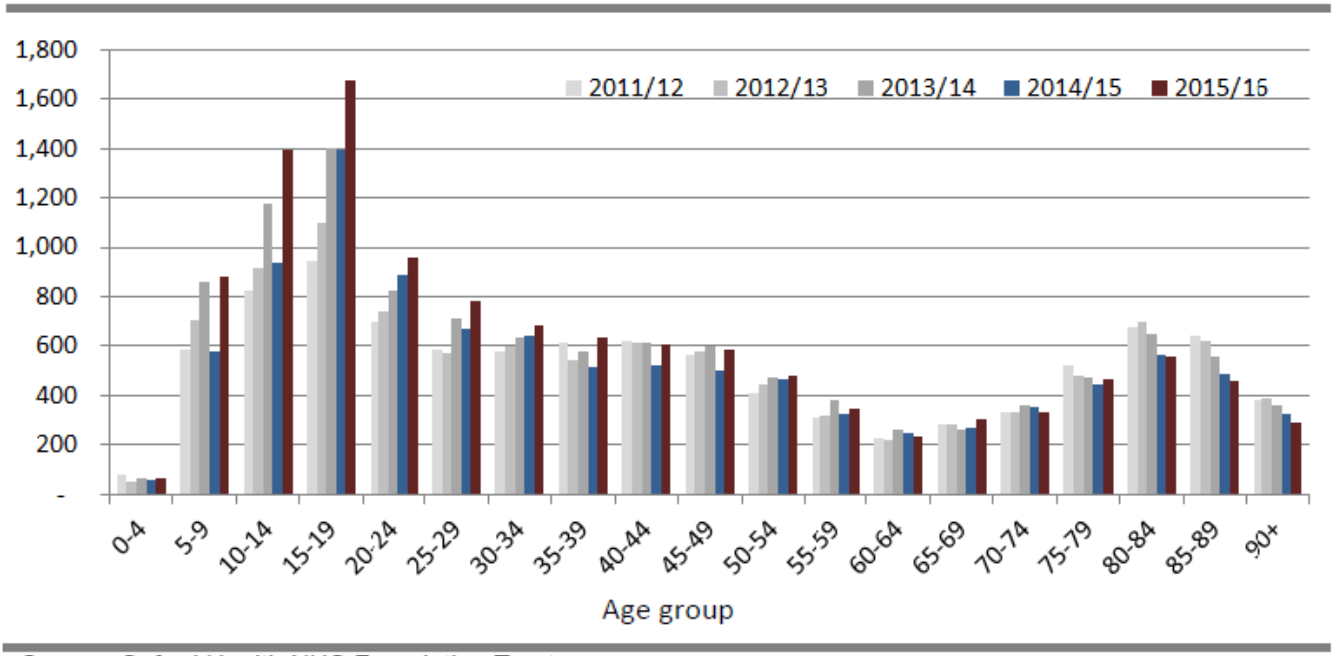
- The most disadvantaged communities and the most disadvantaged groups have the poorest mental and physical health and wellbeing. **Children from the poorest 20% of households have a three-fold greater risk of mental health problems than children from the wealthiest 20%.** Parental unemployment is also associated with a two-to three-fold greater risk of emotional or conduct disorder in childhood. This doesn't mean that one causes the other, it simply points out that the two factors are found together in the same families.

- Children and young people with poor mental health are more likely to have poor educational attainment and employment prospects, social relationship difficulties, physical ill health, substance misuse problems and to become involved in offending.

- These issues are therefore significant and important.

In very general terms I suspect that what we are seeing overall is a generation who are subject to more moderate stresses (cyber-bullying for example), and that they have an increasing awareness of this, and, most importantly that they are seeking help. The chart below shows this through the rise in referrals of young people to mental health services.

Number of Oxfordshire residents referred to Oxford Health mental health services (2011-12 to 2015-16)



Source: Oxford Health NHS Foundation Trust

- The 15-19 age group continues to make up the largest proportion and number of patients referred to Oxford Health mental health services in 2015-16 and has seen the biggest increase since 2011-12.

- Between 2011-12 and 2015-16, the number of patient referrals aged 15-19 increased by 77%

I reported last year that children and young peoples' mental health service had just been overhauled. This is timely. The results of this were that a new contract for a new service model was awarded. The new service focusses on early prevention and intervention in partnership with voluntary agencies, public health services, education and children's social care to ensure children, young people and their families can get information, advice and support (including self-care) when there are emerging mental health problems. This is aimed at preventing more chronic and complex mental health problems, which can affect long term outcomes into adulthood.

We should also note the very valuable contribution our School Health Nurses make to the treatment of mental distress day in day out in our secondary schools.

The new service features:

- A single point of access for all referrals including self-referrals and clear publicised pathways for the most common conditions
- Active support for families and individuals to help them access other community services where this is more appropriate
- Partnership with voluntary organisations to support families better and improve movement between services for the young people with the most complex problems
- Reducing waiting times to improve access to support and treatment using evidence- based interventions to improve long term outcomes into adulthood
- Consultation, information and advice to families, young people and the wider children's workforce and the promotion of self-care and use of technology.
- Prevention and early intervention by working in schools and colleges to provide consultation, training and treatment in partnership with school health nurses and children's social care services

The service will include newly established specialist services such as:

- A dedicated Eating Disorder Service
- A new therapeutic team specifically working with young victims of child abuse and child sexual exploitation
- A new team to work with children who are 'Looked After' and those young people who are on 'the edge of care'
- An Autism Diagnostic Service with support for families after a diagnosis has been made
- A forensic psychiatry post working in the young people's housing pathway providing mental health expertise to some of our most complex young people and building capacity in the housing provider market

The focus for the first year is to deliver the 'single point of access' which will improve access to consultation, information and advice and treatment and, in addition, to start transforming the service into providing prevention and early intervention through working with primary and secondary schools across Oxfordshire. This includes School Health Nurses and improving integration and joint working with Children's Social Care. Voluntary organisations will play a key role as partners in delivering Child & Adolescent Mental Health Services (CAMHS).

This is clearly a substantial change and seems to respond well to the needs of young people. Implementation will take time – working with every Oxfordshire school is a huge task and a long process.

I think these are useful steps in the right direction.

Careful monitoring of this service and of new trends in the overall wellbeing of this age group will be essential.

Self Harm

I also reported last year on self-harm and reviewed the recent upward trend.

The last year has seen a mixed picture.
Measuring self-harm using hospital admissions shows that:

- rates in 10-14 year olds are down slightly
- rates in 15-19 year olds are up slightly
- rates in 20-24 year olds are down slightly

All of these figures are similar to the national picture. The trends we are seeing in Oxfordshire around self-harm are part of a national picture rather than a local one.

The new service mentioned above is intended to help to relieve the stresses that result in self-harm. It will be important to monitor the situation to see if there is a lasting impact.

In addition, last year I reported on an initiative that the Public Health team had undertaken locally. To recap, we commissioned a local Oxfordshire theatre company, Pegasus, to perform a play on self-harm in secondary schools across the county. The play was called 'Under My Skin'. Its aims were to:

- Give young people vital information about coping with feelings around self-harm, stress and the relevant services that can support them.
- Reduce the stigma of discussing self-harm and accessing support.
- Highlight the School Health Nursing service as a first port of call in schools for young people and professionals who have concerns over self-harm.
- Give professionals information and subsequent confidence about how to support a young person, and who to refer to.

The evaluation of the play showed that:

- It went to 28 secondary schools and was very well received.
- Approximately 5000 young people in years 8/9 (ages 12-14) watched the play.
- 50% reported the play increased their knowledge of self-harm a lot.
- 71% of young people knew how to access support after seeing the play.

As a result, we have re-commissioned the play again for the academic year 2016/2017.

It is important that professional help to young people is made part of the mainstream of many services rather than as a stand-alone service.

Examples of this in action are shown by the following 'snapshots' of work in hand in mainstream services across Oxfordshire:

- School Health Nurses have been trained in child & young person mental health through a programme called PPEPcare. The training includes:

  - Supporting young people with low mood
  - Supporting young people with anxiety
  - Supporting young people who self-harm

- In addition, our nurses have run awareness campaigns to ensure that young people are aware of techniques they can use to improve their well-being and where they can access support should they need it.

- School Nurses also support young people with exam stress – and example comes from the Matthew Arnold School where the School Nurse ran sessions with sixth formers approaching exams. This will lead to 'Chill Out Tuesday' and 'Wind Down Wednesday' next year for all young people approaching exams.

- By the end of March 2017, the Oxfordshire Young Carers Service had identified and supported a total of 2,684 children and young adults (aged 0 -25 years) who provide unpaid care to a family member. Caring is also well known as an additional cause of stress for young people. This included 456 new young carers identified in the year 2016-17.

- The Health Visiting service also has a role to play - the County Council have commissioned Oxford Health NHS Foundation Trust to create a specialist post which will set up new postnatal mental health groups and train those who run them. This recognises that addressing mental health needs of mothers is paramount in promoting mental wellbeing and preventing mental health problems in their children.

In summary, self-harm is an important issue. There is evidence that services are responding well, but this situation needs to be actively monitored.

Recommendation

Children and Young Peoples' mental health and wellbeing and its related services should be monitored in future Director of Public Health annual reports.

Chapter 6 – Fighting Killer diseases

Main messages for this chapter:

Part 1. Epidemics and Antimicrobial Stewardship

The improvement in the quality of our living conditions and the advances in modern medicine have meant that the threat of major illness and large numbers of deaths due to communicable disease are seen as a problem of times past.

The continuing vigilance of Public Health services and sound planning of local and national organisations to respond to the spread of communicable diseases means that most of us can go about our daily lives without being aware of the efforts to protect the wider community from disease. The Ebola and Zika outbreaks of recent times are stark reminders of the continuing threat that can arise at any time and present a very real risk to us all, irrespective of borders. The Ebola cases in the Democratic Republic of Congo and elsewhere act as a stark reminder of the need for continual vigilance across the world.

We need to continue to prioritise the work that is done in the background every day of the year to prepare for the worst and the unimaginable. Directors of Public Health work closely with Public Health England and the NHS across Thames Valley to ensure that the response to any threat will be matched by a coordinated response to any outbreak, wherever it may arise. It is important that this partnership and cooperation is continued.

The right response still remains systemic and calm planning and organising ourselves NOW so we can respond when the need arises without fear or panic. The need to remain vigilant still holds true.

A continuing cause for concern is the threat of **antibiotic resistance** and the rise of “superbugs”. Antibiotics are important drugs for animals and humans in fighting bacterial infections which were once life-threatening. Bacteria are highly adaptable and the widespread misuse of antibiotics and inappropriate prescribing of antibiotics continues to lead to bacteria which have developed resistance to the antibiotics which were once effective.

The risk of bacteria which cannot be treated by any existing antibiotics is a real threat here in the UK and throughout the world. We continue to see outbreaks of resistant strains of bacteria, if we do not act we will see the number of resistant strains increase.

Failure for us all to act responsibly now could see antibiotics becoming ineffective and the return of people dying of once curable infections, returning us to the situation before the discovery of penicillin.

How do we keep this work going?

Success depends on several key elements:

- Maintaining a well-qualified and well trained cadre of Public Health specialists in Local Government.
- Continuing to build and maintain long standing relationships with colleagues in Public Health England and the NHS.
- Mainstreaming our plans by working with the Police, Military and many of the other organisations under the auspices of the Thames Valley Local Resilience Forum (LRF).
- Educating and advising professionals and the public of their role as individuals in limiting antibiotic resistance.

It is vital to keep the specialist workforce we have now to continue with this important work.

Part 2. Infectious and Communicable Diseases

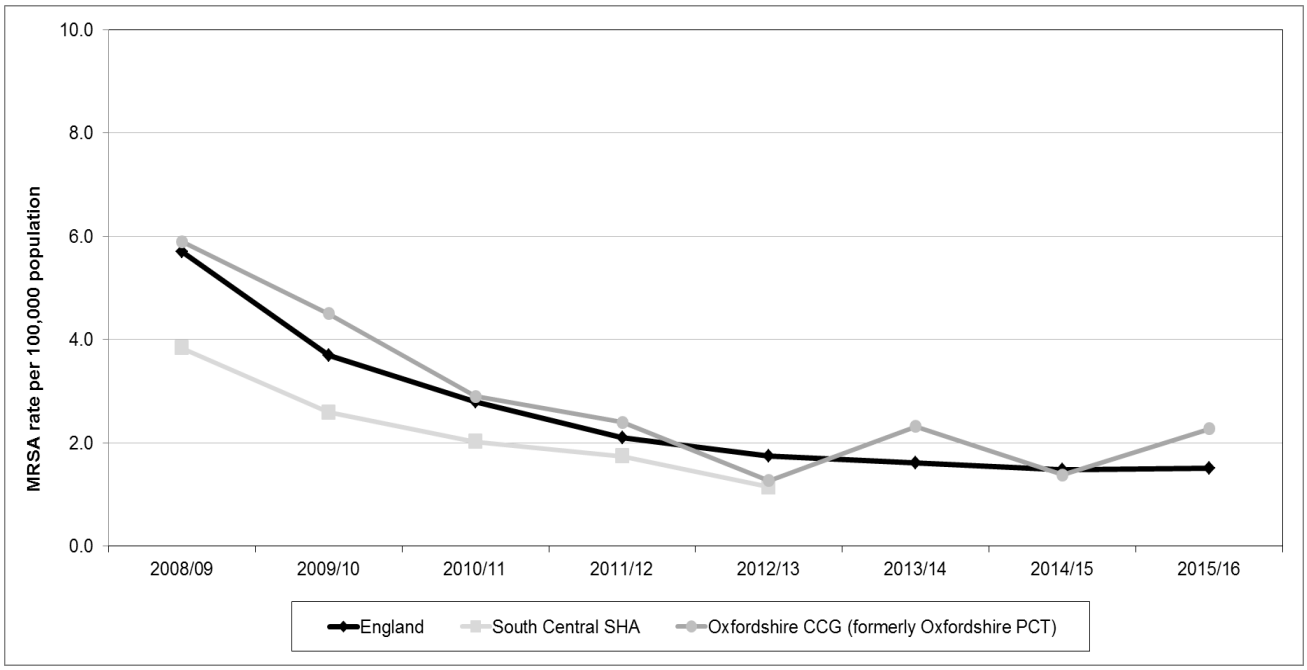
Health Care Associated Infections (HCAIs)

Infections caused by superbugs like Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium difficile (C. diff.) continue to be an important cause of avoidable sickness and death, both in hospitals and in the community. These infections do not grab headlines as they have in the past but they still need everyone to remain vigilant to limit an increase in the incidence of infection.

Methicillin Resistant Staphylococcus Aureus (MRSA)

MRSA is a bacterium found commonly on the skin. If it gains entry into the blood stream (e.g. through an invasive procedure or a chronic wound) it can cause blood poisoning (bacteraemia). It can be difficult to treat people who are already very unwell so it is important to continue to look for causes of the infection and identify measures to further reduce our numbers of new cases of infection. MRSA has fallen gradually in Oxfordshire in response to the direct measures taken by hospital and community services to combat it. The local situation is shown below.

Methicillin Resistant Staphylococcus aureus (MRSA) - crude rate per 100,000 population (2008/09 - 2015/16)



Public Health England (PHE), Health Protection Agency (HPA)

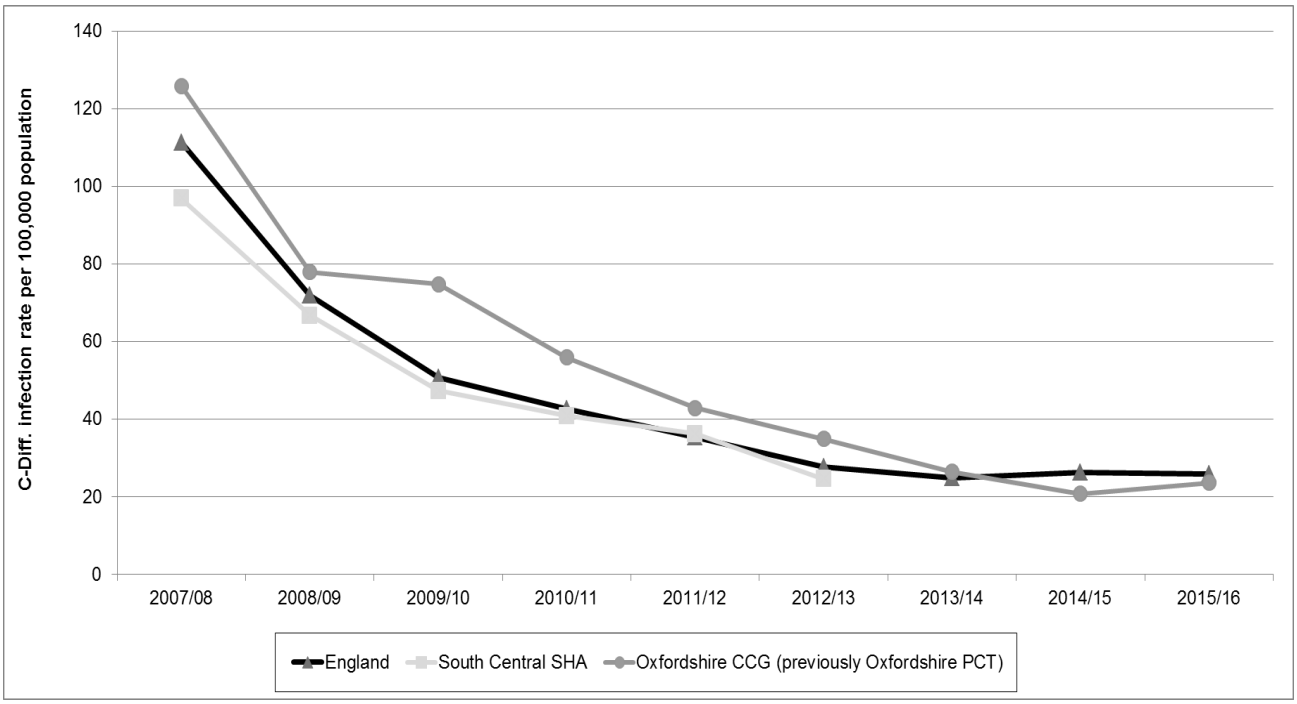
This shows that infections can be tackled, often by traditional hygiene methods. Nationally there is a zero tolerance policy and the rate of MRSA is still higher than we would like. There have been improvements in Oxfordshire over the past few years. However, the levels in Oxfordshire have increased slightly again in 2015/16 to be higher than the national average. This slight increase, which may be a statistical 'blip' due to the small number of cases each year reaffirms why continued vigilance is required by all hospital and community services to combat MRSA infections.

Clostridium difficile (C.diff)

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

A focussed approach on the prevention of this infection has resulted in a steady reduction in cases in Oxfordshire since 2007/08 as shown in the chart below which is in line with the National trend. The reduction in C.diff involves the coordinated efforts of healthcare organisations to identify and treat individuals infected and also careful use of the prescribing of certain antibiotics in the wider community. There are still on-going concerted efforts locally to continue to improve on the rate of C.diff infections.

Clostridium Difficile Infection (CDI) - crude rate per 100,000 population (2007/08 to 2015/16)



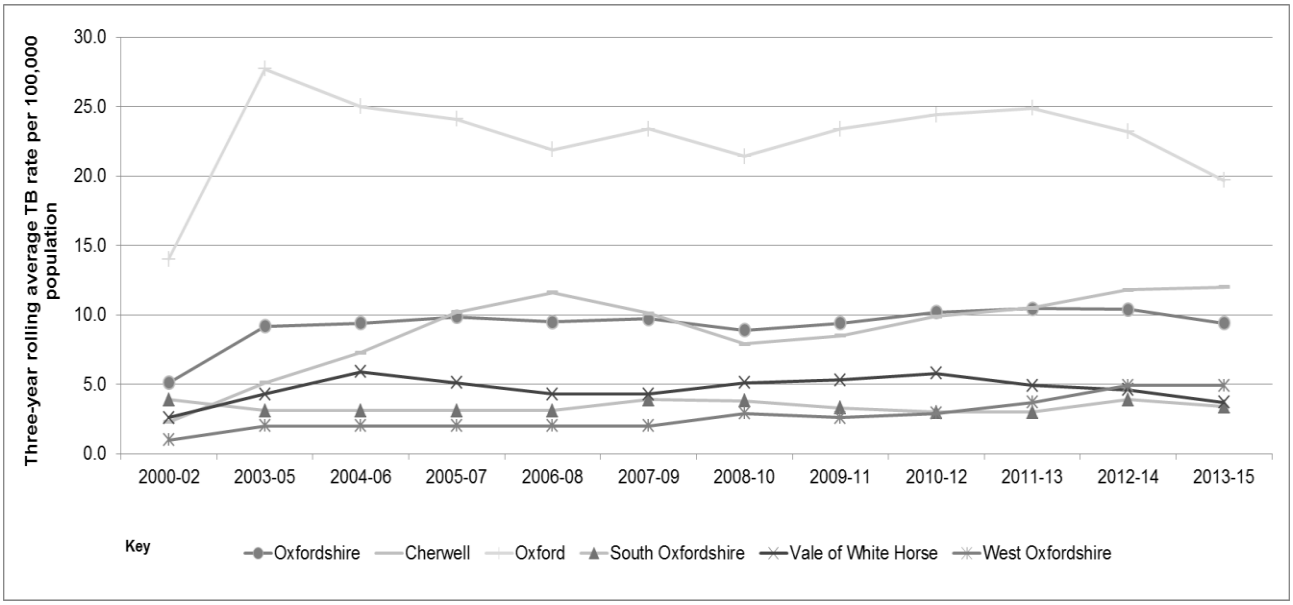
Public Health England (Health Protection Agency)

Tuberculosis (TB) in Oxfordshire

TB is a bacterial infection caused by Mycobacterium Tuberculosis which mainly affects the lungs but which can spread to many other parts of the body including the bones and nervous system. If TB is not treated, active TB can be fatal.

In Oxfordshire, the numbers of cases of TB at local authority level per year are very low. The local figures are shown below.

Tuberculosis (TB) – Incidence rate per 100,000 population (2000-2 to 2013-15)



Public Health England, Health Protection Agency (HPA) Enhanced Tuberculosis Surveillance

The levels of TB in the UK are beginning to show a reduction due to coordinated efforts by TB control boards across England to improve TB prevention, treatment and control.

The rate of TB in Oxfordshire is lower than the National average and similar to average levels in Thames Valley. In the UK the majority of cases occur in urban areas amongst young adults, those moving into the area from countries with high TB levels and those with a social risk of TB (e.g. homeless people). This is reflected in the higher rate of TB in Oxford compared to other Districts in the County.

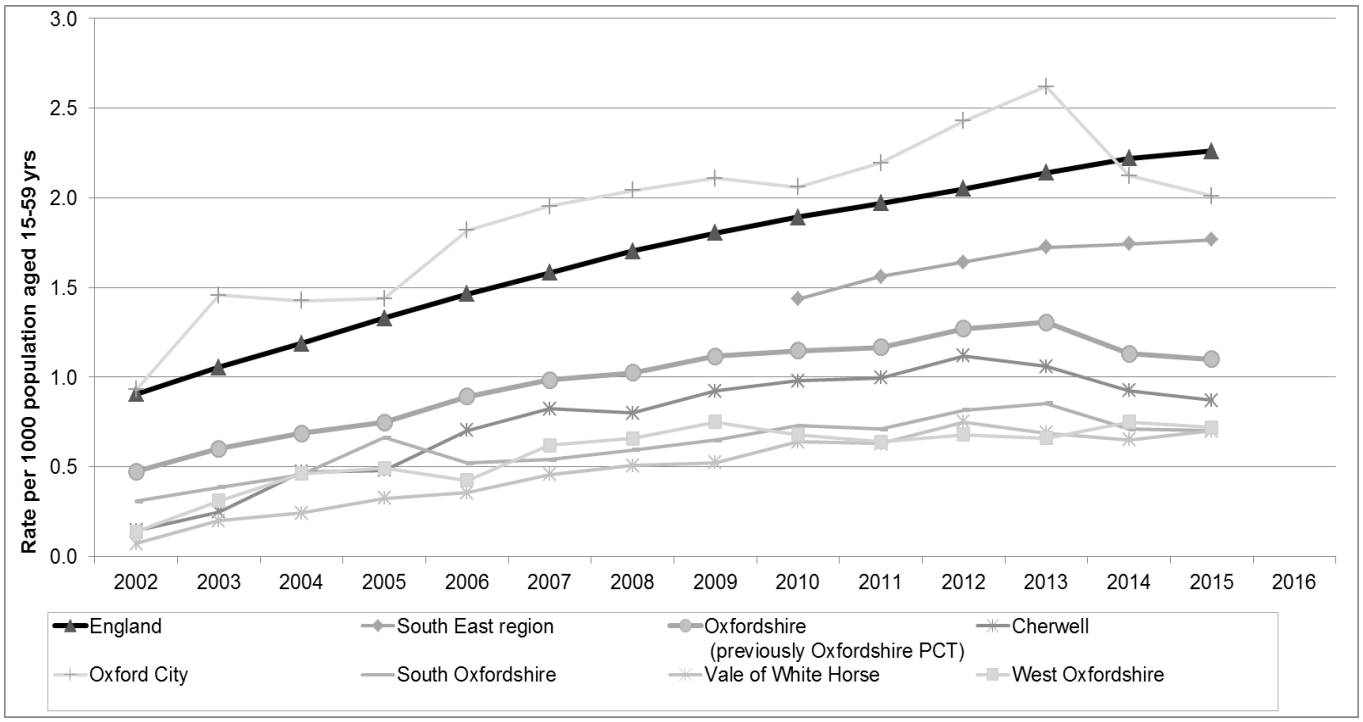
Public Health England has developed a TB strategy to address TB nationally. The TB control boards look at regional levels of TB and services to provide treatment. The Oxfordshire Clinical Commissioning Group is developing a model for a latent TB screening programme as part of a national initiative to identify and treat new entrants from high TB prevalence countries.

Sexually transmitted infections

HIV & AIDS

HIV does not raise public alarm like it did in the 1980s, but is still remains a significant disease both nationally and locally. Due to the advances in treatment, HIV is now considered a long term condition and those who have HIV infection can now expect to have a longer lifespan than previously expected by HIV carriers. As such we expect to have more people living with HIV long term. 2015 data shows that there were 448 people diagnosed with HIV living in Oxfordshire, 221 out of these 448 live in Oxford City. This trend is shown in the chart below and shows another decrease this year across the County.

Rate of diagnosed HIV per 1000 population (i.e. people living with a diagnosis of HIV) aged 15-59 years. England, South East region, Oxfordshire and districts



Public Health England Sexual and Reproductive Health Profiles

Finding people with HIV infection is important because HIV often has few symptoms and a person can be infected for years, passing on the virus before they are aware of the illness. Also the sooner an infected individual begins their treatment the more effective treatment is with a better prognosis for the individual concerned. Trying to identify people with undiagnosed HIV is vital. We do this in three ways:

- Providing accessible testing for the local population. Since it started providing services in 2014, the sexual health service has provided 48,885 HIV tests across the service.

- Through community testing - we have 'HIV rapid testing' in a pharmacy in East Oxford. This test gives people an indication as to whether they require a full test: the rapid test takes 20 minutes and gives a fast result, although fast tracking to the sexual health service for a full test is required to confirm diagnosis.

- Prevention and awareness. Educating the local population about safe sexual practices and the benefit of regular testing in high risk groups. In addition, the eligibility for accessing the condom scheme has been extended to men who have sex with men (MSM) and commercial sex workers, both groups being at higher risk of contracting HIV.

Once diagnosed, the prognosis for HIV sufferers is now good, with effective treatments available. HIV still cannot be fully cured but the progression of the disease can be slowed down considerably, symptoms suppressed and the chances of passing the disease on greatly can be decreased. Beyond Oxfordshire there are interesting developments nationally in preventing the spread of HIV in high risk groups using drugs to halt transmission (PrEP). NHS England will be trialling PrEP over the next three years.

Sexual Health

Sexually Transmitted Infections (STIs) are still high in England with the greatest number of cases in young heterosexual adults, and men who have sex with men (MSM). STIs are preventable through practicing 'safe sex'. Total rates of STIs in Oxfordshire are still below the national average except in the City which has remained at a similar rate since 2013. The local picture is shown in the chart below.

Looking at each disease in turn gives the following picture which is generally good:

- Gonorrhoea- is below national average for Oxfordshire as a whole and all districts except in Oxford City. This is likely to be due to its younger age profile. There is a new system of testing to reduce the number of false positive diagnoses and it is expected that a reduction in diagnoses should be seen when the latest data are released.

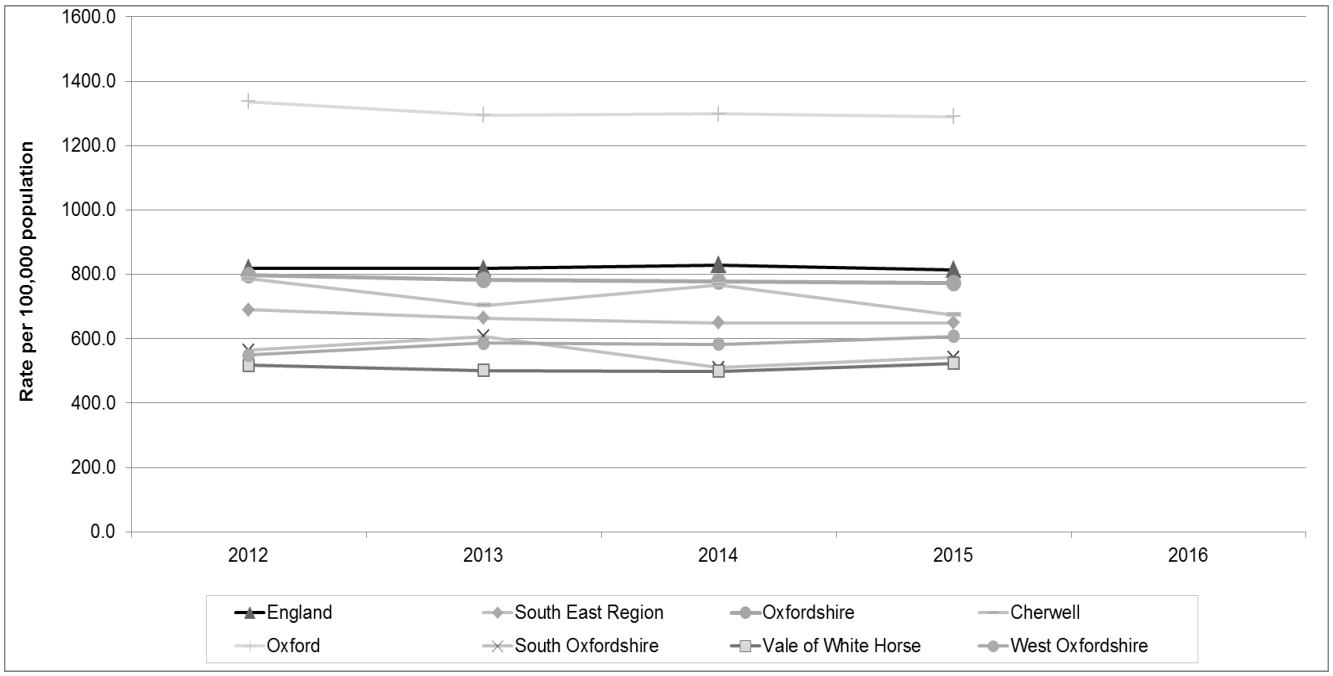
- Syphilis- still continues to fall and is below average in all areas of the County.

- Chlamydia- levels are lower than the national average in all Districts. Following evaluation and consultation the local service has been reshaped to be more focussed on accessing testing through online services. It is hoped that this will be more acceptable and accessible for young people to have a Chlamydia test.

- Genital Warts – rates are still below national average and have seen a decline in line with the National trend. Oxford City still has significantly higher number of cases (reflecting the significantly younger age group) but the trend is stable. With Human Papilloma Virus vaccination programmes in place nationally we anticipate a decline in rates over the coming years.

- Genital Herpes – rates are lower than national average except in the City which has higher levels. However the total number of cases in the year is small. Again this reflects the predominantly younger population of the City.

All new sexually transmitted infections (STIs) rate per 100,000 population aged 15-64 years - 2012 to 2015



Public Health England / Health Protection Agency - Sexual and Reproductive Health Profiles

The local sexual health service, which began in 2014, has seen good levels of activity and this is to be welcomed. The service has improved access to contraceptive and sexual health services conveniently in the same location which has improved the service for local users.

Since the service began in the first three years of operation, the service has delivered

- **91,763 STI treatment and testing consultations**
- **Provided 171,213 tests for STIs and 48,885 HIV tests**
- **Positively identified 32,629 STIs, HIV infections and other sexual health diagnoses**
- **Provided 51,156 consultations for family planning**
- **Fitted 5995 contraceptive devices (Long Acting Reversible Contraception)**
- **Prescribed 27,402 other forms of contraception**
- **Prescribed 3004 Emergency Hormone Contraception Treatments**

The service has continued to deliver on its established reputation in the community as a provider across a range of locations across the county where the local population can access all their sexual health services in one location.

In addition to this in the same period GP providers have delivered 15,760 coils and contraceptive implants and pharmacies have provided 4,103 doses of emergency hormonal contraception.

In line with best practice a partnership of local stakeholders continues to work together to identify and address priorities locally to further meet the sexual health needs of Oxfordshire and further improve on the decline of STI's in Oxfordshire.

Recommendation

The Director of Public Health should report on progress on killer diseases in the next annual report and should comment on any developments.

Health Overview and Scrutiny Committee – 14 September 2017

Chairman's Report

Liaison meetings

The Chairman has attended the following briefings with representatives from health and social care organisations since being elected Chairman of HOSC on 22 June 2017:

- 11 July – Oxfordshire Clinical Commissioning Group
  A briefing on the OCCG's plans for sustainable primary care in Banbury. The Chairman advised that these proposals should be brought to a formal committee meeting.

- 31 July - Oxfordshire Clinical Commissioning Group, Oxford University Hospitals NHS Trust, Oxford Health NHS Trust, Oxfordshire County Council
  Committee members were briefed on the local health and adult social care landscape and the current pressures and priorities for the Oxfordshire health and social care system. This will enable the committee to develop a robust work plan which demonstrates where and how it can have a meaningful impact on local NHS decisions and effectively hold Health bodies to account.

Assurances from the Oxfordshire Clinical Commissioning Group

Following HOSC's scrutiny on 7 August, of the final recommendations for decision in Phase 1 of the Oxfordshire Transformation Plan, the Chairman asked the OCCG for an update on progress in the five areas and a response to the assurances the committee requested.

The Chairman has received the following responses from the OCCG's Director of Governance:

1. Critical Care

The committee asked for assurances that there will be no long term detrimental effects on Accident and Emergency and anaesthetic services at the Horton General Hospital as a result of moving to a single Level 3 Critical Care Unit for Oxfordshire.

OCCG response: As outlined in the Decision Making Business Case (DMBC) (section 7.4, page 25) and reiterated by Dr Tony Berendt at the OCCG Board meeting on 10 August 2017 the majority of Level 3 Critical Care already takes place in Oxford. Removing the remaining Level 3 Critical Care has no impact on the continued provision of other Horton General Hospital services.

2. Acute Stroke Services

The committee asked for clarification being given about the impact of recent changes to guidance on ambulance response times and assurances that stroke rehabilitation will continue to be carried out at relevant local sites around the County, such as the Horton General Hospital and Witney and Abingdon Community Hospitals.

OCCG's response:

Ambulance response times

South Central Ambulance Service have provided the following information:

Within our current processes a FAST positive stroke patient will trigger a Red 2 coding and response. Under current response targets, this response could be a Rapid Response Vehicle (car) or Community First Responder (CFR) or Automated External Defibrillator (AED) to stop the 8 minute target and a RRV can also stop the 19 minute target. Under the current system this could then hide a hidden wait, where the RRV would be sat with the patient at their home address waiting for an ambulance to respond and transport the patient to hospital. In the current system, we could achieve our Red 8 and 19 target, but miss the point of getting the patient to hospital in a timely manner for definitive treatment.

In the ARP proposals a FAST positive stroke patient will trigger a Cat 1 coding and response. The Cat 1 patients have a mean response of under 7 minutes and a 90th percentile of under 15 minutes which can be stopped by a CFR (with additional training), a RRV or an ambulance. The Cat 1 patients have a mean Transport response and a 90th percentile response target (time TBC nationally) which can only be stopped by the vehicle that physically transports the patient. This should mean a stroke patient will receive the right response of the transporting vehicle to get them to definitive care quicker within the new proposals, therefore achieving better clinical outcomes for these patients.

Within the ARP proposals it is expected that stroke patients measured under the AQI for call to needle time (within 60 minutes) will improve nationally through the implementation of ARP."

Rehabilitation

This will continue to be provided around the county. The future of the bed based rehabilitation services will be coved in Phase 2 of the consultation.

Oxford Health are presenting a proposal on the rehabilitation beds in Witney and Oxford for discussion at the HOSC meeting on 14 September.

3. Changes to Acute Bed Numbers

The committee supports the current closure of 110 beds, but cannot support further bed closures without a more comprehensive understanding of the impact this will have on the wider health and social care system, in particular community based services.

OCCG's response: Proposals for permanent closure of any more beds will not be taken forward without discussing these with the HOSC and will be subject to further Thames Valley Clinical Senate review and NHS England assurance. Any proposals would include information on the impacts on the wider health and social care system.

4. Planned Care Services at the Horton General Hospital

The committee was unable to give full support to the proposal without being provided with a more detailed and fully-costed plan in which the local community has been fully engaged.

OCCG's response: We have written to the Chief Executive of OUHT stating we would now like to see a more detailed implementation plan for the planned care proposals which begins to show the increase in footfall at the Horton in line with the overview provided for our DMBC. The CCG will work with OUHT to agree this and to submit proposals for capital. The plan will be shared with the community and HOSC as it develops.

5. Maternity services

The committee strongly opposed the proposal to create a single specialist obstetric unit at the JR and establish a permanent midwife-led service at the Horton General Hospital and agreed to refer the proposal to the Secretary of State for Health should the OCCG Board ratify it at the Board meeting on 10 August.

OCCG's response: As requested by the Chairman of HOSC we have confirmed that whilst the referral process is ongoing the temporary closure of the obstetric services at the Horton will remain in place; as there are still not enough middle grade doctors available. The Midwife led unit will continue to run with the current staffing model and provision of a dedicated ambulance. We have written to the Chief Executive of the Oxford University Hospitals Trust to confirm this.

Letters sent on behalf of the Committee

Referral of the permanent closure of obstetrics at the Horton General Hospital to the Secretary of State for Health

On 7 August Oxfordshire's the Committee met with representatives from the Oxfordshire Clinical Commissioning Group, Oxford University Hospitals NHS Trust and the Oxford Health NHS Trust to discuss the proposals for Phase 1 of the Big Health and Care Transformation Plan being put forward for decision at the OCCG Board meeting on 10 August. At the meeting the committee also heard from a number of speakers, including Members of Parliament, who voiced their grave concerns about the impact of the Phase 1 proposals.

The committee strongly opposed the proposal to create a single specialist obstetric unit at the JR and establish a permanent midwife-led service at the Horton General Hospital. It resolved to refer the decision to the Secretary of State should the OCCG Board agree the proposal on 10 August.

The OCCG Board subsequently ratified the proposal relating to maternity services at the Horton, therefore the Chairman wrote on behalf of the committee referring the matter to the Secretary of State for Health. The letter is printed below:

Date: 30 August 2017
Our Ref: OJHOSC/SoS/HortonMat2

Oxfordshire Joint Health Overview and Scrutiny Committee
County Hall
New Road
Oxford
OX1 1ND

Contact: Katie Read, Policy Officer
Tel: **01865 792422**
Direct Line: 07584 909530
Email: katie.read@oxfordshire.gov.uk

Rt Hon Jeremy Hunt MP
Secretary of State for Health
Department of Health
Richmond House
79 Whitehall
LONDON SW1A 2NS

Dear Secretary of State,

Re: Referral of the permanent closure of consultant-led maternity services at the Horton General Hospital

You recently wrote to me confirming your decision to refer the temporary closure of consultant-led maternity services at the Horton General Hospital to the Independent Reconfiguration Panel (IRP). On behalf of the Oxfordshire Joint Health and Overview Scrutiny Committee (OJHOSC), I am grateful for this action.

However, it is with the deepest regret that I am writing to you again following a special meeting of the OJHOSC held on Monday 7th August 2017. At that meeting, the OJHOSC unanimously agreed to refer the Oxfordshire Clinical Commissioning Group's (OCCG) proposal to permanently close consultant-led maternity services at the Horton General Hospital in Banbury ('the Horton') to you, as the Secretary of State for Health, should the OCCG Board agree the proposal at its meeting on Thursday 10th August. The proposal *was* subsequently agreed by the Board, therefore the OJHOSC makes this referral pursuant to Regulation 23(9)(a) and (c) of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

Background

In 2006 the then Oxford Radcliffe Hospitals NHS Trust (ORH) proposed moving inpatient paediatric and gynaecology services, consultant-led maternity services and the Special Care Baby Unit from the Horton in Banbury to the John Radcliffe Hospital (JR) in Oxford. The Committee believed that the changes were not in the interests of people in the north of the county and referred the matter to the Secretary of State, who supported this view.

On 18 February 2008, The Independent Reconfiguration Panel issued advice to ORH concerning Paediatric Services, Obstetrics, Gynaecology and the Special Care Baby Unit at the Horton. In summary these recommendations were:

1. The IRP considered the Horton Hospital to have an important role for the future in providing local hospital based care to people in the north of

Oxfordshire and surrounding areas. It did however state, the Horton would need to change to ensure its services remained appropriate, safe and sustainable.

2. The IRP did not support the Oxford Radcliffe Hospitals (ORH) NHS Trust's proposals to reconfigure services in paediatrics, obstetrics, gynaecology and the Special Care Baby Unit (SCBU) at Horton Hospital. The IRP does not consider that they will provide an accessible or improved service to the people of north Oxfordshire and surrounding areas.

3. The Oxfordshire Primary Care Trust (PCT) was to carry out work with the ORH NHS Trust to set out the arrangements and investment necessary to retain and develop services at the Horton Hospital. Patients, the public and other stakeholders were to be fully involved in this work. South Central Strategic Health Authority was to ensure that a rigorous and timely process was followed.

4. The PCT was to develop a clear vision for children's and maternity services within an explicit strategy for services for north Oxfordshire as a whole.

5. The ORH was to do more to develop clinically integrated practice across the Horton, John Radcliffe and Churchill sites as well as developing wider clinical networks with other hospitals, primary care and the independent sector.

The IRP advised that the Trust and the PCT were to invest in, retain and develop services at the Horton, as it considered the Hospital to have an important future role in providing local care to people in north Oxfordshire and the surrounding areas.

ORH maintained consultant-led maternity services at the Horton supported by a training programme for junior doctors working in obstetrics. However, in 2012 post graduate obstetric training accreditation at the Horton was withdrawn. This was predominantly due to the low numbers of births at the Hospital, which meant limited exposure to complex cases, and the difficulties experienced in recruiting sufficient numbers of middle grade doctors.

The Trust then developed a Clinical Research Fellow programme to support consultant-led provision, but they reported that national recruitment shortages in obstetric posts led to a reduction in applications which made it unviable. The programme closed in December 2015 and a rotational middle grade rota was created to staff the obstetrics unit.

In September 2016 the Committee was informed that OUHT were intending to temporarily close consultant-led maternity services at the Horton from 3rd October 2016, as they were unable to adequately staff the unit in a safe and sustainable manner.

OJHOSC held a further meeting in September to scrutinise OUHT's contingency plan for continuing maternity and neonatal services at the Horton. This included evidence of the Trust's efforts to maintain consultant-led maternity services and a discussion about the impact of temporarily closing the obstetrics unit and the

associated risks. Assurances were given by the Trust that they planned to reopen the unit by March 2017 on the strength of an action plan to recruit more consultants.

The Committee was also keen to establish that a decision to temporarily close consultant-led maternity services at the Horton General Hospital would not pre-determine the outcome of the Oxfordshire Health and Care Transformation (OTP) Phase 1 consultation. The consultation included a proposal to move obstetric services, the Special Care Baby Unit and emergency gynaecology inpatient services permanently to the JR, whilst maintaining midwife-led maternity services at the Horton.

To monitor the situation carefully the Committee requested regular updates on the status of consultant-led maternity services at the Horton, the number of women transferred to the JR in labour, and the recruitment of obstetricians.

The Trust's update on performance of maternity services at the Horton, dated 23 December 2016, stated that they would not have enough experienced and skilled medical staff in post to reopen the unit in March 2017 as planned. Therefore, at its meeting on 2 February 2017, OJHOSC believed that the material grounds for not referring the matter had changed, i.e. the Trust's recruitment plan had failed and the closure would be longer than envisaged. The Committee considered nothing further could be gained by discussions at a local level and referred the matter to you under Regulation 23(9)(b) of the 2013 Regulations. You recently wrote to me confirming that this matter had been passed to the IRP for initial review.

At a special meeting on 7 March 2017, OJHOSC undertook detailed scrutiny of the proposals being put forward for acute services in Phase 1 of the OTP consultation (running 16 January – 9 April 2017). These were focused on:

- Changing the way hospital beds are used and increasing care closer to home in Oxfordshire,
- Planned care (planned tests and treatment and non-urgent care) at the Horton General Hospital,
- Acute stroke services in Oxfordshire,
- Critical care (help with life-threatening or very serious injuries and illnesses) at the Horton General Hospital, and
- Maternity services at the Horton General Hospital including obstetrics and the Special Care Baby Unit.

During the meeting the Committee heard many passionate appeals from campaign groups, residents, district councils and MPs in the north and west of the county and surrounding areas (including Victoria Prentis MP (Banbury), Robert Courts MP (Witney) and The Rt Hon Andrea Leadsom MP (South Northamptonshire)) for consultant-led maternity services at the Horton to continue, as this would otherwise mean a downgrading of the Hospital. The concerns raised in this meeting formed the basis of OJHOSC's formal response to the consultation and recommendations for the OCCG, which was submitted on 13 March 2017.

In relation to the maternity proposal the Committee felt that the separation of proposals for obstetric services from those for Midwife-led Units (MLUs) painted an ambiguous picture for the future of maternity services in the county. In particular, the

inclusion of example options for Chipping Norton MLU in the Phase 1 consultation document led to confusion and uncertainty about the future of this service and caused unnecessary public anxiety.

The Committee recommended that the OCCG:

- Take immediate action to clarify the proposals for maternity services in the north of the county as a whole in the Phase 1 consultation, or develops an alternative approach to consulting on these proposals;
- Present a comprehensive appraisal of options for maintaining obstetric services at the Horton, including the potential for an obstetrics rota between the JR and the Horton;
- Provide specific answers to:
    - the numbers of mothers transferred from the Horton to the JR during the temporary closure,
    - travel times from the Horton to the JR for these mothers, and
    - the future of ambulance support at the Horton for mothers needing to be transferred.

It was agreed that another meeting of the OJHOSC with OCCG would be held once the OCCG had an opportunity to respond to the committee's concerns.

The committee next met with the OCCG on 22 June to review the outcomes of the consultation. Members were concerned that a considerable amount of additional analysis was to be completed before the OCCG Board would make final decisions on the Phase 1 proposals at its 10 August meeting. Regarding the proposal for obstetric services at the Horton, the Committee was keen to see the OCCG address options for the future of these services in its report to the Board, as well as the outcomes of the JR travel and parking analyses. The Committee agreed to meet again with the OCCG, after their decision making business case was published for the August Board meeting, to review final recommendations for decision.

At a special meeting on 7 August to scrutinise these recommendations, the Committee heard from numerous speakers, including local MPs, about their grave concerns regarding the impact of the Phase 1 changes. Their concerns predominantly focused on the impact of permanently withdrawing consultant-led maternity services at the Horton.

Following robust questioning of OCCG and OUHT representatives the Committee did not believe it had seen a strong enough case for meeting the needs of expectant mothers in the absence of consultant-led services in the north of the county. OJHOSC strongly opposed the recommendation to create a single specialist obstetric unit at the JR and establish a permanent midwife-led service at the Horton and resolved that, should the OCCG Board ratify the proposal at its 10 August Board meeting, it would refer the matter to the Secretary of State on the grounds that it was not in the best interests of local residents and the health service and consultation with the Committee was not adequate.

Reasons for referral

OJHOSC has engaged extensively with the OCCG prior to decisions on Phase 1 of the OTP being made, in an effort to exhaust all other alternatives before a referral to

the Secretary of State and in accordance with Regulation 23(5). However, the OCCG has openly stated that it was only interested in detailed discussions once a decision had been made, refusing to address the Committee's concerns that the closure was predicated on staffing shortages, despite OUHT having filled seven of the nine vacant consultant posts since the temporary closure of the unit. The Committee also feels that the OCCG has failed to engage fully with local partners, such as Cherwell District Council, to explore offers of investment and measures to help with schooling, housing, and cost of living expenses, for example, through the use of 'Golden Hellos' to attract sufficiently skilled staff.

This steadfast refusal to fully investigate and develop alternative models and to exhaust all other possibilities to continue to satisfy the 2008 IRP recommendations is deeply regrettable. Following a decision by the OCCG Board on 10 August to agree the recommendation to end consultant-led maternity services at the Horton, the OJHOSC is referring the decision to the Secretary of State under Regulation 23(9)(a) and (c) for the following reasons:

I. **The needs of local people have not changed and the arguments set out in the 2008 IRP judgement still apply.** The Committee has heard passionately from many members of the pubic, local campaign groups, local politicians, local councils, former Horton doctors, local MPs, the clergy, and Healthwatch Oxfordshire. There was unanimous opposition to the proposals for maternity services in Phase 1 of the OTP and the Committee has yet to see evidence, let alone evidence of a compelling nature, of any change in the fundamental needs of mothers in North Oxfordshire and the surrounding areas that would justify the closure of obstetric services.

   The Committee accepts that there are difficulties recruiting and retaining suitably qualified staff to maintain an obstetric unit at the Horton, but does not consider this just cause for removing a service when the needs of local people have not changed.

   Whilst staff retention may be harder than before, the Trust has demonstrated that it can successfully recruit to the required specialist posts, despite the cloud of uncertainty hanging over the unit. The Committee is also disappointed to hear that the OCCG has not fully engaged with local partners who put forward alternative options for maintaining the service at the Horton. Moreover, the OCCG has not presented the Committee with any options for maintaining obstetric services at the Horton, as requested in OJHOSC's response to the Phase 1 consultation.

II. **The population of North Oxfordshire is set to grow.** The population in North Oxfordshire has grown since 2008 and is set to grow substantially in the coming years, further justifying the need for a consultant-led maternity service in the north of the county.

   By its own admission, the OCCG is looking at a 5-year plan, whereas local authorities in the area are planning for much longer timescales, including up to 2031. Even using conservative estimates for birth rates and housing growth (especially as North Oxfordshire has to take on a supply of housing from Oxford), the number of births at the Horton under a consultant led-service is

expected to grow. Given that before the temporary closure births at the Horton accounted for a fifth of all births in Oxfordshire (excluding the surrounding areas which the Horton also serves), the Committee feels that the OCCG's focus on a 5-year plan that concentrates all consultant-led births for the county at the JR is foolhardy, weakens resilience and does not in any away adequately consider the population growth in the north of the country.

Moreover, consultant-led services at the JR will have to cope with the impact of population growth in the south of the county, which has already seen an increase that is double the national average. The OCCG's plans will put enormous pressure on consultant-led services at the JR site.

III. **Ongoing issues with travel and access from the Horton to the JR for expectant mothers**. The integrated impact assessment commissioned by the OCCG indicates that a change in consultant-led maternity services will mean that only 52% of mothers will be able to access obstetric-led maternity services within 30 minutes, compared with 72% if a unit remained at the Horton. The Committee has major concerns about transport difficulties between Banbury and Oxford, particularly at peak travel times and in inclement weather. This includes both emergency transport for patients and public transport for patients and relatives.

Whilst a dedicated ambulance has been stationed at the Horton during the temporary closure to transport high risk mothers in labour to the JR, the future of this provision is unclear. OJHOSC has already heard anecdotal evidence of mothers' poor experience travelling between the two hospitals and the pressures on the JR affecting waiting times for women in labour.

Furthermore, the OCCG commissioned parking and travel analyses confirmed that there are acute problems with access and parking at the JR site compared to very few issues at the Horton. The qualitative feedback that Healthwatch Oxfordshire gathered indicates that patient travel and parking times at the JR are between 45 and 75 minutes. The Committee is particularly concerned that little detail has been shared about planned investments in parking and access to manage the volume of additional patients at the hospital.

IV. **The lack of a clear picture for countywide maternity services as a result of the two-phased consultation.** The impact of permanently removing the obstetric unit at the Horton on maternity services as a whole, including the Chipping Norton, Wallingford and Wantage MLUs, was not clear in the Phase 1 consultation. The OCCG had stated that once a decision about consultant-led services was made they would have a detailed discussion with the Committee about the impact on midwife-led services as part of the work on Phase 2 proposals. This is despite the Committee setting out its expectations in November 2016 that the impact of options for maternity services at the Horton on surrounding services should be included in the consultation and that nothing in Phase 1 should prejudice the outcomes of Phase 2. The lack of fully developed plans for county-wide maternity services and refusal of the OCCG to address the Committee's concerns about the impact of the Horton proposal on midwife-led services prior to the Board's decision, has led the

Committee to believe that the content of the consultation has been inadequate.

In summary, the Committee does not believe it has seen a robust enough case for meeting the needs of expectant mothers in the absence of obstetric services in the north of the county, particularly as the two-phase consultation has obscured a complete picture for the future of maternity services in the county. Furthermore, the reasons for having a consultant-led service in the north of the county have not changed since the IRP's recommendations in 2008.

For the reasons outlined above, the OJHOSC is referring to you the OCCG's decision to create a single specialist obstetric unit for Oxfordshire (and its neighbouring areas) at the JR and to establish a permanent MLU at the Horton on two grounds:

- Regulation 23(9)(c) - the decision is not in the best interests of the health service or local residents; and
- Regulation 23(9)(a) – the content of the two-phase consultation is inadequate.

I look forward to hearing your response.

Best regards,

Cllr Arash Fatemian
Chairman of Oxfordshire's Joint Health Overview and Scrutiny Committee