Notice of Meeting Public Document Pack

Oxfordshire Joint Health Overview & Scrutiny Committee

Thursday, 20 September 2018 at 10.00 am

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

Membership

Chairman - Councillor Arash Fatemian
Deputy Chairman - District Councillor Neil Owen

Councillors:	one vacancy	Dr Simon Clarke	Laura Price
	Mark Cherry	Mike Fox-Davies	Alison Rooke
District Councillors:	Nigel Champken-Woods	Monica Lovatt	
	Sean Gaul	Susanna Pressel	
Co-optees:	Dr Alan Cohen	Dr Keith Ruddle	Mrs A. Wilkinson

Notes: ***Date of next meeting:*** *29 November 2018*

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	-	*Samantha Shepherd Tel: 07789 088173* *Email: Samantha.shepherd@oxfordshire.gov.uk*
Committee Officer	-	*Julie Dean Tel: 07393 001089* *Email: julie.dean@oxfordshire.gov.uk*

Peter G. Clark
Chief Executive

September 2018

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 - 26)

To approve the minutes of the meeting held on 21 June 2018 (**JHO3**) and to receive information arising from them.

For ease of reference when considering any Matters Arising from the last meeting, an actions list for 21 June 2018 is attached at **JHO3** for information.

4. Speaking to or Petitioning the Committee

5. Forward Plan (Pages 27 - 30)

10:15

The Committee's Forward Plan is attached at **JHO5** for consideration.

6. Update Briefing - Evaluation Framework & Best Practice Examples (Pages 31 - 38)

10:20

The Committee will consider proposals for the evaluation of action taken following the CQC system review (**JHO6**).

7. 2018-19 Oxfordshire System Winter Plan (Pages 39 - 62)

10:45

The Winter Plan 2017/18 was presented to this Committee in November 2017 and an evaluation considered by this Committee at the last meeting in June 2018.

This report (**JHO7**), prepared by the Systemwide Winter Planning Group and approved by the Integrated System Delivery Board, follows up on the evaluation regarding the subsequent effectiveness of the Plan, as requested by Committee at its June 2018 meeting.

This item will also outline the Winter Plan for 2018/19 which will include learning from the previous year(s).

8. CCG: Key and Current Issues (Pages 63 - 66)

11:30

CCG will update the Committee on key issues for the CCG and will outline current and upcoming areas of work. This includes an update on Cogges GP Practice, Witney (**JHO8**).

9. Planning for Future Population Health & Care Needs (Pages 67 - 74)

12:15

To consider a report (**JHO9**) from the Clinical Commissioning Group and the Oxford Health Foundation Trust giving an outline framework for working with local communities to review local health needs, current and projected demographics and local assets, to inform service change.

The report includes a timeframe and consultation plan for developing options for the local area that includes Wantage Community Hospital. Please note there will be a number of A3 copies of the Annexes supplied at the meeting for ease of reference.

13:15 - LUNCH

10. Healthwatch Oxfordshire - Update (Pages 75 - 78)

13:45

Rosalind Pearce, Chief Executive Officer, Healthwatch Oxfordshire (HWO) will be present to report on the views gathered by HWO and its latest activities (**JHO10**).

11. Annual Report of the Director of Public Health 2017/18 (Pages 79 - 170)

13:55

An Annual Report is a statutory duty of each Director of Public Health and it is a duty of the County Council to publish this report.

The Director of Public Health, Dr Jonathan McWilliam will present his independent Annual Report for 2017/18 (**JHO11**). Members of the Committee are asked to receive the report and consider the key issues which it would like to see taken forward in the year ahead.

12. OHFT Stroke Rehabilitation Services Pilot report (Pages 171 - 180)

14:25

The report (**JHO12**) includes:

- The Business Case for longer-term changes following the Stroke Rehabilitation Services pilot; and
- An evaluation of the pilot to include data and analysis to show the impact on staff and patient outcomes (including detailed patient feedback)

13. Chairman's Report (Pages 181 - 190)

14:55

The Chairman's report is attached at **JHO13**. It includes an update on health and social care liaison and the MSK Task Group.

Declarations of Interest

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

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

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

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

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

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

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

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

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

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

For a full list of Disclosable Pecuniary Interests and further Guidance on this matter please see the Guide to the New Code of Conduct and Register of Interests at Members' conduct guidelines. http://intranet.oxfordshire.gov.uk/wps/wcm/connect/occ/Insite/Elected+members/ or contact Glenn Watson on **07776 997946** or glenn.watson@oxfordshire.gov.uk for a hard copy of the document.

OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 21 June 2018 commencing at 10.00 am and finishing at 4.15 pm

Present:

Voting Members:	Councillor Arash Fatemian – in the Chair
	District Councillor Monica Lovatt (Deputy Chairman) Councillor Mark Cherry Councillor Dr Simon Clarke Councillor Mike Fox-Davies Councillor Laura Price Councillor Alison Rooke District Councillor Neil Owen District Councillor Susanna Pressel Dr Alan Cohen Dr Keith Ruddle Councillor Nick Carter (In place of Councillor Kevin Bulmer)
Co-opted Members:	Dr Alan Cohen and Dr Keith Ruddle

Officers:

Whole of meeting	Strategic Director of People; J. Dean and K. 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.

23/18 ELECTION OF CHAIRMAN

(Agenda No. 1)

Councillor Arash Fatemian was elected Chairman for the duration of the Council Year 2018/19.

24/18 ELECTION OF DEPUTY CHAIRMAN

(Agenda No. 2)

Prior to appointing the 2018/19 Deputy Chairman, the Chairman, on behalf of all members of the Committee, led a vote of thanks to the outgoing Deputy Chairman, District Councillor Monica Lovatt, for all her hard work and support during 2017/18.

District Councillor Neil Owen was appointed Deputy Chairman of the Committee for the duration of the 2018/19 Council Year.

25/18 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 3)

Councillor Nick Carter attended for Cllr Kevin Bulmer, District Councillor Phil Chapman for District Councillor Sean Gaul and apologies were received from District Councillor Nigel Champken-Woods and Anne Wilkinson.

The Committee recorded its disappointment that South Oxfordshire District Council had not been represented for a number of recent meetings.

26/18 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 4)

There were no declarations of interest submitted.

27/18 MINUTES

(Agenda No. 5)

The Minutes of the last meeting held on 19 April 2018 were approved and signed subject to the following amendments:

- Minute16/18, Care Quality Commission Local System Review - Page 6, paragraph 2, sentence 1 – to delete the words 'the provision of beds' and to substitute with 'any beds were closed';
- Minute 17/18, OCCG: Key and Current Issues' – Page 9, paragraph 2, sentence 2 – to delete the word 'the';
- Minute 20/18, Oxford University Hospitals NHS Foundation Trust (OUH) Quality Account – page 13, penultimate paragraph – delete the words 'to return to' and substitute with the 'email members of the Committee with their priority areas as they were finalised';
- Minute 21/18, 'HOSC and Health 'Ways of Working Workshop report and draft principles' – Page 14, penultimate paragraph prior to the resolution – to amend to (amendments in bold italics):

  '***Cllr Laura Price*** then proposed, and ***Cllr Glynis Phillips*** seconded, that the Planning Group be held in public session. This was lost by 3 votes to 7. The Chairman ***then*** proposed, and was duly seconded, to formally adopt the recommendations contained in the report.

Matters Arising

The Chairman agreed that issues in relation to Wantage Hospital, which were referred to at the last meeting, could be raised again under Agenda Item 9 – OCCG key and current issues.

28/18 SPEAKING TO OR PETITIONING THE COMMITTEE
(Agenda No. 6)

There were no requests to address the Committee or to submit a petition.

29/18 FORWARD PLAN
(Agenda No. 7)

The Committee **AGREED** to include the following into an updated Forward Plan and to request the Officers to schedule a prioritisation session at the next meeting in September:

- To revisit the MSK Services following the findings of the Working Group (February 2019);
- Health Inequalities update (in 6 months time);
- Winter Plan;
- GP appointments – to include representation from the GP federations; and
- To prioritise School Health Nurses and the Health Visiting services and the reorganisation of the Oxfordshire Health & Wellbeing Board;

30/18 UPDATE ON OXFORDSHIRE WINTER PLANS 2017/18
(Agenda No. 8)

At the time last year's Oxfordshire Winter Plans were presented to the Committee in November 2017, the Committee asked to review their subsequent effectiveness. Members considered the report JHO8 from the Oxfordshire Clinical Commissioning Group (OCCG) which contained an evaluation of last year's Plan.

The Chairman welcomed OCCG's Chief Executive, Lou Patten and Chief Operating Officer, Diane Hedges; Karen Fuller, Deputy Director, Adult Services, Oxfordshire County Council (OCC); and Sam Foster, Chief Nurse, together with Sarah Randall, Deputy Director of Clinical Service, Oxford University Hospitals NHS Foundation Trust (OUH), to the meeting. Stewart Bell, Chief Executive, Oxford Health and Dr Kiren Collison, Clinical Chair, CCG joined the Panel to respond to questions later on in the session.

Diane Hedges introduced the report JHO8 which covered all angles of the urgent care pathway. Although the focus was on how urgent care supported patients, the report also covered the whole range of options for patients, such as the option to call

the 111 service which was supported by clinical advice, the Out Of Hours (OoH) service and the Minor Injuries Units (MIU). It also covered examples of interventions made to try to encourage people not to use the urgent care services, such as the pilot use of the SoS bus in Oxford, the use of the OoH service for patients requiring repeat medication and the use of advice from pharmacy services direct from the 111 service so as not to take up GP time. A wide range of approaches were also being used, such as safe havens for people suffering from mental health illnesses. She stated that the GP Access Fund should increase access to these.

Diane Hedges also informed the Committee that, as potentially expected, the 4 hour target for people waiting in Accident & Emergency (A & E) had not been met and the service had been escalated to the highest level. In January/February, when pressures had been felt nationally, operations had been cancelled and Trusts had been requested to re-think their approaches to elective operations. It had been the worst winter in terms of weather nationally with huge numbers of patients waiting to be treated. However, in adversity, alternative solutions had been found to assist in different areas of work, for example, in the approach to home care. Patients had been assessed on an individual basis to enable them to move from their hospital beds more quickly. More care home beds had been bought and the number of community beds had been extended to avoid risk, wastage etc.

Lou Patten also highlighted another example of real success which had been the implementation of much tighter assessment systems in hospital and community hospitals, with less duplication, which had resulted in good use of community hospital beds. Assessments of Delayed Transfers of Care (DToC) patients who had occupied a hospital bed for 7 – 21 days, were linked to the home circumstances of the patient in the first instance, which had resulted in strong progress in this area. OCC had led this work which had gleaned a better response and had encouraged people to work together. A working party team was already reviewing this shift in emphasis to the individual as against the bed, and the social and therapeutic impact of this; and was looking at what was learnt, with a view to reorganising the approaches to winter pressures for 2018/19.

Questions asked and responses given were as follows:

When and where were the extra beds planned and where were the evaluations of action taken so that this could be measured against in the future? Sam Foster responded that this would be undertaken in September in order to measure capacity. A Committee member stated that a clear understanding of which funding streams each intervention drew upon would also be required, for example, the Better Care Fund, the OCCG or OCC pots etc. In addition, learning about how effective the additional clinical resources given by the South Central Ambulance Service (SCAS) had been, together with information about whether it had been a one off pot of funding to try a different way of working. Also, how learning would take place from this experience? how were staff feeding into them? were they joint plans? and what roles were available for staff to apply for if they were moving from one position to another? Diane Hedges responded that the extra resourcing had gone into the procurement of urgent 111 services to provide for clinicians. Learning had taken place on which area of clinical service had had the best impact within workforce constraints. The Accident & Emergency Development Board had considered how to

best access GP hubs and whether they could increase capital access and clinical advice. She added that it had been a challenge, as it was in every area, to supply sufficient numbers of clinicians.

A member asked how many patients did the plan equate to? Sam Foster responded that collecting and measuring data as a system was quite tricky, but the figure tasked with equated to 44 beds or beds equivalent. Some guidance would be coming in relation to this work. A member commented that whatever method of evaluation was chosen, it would have to have scientific rigour;

The representatives were asked why they were not able to do what they had achieved so successfully in previous years and what challenges did they face in putting it together? Lou Patten responded that the situation had been very different this year. Significantly more comprehensive reflection had taken place and there had been more emphasis on the empowering of clinicians. The challenges associated with funding streams was that they often came late.

A Committee Member asked where the third - party providers came from and what was the cost of backfilling job vacancies? Diane Hedges responded that the CCG had a good relationship with Age UK. Sam Foster commented also that Age UK had proved to be very helpful in their support for OUH in getting patients back into their own beds at home. The Trust was looking to work with additional agencies. She undertook to let the Committee have the costs involved.

Sam Foster was asked how long non-urgent surgery had been postponed for and when did they plan to catch up? She replied that non - urgent surgery for patients had been cancelled across the Trust at the behest of national NHS. These patients had now been caught up with and there were now no long waits. Diane Hedges stated also that some patient beds had been cancelled due to workforce pressures. Sam Foster referred also to the national shortage of registered nurses, of whom more were leaving than joining the service (the Board papers provided more detail than they had in the past in relation to staffing, also giving more clarity on where the vacancies lay and on recruitment). The focus was on staffing for theatres and emergency departments. The Trust currently had 250 offers out to overseas nurses. There had also been joint recruitment to vacancies within the system which had proved to be successful in accordance with the initial working party. Success had also been achieved with the numbers of temporary workers who had been made permanent. This had also incentivised large numbers to work extra hours in order to keep maximum capacity open. The Working Party had also ensured escalation if it was deemed necessary and it was also working towards paying support workers more money. Its focus was on the optimum safety, as it was aware that temporary staff came with risks. In addition, a significant amount of monitoring of emergency plans was undertaken to ensure that the situation in relation to elective and unplanned operations was in a better fashion than last year.

A member asked if any analysis had been undertaken into what constituted an emergency at A & E; and was there any evidence of a definition/categorisation of presenting which might be included in a business case on how A & E could be developed in the future. Also, was the 4 - hour target realistic nowadays – could it be achieved or should it be scrapped? Sam Foster explained that patients were triaged

immediately on entry. If they were brought in by ambulance, then they were triaged as a priority. If they presented with a relatively minor clinical problem, they were placed in GP streaming. The latter service was up and running at the John Radcliffe Hospital and numbers attending had increased. She undertook to bring back to Committee a case mix with information on where they had been treated. The mix of patients did tend to change in the winter with more presenting with influenza and respiratory disease etc. She added that there was a significant amount of focus currently on trying to do things differently in A & E departments and decisions were generally made on the next steps within 30 minutes, thus improving performance statistics to 90%. There had been no further 12 - hour trolley waits in April. The system was not quite there as yet and there was a need to ensure the Winter Plan was part of the Urgent Care improvements. Sarah Randall commented that evidence had seen improvements which had the most impact on those patients with extended stay (7 – 21 days) in hospital. Evidence had proved that the local health economy statistics were at their most satisfactory where hospitals had lower occupancy rates, which were in turn cheaper. The work being undertaken on reducing the 4-hour target and helping extended stay patients to return to their own homes had given the system a head start in comparison with other areas (10 – 20% reduction). This was equivalent to a 44 bed reduction. There was a will to achieve this target but the 4-hour target was very complex and necessitated high impact action being taken as a system - and sometimes required more work to get it organised.

With regard to a comment from a member about the need for patients to obtain care in a home situation, rather than in a care home, Sarah Randall responded that the question of providing ‘in house’ carers was being looked at in the OCC review. This was currently a large area of learning within Social Care, as well as that of system working with OUH and Age UK on patient outcomes. This was in a bid to take services away from a hospital situation and to centre the service around the patient themselves and what other support they had around them. She added that this would also have a positive impact on the DToC situation. She stated that the policy of Adult Social Care was to support the patient within their own home as much as possible, using facilities such as extra care housing, care support at home and using community support at home. She added that locality bases were working very actively together.

In response to a question about whether a proportion of patients were being regraded from one of requiring an emergency operation, to a non-emergency status, Diane Hedges gave her reassurance that it was not about regrading, but more about giving the correct advice to services. The CCG was looking to only having a reasonable number of people referred to urgent care, via the emergency services, and were asking clinicians to support that approach, by giving their clinical view. Lou Patten stated that there were strong indications in other areas, with similar demographical linkage, that this approach was both workable and cost-effective. Diane Hedges added that a whole range of emergency areas were now using clinicians and GPs, by, for example, increasing the level of GP involvement into the 111 service, GP support to the Out of Hours practices and hubs, and the offer of additional week-end appointments at surgeries. This had often caused a stretch on daytime services, tensions in the system, pressures on OH and on OCC funding. This work had been brought together by GP Federations, the Local Medical Council, OUH and the CCG. Lou Patten added that GPs had to offer a broad range of clinical competencies and it

was necessary to comprehensively evaluate where this precious resource was being placed, and how it helped patients in the system.

A member asked if the extra GPs were being brought in from outside or whether they were already in the system. Diane Hedges and Lou Patten responded that the additional resource was often managed by a group of practices together, but it was in the province of the GPs themselves to manage their own resources. They had provided these additional resources either by extra recruitment or by operating leaner practices.

A member asked if a patient's medical record could be instantly accessed by staff on admittance from another hospital. Stewart Bell responded that currently a number of different systems were in play. An Oxfordshire care summary was in place to view essential information such as patient notes from other systems. Not all were available, but good progress was being made to achieve this, for example, the OoH's service was able to access GP records.

In response to comments from a member, Diane Hedges endorsed the importance of sustaining primary care. The nature of primary care was changing. Nationally, the introduction of different sorts of skill mix to surgeries in order to maximise GP time was under investigation, such as the introduction of clinical pharmacists to attend to, for example, the multiple medications for older people. Also the numbers attending Minor Injuries Units had reduced during the winter period and there was a need to understand why this was happening and what injuries patients were presenting with in order to make the best use of the service and the maximum use of services already in place.

Lou Patten added that GPs already had a good idea about how they could enhance their capacity and now it was about listening to the GP Federation Alliance, together with Oxford Health, for possible formal collaborative integration of services. In response to a question about why the GP contribution to the Winter Service Plan was not sustainable all the year round, Dr Collison explained that in primary care different levels could approach the problem ie. in the practice itself, at cluster or locality level. At local level there were possibilities, such as the introduction of nursing practitioners to take some of the GP load, or the movement of some of the GP's paper work into the back office. There was a significant time reduction at cluster level which could be achieved, for example, the looking after older people in a more proactive way. At locality level, urgent access partners were available, together with visiting services. Notwithstanding this, there were many gaps in GP workforce and aspects of the job were being looked at to provide the variety which GPs were looking for, for example, rotation around different areas of the job.

Lou Patten was asked if it would be possible to develop a model which would result in a radical reduction in the numbers of patients attending A & E. For example, some local communities could perhaps pilot schemes to this end. She responded that she sat on the regional A & E Board and agreed that it was about understanding the population, getting into the communities, looking at what voluntary services were available and then assimilating the key factors. This could then be brought to five key priority areas.

At the close of the session, the Chairman thanked all representatives for their attendance and their input and requesting the following:

(a) keeping evaluation reports and future plans focused and brief, and with the inclusion of some measurable impacts and targets and some indication if where original GP hours came from;
(b) more information on the plans going forward for GP contribution, including what would be a measurable impact in percentage terms;
(c) information on whether there was an issue around 7 day working in some localities and where was it not happening? Why was this? And what impact it was having in the areas where it had been introduced;
(d) more information on whether Oxford City was the best place for the SoS bus and not Banbury? Was this service better suited to the city where there were greater numbers of people, in order to discourage people from going to A & E?
(e) more information on who the third party providers were in relation to the 111 service and how Age UK assisted in returning patients to their own homes?
(f) some detail on the additional costs of backfilling staff vacancies with agency staff and whether private providers had been used; and
(g) more detail on hospital bed closures.

31/18 OCCG KEY AND CURRENT ISSUES

(Agenda No. 9)

Lou Patten and Dr Kiren Collison, Chief Executive and Clinical Chair respectively, CCG gave an oral report on the current key issues for OCCG. They were also accompanied by Stuart Bell, Chief Executive, Oxford Health (OH).

Lou Patten reported on the following:

- The CCG was now involved in estates and infrastructure in conjunction with the County and district councils via the Growth Board and meetings related to the Oxford/Cambridge expressway. A fruitful meeting had taken place with West Oxfordshire District Council looking at both planning and infrastructure;
- She had met with the Deer Park PPG to gain their views on processes and transparency for when the CCG decided the trigger points at which GP practices and GP providers were required to look at how else to provide for a growing population;
- Work continued with providers to discuss how the plans for winter pressures could be executed, at the same time embedding the CQC work, but also ensuring that services were tailored to localities. Details of how the Government monies must be spent were yet to be worked through and the Committee would be kept updated. She reported that she had informed the regulator that if there was not a similar injection of monies for Social Care, then Oxfordshire would struggle to provide what was required. In response to a comment from a member about the lack of national guidelines on this matter, and if Oxfordshire was to become a pioneering authority in this regard, more money would be required from the DoH, she stated that she had asked for some money to oversee it, to accompany the money the

CCG would commit for managerial resource. She added the end result would be a transparent look at how the CCG saw resources and how it was taking forward the market for new GPs.

Questions and responses received were as follows:

Lou Patten was asked about CCG input into the expressway consultation. She responded that she had heard at the Growth Board that the Police and Ambulance flows would be favoured by very good transport links and intended to query with NHS England how it would affect patient flow. A member informed the Committee that the proposal for the corridor was about to be announced and urged the CCG to consider the time-scale in respect of consultations. Stuart Bell pointed out that one of the most important implications arising from this venture was to consider the more strategic planning of services for Health and their sustainability, for example, for cardiac services.

A member asked whether the population planning ought to have a 20/30 year time-frame, rather than a 5 year one adopted by the NHS; a point which had been made as part of the IRP submission in relation to the Deer Park Surgery closure. Lou Patten responded that, in order to conduct a dialogue, planning needed to be about understanding the type of local populations and evidencing their needs. Only then could the physical infrastructure needs be looked at. Stuart Bell stated that there was a need to consult other organisations such as Oxford Health and the GP Federations about the locality in which to place services, for example, x ray services. I addition it was necessary to know the proportion of patients currently attending Oxford who could go to local centres.

A member raised the question of whether the beds closed at Wantage Hospital would be reopening in the near future, emphasising that it had now been 2 years since the temporary closure. She urged the OCCG to conduct the awaited review after the beds had re-opened, as the beds were needed within the community. She added her view that the issue concerned the building which, in her view, would require a full public consultation as a major service change. Lou Patten responded that there was a strong clinical case for patients not to be in bed for too long as it caused a rapid loss of independence. She added that consideration would be given in the system review to the use of hospital facilities to their best possible purpose and to suit the needs of the patients. The need was to develop something which was fit for purpose locally. She gave as an example of this the recent establishment of the rapid assessment clinical units at Townlands Hospital, Henley.

A member asked about the situation in relation to the Horton Hospital's Maternity Unit premises, commenting that, in their view, they were not up to specification. Lou Patten stated that the Horton Hospital had a very vibrant future and there would be facilities provided in the future for patients living in a locality which would be larger than Banbury itself. There would be an opportunity to bid for capital monies, which was a very convoluted process. It had been found to be very helpful if the bid for estates contained a description of how buildings would be utilised. She added her view that this needed to happen with speed.

Lou Patten and Dr Collison were thanked for the report and all were both thanked for their attendance.

The Committee **AGREED** to request the CCG to prepare, for submission to the next meeting, an outline timetable/Plan for the system capacity review, to include physical assets describing what the population needs were – and also to include, if it was deemed a significant change of service, the plans to consult.

32/18 CARE QUALITY COMMISSION (CQC) LOCAL SYSTEM REVIEW

(Agenda No. 10)

The Chairman welcomed the following representatives from the CCG, OH, OUH and OCC:

- OUH – Dr Bruno Holthof and Sam Foster – Chief Executive & Chief Nurse
- OH – Stuart Bell, CBE – Chief Executive
- CCG – Lou Patten – Chief Executive
- OCC – Kate Terroni, Director of Adult Services & Helen Sanderson

A briefing paper was attached at JHO10 and a presentation was given. The Committee thanked all for the useful paper, particularly because it contained specific examples.

Questions from the Committee and responses received were as follows:

- Kate Terroni was asked if there was a clear business case to roll out Amazon Echoes to assist older people living at home. She responded that there was and this was an endeavour to avoid the need for carers for particular tasks;

- Dr Holthof was asked if the AGE UK provision for patients in hospital would be via new monies or would it be via existing contracted services with Age UK. He responded that the Trust would pay and no extra funding would be received for this additional service;

- A member commented that 48% was a useful statistic in relation to keeping people out of hospital and asked what the mortality rate was. Dr Holthof undertook to send a paper for information;

- In response to questions asking who was commissioning the Wellbeing Teams? who was funding the delivery of the service? and who was accountable for the recruitment of outside organisations and development of the service? Kate Terroni responded that OCC was funding the Wellbeing pilot and was accountable for the delivery outcome for the one - year pilot. She added that it demonstrated a new way of working locally and it was her view that it was accompanied by the right values and

attitudes. Moreover, Adult Social Care was to set up some flexible home care services looking at a whole range of options for delivery. She added that the private sector would be encouraged to participate. Performance screening would look at workforce issues and an Officer would be attending a future meeting to present the outcomes and respond to questions;

- Kate Terroni was asked if OCC would be supporting the ongoing work to gain recognition for the inclusion of care workers into the definition of key workers. She responded that there was a need to work up a definition of key workers and would come back to Committee on this issue if required;

- Kate Terroni was asked if the potential partnership agreement with Cherwell DC might address the need for housing and recruitment of staff workers. She responded that Lou Patten and herself had met the previous day and had agreed that there was a potential to look at housing at local level, which could be quite exciting if the opportunity arose;

- In response to a question about how home care scheduling worked for self-funders, she reported that there was a very active and vibrant domiciliary provider market with whom they were working. She added there was also a willingness to help them to look at current service users and also at people who would potentially need care packages in the future in order to assist in the targeting of particular agencies to suit needs;

- In response to a number of questions relating to the quality checks that were in place for the carers of patients coming out of acute care, Sam Foster responded that nurses would be SEN trained with 2 years of training from the National Medical Council. Kate Terroni added that Social Care paid staff also had to be regulated regulated. Service providers would be expected to submit all appropriate data and would be expected to be working to assured models to ensure safeguarding issues were addressed. There was also some expectations put in place for volunteers. The Chairman added that this Committee would be picking up this up with the CGC at the September meeting. Helen Sanderson added that skills appropriate to the advised level would need to be up and running in Oxfordshire where system leaders were gathering an army of volunteers who would require training. OCC's Performance Scrutiny Committee was investigating this further;

- Stuart Bell and Dr Holthof were asked about the refreshed vision for the integrated Health and Social Care service, as monitored by the Health & Wellbeing Board (HWBB) whose constitution and methods of working was under review. Stuart Bell reported that both himself as Chief Executive of OH and Dr Holthof, as Chief Executive of OUH had now joined the Board as system leaders. The vision had been agreed at the special meeting of the HWBB on 10 May 2018. He added that a new Strategy for Older People would take time to construct and was expected in the Autumn. When asked about resilience and system level measurement, he reported that there were many measures in existence but so far there was no

system method of measuring the patient flow through the system. Lou Patten added that the AQC Panel was to look at the evaluation of the programme. She pointed out that the revision of the HWBB would bring with it an opportunity to bring about a better informed, better experience of how it would deliver services in an integrated way. It would become all the more important to share ideas about how to configure itself, in particular the promotion of integrated care in Oxfordshire in a much more focused manner. The HWBB would be the statutory vehicle with which to provide that and give it oversight. It was also an opportunity for a much more active discussion with the district councils on health matters and more focus on health at county level. Dr Holthof added that the four system leaders would be working diligently to re-design the governance, hold fewer meetings and focus on the right topics leading to the Board implementing some of the actions which would make a difference for patients;

- A member put forward their view that understaffing and under resourcing in the reablement service had been major factors in the problems experienced previously with DToC. Kate Terroni stated that it was important that reablement was part of the system. There had been a significant amount of good work to improve the situation and to ensure that it was not seen in isolation in relation to the delivery of the contract. This was an important issue for system leader discussion. Sam Foster responded also that an example of some improvement work undertaken internally was a peer review with some of the patients to ascertain that a community hospital bed was not always required and patients were able to go home earlier when discharged to reablement teams;

- In response to a question from members asking if housing for key workers was being investigated, Stuart Bell cited a piece of work entitled 'Homes First' had been undertaken with Adult Social care and Age UK to get patients home first. Its aim was to reduce the burden of domiciliary care. He added that sub-contracting with OH had enabled delivery of 96% of the contract, but it should be kept in mind that demand had significantly outweighed capacity.

At the close of the discussion, the Committee **AGREED** to request to view:

(a) the framework for the measures that would be put in place; and
(b) any examples of best practice from elsewhere which had been used to cut delays.

33/18 HEALTHWATCH OXFORDSHIRE

(Agenda No. 11)

Rosalind Pearce, Chief Executive Officer, Healthwatch Oxfordshire (HWO) attended to present the HWO update (JHO11). She also presented a short video which had been co-produced by the Luther Street Medical Practice Patient Participation Group

(PPG), how the Luther Street Medical Practice staff, on the work of the Medical Centre's PPG. She stated HWO was working well with the PPG and that this was an example of the PPG going to where the patients were rather than the other way around. The Committee thanked her for bringing the video to the Committee's notice.

In response to concern expressed by a member that 40% of children were known to have tooth decay by the age of 5 and the need to target this in areas of deprivation, Rosalind Pearce responded that a HWO report was due for publication at the end of July which included a survey of care homes on dentistry provision for their residents. She added that in her view this was a classic area of joint responsibility for the Public Health and NHS areas. She also added her agreement of the importance of dental care beginning at a very early age.

A Committee member informed the Committee that there had been much concern expressed at a recent voluntary sector forum she had attended; and also expressed in discussion on the streets of Wantage, about the temporary loss of community care bed facilities at Wantage Hospital following its temporary closure 2 years ago.

A member supported the different approaches/interventions being taken in relation to people's health and wellbeing, such as the Health Checks project which targeted young men. Ros Pearce agreed that if HWO had not undertaken this it would not have reached these men in the normal manner. She also expressed the hope that others would learn from this approach taken by HWO.

Ros Pearce was thanked for her report.

34/18 UPDATE ON IMPLEMENTATION OF RECOMMENDATIONS FROM THE OXFORDSHIRE HEALTH INEQUALITIES COMMISSION

(Agenda No. 12)

In response to a request made by this Committee for progress on the review from the Oxfordshire Health Inequalities Commission to be reported every 6 months to ensure that health inequalities remained a priority, an update report was attached at JHO12. Dr Kiren Collison, Clinical Chair of the OCCG and Vice – Chair of the Health & Wellbeing Board, and a member of the Implementation Group which she also chaired, joined Dr McWilliam and Jackie Wilderspin, Public Health, OCC at the table.

Dr McWilliam introduced the item giving a brief overview of the process, reminding the Committee that the recommendations had no force of statute and some were very broad about society as a whole. Jackie Wilderspin spoke to the report highlighting the following key issues:

- A multi-agency group met quarterly which included membership from the district councils, OCC, OCCG and other bodies to consider how and who would take forward the recommendations of the Commission;
- Six priority areas had been highlighted and there was now a basket of indicators on 'Oxfordshire Insight''
- Little progress had been made on the setting up of the Innovation Fund as groups did not wish to duplicate what was already in existence;

- A workshop had been held to look at the reasons why benefits were not taken up, the outcomes of which would be taken to the Implementation Group to take forward;
- Good work had taken place on social prescribing which was OCCG led;
- Physical activity issues had been targeted and OXBAR had agreed to take them forward;
- A specific initiative on prevention issues had been taken on by the Oxford City Locality Group, working with Mental Health; and
- The Implementation Group was due to meet in July and wold be focusing on the list of recommendations, where progress had not yet been made.

Dr Collison commented that Health Inequalities should form a part of every workstream within Health and Social Care stating that there was a significant amount of work to do in relation to recognising its importance. She undertook to provide further information to members of the Committee in relation to recommendation 48 relating to the gathering of information on race.

When asked about how Health Inequalities for people suffering from mental health illness was being addressed, Dr McWilliam responded that this was included across the board, along with those for people with a learning disability (recommendation 39).

A member asked why the Commission did not address recommendations that related to the link between housing and health inequality, for example, to work more closely with housing associations in order to improve inequalities. Jackie Wilderspin stated that the report was a product of the evidence the Commission had taken from local data sources and responses received – and the links with housing had not been included in the report. Dr McWilliam added that Health had been a missing piece in local planning. However, its role was now much to the fore and was about to enter the workstream as a topic.

A member asked if there was anything that needed to be done to encourage people to provide the Implementation Group with the required information on factors which did not fit in with the familiar, such as transport. Jackie Wilderspin responded that the work was now progressing to the last few recommendations where there was a need to think about what to do if the knowledge was not there.

The Committee **AGREED** to:

(a) scrutinise the process again once the work on the priority areas had been completed with a view to using the Committee's influence to assist in the successful implementation of the recommendations; and
(b) in relation to recommendation 16, to suggest to the Commission that an additional clause be added in retrospect, that existing providers of social housing be brought into the Commission's orbit.

35/18 STROKE REHABILITATION SERVICES - PILOT REPORT
(Agenda No. 13)

Stuart Bell, Chief Executive, Oxford Health, presented a report (JHO13) which reported back on performance, outcomes and the next steps following the Stroke Rehabilitation Services pilot. He stated that the move had taken place in February from Witney to the Abingdon site. Since then it had been found that the length of stay had reduced which meant that patients were able to go home more quickly.

Attending alongside Mr Bell was Dr Robbie Dedi, Deputy Medical Director, OH and Sara Bolton, Allied Health Professions Lead, OH.

Cllr Rooke reported that some members of the Committee had made a very interesting visit to the Stroke Unit and had found the staff to be very engaged in their work. Questions asked and responses received were as follows:

In response to questions from members regarding a recent Healthwatch Oxfordshire report which had stated that a number of patients at Abingdon were waiting for a discharge package for occupational therapy and physiotherapy; and 70 patients were waiting for assessment, Sara Bolton stated that therapy was provided on the Unit and exercises were also given for patients to do at home on leaving the Unit. She added her awareness that there were waiting times in the Community Therapy service, stating that the Team would provide more information to the Committee on this subject.

In relation to a question asking at what point did a patient begin to deteriorate without physiotherapy, Sara Bolton stated that it depended upon the individual's treatment plan. If a patient required therapy immediately following discharge then it would follow through as a seamless process. Sometimes hospital patients were given extra therapy. Dr Dedi added also that even without therapy, the level of functioning deteriorated the longer a person was in a hospital bed. Therefore, getting these patients home would improve their situation.

In response to a question about whether there had been input from families /carers regarding the travel aspect of the move, Dr Dedi stated that there had been no specific complaints or consistent carer feedback regarding the transfer. The patients were made aware of the benefits of co-locating which were that they would be better cared for and would be moved back to their home more quickly.

A member asked about the costs of recruiting nursing staff. Sara Bolton responded that the Trust continued to have a very active recruitment process which had been extended to embed agency staff further into the Team. This, however, was not a long - term plan. Also, in response to a question about how many staff had left the service as a result of the transfer, how many had transferred and how many had returned, Sara Bolton stated that she did not have the current details with her of who had left the service. However, four support workers had discussed a transfer to Abingdon which would create a good Team.

The Chairman requested at this point that representatives returned to a future meeting once the evaluation pilots had been completed, adding that the Committee would be interested, in particular in the patient feedback and the impact of the closure on Witney Hospital, on, for example, staffing.

A member asked if being treated whilst in hospital strayed into a grey area with regards to means testing. Dr Dedi responded that stroke specialists/therapists were present at the Unit. Specialist therapy was not related to means testing. Therapy reduced the need for ongoing care and should minimise the need for ongoing treatment.

The representatives were asked when the pilot was scheduled to end and what criteria was in use to measure success. Dr Dedi responded that the Trust had been confident at the start of the scheme and even within a few months it had been demonstrated that outcomes had been met and it had showed its worth. He added that there were many reasons for continuing with the pilot, and to continue with the arrangement thereafter.

The Chairman stated that a further report on the outcomes would be useful for assessment purposes. Dr Dedi responded that those receiving intense and regular therapy were difficult to measure as the numbers were too small. However, the Trust would be measuring staff, friends and family outcomes and clinical outcomes; and would also be reporting against the national data. In relation to a comment from a member stating that expediency would be welcomed as it was understood that the Oxfordshire Community Therapy Unit was causing many problems, Sara Bolton reported that the CCG was in the process of commissioning a stroke review to determine whether the correct rehabilitation model was in place, which included OCE.

At the close of the session, the Committee **AGREED** that it was encouraged by the early indications, but needed to see the outcomes-based data of the pilot and the service's impact on the County before taking a final decision. It therefore reserved the right to finalise the review until a presentation was given on the final data, as indicated above.

36/18 TRANSITION OF LEARNING DISABILITY SERVICES

(Agenda No. 14)

Following the transfer of specialist learning disability health services from Southern Health Foundation Trust to Oxford Health in July 2017, Sula Wiltshire, the OCCG's Director of Quality and Lead Nurse attended to present an overview report (JHO14) of the transition which included a consideration of whether lessons had been learned. She was supported by Chris Walkling, Senior Commissioning Manager for Mental Health at the CCG and the co-chairs of the Oxfordshire Transforming Care Partnership Board, Gail Hanrahan (Oxfordshire Family Support Network) and Paul Scarrott (My Life My Choice).

She introduced the report by stating that the OCCG had undertaken this piece of work at the request of this Committee, its focus being on quality and safety from the users and carers' perspective. She informed the Committee that this had been very much a shared piece of work with Southern Health, Oxford Health and 'My Life My Choice'.

Paul Scarrott informed the Committee that he had sat on the Board during its consideration of the transition and its view was that the transition had gone smoothly, with no staffing problems encountered. The Oxfordshire Family Partnership Network had been successfully embedded within the process which had involved families and users in the process. It had also co-chaired the Board. The Network had been part of the whole of the process, for example, viewing and commenting on, if necessary, letters to families prior to despatch. This had been very good from the Network's perspective.

The Chairman stated that this information was very reassuring and positive, asking if Oxfordshire was the only place who had experienced this level of involvement. Gail Hanrahan explained that this had been a difficult process to be a part of initially, given the mistrust from families following Conor Sparrowhawk's death. She added that it had been a risk of reputation for their organisations to be a part of the process. She added however that there would always be a mistrust of the NHS, given the recent Leader's report and the Mazar's review. A benefit had been the learning for the NHS that the involvement of families was required when changes were made to a service. As a result of this involvement there was now more trust in the process and knowledge that the views and input of families were required to create a more level playing field.

A Committee member thanked Gail Hanrahan and Paul Scarrott, on behalf of the Committee stating that there was a need for more of this method of involvement within the NHS when difficult changes were proposed. Sula Wiltshire was asked if there had been any interaction the ongoing health inequality work within the County. She responded that, as a result of the Mazar's report, a joint report had been undertaken between the OCCG and OCC's Safeguarding Adult Board. As a result, a sub-committee had been created reviewing mortality and morbidity. This had been set-up prior to the formal requirement to look at it. She reiterated the importance of learning lessons. For example, it had been found that people with a learning disability and/or autism were not invited to breast/bowel screening examinations. In general, hard work was in progress with local providers and there was a passion to improve the lot for these people, as they were the most vulnerable in our society. She added that it was about how to strengthen services around it and create a bigger footprint. As the services were quite specialised, the Safeguarding Board was working with colleagues in Buckinghamshire and Berkshire looking at how to strengthen the expertise of providers in this area. She added that the Chair of the Health Inequalities Steering Group had also taken up the offer of help and co-operation in this regard. She was unsure about whether Professor Griffiths had taken evidence from for the Commission report, but undertook to find out.

A Committee member commented that more funding had been made available by the CCG for the transition of the service and asking whether the contract value had been increased. Sula Wiltshire responded that that the local authority held the contract for Southern Health and it was clear where these resources would like to be placed. It was about ensuring that when and where investment was received, the desired outcomes were realised. Chris Walkling added that the contract would include a secure learning disability service as there was concern in the whole of southern England that patients often stayed longer in medium secure services with nowhere to

go on to. Discussions were ongoing about developing the medium secure service locally on the same site, in order to increase provision.

A member asked if out of area placements were more expensive and logistically more complicated? Chris Walkling responded that a 'lift and shift' approach had been taken as part of the transfer. There were no local beds at the point of transfer and then, as part of the Transforming Care Programme, they were looking at developing services. Negotiations were in progress with a Hertfordshire NHS Trust in relation to out of area beds and specialist learning disability beds moving closer geographically, with Oxfordshire looking at developing short stay admissions. Numbers were relatively small for short stay, but no necessary lengths of stay were being reduced.

Gail Hanrahan reported that the Oxfordshire Family Support Network had been in contact to ask how the beds were being used, to ensure that an independent advice and support network was in situ. She added that currently they were working with two families alongside colleagues at Oxford Health in the Intensive Support Team. Parents were working with Oxford Health to ensure that any move back home was smoother. There had been some difficulty encountered in relation to where they would go when they returned. She added her view that there was a need for other services in Social Services and Social Housing to work together on this matter.

Paul Scarrott commented that a friend was experiencing difficulty in seeing their daughter in a home in Birmingham. However, now that she was back living closer, communication had been much improved. Chris Walkling responded that they were working more closely with family carers – and families went out to other areas to view what was being provided.

In response to a question about what additional help and support could be made available, Gail Hanrahan stated that the development of new services needed to be in equal partnership with families and carers. Her membership of the Board, together with that of Paul, had resulted in them feeling valued. They had been paid consultancy rates in recognition of their huge expertise as parents. The Board could not make any decisions unless they were present. Paul Scarrott added that it had been an excellent experience, in particular the experience gleaned when working with other people with a learning disability, and bringing what was learned back to the Board. A Member suggested that perhaps this was a learning experience which all needed to take on board when working with patient groups. HOSC ought to be asking why others were not using this valuable experience.

Sula Wiltshire was asked when the CCG would be moving on to the evaluation of the impact on patients. She responded that this was part of the improvements to the service, for example, the work ongoing in relation to access to health checks and inclusion as part of the screening programme to detect illnesses at an earlier stage. The CCG intended to track this via the Transforming Care Partnership.

The Committee **AGREED** to request the CCG's return, at a later date, to the Committee's Forward Plan in order to review the evaluation of the changes.

37/18 CHAIRMAN'S REPORT

(Agenda No. 15)

The Chairman addressed his report (JHO15).

At the request of the Committee he undertook to:

(a) raise formally with South Oxfordshire District Council the question of representation at this Committee;
(b) include in future reports a correspondence record; and
(c) circulate the Task & Finish Group report on MSK services to all members of the Committee. He took this opportunity to thank the three members of the Group for their valuable work. These were Dr Cohen, Cllr Monica Lovatt and Cllr Laura Price.

It was **AGREED** to receive the Chairman's report.

38/18 DATES OF FUTURE MEETINGS

(Agenda No. 16)

The dates of future meetings are as follows:

(All to take place on a Thursday to begin at 10am, with a pre-meet at 9:15am for members of the Committee only)

20 September 2018
29 November 2018
7 February 2019
4 April 2019
20 June 2019
19 September 2019
21 November 2019
6 February 2020

..... in the Chair

Date of signing .....

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HOSC Actions from 21st June 2018

Item no	Item	Action	Lead	Progress update
29/18	Forward Plan	Amend Forward Plan to include: a) Revisiting MSK services following results of working group (Feb 2019) b) Health Inequalities report (in six months) c) Winter Plan d) Prioritise – school health nurses, health visiting services, HWBB e) GP appointments – include reps from GP Federations	Sam Shepherd (OCC)	Complete. Forward Plan on agenda for 20th September 2018.
29/18	Forward Plan	Schedule a prioritisation meeting for September	Sam Shepherd (OCC)	Postponing action due to competing priorities for HOSC in September. Will explore during initial meeting of the HOSC Planning Group in October 2018.

HOSC Actions from 21st June 2018

Item no	Item	Action	Lead	Progress update
30/18	Winter Plan	Feedback to the Committee on: a) Who the third party providers are in relation to 111 and how Age UK assist in returning patients to their homes. b) Detail of the additional costs of backfilling staff vacancies with agency staff and whether private providers had been used. c) More detail on hospital bed closures. d) Evaluation reports and future plans to be focused and brief, including some measurable impacts/targets e) September report to include info on 7 day working – where this isn't happening, why and what impact it's having. f) September report to include what went well in working with other agencies (e.g. Age UK).	Diane Hedges (CCG)	Briefing circulated regarding 7 day working in Chairman's report. Bed closure information to follow. Winter Plan is on the agenda for 20th September 2018; evaluation information included in item.
31/18	CCG update	Outline timetable/framework for working with local communities to review local health needs, current and projected demographics and local assets to inform service change (incl. physical assets – describing what population needs are – if significant change to services, have a duty to consult)	Lou Patten (CCG)	On agenda for 20th September 2018
32/18	CQC system review	Circulate evidence paper to committee behind the quoted 48% mortality rates for people aged over 85 who've had a hospital admission within the last year	Sara Randall (OUH)	No update provided.

HOSC Actions from 21st June 2018

Item no	Item	Action	Lead	Progress update
32/18	CQC system review	HOSC to request the Council's Performance Scrutiny Committee look in more detail at how quality and safeguarding checks are carried out on volunteer staff when scrutinising the adult social care workforce in July.	Cllr Arash Fatemian (HOSC)	HOSC's request was included on the agenda for Performance Scrutiny on 5th July. The Committee was assured that the volunteers employed by the Wellbeing teams are subject to the same levels of safeguarding assessment as paid staff. There was a recognition that care providers are also using volunteers and this is a draw on the same resource pool.
32/18	CQC system review	Circulate the refreshed vision for an integrated system (agreed at HWBB).	Kate Terroni (OCC)	Complete
32/18	CQC system review	Evaluation report of the HWBB to come to HOSC for scrutiny in future	Sam Shepherd (to add to Forward Plan)	Complete. Forward Plan on agenda for 20th September 2018.
34/18	Health inequalities	Progress on gathering data on race/ethnicity to be established and an update circulated to committee	Kiren Collison (CCG)	To be included in next Health Inequalities Commission recommendation update to HOSC.
35/18	Stroke rehab	Report back to the Committee in September, including: a) Business case for longer term changes b) Staff impact of the changes c) Evaluation of the pilot with hard evidence of improved outcomes and including detailed patient feedback	Dominic Hardisty (OH)	On agenda for 20th September 2018

HOSC Actions from 21st June 2018

Item no	Item	Action	Lead	Progress update
36/18	Transition of LD services	Linking with Health Inequalities work to ensure improvements are made in making reasonable adjustments (by local providers and GP)	Sula Wiltshire (CCG)	The Oxford Health Learning Disabilities service has developed a range of materials to support providers, including primary care, to make reasonable adjustments for people with learning disabilities. The materials are being promoted as part of the Oxford Health team's engagement work to develop and implement a revised primary care liaison and support offer. Practices are receiving further support from Oxfordshire Clinical Commissioning Group in this area via the 2018/19 Primary Care Local Investment Scheme. Oxford Health are also leading on the development of a health and social care learning disability workforce development plan which will be submitted to the Transforming Care Partnership Board for approval in September 2018. The plan includes providing support to colleagues to make reasonable adjustments across health and social care.

HOSC Actions from 21st June 2018

Item no	Item	Action	Lead	Progress update
36/18	Transition of LD services	HOSC to receive a report on the benefits of the changes to patients when they are available	Sula Wiltshire (CCG) Sam Shepherd (to add to Forward Plan)	Date to be agreed
37/18	Chairman's report	Seek and encourage representation from South Oxfordshire District Council at HOSC meetings	Cllr Arash Fatemian (HOSC)	Complete
37/18	Chairman's report	Include in future Chairman's reports a correspondence record of who has requested to speak to the committee and on the subjects	Julie Dean/ Sam Shepherd (OCC)	In progress

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HOSC Forward Plan – September 2018

The scrutiny work programming guide was shared in July 2017 and is designed to help assess the relative merits of topics brought forward in order to prioritise areas of focus for scrutiny through a transparent and objective process. The "PICK" methodology can help scrutiny committees consider which topics to select or reject. This is:

Public interest	➢ Is the topic of concern to the public? ➢ Is this a "high profile" topic for specific local communities? ➢ Is there or has there been a high level of user dissatisfaction with the service or bad press? ➢ Has the topic has been identified by members/officers as a key issue?
Impact	➢ Will scrutiny lead to improvements for the people of Oxfordshire? ➢ Will scrutiny lead to increased value for money? ➢ Could this make a big difference to the way services are delivered or resource used?
Council performance	➢ Does the topic support the achievement of corporate priorities? ➢ Are the Council and/or other organisations not performing well in this area? ➢ Do we understand why our performance is poor compared to others? ➢ Are we performing well, but spending too much resource on this?
Keep in context	➢ Has new government guidance or legislation been released that will require a significant change to services? ➢ Has the issue been raised by the external auditor/ regulator? ➢ Are any inspections planned in the near future?

Meeting Date	Item Title	Details and Purpose	Organisation
Nov 2018	New Governance of the Health and Wellbeing Board	The reorganisation of the Health and Wellbeing Board. • How effective is the Health and Wellbeing Board at driving forward health, public health and social care integration? • Is there effective governance in place to deliver this? • How well is the Health and Wellbeing Board preparing Oxfordshire's health and care system for	HWBB

Updated: 10 Sept 2018

Meeting Date	Item Title	Details and Purpose	Organisation
		greater integration?	
Nov 2018	Health visiting services	• Impact of changes to children's centres on provision of health visiting service • Scrutiny of newly commissioned service • 0-5 health visiting services	PH & OH & CEF
Nov 2018	School Health Nurses	• The impact of school health nurses in secondary schools and future service plans • The recommissioned services	PH, OH
Nov 2018	Transition of LD services	• HOSC to receive a report on the benefits of the changes to LD services for patients	CCG
Feb 2019	Report from Task and Finish Group on MSK Services	Final report from the HOSC Task and Finish Group on MSK Services. To be jointly presented by HOSC and the CCG.	HOSC/CCG
Feb 2019	Health inequalities	• Review of progress in the Health and Wellbeing Board's progress with the Health Inequalities Commission recommendations. • (request made on 16/11/17 that progress be reported to HOSC every six months to ensure health inequalities remains a priority).	HWBB
April 2019	Quality Reports	• Quality Reports from: Oxford University Hospitals, Oxford Health and SCAS on the progress against their high level priorities. • Formal response from HOSC required on the final draft accounts	OH/OUH/SCAS/Federations
June 2019	HWBB Annual Report	An annual report to HOSC on the activity of the HWBB, covering: • Activity of the Board over the financial year 2018/19	

Updated: 10 Sept 2018

Meeting Date	Item Title	Details and Purpose	Organisation
		in pursuit of the Health and Wellbeing Strategy • How it performed against its aims and objectives during that period, including an overview of performance for all the sub-partnerships of the Board (e.g. HIB/Children's Trust & Integrated Systems Delivery Board). • Report to include assessment of how revised governance arrangements are working • Plans for 2019/20.	
June 2019	Winter Plan 2018/19	• Evaluation of the Winter Plan 2018/19	
Future Items			
	CQC Action Plan progress	• Progress on the CQC Action Plan, as determined through the second local area review • Local review is taking place in November 2018- report date to be confirmed	
	GP appointments	• Scrutiny of GP appointments. • What are the numbers of GP appointments available in Oxfordshire and where? • What are the trends with GP appointments, nationally and locally? How long, how many, at what times and in what locations in the county. • What are the costs of GP appointments?	CCG/ GP federations
	Health in planning and infrastructure	• How is NHSE engaging in the planning process, incl. the Health approach to CIL and s.106 funding • Learning from Healthy New Towns.	CCG, NHSE, Districts/City Planners, PH, OCC Infrastructure

Updated: 10 Sept 2018

Meeting Date	Item Title	Details and Purpose	Organisation
		• Impact on air quality and how partners are addressing this issue. • How can HOSC best support the planning function	
	Dentistry	• Scrutiny of NHS dentistry services in Oxfordshire	
	GP appointments	• Update on the success of weekend and evening GP appointments – share data on demand and how this is monitored	CCG
	Anaesthetist training at the Horton General Hospital	•	OUH
	Healthcare in Prisons and Immigration Removal Centres	• More in depth information on performance and how success is measured. • New KPIs in place from April 2017	NHS England
	Pharmacy	• Levels of access and changes to pharmacy provision, incl. mapping provision and impact on health inequalities	
	Social prescribing	• The roll out and outcomes of social prescribing pilots and learning that can be shared. (Berinsfield vs. Cherwell)	
	Health support for children and young people with SEND	• How is Health contributing to improving outcomes for children and young people with Special Educational Needs and Disabilities and working with partners in Education and Care? • Linked to outcomes of SEND Local Area Inspection	OH, OUH
	Priorities in Health – Lavender Statements	• How the CCG manages competing priorities – Thames Valley Priorities Forum	CCG
	Commissioning intentions	• Committee scrutinises the CCG Commissioning Intentions	CCG

Oxfordshire Joint Health Overview & Scrutiny Committee 20 September 2018

Update Briefing - Evaluation Framework & Best Practice Examples

1. Executive Summary

Evaluation Framework:

- It is vitally important that the system measures how the work it is doing impacts directly on the people that use its services.
- Oxfordshire System Leaders propose that the evaluation framework is based around the whole health and social care system, which would encompass the CQC Action Plan.
- The system framework will:
    - include measures which track performance against long-term priorities, current priorities and the 'NHS social care interface dashboard' which the CQC used to determine the systems that would be subject to a Local Area Review
    - remain focused on system priorities, therefore measures may need to change over time to reflect priorities
    - be approved and owned by the Health & Wellbeing Board
    - be reported regularly to HOSC

Best Practice

- Examples of using best practice include
    - System Leadership for Urgent Care and Winter 2018/19
    - Workforce
    - Falls and Frailty Project

2. Background

In April this year following a presentation on the progress of the work being carried out in response to the CQC Local Area review, the committee asked Oxfordshire System Leaders to develop an evaluation framework to measure how actions taken in response to that review would improve outcomes for people who access services.

At the last HOSC meeting in June, Oxfordshire System Leaders reported that there is no national framework for measuring the performance of action plans developed as part of the CQC's programme of local system reviews. Similarly, the Department of Health & Social Care have not yet developed a performance framework for measuring a health and social care system in its entirety. It was also noted, that a number of performance indicators are already being measured and reported on and it is from these that a performance framework would be drawn together.

At the last meeting the committee received a presentation highlighting some innovative approaches to delivering services and an example of how Oxfordshire is learning from best practice from elsewhere. The committee requested that System Leaders came back in September with some additional examples of how best practice was being incorporated into work.

3. A suggested approach to Evaluation

3.1. Ensuring an evaluation framework accurately measures system performance

Governance leads from across the system have begun the process of exploring the use of an evaluation framework focusing on the CQC Action Plan. However, after completing the initial scoping work this group now feels strongly that devising a new evaluation framework focusing on how one action plan (of many) impacts on people who receive services is not the way forward for a number of reasons:

- The CQC have provided Oxfordshire with an objective, trusted assessment of the local situation and improvement needed

- In many cases the recommendations and actions that have been agreed are very specific and form part of much broader pieces of work taking place across the system. Agreeing specific measures against the CQC action plan would not reflect or measure the other work that is happening across the system

- It is the Joint Health and Wellbeing Strategy, not the CQC Action Plan, that provides the overarching plan for the system. This strategy contains measures which are used to track progress towards delivering on the systems priorities. Reporting performance against these measures will provide a more complete and longer term strategic view of how the whole system is performing

- Many of the actions in the CQC Action Plan are strategic in nature and it would be very difficult to link them to specific impacts on people. For example, system leaders creating the required culture to support service interagency collaboration is unlikely to have a direct measurable impact on people receiving services

- The time and resource taken in defining a bespoke framework and regularly collating the information from across five organisations (and GP federations) would detract from the effort being made to deliver the change required

3.2. The Framework

It is vitally important that the system measures how the work it is doing impacts directly on the people that use its services. This should be done by using measures that cover the variety of services that make up the system and the range of people who receive those service.

Therefore, Oxfordshire System Leaders propose that the evaluation framework is based around the whole health and social care system, which would encompass the CQC Action Plan.

3.2.1. Part 1 - Measures in the Joint Health & Wellbeing Strategy & other current priorities

Measures to be included in the framework should be drawn from the existing Joint Health & Wellbeing Strategy as these focus on system priorities, are currently being measured and have agreed targets.

The strategy has three priorities for vulnerable adults and older people of which two are most relevant to the CQC review findings, it is from these that relevant measures have been selected for the proposed framework

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

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

It should be noted that a number of key system strategies including the Joint Health & Wellbeing Strategy are currently being updated. Section 2.6 describes how this part of the framework will be periodically updated to remain focused on current priorities.

This part of the framework should also include measures which are focused on other current system priorities that are not covered by the strategy. Hence the inclusion of the two reablement related measures in the proposed framework.

3.2.2. Part 2 - Measures used by CQC for Local Area Reviews

The CQC used six key measures from the 'NHS social care interface dashboard' when determining which systems would be subject to a Local Area Review. It therefore follows that it is against those measures that a system should evaluate itself to show how the actions taken following the review are contributing to improved performance. This would also allow the system to measure itself against its performance before the review.

3.3. The Measures

It should be noted that a framework of this kind needs to be iterative to remain focused on system priorities which change over time. The measures described below cover:

- Long-term system priorities
- Current priorities
- CQC selected measures to determine Local Area Review

Ref	Measure	Target

Part 1 – Joint Health & Wellbeing Strategy & Current Priorities		
1a	Reduce the number of avoidable emergency admissions for acute conditions that should not usually require hospital admission for people of all ages	997 or fewer
1b	Number of people waiting a total time of less than 4 hours in A&E	95% or above
1c	Reduce the average number of people who are delayed in hospital	83 or fewer
1d	Proportion of all providers described as outstanding or good by CQC remains above the national average	81% or above
1e	Number of older people placed in a care home per week	16.5 or fewer
1f	Increase the number of hours from the hospital discharge and reablement service	8920
1g	Increase the number of hours of reablement	5750
Part 2 - NHS Social Care Interface Dashboard		
2a	Emergency Admissions (65+) per 100,000 of the 65+ population	*tbc*
2b	90th percentile of length of stay for emergency admissions (65+)	*tbc*
2c	Total Delayed Days per day per 100,000 of the 18+ population	Average of 87 per day by March 2019
2d	Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	85% or more
2e	Proportion of older people (65+) who are discharged from hospital who receive reablement / rehabilitation services	3.3% or more
2f	Proportion of discharges (following emergency admissions) which occur at the weekend	*tbc*

3.4. Ownership and Approval of the Framework

The Health & Wellbeing Board should approve and own the system evaluation framework. The board have not formally met since the proposed framework has been devised and have therefore not yet had the opportunity to agree to the measures set out in this paper. This does however give HOSC the opportunity to comment on the framework prior to it being submitted to the next Health & Wellbeing Board for approval.

3.5. Reporting

It is proposed that progress against each measure in the framework is reported regularly to HOSC. This could be in the form of a written submission or a short presentation from System Leaders.

3.6. Ensuring the Framework remains focused on priorities

The Joint Health and Wellbeing Strategy is currently being refreshed by the Health & Wellbeing Board, this strategy sets the long-term goals and vision for the Oxfordshire Health and Social Care System.

There are five working groups and sub-committees under the Health & Wellbeing Board whose priority is to implement the Joint Health & Wellbeing Strategy. To enable this, each group has plans and strategies with reporting frameworks to measure the impacts and provide assurance to the Health & Wellbeing Board. The Integrated System Delivery Board and two Joint Management Groups are delivering the majority of the CQC requirements.

To ensure the framework remains focused on current priorities, measures from the reporting frameworks that these groups develop through their updated strategies and plans will be added to the framework as they are agreed.

4. Examples of Best Practice

4.1. System Leadership for Urgent Care and Winter Planning

On 26 & 27 July 2018, Oxfordshire System Leaders attended the NHS Improvement facilitated 'Improving Emergency Care Leaders Forum'. This event brought together leaders from Health & Social Care Systems across the country to learn about national best practice examples in improving the quality and performance of emergency care.

Oxfordshire System Leaders took inspiration from many of the presentations at the event which led to the development of a single system approach to both Winter and the leadership of Urgent and Emergency Care. This includes a dedicated Winter Team across commissioning and provider partners from health and social care, and a dedicated System Lead for Urgent Care who is the Winter Director.

HOSC will hear more about winter planning in the separate agenda item.

4.2. Workforce

The Oxfordshire Joint Workforce Programme has been working closely with several national organisations to identify and learn from best national best practice, this includes organisations such as Association of Directors of Adult Social Services (ADASS), Skills for Care, Skills for Health, Health Education England and the Department of Health and Social Care.

4.2.1. Care Certificate

Building on what was learnt from a pilot in North West London, funding of £20k has been secured from Health Education England to fund work relating to the Care Certificate. This money will be used to standardise the qualification in Oxfordshire, and work towards it being universally accepted across the Oxfordshire Health & Social Care system as an agreed quality standard - this is recognised nationally as portability.

The Care Certificate is the set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors and aims to improve consistency and quality in the delivery of care.

The funding will enable a pilot of 60 places to confirm Care Certificate standards, signpost in terms of literacy and share learning and best practice across GP surgery support staff, domiciliary and Care Homes Staff.

4.2.1. Recruiting under-24s year olds

Inspiration was taken from work originally undertaken by the London Borough of Newham, when submitting a bid for £45,000 of funding from Health Education England. If awarded this funding will be used to pilot a recruitment drive with school/college leavers, create opportunities to promote careers in care, including volunteering opportunities with the Duke of Edinburgh Gold Award.

4.3. Falls and frailty project

This was originally conceived as a Service Development Project by a clinician in the South Central Ambulance Service in conjunction with Health Education Thames Valley. This was a one-year project for an Emergency Care Practitioner to work with an Occupational Therapist responding to 999 calls for patients who had fallen.

The project provided definitive care for these patients encompassing, acute assessment and treatment for the fall alongside functional assessments and the provision of treatment and equipment to ensure that patients were correctly assessed and referred and that subsequent risk of falls was reduced.

Due to the success of the initial trials in Reading it has now been commissioned across Oxfordshire and is currently being developed ready to go live for winter.

Responsible Officers

Kate Terroni – Director for Adult Services - Oxfordshire County Council
Louise Patten – Chief Executive - Oxfordshire Clinical Commissioning Group
Stuart Bell – Chief Executive - Oxford Health NHS Foundation Trust

Bruno Holthof – Chief Executive - Oxford University Hospitals NHS Foundation Trust
Will Hancock – Chief Executive - South Central Ambulance Service

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2018/19 Oxfordshire System Winter Plan

Prepared by Systemwide Winter Planning Group
Approved by Integrated System Delivery Board
August 2018

Aim of the System Winter Plan

Winter period is 1 November 2018 to 31 March 2018

To ensure the Oxfordshire health and care system:

- is **Resilient** throughout the winter period - providing safe, effective and sustainable care for the local population
- has sufficient **Capacity** available to meet likely demands over winter
- is able to deliver **Care** for Patients/clients in the most appropriate setting
- ensures **Safe and Effective** transfer of patients/clients within the system
- Is able to **Achieve** national and local access targets and trajectories across the system

Home First Ethos

- Prolonged bed rest in older people can lead to substantial loss of muscle strength and physical activity. 10 days in a hospital bed (acute or community) leads to the equivalent of 10 years ageing in the muscles of people over 80.

- Patients' time is the most important currency in health and social care
  #Red2Green #Last1000days #endPJparalysis

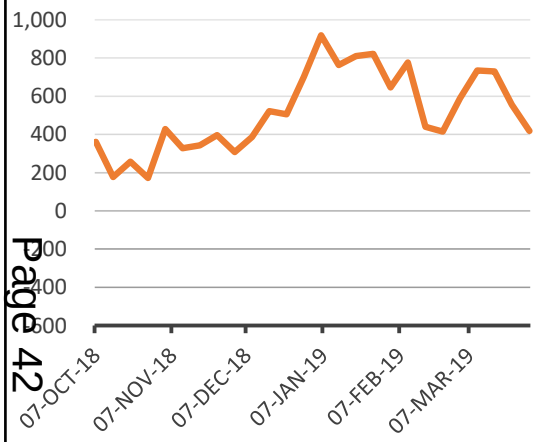
- 'No Wasting of Patient's Time' –
  Unnecessary Waiting + Sleep Deprivation = Deconditioning

Our overarching aim is to prevent deconditioning and enable independence for older people in hospital.

Oxfordshire's Winter Plan

On a page

The Issues



The Risks

Demand risks

- Significant increase in flu
- Significant adverse weather event
- Significant supply chain issue

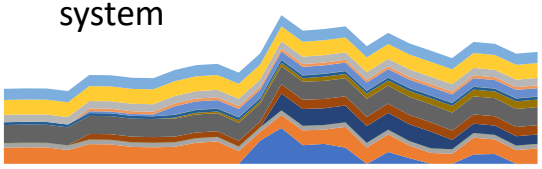
Capacity Risk

- Major provider failure
- Major staff shortages
- Significant business continuity issue

A **shared business continuity** approach to managing risks

The Actions

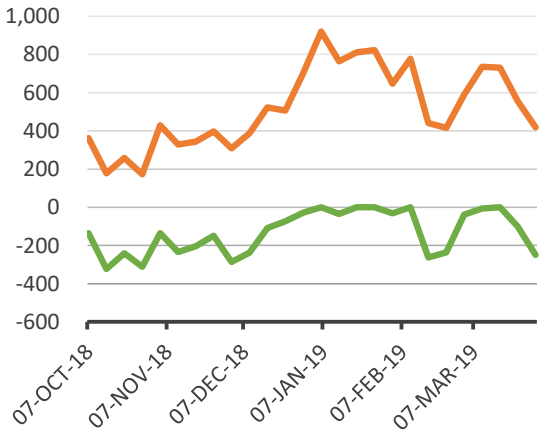
- Organisational winter plans
- Shared agreement
- An investment portfolio
- Projects to make the difference
- An integrated winter team to deliver and manage across the system



The Team

- A **winter director** coordinating a **single team** (OCC / OUHFT / OHFT / SCAS / OCCG) managing flow and performance across the health and social care system
- Seconded in staff, responsibility, and authority
- Operating **seven days** a week, 8 to 8
- The winter director accountable to chief executives and works with COOs across the system to **build trust and deliver outcomes**

The Outcome



Oxford Health NHS
NHS Foundation Trust

Oxford University Hospitals NHS
NHS Foundation Trust

South Central Ambulance Service NHS
NHS Foundation Trust

Age UK

PML Principal Medical

Oxfordshire County Council

NHS Oxfordshire Clinical Commissioning Group

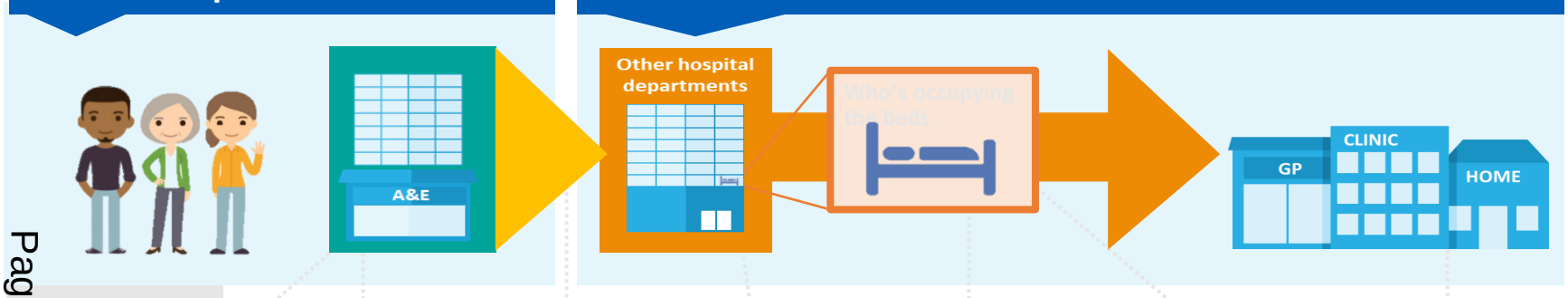
What is the size of the winter gap and what is driving this?

THE ISSUES AND RISKS

NHS Improvement Economic Review
Oxford: summary of factors affecting performance

The A&E department

Patient flow



Key factors

Workforce	Resilience	Admissions	Bed occupancy	Flu	Long stay patients	Discharges

The A&E department, demand and discharges improved in 2017/18

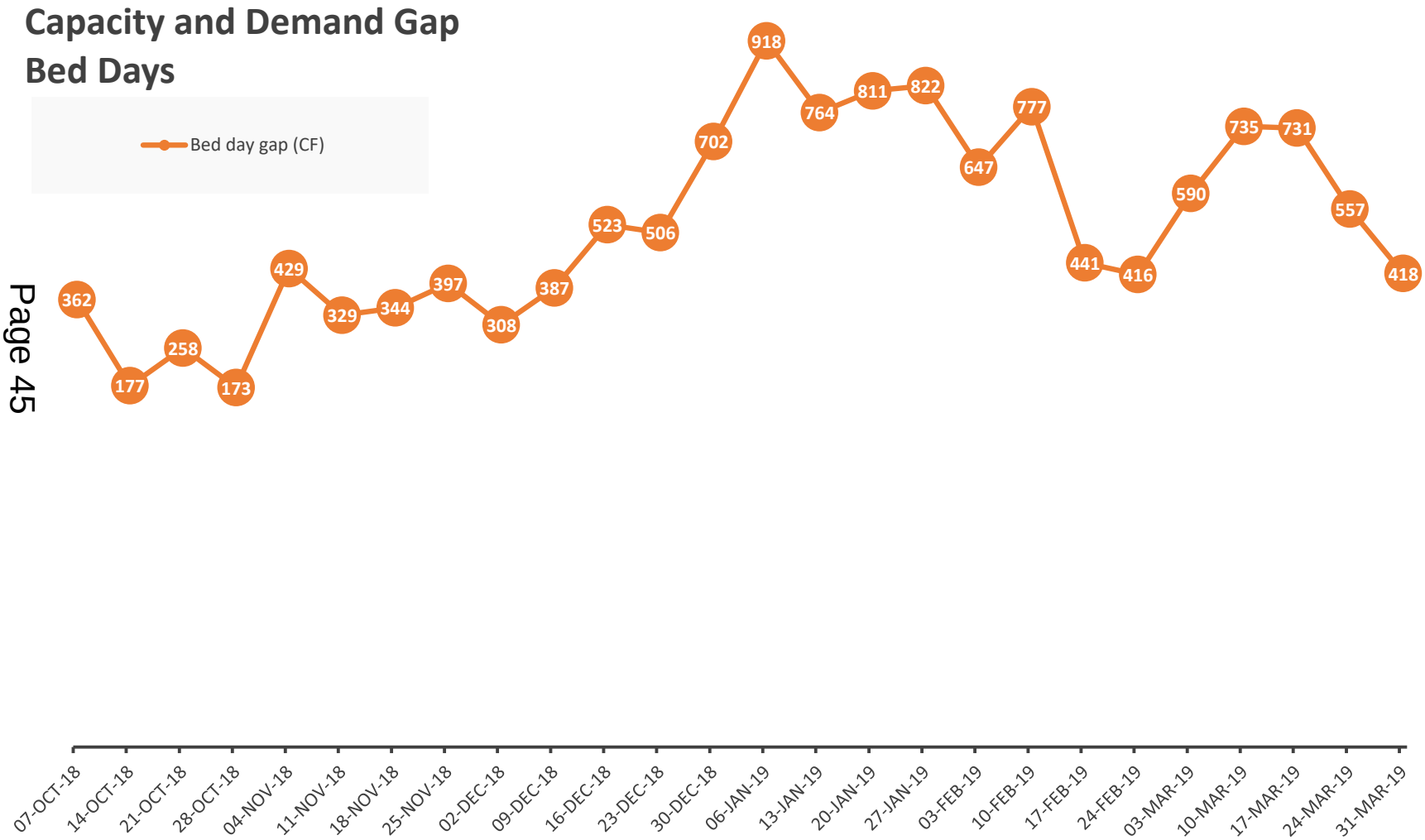
Rising occupancy reduces performance, with accelerating effects above **92%**

1/3rd of the growth in emergency admissions came from flu in winter 17/18

Long stay patients can decrease performance by reducing bed flexibility

In hospital metrics deteriorated in 2017/18

The Bed Equivalent Capacity Gap Over Winter



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Business Continuity (Plan B)

- Agreement to bring together Business Continuity leads across organisations to plan responses to risks – so surges in activity for say snow, flooding, extensive flu
- The winter director will lead this in conjunction with the winter planning group.
- Shared responsibility and shared plans

What have we done so far

THE ACTIONS

Learning from Winter 2017/18

- Building on work already started in 2017/18 we aim to further strengthen our Home First approach
- There are further opportunities to improve flow out of hospital through a person-centred approach focussed on people's strengths and capital. Using the learning from the Age UK work in short stay wards and Red Cross Pilot in ED.
- We can continue to make significant improvements from and high quality and consistent MDT approaches and our approach to long stay patients (e.g. OCC-OH work in community hospitals and OUH-OCC work around stranded patients)
- System focus on long stay patient approach

Review of 2017/2018 initiatives

Scheme	ED attendance	Admission avoidance	Length of Stay	Continue
Flu Vaccinations for Social care workers-new scheme to provide vaccination to key workers in social care, care homes and domicilary care	✓	✓		✓
Improving Nutrition – to improve nutritional support to care home through increased dietician support	✓	✓		✓
Increase in Hours of Provision – to provide additional appointments during the winter period.	✓	✓		X
Increasing Flu Vaccinations for at risk groups	✓	✓		✓
NHS Urgent Medicine Supply Advanced Service (NUMSAS); Repeat prescription supply via community pharmacy to reduce the burden on emergency care services of handling urgent medication requests.	✓			✓
Minor Ailment Scheme to provide care and support through community pharmacy NHS Urgent Medicine Supply Advanced Service (NUMSAS). Repeat prescription supply via community pharmacy to reduce the burden on urgent and emergency care services of handling urgent medication requests.	✓ ✓			✓ ✓
North East Oxfordshire Training Pilot for non-registered staff – increased training provided to support patients and to recognise the deteriorating patient.	✓	✓		complete
Medication Review – to reduce inappropriate polypharmacy and review patients at risk of admission	✓	✓		✓
Minor Ailment Scheme to provide care and support through community pharmacy	✓			✓
Patient Group Direction for Urinary Tract Infection Management supplied by pharmacy	✓			✓
SOS Bus – stationed in the centre of Oxford to respond to alcohol related incidents and minor injuries.	✓			✓

Review of 2017/2018 initiatives

Scheme	ED attendance	Admission avoidance	Length of Stay	Continue
Specialist Continence Prescribing Service – a specialist service to provide increased support to patients	✓	✓	from Jan 19	✓
Patient Transport Service support to ED – additional support to support discharge and transfer patients home.			✓	✓
200hrs of Contingency care – to provide additional domiciliary care capacity to support the HART team			✓	X
Care Home Support Service – to focus support on discharge and supporting discharge of more complex patients.			✓	✓
Community Hospital Home Leave-with virtual beds held on each ward to support early supported discharge from community hospitals.			✓	✓
Complex Discharges – to improve this process for patients and commissioning of additional capacity to support these patients			✓	✓
Hospital at Home – collaborative working to improve patient pathways.	✓	✓	✓	✓
Therapy Support to HART – to increase reablement support				within contract
Third sector Initiative to develop a model to provide alternative support to patients to reduce social admissions.		✓		✓STP funds
Trusted Assessor – improved liaison and communication to ensure timely discharge.			✓	✓
Short Stay ward			✓	✓
Stranded patients			✓	✓
Staffing premium payment		✓	✓	✓
Age inclusive s136 suite	✓	✓		✓
Crisis café/sanctuaries	✓	✓		TBC

Organisational Winter Planning

- Each partner organisation (OUHFT, OHFT, OCC, SCAS) have in place detailed winter operational specific to their organisations and focused on their areas of work.

Winter Investment

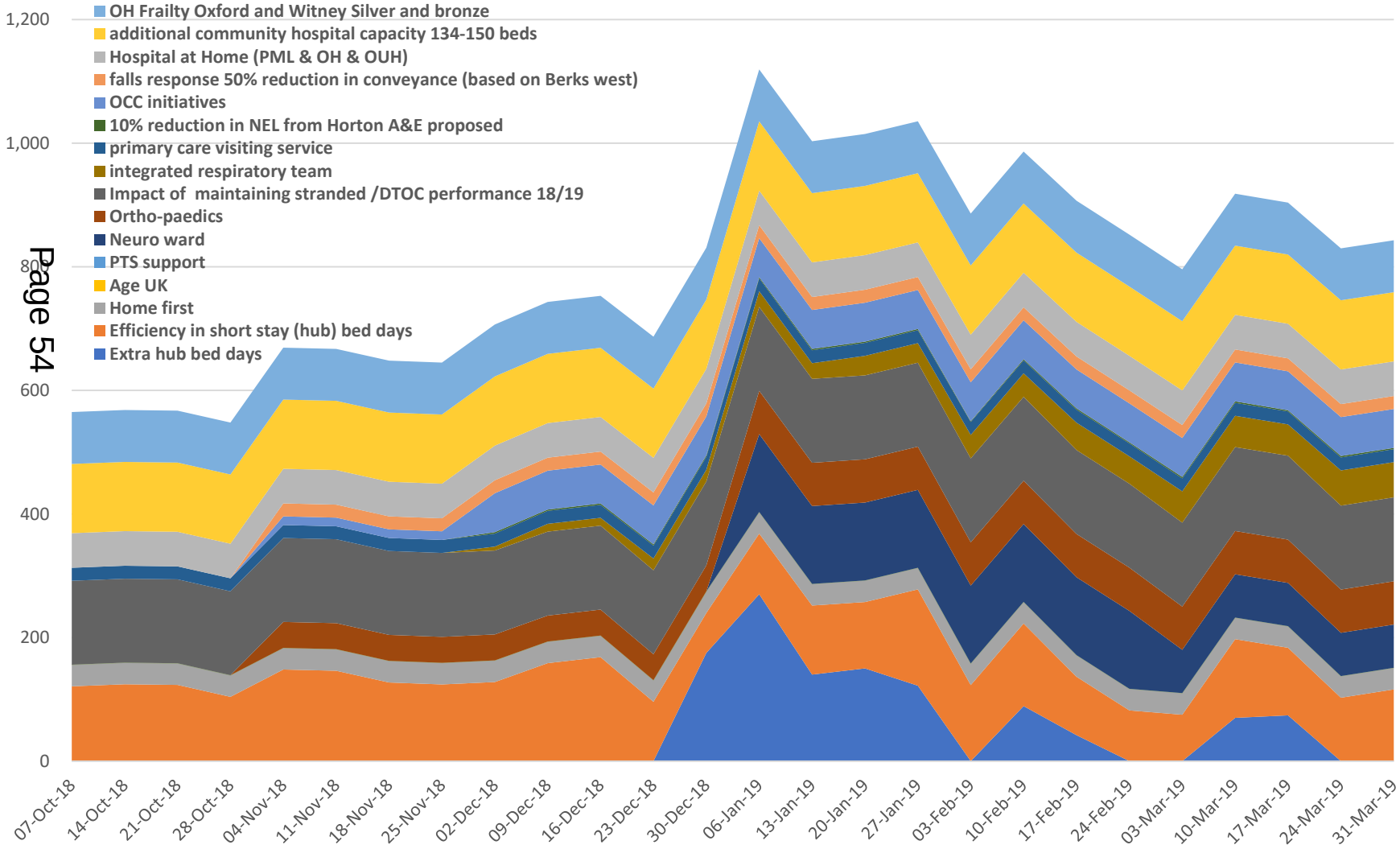
- In line with NHSE /I Operating Plan guidance there is the expectation that funding is included within baseline.
- The majority of the 18 specific projects delivering change are in organisations baseline funding
- An **additional £700k** has been identified to further support winter within OCC/CCG Pooled Budget.
- The winter planning group is recommending the following projects are funded to deliver additional support over winter 2018.
- This is on the assumption funding is for **actual spend from November 2018 only**, and is subject to the control of the winter team
- If there is additional funding our next priority is ongoing delivery of the **mental health safe haven (£70k)**
- This has been signed off by the Integrated System Delivery Board

Project	Cost
SOS Bus	25,191
Mental Health Safe Haven	30,000
Scale up of Primary Care Visiting Service	40,640
Transport Support to ED and discharge	92,000
Enhancements to home care flow	100,000
VCS Discharge Support (AGE UK)*	60,000
Home First expansion	200,000
Bed Purchase (mid case procurement)**	152,000
	699,831

* plus £80k of STP funding for a total of £140k

** this is the mid case, a best case scenario on procurement could deliver a £391k saving

Making the difference



A system team

- A **winter director** coordinating a single team managing flow and performance across the health and social care system
- Operating **seven days** a week, 8 to 8
- The winter director accountable to chief executives and works with COOs across the system to **build trust and deliver outcomes**

- The integrated team acts for the system not for the individual constituent organisations
- The integrated team take responsibility for delivery
- Members of the team work exclusively to deliver performance across the whole system
- The team needs to be largely self-sufficient and over time will share team responsibilities across organisational and (where appropriate) practitioner boundaries.
- The team will have deployable resources to manage flow which will be delivered from winter plan investment and prioritisation of business as usual

Provides an integrated approach to planning, daily escalation and delivery of urgent care flow on behalf of the system to achieve performance of

- **4 hour trajectory and no 12 hour trolley waits**
- **No ambulance handovers over 30m**
- **Super-stranded reduction trajectory (inc. current level 2 escalation)**
- **Better Care Fund DTOC trajectory and local target to achieve 3.5%**
- **Delivers the winter plan**
- **Supports the development of a longer-term approach to integration planning, escalation and delivery of urgent care beyond winter.**
- **Manages system risk**
- **Reports daily and longer-term learning**
- **Shares good news stories and improves practice.**

Communications Plan

- The communication teams from OCCG, OHFT, OUHFT and OCC are working together to support the production and delivery of the Oxfordshire's Winter Communications plan.
- The plan aims to support Oxfordshire's System Winter Plan objectives and to ensure that people are aware of and take action to keep well and help avoid an admission this winter.
- Activities tie together national initiatives, including the NHS England '**Help us, Help you**' campaign, which includes information on self-care and sign posting and the national seasonal flu campaign, with a focus on encouraging targeted groups to ensure they have their flu immunisation.
- A proactive approach to media is being developed and media partnerships explored to maximise positive coverage; this will be supported by a team of 'spokespeople' from across the system.

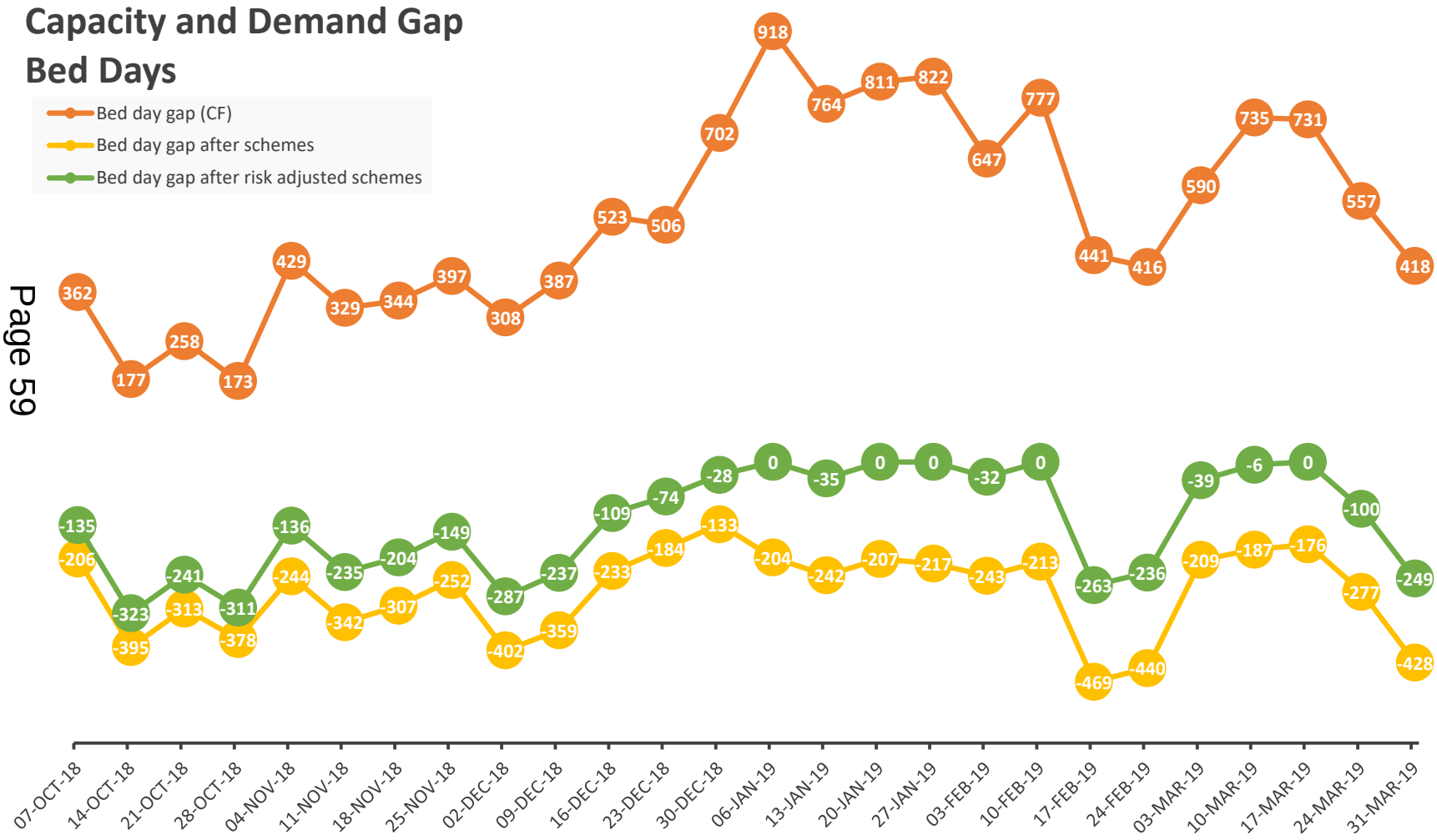
The actions

- **Tehmeena Ajmal appointed as the Winter Director** and system now doing enabling work to support scope of control and team membership from each organisation
- There is **system agreement on the target** to create the required bed equivalent capacity to support the Oxfordshire system for winter 18/19
- We have **system assurance on the bed equivalency impact** included within the plan and there is system commitment to close this gap.
- Through the system winter group a number of **out of hospital initiatives** have been developed and agreed which will provide further capacity and an investment portfolio
- Continued rigour and **CEO oversight on the Stranded patient work**
- **Collective responsibility** for delivery across the system with Organisational winter plans
- A clear **communications plan**

What have we done so far?

THE OUTCOME

The Gap Over Winter



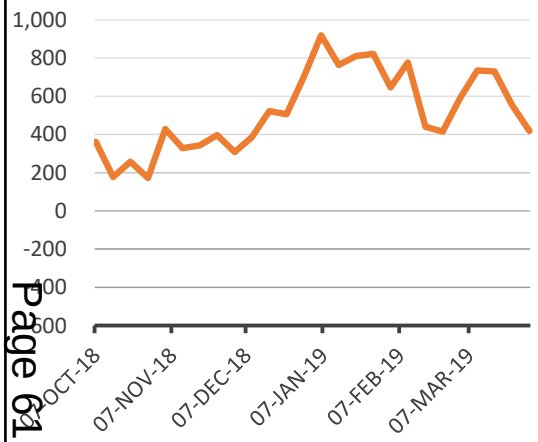
And questions

THE WHOLE PLAN

Oxfordshire's Winter Plan

On a page

The Issues



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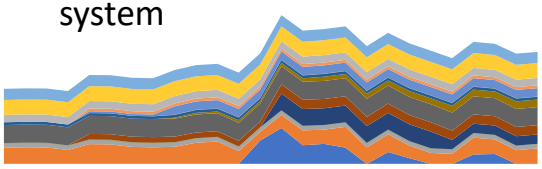

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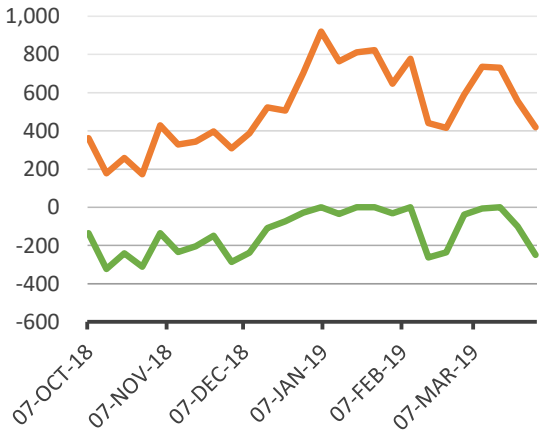

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NHS
Oxfordshire
Clinical Commissioning Group

Oxfordshire Joint Health and Overview Scrutiny Committee

Date of Meeting: 20 September 2018

Title of Paper: Oxfordshire Clinical Commissioning Group: Key & Current Issues

Purpose: The following paper aims to provide the Oxfordshire Joint Health and Overview Scrutiny Committee with an update on:

- System Demand
- Response to Secretary of State / IRP regarding obstetric services at the Horton General Hospital
- Cogges Surgery Update
- Developments in Banbury
- Vasectomy Services in Oxfordshire

Senior Responsible Officer: Louise Patten, Chief Executive, Oxfordshire Clinical Commissioning Group

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Oxfordshire Clinical Commissioning Group: Key & Current Issues

1. System Demand

Health care service demand across Oxfordshire remains high across urgent and emergency care and mental health services. We continue to work as a system to understand the drivers of this demand and implement actions to ensure our service users get to the right place, first time for their care.

Health and Social Care Partners have appointed a Winter Director, our first System appointment, who will lead a single team (with members from all organisations) to manage patient flow and performance across the health and social care system. The team will operate seven days a week, 8 to 8. The director is accountable to the system chief executives and will work alongside the chief operating officers across organisations to ensure our urgent care services deliver for our patients. There is more detail on this within our Winter Plan for 2018.

2. Secretary of State/IRP response regarding obstetric services at the Horton

We welcome the confirmed date (28 September) for the first Joint Overview and Scrutiny Committee with Northamptonshire and Warwickshire Councils. This heralds a more inclusive approach to addressing the recommendations from the Secretary of State on the basis of advice received from the IRP.

At the Joint Meeting we will be presenting a draft plan for the remaining work that the IRP has requested, including our proposals for how we will engage with the public, staff and service users. We are expecting to receive feedback from the Joint HOSC on whether this plan can go ahead into implementation phase and will be requesting clarity on how often and at what stages the Joint HOSC wish to see the progress made. This staged approach to scrutiny of the work during implementation, rather than just at the end of the process will help to ensure we can conclude this work effectively and appropriately.

3. Cogges Surgery Update

The two GP partners at Cogges Surgery in Witney have given six months' contract notice for providing GP services to around 7,700 people in the town and some surrounding villages.

In line with our statutory responsibilities, the CCG immediately commenced a process for developing service provision options when this contract expires. This

work is undertaken through the Primary Care Commissioning Committee, papers are available on our website.

Part of our work has been to engage early with the registered patients and local stakeholders. Through the PPG, we are working to ensure patients are kept informed and involved in determining the options and making decisions about how to proceed.

We are very grateful for the time and effort that the PPG has taken in helping us with this issue.

At the time of writing we are exploring if there is an option that would see a current Oxfordshire practice run Cogges as a branch surgery. We have written to all GP practices in Oxfordshire and if we have suitable interest we will pursue this as a local solution and therefore we may not require an external procurement process.

We have committed to keep patients informed as we progress; we have written to all patients aged 16 and over who are registered with the practice to inform them of what is happening. We have also set up a reference group of patients who are willing to support us with our communications.

We have a dedicated space on the OCCG website that holds up to date information, including a Q&A that is being added to regularly and can be found here.

4. Developments in Banbury

4.1. Primary Care

The end of the previous Banbury Health Centre contract on 30 June 2018 offered an opportunity for the CCG to seek a solution that would bring sustainability to Banbury primary care. Work began to identify a provider who would provide primary care services at the Banbury Health Centre site and who would also work with existing practices in order to develop a long term sustainable solution for primary care in Banbury.

The contract was awarded to Principal Medical Limited (PML), the previous provider of services at Banbury Health Centre, making transition to the new provider relatively seamless. PML have already made good progress in establishing a more joined up approach to service delivery across the Banbury GP Practices.

Woodlands Surgery and West Bar Surgery have been working collaboratively with PML and Banbury Health Centre to deliver primary care ‘at scale’ in line with the national direction. The Practices and PML have been actively engaging with each practice patient Participation Group (PPG) and have held a joint PPG meeting. The new model will see patients being able to access services from four sites which include Banbury Health Centre, Woodlands Surgery, West Bar Surgery and its branch surgery at Hardwick Surgery.

Further information on the new model and is benefits can be found in the latest update to Oxfordshire Primary Care Commissioning Committee here.

4.2. Integrated Front Door at the Horton

Good progress is being made with this project that aims to offer a single access point and an integrated team for patients requiring urgent care at the front door of the Horton.

The clinical model is currently being developed with clinicians from all our system organisations and will incorporate clinical streaming in A&E, GP out of hours services and some of the services that were previously part of the Banbury Health Centre contract. By moving the staff into a single working model, we can support patients better by improving access to the most appropriate clinician or professional, making best use of the workforce and reducing duplication.

The service is aimed at people who urgently need medical care; GP practices in Banbury will continue to offer same day appointments and some evening and weekend appointments at the Hub and patients are encouraged to use this as appropriate in the first instance, or to call 111 if they are unsure.

The new arrangements are planned to start in November 2018 so patients will have the benefit for the winter.

5. Oxfordshire Vasectomy Service

We have been made aware of an issue regarding the current vasectomy service. Staffing and service capacity issues (caused by the provider supporting at short notice our termination services) created a reduction in capacity to deliver the vasectomy service for 6 months up to May 2018. This has caused significant backlog issues and as a result the CCG has agreed that no further referrals will be accepted until this backlog has been sorted. Any exceptions (for example, if the procedure was deemed urgent by a clinician) will be dealt with via our Individual Funding process.

Whilst OCCG commissions 375 procedures per year, other CCGs have decommissioned the service completely. At the time of writing, the Thames Valley Priorities Committee guidance is being reviewed and the CCG will be considering its options for future service provision, including whether to decommission this service.

We will keep the HOSC informed of progress on this issue.

Oxfordshire Joint Health and Overview Scrutiny Committee

Date of Meeting: 20 September 2018

Title of Paper: Planning for future population health and care needs

Purpose: The following paper is a draft outline framework (to be approved by the Oxfordshire Health and Wellbeing Board) for working with local communities to review local health and care needs, current and projected demographics and local assets to inform future services. Also included is a proposed process and timescale, set within the context of the framework, for decisions about the service requirements for the Wantage population and Wantage Community Hospital

Action:

1. The HOSC is asked to comment on the overall approach and timescales of the framework
2. The HOSC is asked to comment on the overall approach to the proposed patient engagement.

Senior Responsible Officers:

Louise Patten, Chief Executive, Oxfordshire Clinical Commissioning Group

Stuart Bell, Chief Executive, Oxford Health NHS Foundation Trust

Planning for Future Population Health and Care Needs

1. Introduction

In June, the H&C system agreed to bring back to the September HOSC meeting:

1) The draft outline framework (to be approved by the Health and Wellbeing Board) for working with local communities to review local health and care needs, current and projected demographics and local assets to inform future services;
2) A proposed process and timescale, set within the context of the framework, for decisions about the service requirements for the Wantage population and Wantage Community Hospital

2. Planning Future Population Health Needs – Draft Framework

Appendix 1 sets out an emerging framework for how commissioners and providers of health and care services in Oxfordshire propose to work together to meet the health and care needs of the population today and in the future.

Oxfordshire system partners have been working to strengthen partnership working across health and social care. Best practice for Integrated Care Systems is to develop an evidence- based approach to planning for the design and delivery of services, engaging the public and key stakeholders at an early stage in order to fully understand the health and care needs of our populations. Once we have collectively understood these challenges, we can develop solutions together for the future delivery of services to meet those needs.

This work is owned by the Health and Wellbeing Board, with a strong sense of co-production at District Council level. It is important to note that this remains in draft format for comment as it has not yet been through an approval process by our District Councils, key stakeholders and the Health and Wellbeing Board.

The draft framework uses the learning from community based initiatives such as the Healthy Towns projects and recognises the critical importance of engagement with local residents, stakeholders, clinicians and professionals at an early phase and throughout the cyclical planning process. The specific design of these approaches will be bespoke to the population or geographical area covered by the framework.

The HOSC is asked to comment on the overall approach to the proposed patient engagement. This will be incorporated into the draft document.

3. Wantage Hospital decision timescale

The HOSC has specifically asked for an indicative timescale for the decision on the future of the Wantage Community Hospital. This timescale has been set in the wider context of this Locality Planning work, as we need to ensure we have described the wider health and care needs of the future Wantage and South West Oxfordshire population in order to support any options appraisal.

Appendix 2 sets out an outline timescale for the application of the emerging framework in the South West Oxfordshire locality, including the Wantage population. Please note that there may be several points within this process where decisions could be made about services for Wantage and the South West Oxon Locality population; these are illustrated within the document.

It is important to note that capacity within Oxfordshire CCG, District Councils and County Council means that it will not be possible to look concurrently at all 6 Localities across Oxfordshire. However, we have agreed to prioritise the SW Locality as we must address the questions about future use of Wantage Hospital, so this work will be undertaken first, subject to sign off by the Health and Wellbeing Board.

The HOSC is asked to comment on the overall approach and timescales.

Louise Patten	**Stuart Bell**	10 September 2018
Chief Executive	Chief Executive	
Oxfordshire CCG	Oxford Health	

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Planning for Future Population Health and Care Needs (Draft September 2018)

Proposal for an emerging framework approach

This framework aims to develop an evidence- based approach to planning for the design and delivery of services, engaging the public and key stakeholders at an early stage in order to fully understand the health and care needs of our populations. Once we have collectively understood these challenges, we can develop solutions together for the future delivery of services to meet those needs.

The framework and the stages within it can be practically applied at the most appropriate geographic or population level. There is a clear emphasis within this approach on locally developed solutions. There will be a balance to addressing challenges locally with those that impact on a wider geography or population and need to be addressed at a broader level or for a greater population.

Public involvement and engagement will be critical throughout, along with the involvement of clinicians and care professionals. The specific design of these engagement approaches will be bespoke to the population or geographical area covered in the scope of the use of the framework.

Principles of the approach – what we will and will not do

In line with the overarching principles of the Health and Wellbeing Board, we will uphold the triple aim for the people of Oxfordshire:

Better Health – improved population health and wellbeing
Better Care – transformed care delivery, improved quality and patient experience
Better Value – sustainable finances and optimal use of the Oxfordshire Pound

This is a **system approach** – all partners will work together with local communities to determine how best to meet future health and care needs, with solutions developed as a system not as individual organisations;

- **Population health management** principles will be followed – planning will include prevention and the wider social determinants of health;
- We will promote and enable **community and patient involvement** and engagement throughout - this will include co-design of approaches and co-production of key outputs;
- We will promote and enable **clinical and professional leadership;**
- Our work will be based on **parity of esteem** and address both physical and mental health;
- Future solutions and models of care will be **based on evidence** and will consider innovation and best practice from elsewhere;
- We will undertake appropriate **reality checks** – are proposals realistically affordable, attainable, can we be sure of a workforce to deliver the model(s), are the proposals right for Oxfordshire or a specific community within our County;
- We will sense check the level (geographic or population) at which solutions are being planned and developed – we will not fragment or isolate decision making;
- All planning approaches will be supported by robust **clinical and business cases** in the development of possible options;
- We will follow **best practice** and locally agreed change management approaches

The key stages of the emerging framework have been summarised in the diagram overleaf.

Appendix 1
Emerging Framework Summary

Stages can be run concurrently

Discussion Draft September 2018
Subject to Health and Wellbeing Board Approval

	Planning and Co-design	Population Health and Care Needs	Review of Services and Assets	Innovation and Good Practice	Meeting Population Needs	Development of options
Key Activities	• **Co-design the detailed approach with particular emphasis on local involvement** • Informed by JSNA and community profiles confirm the scope of the focus of the work – neighbourhood / Town / locality etc • Establish a core project team • Establish a stakeholder group • Establish a clinical / professional group • Develop involvement strategy and communications plan • Hold a community event(s) to introduce and kick off the project	• Start population health management approach • Build on existing work to understand the current and future population needs • Identify key leads to be engaged in development of specific aspect of the needs assessment work • Segment the population to identify and consider need use modelling to predict trends and changes • Identify any urgent or immediate concerns that require action • Plot out timescale for significant population changes linked to growth deal	• Identify key individuals and organisations to undertake review • Map what services are provided by whom, where and when • Map which population accesses the services • Identify physical assets and the services provided from those assets • Capture any sustainability issues – workforce, physical condition of buildings, non recurrent funding etc • Where possible highlight activity - what population segments access which services	• Identification of innovative approaches to the future delivery of services • Identify and understand the successes and impact that early adopter sites have achieved • Consideration of latest ideas and clinical good practice • Establish local views and ideas from those delivering services on how services could be provided differently in the future with innovation and integration • Work to identify initiatives and programmes that will address wellbeing and prevention	• **Co-design a range of small solution building events or a significant accelerated event** • Draw up suggestions and proposals directly informed by the preceding stages that will meet the identified population needs • Test whether or not all challenges or gaps can be addressed locally • Considering population health management what impact and benefit could wellbeing and prevention initiatives have for the future • Challenge – are emerging solutions / proposals affordable and deliverable	• **Further refine options informed by local engagement events** • Any additional detailed modelling and analysis to test proposals • Present options tested against deliverability, operational sustainability, affordability • Utilise a recognised Outline Business Case approach such as a 5 case model to summarise options for consideration • Identify any quick wins • **Confirm any potential significant service changes**
Page 72 Key Questions to be answered	• **How can co-design be enabled?** • **How will the approach be organised?** • **Who will lead the project from the system?** • **Who should be involved in this work locally?** • **How do people want to be involved?**	• What are the needs of the population across health and care? • What are the specific needs of segments of the population? • What future developments are planned that may change population requirements? • Is any immediate action required? • **What are local views of need?**	• What, where and when services are provided? • Where do patients that access the services travel from? • What are the physical assets in the system? • **What services do local people value and why?** • **What do we understand about local groups and schemes?**	• What emerging clinical and professional best practice is relevant to this population? • What future opportunities should we consider with respect to innovation and new models of care? • How could a less fragmented more integrated approach to health and care be if benefit?	• How could we work together as a system to best provide services to meet the needs of the population and at what scale? • What provider delivery models, commissioning approaches, clinical and service delivery models support that? • What can wellbeing and prevention support?	• What are the possible for options for the future delivery of services that meet tests for deliverability • Do any options meet a test for significant service change? • What options are there for initiatives that will support and promote healthy living in the longer term?
Community Involvement	• **Co-design of approach** • **Initial public event with the community** • **Co-production local communications and engagement plan** • **Establishment of stakeholder group**	• **In line with co-designed approach e.g public events** • **Delivery in line with co-produced communications and engagement plan e.g. use of local Area Committees or similar to highlight findings**	• **In line with co-designed approach e.g public events** • **Delivery in line with co-produced communications and engagement plan e.g. use of local Area Committees or similar to highlight findings**	• **In line with co-designed approach e.g public events** • **Socialise emerging case for change locally** • **Innovation events**	• **2 day 'Open Space' solution building event** • **Delivery in line with co-produced communications and engagement plan**	• **Continued involvement with community** • **Development of options**
Deliverables	• **Co-production a project plan including timeline** • Confirmation of a core team • Establishment of local clinical and professional steering group • Establishment of local community stakeholder group • **Initial public event**	• Understanding of population summarised specific to area • Specific trends and trajectories for population segments • Summary of known population changes plotted over years • **Understanding of local views of need**	• Clear picture of what services are provide where, when and by which organisation • An understanding of those services provided by the third sector • Picture of social capital • A summary of physical assets • Understanding of distance travelled to access services	• Options and opportunities for what innovative approaches across health and care can meet the needs of the population • Ideas for how to work in a more integrated way • Ideas for a longer term approach to the management of health and wellbeing	• Ideas and proposed solutions / options appropriate for the population and realistic scale • Options for new models of care • Suggestions for integrated delivery • **Community involvement in solution building** • Scale of service delivery	• A set of possible options for the future delivery of services across health and care, linked to key time or population change triggers • Proposals for longer term approaches that address wellbeing and prevention to improve overall healthy living

Appendix 2

Draft outline timescale for South West Oxfordshire Locality

Planning for Population Health and Care Needs
Draft Sept 2018

Discussion draft - subject to Health and Wellbeing Board Approval

Note: Dates and tasks subject to change

Ref	Framework stages	2018 October	November	December	2019 January	February	March	April	May	June
1	**Planning and Co-design**									
1.1	**Co-design approach for locality (will influence detailed stage design and deliver)**									
1.2	**Establish and confirm core team**									
1.3	**Identify key community leaders to support project establishment**									
1.4	**Co-produce Project Plan and timeline**									
1.5	**Establish of local community stakeholder group**									
1.6	**Establish of local clinical and professional steering group**									
1.7	**Initial public event(s)**									
2	**Population Health and Care Needs Assessment**			★						
2.1	**Population Health Management Analysis**									
2.2	**Identification of trends and trajectories**									
2.3	**Specific Population Segmentation Assessment**									
2.4	**Mapping of Housing and Growth Deal Impact**									
2.5	**Identification of any immediate required actions**									
2.6	**Capture local population view of needs**									
3	**Review of Services and Assets**			★						
3.1	**Mapping of existing service provision**									
3.1.1	Health Services									
3.1.2	Social Care Services									
3.1.3	Care Services									
3.1.4	Third sector services									
3.1.5	Wellbeing health and leisure services									
3.2	**Mapping of physical assets and points of delivery**									
3.2.1	Travel maps of usage									
3.3	**Mapping community assets and infrastructure**									
3.3.1	Social capital									
3.3.2	Travel									
3.3.3	Leisure facilities and opportunities									
3.3.4	Community groups and organisations									
3.3.5	Good neighbour schemes									
3.4	**Identification of any sustainability issues**									
3.4.1	Workforce									
3.4.2	Funding									
3.4.3	Physical building condition									
4	**Innovation and Good Practice**									
4.1	**Co-production of community ideas for future services design**									
4.2	**Learn from good practice to identify options and opportunities for innovation**									
4.3	**Identify and share current and emerging good practice**									
4.4	**Identify and explore successful new models of care (relevant to population)**									
4.5	**Explore benefits of integrated delivery**									
4.6	**Explore opportunities for longer term approaches to the health and wellbeing**									
4.7	**Deliver innovation and learning events**									
5	**Meeting Population Needs**						★			
5.1	**Co-design a range of small solution building events and / or a significant event**									
5.2	**Identify what services are required and in what timeframe**									
5.3	**What impact could wellbeing and health lifestyle interventions bring**									
5.4	**How could community initiatives support the population now and in the future**									
5.5	**Test emerging solutions for scale, deliverability and affordability**									
6	**Development of Options**						★			
6.1	**Co-production of community ideas for future services design**									
6.2	**Further refinement of options informed by engagement events**									
6.3	**Apply an outline business case approach to options (e.g. 5 case model)**									
6.4	**Identify quick wins**									
6.5	**Confirm any potential significant service changes**									
7	**Communications and Engagement**									
7.1	**Co-produce and implement communications, involvement and engagement plan**									
7.2	**In line with the locally developed approach encourage and enable local community involvement**									
7.3	**Co-design a timetable of community engagement events**									
7.4	**Additional deliverables specific to each project and local requirements**									

Wantage Gateway ★

Questions in relation to the future of Wantage Community Hospital have been set in the context of this outline timeframe for the South West Oxfordshire Locality. This is to ensure that the wider health and care needs of both the Wantage and South West Oxfordshire population inform any options appraisal.
The yellow stars indicate the key points at which it is anticipated that specific service decisions in relation to services for Wantage and the South West Oxfordshire population could be made.

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healthwatch Oxfordshire

Your voice on health and social care

Healthwatch Oxfordshire Update September 2018

1. Our Annual Report 2017/18 was published in June and can be found on our website www.healthwatchoxfordshire.co.uk. We have produced an 'At a glance' sheet that gives a quick and accessible summary of the report, this can also be found on our website.
2. Healthwatch Oxfordshire has published two reports about access to NHS dentistry:
    a. 'Treatment only when needed: Dental services in Care Homes' was published in August 2018. The report details our findings of a survey carried out of all the care homes in Oxfordshire. One in five care homes responded and the main findings are that nearly half people living in the care homes did not access dentistry at all; there are significant gaps in provision; and that some care homes struggle to obtain dental services for their residents.
    b. 'Filling the Gaps – Access to NHS dentistry' was published in September. This research was prompted by at we heard in Bicester in October 2017. We decided to look more deeply into the issue and ask ourselves further questions:

- What is the public's experience of using dentistry services?
- Is access to NHS dentistry a problem in other areas of Oxfordshire?
- What is working well?
- Are there barriers to people accessing NHS dentists?
- Are there areas for improvement that the dental surgeries and / or commissioners could address?

To find out the answers to these questions, between October 2017 and May 2018 we launched a county-wide project focusing on NHS dentistry. The main findings of the research fell into two categories – access to NHS dentists, and information about dentistry.

Both reports can be found here https://healthwatchoxfordshire.co.uk/our-reports/healthwatch-oxfordshire-reports/

Healthwatch Oxfordshire has invited key stakeholders to a workshop on 17th September to discuss our findings and begin to identify how they can be addressed.

First quarter update April to June 2018

Luther Street video, shown at the June HOSC meeting, nominated for award

Healthwatch Oxfordshire has been shortlisted for a national award by Healthwatch England. The nomination is for the video 'Patient Voices…Our Story', which Healthwatch Oxfordshire and local filmmaker Nicola Josse made with the Patient

Participation Group of Luther Street Surgery, Oxford, and Oxford Health. This GP practice service the city's homeless population and the film highlighted how the patients themselves were getting involved to shape how services are run.

The film was made with a grant from NHS England's Celebrating Participation in Healthcare scheme and was filmed earlier in the year. The overall winner from each category will be chosen by a panel of judges at Healthwatch England's annual conference in October 2018.

Feedback Centre continues to attract reviews
During the first quarter of the year, 312 individual reviews were left on Healthwatch Oxfordshire's new Feedback Centre.

Topics ranged from GP services and dental surgeries — most notably in Wantage and Grove - through to people's experiences with community physiotherapy services since they were out-sourced to a private provider, Healthshare.

Reviews came both from members of the public visiting the website, and staff members collecting reviews at events and entering them on to the site later.

Meeting the public
During the first quarter of the year, Healthwatch Oxfordshire attended 49 outreach events, including:

- Bicester Volunteer Fair
- Oxford Eid Extravaganza
- 13 group visits including 10 as part of the Wantage town project
- nine meetings with voluntary sector organisations as part of our Voluntary Sector Projects activity
- three hospital sessions
- eight meetings with community support centres as part of Healthwatch Oxfordshire's Day Centre project
- five patient participation group events attended,
- eight outreach stands in Wantage,

We heard from 2,870 people, listened to in groups, on the street, in public places and through surveys.

Reporting back on what we heard
Healthwatch Oxfordshire published five reports during the first quarter of 2017/18. These were:

- Enter & View (1)
- Focus on OX4 (town event)
- Health Overview Scrutiny Committee (2)
- Wantage Voluntary Sector Forum (with video on Healthwatch Oxfordshire website).

In addition, both verbal and written reports were made to: Healthwatch Oxfordshire Board, Oxfordshire County Council, Oxfordshire Health & Wellbeing Board, Health Improvement Board, Children's Trust, Oxfordshire Adult Safeguarding Board, Care Quality Commission, Thames Valley NHS Committees.

Making the news
During the first quarter of the year, Healthwatch Oxfordshire appeared in the local media or was approached for comment 70 times.

These included live radio interviews, pre-recorded television interviews, quotes in the press on health-related issues, and coverage of Healthwatch Oxfordshire's own activities.
Healthwatch Oxfordshire also published 12 online newsletters and other updates.

So, what?

We are always asking ourselves 'so, what'? We listen to people's experiences and what is the impact? How did we influence commissioners and providers? Often it takes time to have an impact, to influence decisions, to influence planned approaches to delivering health or social care services. Below are three recent examples of how Healthwatch have either influenced or had an impact:

a. Patient involvement in commissioning

NHS England approached Healthwatch for help to recruit service users to the Oxfordshire Diabetic Eye Screening Service procurement panel as it had been unable to recruit anyone. We sent a call out by email to Oxfordshire Sport and Physical Activity (OXSPA), Patient Participation Group Locality Forums, put a news item on our website, and included it in our News Briefing. Within a few hours of the request NHSE received an expression of interest from a patient.

Result! A patient's experience and voice secured to inform and influence NHS England commissioning and a very happy, and amazed, NHS England person.

b. Influencing quality

In May 2018, Healthwatch Oxfordshire commented on the Oxford University Hospitals NHS Foundation Trust's (OUHT) draft Quality Account and asked 'that within quality action plans for 2018/19 the Trust will once again focus on improving administration and communication with patients that meet the needs of patients'. OUHT responded the same day as follows:

'Many thanks for your statement. In response to your feedback we will add to the Quality Priority about lean process to include consideration of streamlining processes that meet the needs of patients'.

What next? Healthwatch Oxfordshire will monitor this commitment on a regular basis and report back via our website and regular reports to the Board.

c. Making information accessible to the public

The Oxfordshire Adult Safeguarding Board (OSAB), of which Healthwatch is a member, produces a Chair's Report after each Board meeting for public consumption. The July Report contained several acronyms (some of which even we

struggled with) which made it difficult to understand for those people not immersed in the system. We contacted the OSAB team and requested that a revised report be issued with 'acronyms in full first time used and requested that future reports will not use acronyms'. A revised report, acronym-free, was issued within 24 hours and we received confirmation that acronyms will not be used in future. We posted this revised document on our web site and in our news briefing – now more easily read and understood by those not immersed in the world of adult safeguarding.

What next? We are committed to monitoring publications for the public or fellow professionals to be understood by them when they read them!

Healthshare and MSK

Healthwatch Oxfordshire has reported to the HOSC Task & Finish Group MSK and Healthshare. We included eight patient stories, together with what we had heard from patients via our telephone and Feedback Centre. In total we have heard from more than 50 patients all often describing a dire patient experience, summarised as follows:

- confusing and poor communication between Healthshare and the patient
- often long and complicated patient experience through from GP referrals, Healthshare, to GP referral, to Healthshare, to hospital, back to Healthshare, referrals…and so it goes on
- people not being able to contact Healthshare by telephone despite frequent, and often over a long period of time, making calls; emails not being answered
- patients not knowing where to go to make a complaint
- long waiting times for appointments

In our report we made recommendations that would improve the patient experience and increase the level of accountability and scrutiny of the service provided by Healthshare. Our report will be published on our website.

DIRECTOR OF PUBLIC HEALTH FOR OXFORDSHIRE

ANNUAL REPORT XI

Reporting on 2017/18
Produced: August 2018

Contents

Foreword

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

This is my 11th Annual Report for Oxfordshire.

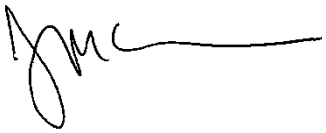
It uses science and fact to describe the health and wellbeing of Oxfordshire and to make recommendations for the future.

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 stimulating debate and in shaping the County's services for the future.

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

With best wishes,



Dr Jonathan McWilliam
Director of Public Health for Oxfordshire.
August 2018

Acknowledgements

Compiling this report would not be possible without the administrative and statistical support of Alan Rouse, Sue Lygo, Margaret Melling and Philippa Dent – thank you all.

I would also like to thank Rosie Rowe from Cherwell District Council and Azul Strong Corcoran from Oxford City Council for their help in compiling the information for Healthy New Towns in chapter two – thank you.

Introduction and Overview

This is an independent report about the health and wellbeing of Oxfordshire residents in the broadest terms. It focusses on the two main questions which we face as a County, namely:

How do we cope with demographic growth and change
and
How do we adapt to the stresses and strains of modern life that affect our health.

The solutions lie in:

- Working together to meet the challenges of population growth and ageing by creating communities which help to promote good health, prevent disease and which encourage a stronger sense of community.
- Joining up our efforts to prevent ill health more coherently.
- Adapting lifestyles to increase physical activity and reduce obesity.
- Looking after our mental health by learning how to promote our mental wellbeing.
- Focussing on services for all which also target disadvantage.
- Remaining on our guard about infectious diseases.

My assessment of progress in the last year is positive overall:

- There is strong evidence that health and wellbeing in Oxfordshire is good compared with England as a whole and indicators of disadvantage on the whole are improving. Nonetheless pockets of disadvantage remain to be tackled.
- Unemployment remains low and the economy relatively prosperous.
- Organisations are working together more smoothly and creatively – there are many green shoots.
- We are working well with Government to attract investment and keep the value of the 'Oxfordshire Pound' high.

Relative prosperity also brings with it challenges, particularly around high house prices and workforce shortages.

The increasing number and proportion of older people remains a major challenge for services as does the rising rate of obesity.

The report documents these themes throughout.

The challenge is to now press home the gains we have made for the benefit of all while tackling the challenging topics and areas of persistent disadvantage.

In summary the main message is:

From a health and wellbeing point of view, the old distinctions between health planning, place planning, infrastructure planning and economic planning no longer hold good. They are inextricably intertwined and we must deal with them as a whole to ensure our future health and prosperity.

Chapter 1: Meeting the Demographic challenge

Demographic change is having an impact on the way we live in Oxfordshire. The big question is, how do we cope with it?

We all know that life is changing rapidly…….

Everyone says the pace of life has never been so fast. Many of us are busier than ever, our roads are crowded, many things are done on-line, and if it can't be delivered next day we are disappointed…….and you need a pretty good job (often with a partner) to get on the housing ladder at all.

Our young people are 24/7 plugged into electronic devices.

Food shops display a bewildering array of goods catering for a myriad of global cuisines.

GPs are hard pressed and instead of the traditional appointment you may well have a phone call, skype call or be seen by a nurse instead.

Our forebears simply wouldn't have recognised it.

Despite everything though, we are living longer and many diseases which carried people off 25 years ago (heart attacks and many cancers) are more under control…… this is great in itself, but brings its own 'new crop' of issues in its wake – loneliness, an ageing population of carers and the rise of diseases such as dementia.

Also, there are still the 'haves' and 'have-nots' in our County: there are still disadvantaged groups in which good health is less likely.

So, as this report is all about a factual, current portrait of the health of people in Oxfordshire, I want to use it to take a look at some of these issues and how we might tackle them.

Chapter 1 looks at the biggest issue – demographic change - and what that means for us all.

Chapter 2 looks at how we can cope with change by improving the design of our towns and villages. This is called creating healthy communities and it is one of the most promising new developments to emerge over the last decade.

Chapter 3 looks more closely at disadvantage and how it affects us

Chapter 4 looks at the contribution of modern lifestyles and the particular impact of obesity.

Chapter 5 considers how to be mentally healthy in a fast-moving world

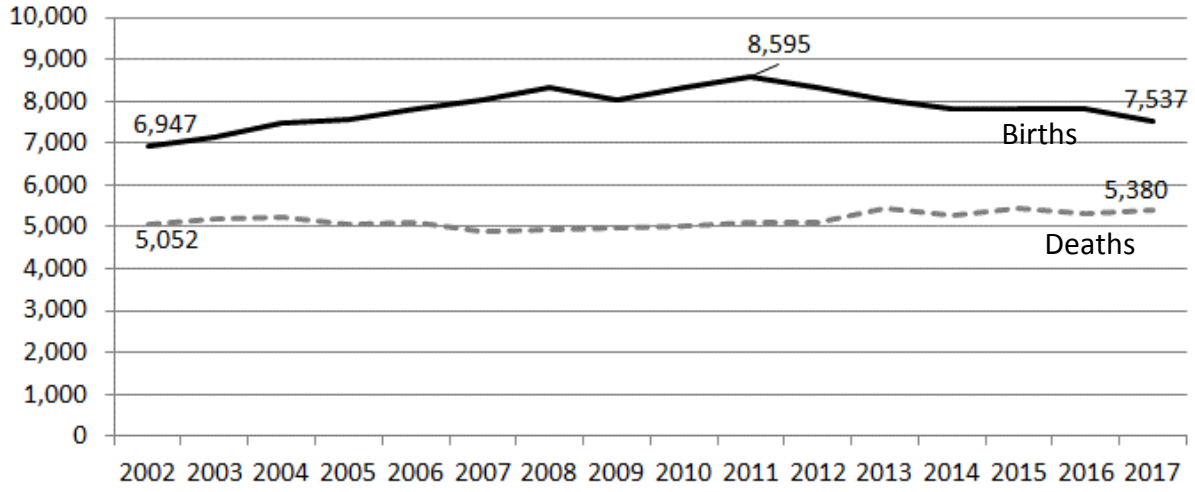
Chapter 6 takes a look at infectious disease - the *'Captain of the Men of Death'* still biding its time in the wings.

So, looking at demographic change directly, what do the facts show?
First, we'll take a look at the engine that drives demographic change: population growth. Basically, populations grow for two reasons which make common sense:

1) More people are born each year than die each year and;
2) More people move into a place than move out.

We can look at each in turn. First, births and deaths. The chart below shows the recent trends:

Oxfordshire: total number of births and deaths per year 2002 to 2017



ONS mid-year population estimates

The chart shows that:

- The number of births has grown overall from 6,947 per year to 7,537 per year and has fluctuated over time with a peak around 2011. This is a rate of 57.1 births per 1,000 women aged 15 to 44 (called the general fertility rate).

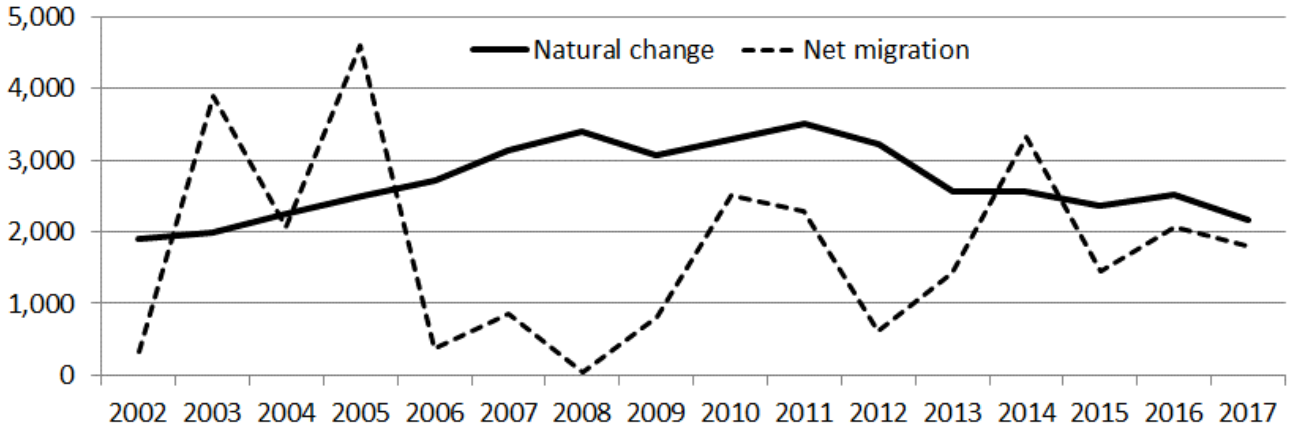
- The number of deaths has been fairly constant over the last 25 years at just over 5,000 deaths per year.

- **The number of births is greater than the number of deaths by roughly 2,500 per year – so, if all else were equal, the population would grow.**

However, people don't just stay put all their lives. They move around a lot within the UK and go overseas. Similarly, new migrants arrive from other countries. This is summed up in 'migration statistics'. Over the last 15 years, Oxfordshire has had 'net inward migration' of roughly 2,000 additional people per year.

Putting together population increase due to more-births-than-deaths (called 'natural change' in the jargon) and change due to migration gives the following picture:

Oxfordshire: Natural Change and Net Migration (ONS)



ONS mid-year population estimates

The chart shows that:

- The population of Oxfordshire is increasing each year.
- The size of the increase fluctuates widely from a minimum of around 2,200 more people per year to a maximum of around 7,200 more people per year.
- The average increase is around 5,000 more people per year.
- Almost every year births and deaths contribute more to the total than does migration.
- Natural change (births minus deaths) has been above net migration (internal and international, in-migration minus out-migration) for each year since mid-2002 with the exceptions of 2003, 2005 and 2014.

This is the engine of population growth. This is why Oxfordshire is growing.

Of course, some migrants settle in Oxfordshire and start families here too. The table below shows births in 2016 in Oxfordshire by their mother's country of birth.

Births by Mothers Country of Birth
Births in Oxfordshire by mother's country of birth (2016)

	within UK		EU incl. 'New EU'*		New EU*		Rest of Europe (non EU)		Middle East and Asia		Africa		Rest of World	
Cherwell	1,328	72%	249	14%	179	10%	28	2%	114	6%	56	3%	61	3%
Oxford	894	49%	315	17%	165	9%	57	3%	325	18%	102	6%	118	7%
South Oxon	1,229	80%	159	10%	105	7%	14	1%	51	3%	43	3%	44	3%
Vale of WH	1,098	76%	139	10%	77	5%	9	1%	86	6%	56	4%	48	3%
West Oxon	959	85%	102	9%	66	6%	7	1%	24	2%	20	2%	22	2%
Oxfordshire	5,508	71%	964	12%	592	8%	115	1%	600	8%	277	4%	293	4%
England		*71%*		*11%*		*8%*		*1%*		*10%*		*5%*		*2%*

Source: ONS live births by parent's country of birth; *The 'New EU' constitutes the countries which joined the European Union (EU) between 2004 and 2016.

The table looks a bit dry on the face of it, but it hides some interesting facts as follows:

- 7 out of 10 births are to mothers born in the UK and 3 out of ten mothers aren't born in the UK.
- This is the same as for England as a whole and shows just how mobile people are these days.
- In Oxfordshire as a whole, 21% of births in 2016 were to mothers born in Europe (excluding UK), 8% from the middle East and Asia and 4% from Africa.
- The same figures differ widely between the Districts: in Cherwell for example, 16% of mothers were from Europe (excluding UK), 2% from the Middle East and Asia and 2% from Africa.
- In the City a very different picture is seen, with 29% of mothers coming from Europe (excluding UK), 18% from the Middle East and Asia and 7% from Africa.
- This means that in the City, just over half of all births are to mothers not born in the UK.

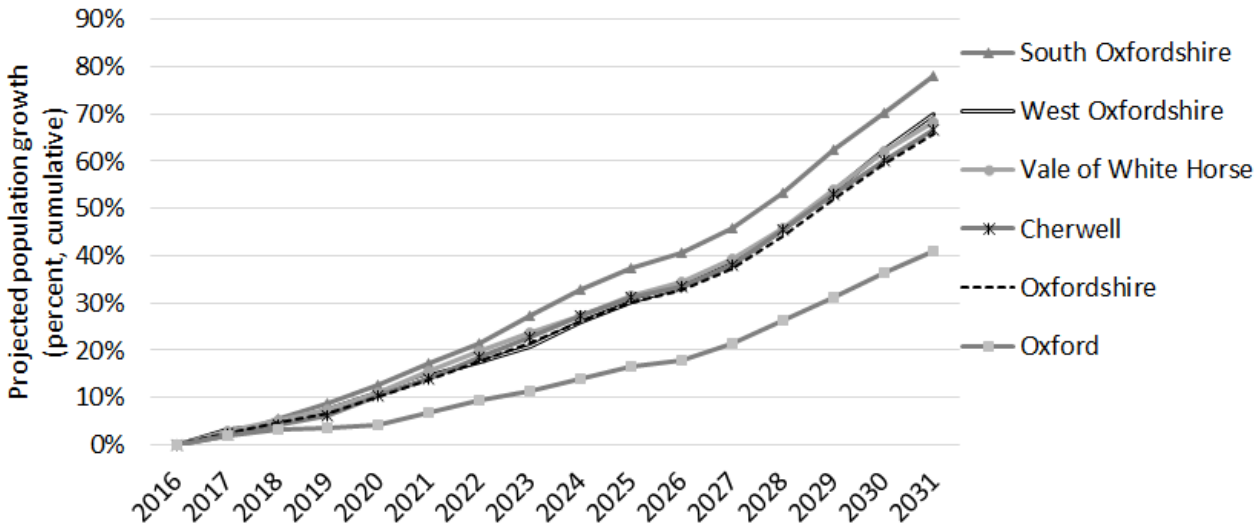
Demographic Change in the 85 plus age group

Let's drill down now into some of the more specific changes which demographic change brings.

The first big change is by now very familiar – the increase in older people as a result of living longer on average – fantastic news, which also brings challenges for services.

What does it look like across Oxfordshire for those aged 85+?

Cumulative growth in population aged 85+ in Oxfordshire 2016 to 2031



Office for National Statistics 2016-based population projections

The chart shows that:

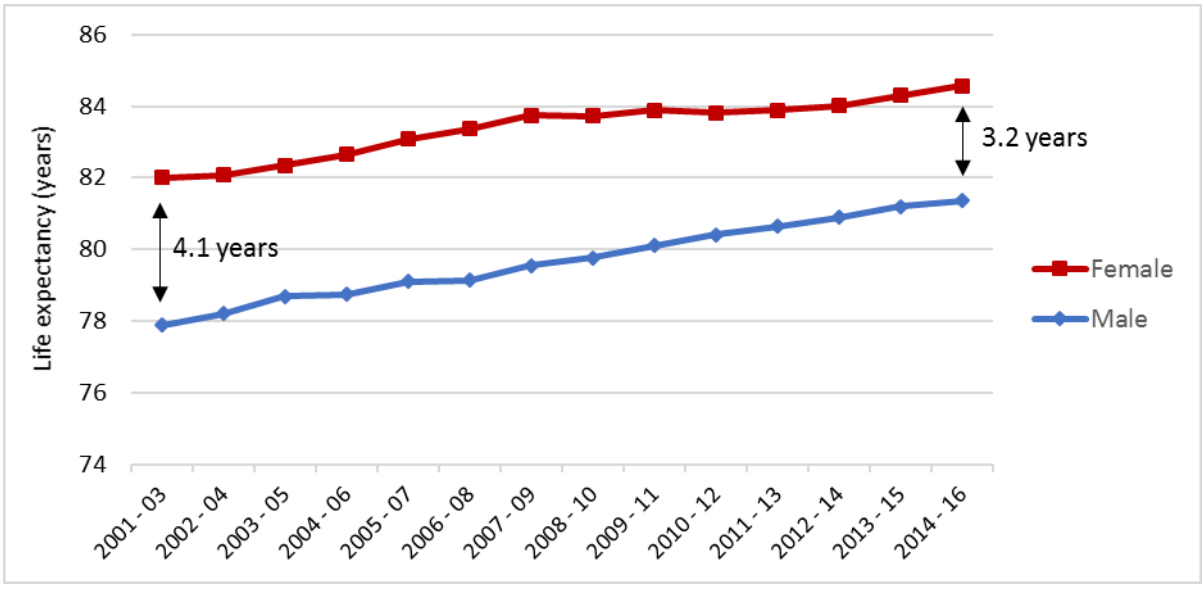
- Over the next 15 years the 85+ population will continue to increase rapidly at between 60%-80% in all Districts.....
- Except for the City where the growth will be lower – at around 40% - because of a younger population

This means that services will continue to find difficulty in coping with this most needy section of society in terms of health and social care. New methods of delivering care will need to be found which do not require intensive travel and which rely as little as possible on centralised hospital beds. New ways of keeping people healthier for longer will need to be found. The pressures on services experienced over the last decade are set to continue.

Life Expectancy

I've said already that this change is driven by longer lifespans and the chart below gives more information on life expectancy:

Change in Life Expectancy in Oxfordshire – males and females to 2014-16



Source: ONS Figures are based on the number of deaths registered and mid-year population estimates, aggregated over 3 consecutive years. Note that scale does not start at 0

The chart shows:

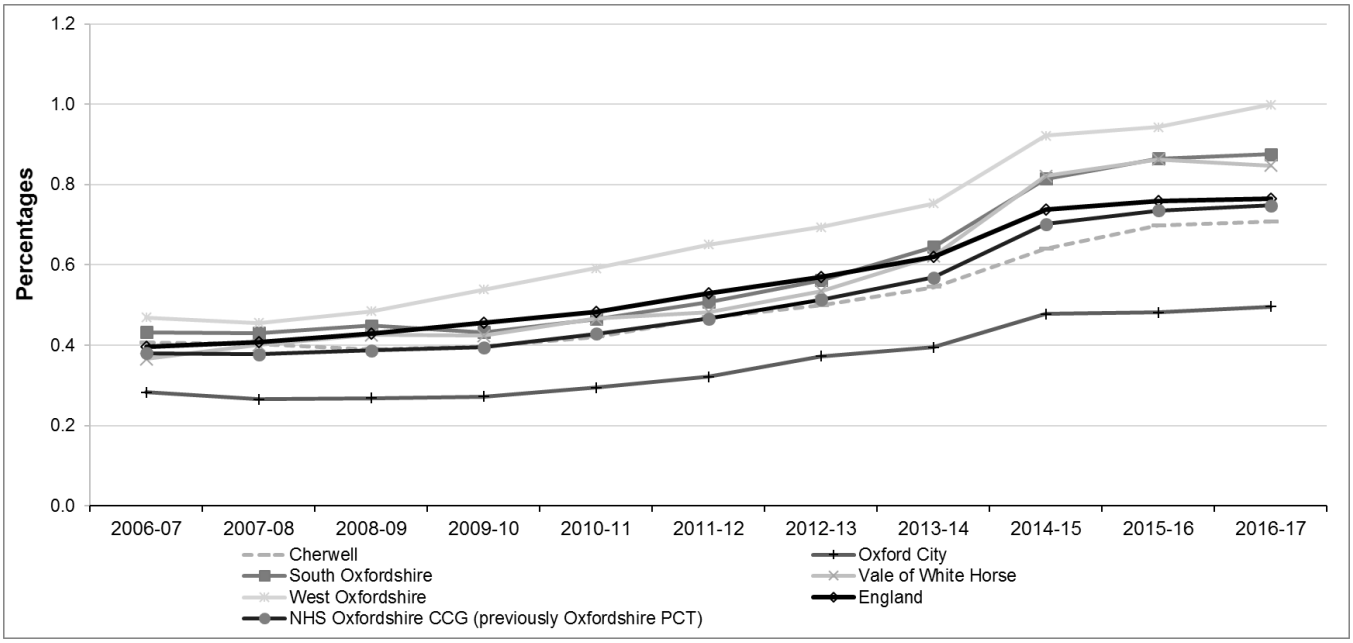
- Both males and females are living longer – the trend looked to be plateauing out a few years ago, but now is swinging up again so that women are now living on average to over 84 and men to just over 81.
- Women live longer on average than men - the gap is now 3.2 years, a slight increase on 3.1 years last year.

An ageing population is to be celebrated, but it also brings challenges. For example, longer life and a decline in heart disease and some cancers means that more people live for long enough to suffer from dementia.

Dementia

The chart below shows the current recorded cases of dementia as a percentage of those on GP's books.

**Percentage of patients with a recorded diagnosis of dementia in the GP registered population –
2006/07 to 2016/17**



Source: Quality Outcomes Framework 2016/17

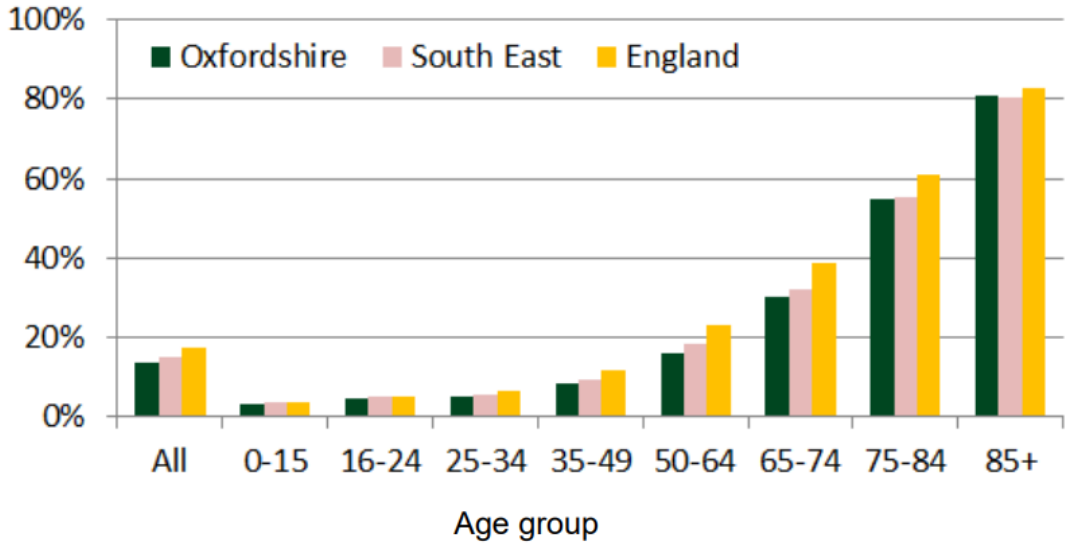
Some of this increase is due to better awareness of dementia in general, and better detection of dementia by GPs and some of it will reflect that there are more people surviving into the age groups where dementia is more common.

Chapter 2 looks at how communities might be designed better to help with this, and Chapter 4 looks at promoting mental wellbeing and positive mental health and looks at how dementia might be prevented or delayed.

Physical Disability

Old age also brings with it, on average, more physical disability. The chart below shows the percentage of people by age group who feel that they are limited by ill health or disability.

Percentage of residents in households* by age with daily activities limited by ill health or disability (a little or a lot) 2011, Oxfordshire vs South East and England



Source: ONS Census 2011 from nomis, table DC3302 *excludes people living in communal establishments such as care homes

The chart shows that:

- The percentage of people affected rises sharply with age – up to around 80% of people aged 85+ report ill health or disability of some kind.
- The figures for Oxfordshire are slightly better than for England as a whole but broadly mirror the national and regional pictures.

The positive message in these statistics is that there is scope to work with people in their 50s and 60s to find ways to prevent or delay chronic disease and disability.

Impact on carers

The other impact of an ageing population is the impact on carers of older people, many of whom are in their 60s and 70s themselves. The national survey of carers, carried out in 2016 gives a rough indication of the numbers of local carers.

- Around 60,000 Oxon residents provide unpaid care for others, of whom around 17,000 provide 20 or more hours per week.
- Many of the carers are over 65 and are suffering from ill health themselves.
- Around 35% of those who responded to the survey said that they had seen their GP because of their caring role.

These figures are inexact, but show that as a society we are heavily reliant on the ability of carers (usually family members or spouses) to care. Looking after their wellbeing remains a high priority. Continuing to work with this group to help them to stay healthy for longer is essential.

Ageing - there is good news!

Ageing brings its difficult issues but there would also seem to be compensations – Chapter 4 Promoting Mental Wellbeing and Positive Mental Health shows that many measures of wellbeing and contentment shoot up following retirement age.

Loneliness

Another fact of modern life is that many people experience loneliness.

A report on the Impact of Loneliness from Public Health England in 2017 highlighted the impact on individuals and for services:

Impact on individuals:

- Social isolation and loneliness are harmful to physical and mental health and increase the risk of illness and early death.
- Social isolation and feelings of loneliness can also cause stress resulting in behaviour that is damaging to health - such as drinking too much.
- Having good social networks and friendships not only have an impact on reducing the risk of early death or developing certain diseases, but they also help individuals to recover better when they do fall ill.

In terms of impact on services, lonely people are likely to:

- visit their GP more often;
- have higher use of medication;
- use accident and emergency services more;
- use adult social care more;
- make more use of mental health services;
- have early admission to residential or nursing home care.

Public Health England also found evidence to suggest a strong relationship between low socioeconomic status and social isolation. *In other words, disadvantage and loneliness go hand in hand – yet another reason for continuing to tackle social disadvantage. Social disadvantage experienced earlier in life can also increase the risk of isolation in younger age groups.*

Using national figures from the Community Life Survey the table below shows that it is estimated that 20,400 (around 1 in 6) older people in Oxfordshire (aged 65+) experience loneliness at least some of the time, of which **3,500** older people experience loneliness “often or always”.

Table 1 Estimate of the number of older people (65+) in Oxfordshire experiencing loneliness

		Lonely often/always		Lonely some of the time		
	Oxfordshire population mid-2016	Percentage	Oxfordshire estimate (count)	Percentage	Oxfordshire estimate (count)	TOTAL estimate
people aged 65-74	65,500	2.89	1,900	11.38	7,500	9,300
people aged 75+	55,500	2.95	1,600	17.04	9,500	11,100
TOTAL	121,000		3,500		16,900	20,400

Sources: ONS mid 2016 population estimate original release; Percentages are from ONS 2016-17 Community Life Survey (not including confidence intervals) as cited in ONS Analysis of characteristics and circumstances associated with loneliness in England

Developing new national measures of loneliness

The government is developing a strategy to alleviate loneliness in response to the report of the Jo Cox Commission on Loneliness published in December 2017. As part of this, the Office of National Statistics (ONS) is working on new national measures of loneliness with the help of a cross-government group, charities, academics and other stakeholders. This is to be welcomed.

A recently published (April 2018) ONS analysis, found three profiles of people at particular risk from loneliness:

- Younger renters with little sense of belonging to their area
- Unmarried, middle-agers with long-term health conditions.
- Widowed older homeowners living alone with long-term health conditions.

As this work develops it should give us better information with which to plan future communities and future services to help tackle loneliness.

What about demographic changes in the population of young children?

Well, it depends on what you count! If you just use the current birth rate, you would predict a fall in the number of very young children by 2031, but if you add in planned housing growth you get an increase.

The chart below shows the disparity – looking at Vale of White Horse District and Cherwell District for example, without housing growth one might expect a decrease but with housing growth one would expect a 36% increase – that's 2,700 more children in the Vale and 3,400 more children in Cherwell - a massive difference.

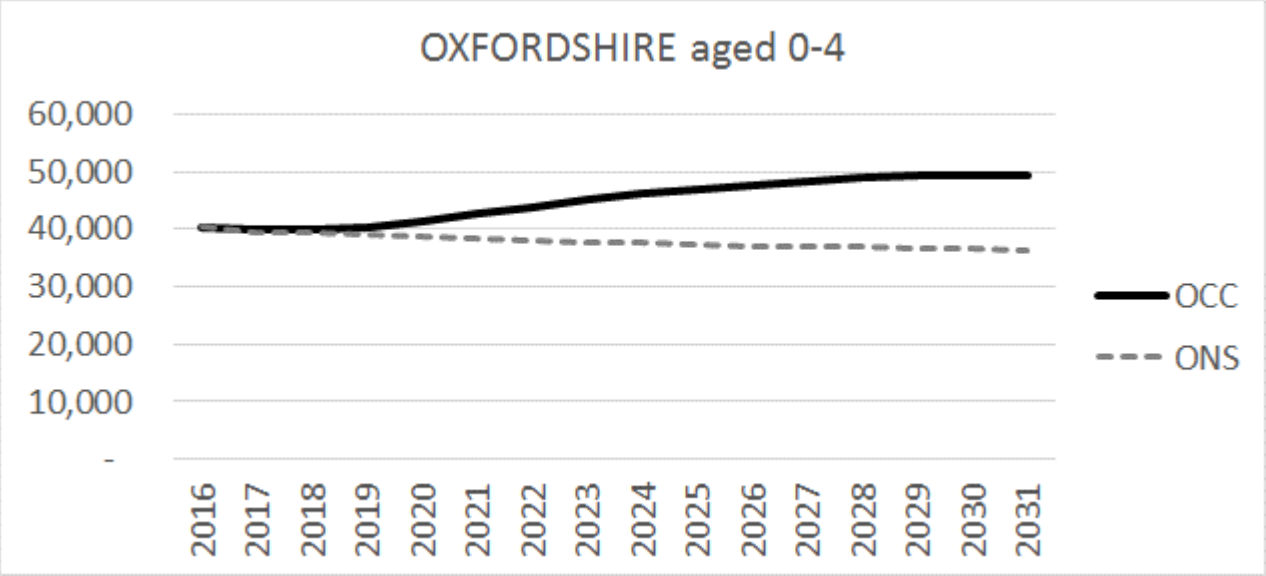
Count of children aged 0-4, 2016 and 2031, ONS vs Oxfordshire County Council projections

	ONS 2016-based				Oxfordshire County Council 2016-based			
	2016	2031	difference		2016	2031	difference	
Cherwell	9,269	8,346	-923	-10%	9,400	12,800	3,400	36%

Oxford	9,033	7,449	-1,584	-18%	9,100	8,000	-1,100	-12%
South Oxfordshire	8,161	7,638	-523	-6%	8,200	10,900	2,700	33%
Vale of White Horse	7,647	7,208	- 439	-6%	7,600	10,300	2,700	36%
West Oxfordshire	6,248	5,697	-551	-9%	6,200	7,500	1,300	21%
Oxfordshire	40,358	36,338	-4,020	-10%	40,300	49,300	9,000	22%
South East	542,383	515,877	-26,506	-5%				
England	3,429,046	3,269,597	-159,449	-5%				

The data in the table is shown below in a more user-friendly format and shows the difference housing growth is predicted to make to the County as a whole.

Count of children aged 0-4 2016 to 2031:
Oxfordshire County Council vs Office of National Statistics projections



The chart clearly shows an increase from 40,000 to 50,000 children in the 0-4 age group by 2031 if one takes housing growth into account. These are clearly the figures we need to use for planning and they will have a clear impact on our future need for schools, health visitors, social services and GP services.

Housing Issues

I want to turn now to look at the impact of housing on demographic growth. More people means that more accommodation is needed to house them. Oxfordshire's Strategic Housing Market Assessment sets out a need for 100,060 additional homes between 2011 and 2031.
In the 5 years 2011-12 to 2016-17, a total of 16,800 new homes have been built in Oxfordshire (an average of 3,000 per year). This leaves 82,300 to be built by 2031, this is equivalent to a rate of just under 6,000 homes per year.

The table below shows the number of houses planned by each District up to 2031. In total, 47,000 homes are planned.

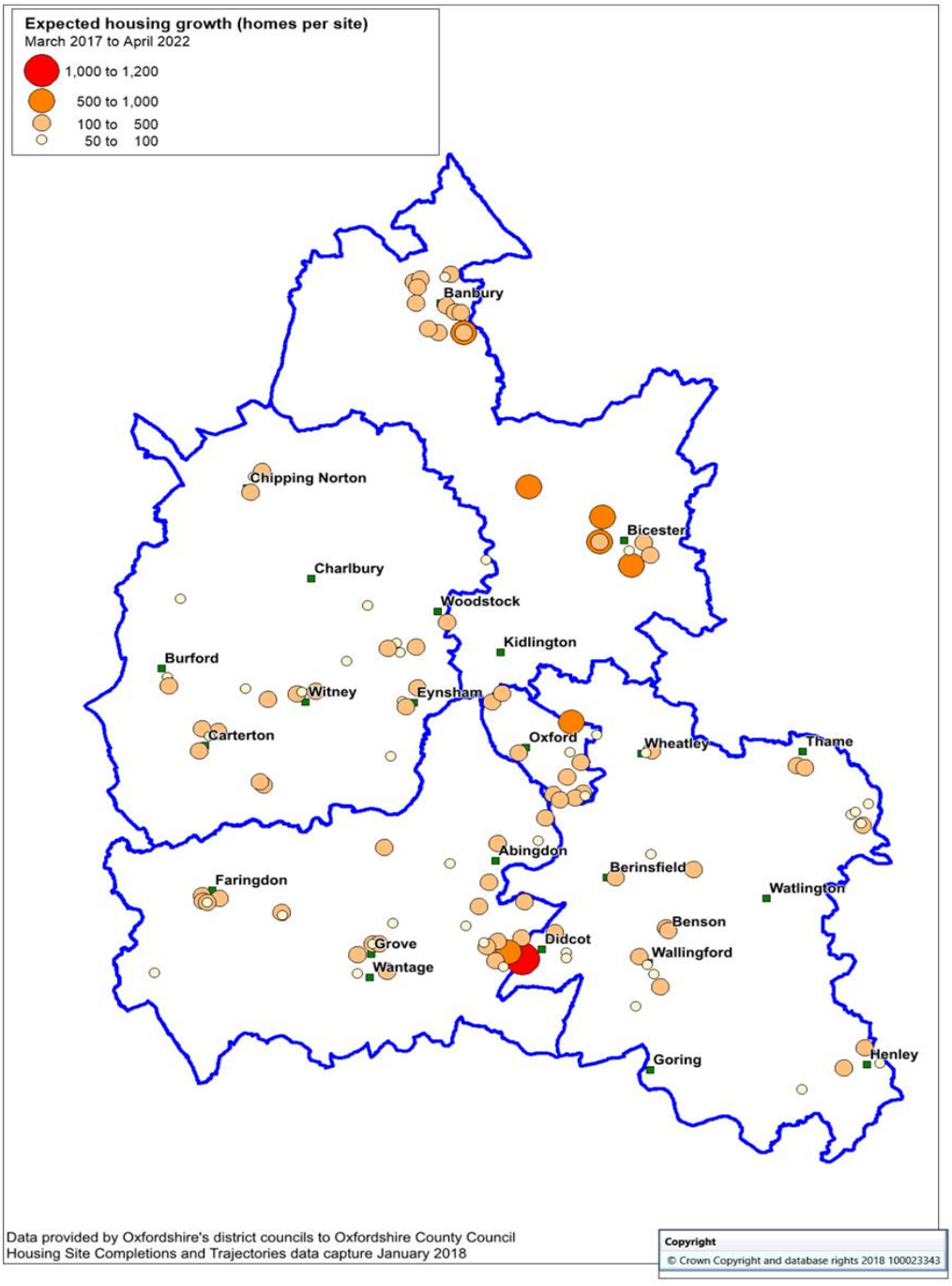
Homes built in Oxfordshire and expected housing growth in Oxfordshire 2011 to 2031

	Total new homes needed over 20 years 2011 to 2031 (inc re-allocation of Oxford's unmet housing need)	Homes built 2011/12 to 2016/17	Remainder by 2031 to meet 100,060 new homes
Cherwell	27,200	4,579	22,621
Oxford City	13,700	1,744	11,956
South Oxfordshire	20,450	3,397	17,053
Vale of White Horse	22,760	4,680	18,080
West Oxfordshire	15,950	2,369	13,581
Oxfordshire	100,060	16,769	83,291

The map on the next page shows where the areas of housing growth are most likely to be. The bigger and the darker the spot, the more houses are planned.

You can see at a glance that:

- Planned housing growth is spread across the County.
- Didcot and Bicester stand out as areas of particular growth with clusters of development around Banbury, Oxford and many of our market towns
- The expected growth around market towns such as Faringdon, Grove and Carterton is smaller but significant. The growth is less than elsewhere but is high compared to the number of existing homes, which may affect the character of the local community.



House prices and stresses in the care market

Of course, building houses is one thing. Being able to afford to live in them is another - and is a pressing problem in Oxfordshire. Expensive housing makes it difficult for lower paid workers and their families to live in Oxfordshire. This leads to the staff shortages we see across the County – for example, there are over 500 nursing vacancies in Oxfordshire at any one time and 'home care' workers are also strongly affected.

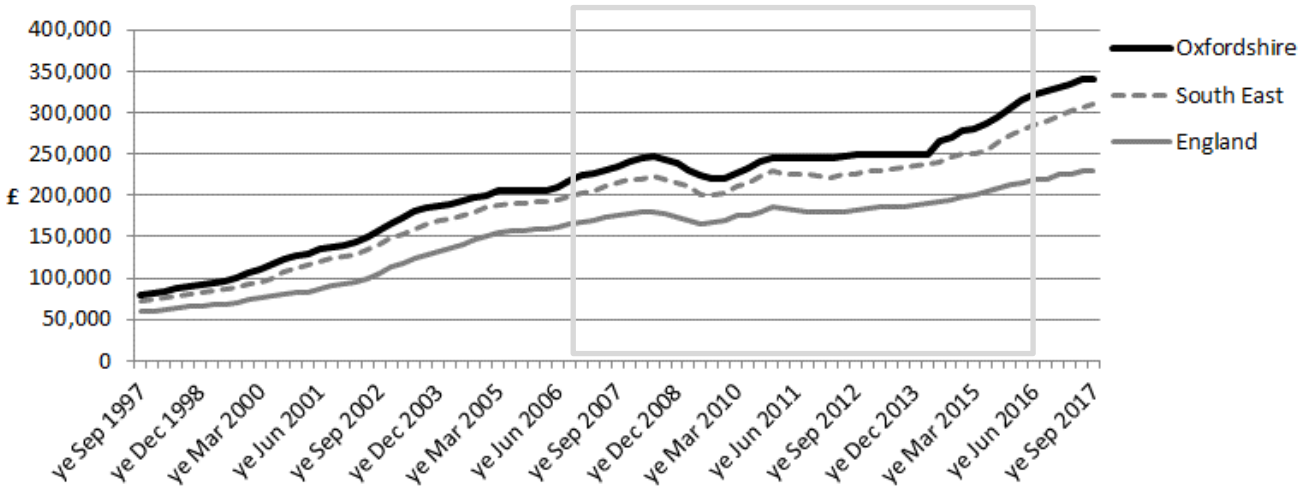
Unemployment is very low in Oxfordshire and the local economy is one of the most buoyant in the UK. This success has a down side however – an equally buoyant - and therefore expensive - housing market…….

The table below shows the latest data on average house prices.

Median house prices 2007 to 2017

The chart below shows how house prices in Oxfordshire have outstripped England's prices and topped the South-East Region's prices.

20 year trend in Median house prices (year ending) September 1997 to September 2017



Source: ONS Median house prices for administrative geographies, released April 2018

The table below shows prices across the Districts, looking at the cost of a mid-priced house.

Median house prices 2007 to 2017

	Year ending Sept 2007	Year ending Sept 2017	*Difference*	*%*
Cherwell	£195,000	£297,500	*£102,500*	*+53%*
Oxford	£250,000	£400,000	*£150,000*	*+60%*
South Oxfordshire	£270,000	£380,000	*£110,000*	*+41%*
Vale of White Horse	£244,950	£340,000	*£95,050*	*+39%*
West Oxfordshire	£230,000	£329,995	*£99,995*	*+43%*
Oxfordshire	**£235,000**	**£340,000**	***£105,000***	***+45%***
South East	£215,000	£310,000	*£95,000*	*+44%*
England	£175,000	£230,000	*£55,000*	*+31%*

Source: ONS Median house prices for administrative geographies, released April 2018

The chart shows that:

- Oxfordshire's average house price is well above the average for England and above the South East as a whole.
- Prices have risen sharply over the past 10 years – more sharply than in England or the South East - making a sort of 'Oxon inflation factor' of 45% compared with 44% in the South East and 31% for England as a whole.
- Within the County, prices in the City have risen faster than elsewhere, up 60%, making working in the city's hospital services and living locally even more difficult for lower paid staff.
- During the same period house prices in Cherwell have also risen dramatically by 53%

So, to sum up:

Demographic change presents a distinct cocktail of triumphs and challenges to Oxfordshire:

- Health is generally good and the local economy buoyant.
- The population is growing fast.
- House prices are high and recruitment to essential staff groups is difficult.
- Housing growth is set to continue which will bring more young families and children
- The population is increasingly culturally diverse.
- The population is ageing and new patterns of disease have emerged eg dementia.
- Carers are vital to service delivery.

So, what do we do?

We can't spend our way out of this situation given the current financial situation, so we have to innovate our way out.

For public services this means:

- Working together in a more joined-up way and working positively across organisational boundaries
- Linking the planning work of the NHS, Social Care, District and City Councils and Public Health together much more strongly
- Finding solutions which use the new technologies now available to support people electronically rather than face to face contacts.
- Helping communities and residents to help themselves.
- Preventing problems before they start and joining up our preventative services more coherently.
- Systematically targeting services at those who are already ill and in whom further deterioration can be prevented. This means getting 'upstream' and working with people who have chronic diseases or care needs to stabilise them and keep them healthier for longer.
- Using all of these factors to create a new range of services
- Using all these factors to design communities which support good health.

These issues and solutions are amplified throughout this report. The next chapter looks at bringing together health concerns with local planning to create healthy communities. Chapter 3 looks at the challenges of those particularly at risk – the disadvantaged. Chapter 4 looks more closely at obesity and its impact on disease patterns, and chapter 5 looks at promoting good mental health which is a key ingredient to staying well for longer.

What did we say last year and what did we do about it?

Last year's recommendations called for a much more joined-up planning system overall across Oxfordshire. And there are many positive initiatives to report. All local authorities are working together to create a Joint Strategic Spatial Plan. This is good progress. We also secured a Growth Deal with Government enabling infrastructure to keep pace with housing growth (see chapter 2 for details)

The Healthy New Towns approach (also discussed in detail in the next chapter) has also moved forward and the shared learning from this has begun to influence planning of new and existing settlements in the County -this is very good news.

NHS, Social Care and Public Health services are now working much more closely together under a re-designed Health and Wellbeing Board. A new strategy for services for older people is being drafted as I write. This change was helped by a Care Quality Commission review of services for people going into, through and out of the hospital system which strongly supported better joined-

up working under a re-organised Health and Wellbeing Board. All organisations are responding strongly and positively.

The NHS nationally has the bit between its teeth when it comes to promoting preventative initiatives at scale through a policy known as 'Population Health Management' which is also being embraced by Local Government. This means looking at whole populations, or subgroups, identifying why people become ill, and creating services aimed at preventing further deterioration. This is a very important shift in thinking and is to be welcomed. This includes the coordination of preventative services across the County recommended in last year's report.

The NHS has begun to change the basis on which it works in a helpful way. Health policy five years ago was dominated by creating 'internal markets' in health care with distinct commissioning and providing organisations linked by negotiated contracts. This policy is now giving way to a more collegiate approach in which all organisations work together for the good of Oxfordshire, drawing on one 'bag' of tax-payers' money. This also includes finding new ways of working with social care and public health services. This is a positive development.

Recommendations

1. The Health and Wellbeing Board should develop as a priority a Joint Health and Wellbeing Strategy which embraces the philosophy of 'population health management' as well as creating a new strategy for older people and targeting inequalities.

2. Joint work between the NHS, County Council and District Councils to get health and wellbeing issues into the planning of places and highways should continue apace.

3. Work already begun to coordinate preventative services better between all Local Authorities, the NHS and Social Care should continue as a priority.

Chapter 2: Creating Healthy Communities

There has been a sea change in thinking about how we should plan communities over the last decade – and it is still gathering pace. It is no longer a matter of simply planning houses and sewers and roads, it is a matter of planning vibrant communities which support people to live healthier lives – and it is a vitally important issue.

If we are to cope as a society we need to integrate health and wellbeing issues into the way we plan our communities locally, regionally and nationally.

I'm talking here about health concerns on the large scale - issues such as:

- coping with demographic growth
- building health promotion into community design to prevent obesity, chronic disease and loneliness and to be 'dementia friendly'.
- coping with an ageing population structure and planning for a projected 2 million cases of dementia nationally by 2030.
- hard-wiring provision of future health services into planning systems
- designing community facilities and schools which reach out to engage the whole community
- considering ambulance journeys and patient access in the design of new roads
- planning major roads that make the best use of hospitals across the country and beyond

All easy to say, but difficult to do without teamwork, creativity and political will at all levels - and harder to do in times of financial restraint.

Why is it a challenge?

The existing planning system is complex and labyrinthine, depending as it does on a cocktail of government policy, local plans, agreements between Local Authorities, deeply held public views, developer contributions, legislative frameworks and the commercial interests of developers.

Major schemes are even more complex, requiring the interaction of many government departments, multiple agencies, pressure groups and many local authorities across neighbouring counties.

Money is scarce, and the prizes go to schemes which also deliver more economic growth and more houses for more people who must then also be catered for in terms of health and social care, schools and amenities.

The goal is to achieve a 'winning hand' combining future economic prosperity with communities one actually wants to live in. These in turn must make healthy lives easier to lead and build in access to the facilities we will all need.

I want to use this chapter to review some of the key stages of our local journey along this path and to showcase the contribution of the Cherwell District Council and City Council led Healthy New Towns.

The initiatives of local leaders to put health issues into planning.

The key stages I have seen in recent years towards these goals have been:

- Closer working between key organisations to achieve important deals from Government resulting in road improvements around the County (e.g. at Harwell and the Oxford ring road), the Growth Deal and current work on a Housing Infrastructure Fund bid. Close working between all Local Authorities, the Local Enterprise Partnership and the Universities has been an important success factor.

- Strategic infrastructure planning has also benefitted, first with a shared assessment of Oxfordshire's strategic requirements and secondly through the agreement to have a Joint Strategic Spatial Plan for Oxfordshire which will be put together over the next few years and which will incorporate health and wellbeing issues from the outset.

- The successful bidding for two of the ten Healthy New Town pilot sites in England led by Cherwell District Council and Oxford City Council (see more below).

- The initiative of local leaders to generalise the lessons learned from putting health into planning through local conferences culminating in an event earlier this year hosted by Cherwell District Council and the City Council. At this event Leaders and senior officers from Local Authorities, the NHS, the Local Enterprise Partnership and other key organisations met to review progress made through the Healthy New Towns and began to discuss how to generalise the emerging lessons.

- Discussions held over the last 18 months between Chief Executives of our two large NHS Trusts, Local Government the Local Enterprise Partnership and our Universities to discuss the long-term planning aspirations of those bodies.

- During this time, the Public Health team have worked closely with the County Council Communities team so that it is now second-nature to include active travel and features such as cycle paths in new developments. This can be seen clearly in our Local Transport Plan.

- The recent re-design and strengthening of the Health and Wellbeing Board also improves opportunities for it to work alongside the Growth Board as part of a constructive dialogue.

- ……And last but not least, the recent difficult discussions over the recent consultation about re-shaping health care across the County really did serve to put the issues of transport, travel and access issues at the top of the agenda, showing that these issues cannot be considered in isolation.

In all this I need to say that I am a doctor, not a planner. I come at this from a public health point of view, but over the last five years there has been a really creative exchange of ideas between us as the penny has dropped that we won't cope with population growth and ageing unless we plan for health and wellbeing as part of infrastructure and housing planning.

The acid test for all these approaches to get health and wellbeing into planning is: do they actually work on the ground?

That is where the value of the Healthy New Town pilots comes in - they are practical experiments in what can actually be done and are therefore extremely valuable to us all. ***The learning from these two sites is pure gold and a real gift to Oxfordshire.***

Focus on the Healthy New Towns in Bicester and Barton.

I believe that many of the initiatives in the Healthy New Towns can be applied in other areas across the County and that they help point the way forward for the County as a whole. I think it is vital that this learning is shared so I am going to go into the topic in some detail.

The Healthy New Towns chime with so many of the concerns raised in this report and link to:

Chapter 1 on population growth, house prices, dementia and loneliness

Chapter 3 on tackling inequalities and disadvantage

Chapter 4 on obesity and healthy lifestyles and 'shifting to prevention'

Chapter 5 on mental wellbeing.

The Healthy New Towns offer new solutions to some of the key problems facing Oxfordshire over the next decade – that is why they are vital and that is why they are exciting, and that is why the learning should be sustained.

To push the point home, I am including below a checklist of the types of issue that can be tackled. You will see that they are the pressing priorities for the County as a whole:

Potential Benefit to Oxfordshire of the Heathy New Towns: Checklist	
Plan healthy communities and healthy housing growth: bring organisations together with a common ambition	
Engage local people in planning and health care	
Encourage exercise	
Fight obesity	
Help to cope with dementia	
Fight loneliness	
Bring together NHS and Local Authority planners and developers	
Involve the voluntary and community sector	
Work with local schools to improve children's health	
Find new ways of delivering health services	
Help tackle chronic diseases like diabetes	
Reduce social disadvantage and inequalities	
Promise help to an overburdened NHS	

What does the term 'creating healthy communities' mean?

As set out in the previous chapter we know that one of the key challenges for Oxfordshire is population growth linked to the need to provide more housing. The shortage of affordable homes is particularly acute in Oxfordshire and this has been one of the driving forces for the county and district councils agreeing a Growth Deal with national government to build 100,000 new homes by 2031.

The scale of the Growth Deal means that Oxfordshire now has a great opportunity to ensure that it supports the creation of healthy communities, not just large housing estates. Creating healthy communities is described as:

'a collaborative process which aims to create sustainable, well designed communities where healthy behaviours are the norm and which provide a sense of belonging, a sense of identity and a sense of community'

Crucially, creating healthy communities is not just about new developments; it applies to any place experiencing significant housing growth and is a mechanism for integrating new estates with existing communities so that all residents have the opportunity to benefit in terms of health and wellbeing.

Over the past two years Bicester and Barton in Oxford have been testing out how to create healthier communities as two of ten demonstrator sites for NHS England's Healthy New Towns programme. NHS England has provided three years of modest funding for these sites to test out innovative ways of shaping communities to promote health and wellbeing, prevent illness and rethink the way that health and care services are provided. They are the test beds for all our futures.

The following section describes the progress that both sites have made over the past two years in testing innovations in the built environment, working creatively with local people through 'community activation', and developing new models of care, and how they have started to share the learning with a view to replicating this approach across Oxfordshire.

Barton Healthy New Town

Barton is an area on the western outskirts of Oxford, just outside the ring road, bounded by the A40 only 3.5 miles from Oxford City Centre. Built in 1946, the estate was originally developed to provide social housing for residents of Oxford. The population of the Barton and Sandhills ward has grown by 9% since 2006 and now stands at 7,411. With a further 885 new homes planned at Barton Park (delivered by Barton Oxford LLP a joint venture between Oxford City Council and Grosvenor) in the next 7 years, a further 3,000 new people are likely to move into the area as a result of the new development.

The 2015 Index of Multiple Deprivation showed Barton to be among the 20% most deprived areas in England. Life expectancy at birth in Barton and Sandhills is 77.5 years for males, 81.6 for females. For males this is 12.6 years less than North Oxford ward (about 4 miles away) and 5.5 years less for females.

The Barton Healthy New Town programme is being delivered through a partnership between Oxford City Council, which is the lead delivery partner, Grosvenor Developments Ltd, Oxfordshire County Council's Public Health team and Oxfordshire Clinical Commissioning Group. The project aim was set early on in year one for '***All Barton residents (Barton and Barton Park) to have an equal opportunity to good physical and mental health and good health outcomes***.'

Bicester Healthy New Town

Bicester Healthy New Town

Bicester is a market town located within Cherwell District Council's administrative area in North Oxfordshire. The town currently has approximately 13,000 dwellings and a population of about 30,000 people. Over the next 20-30 years a further 13,000 homes are planned to be built which will effectively double the size of the population. Cherwell District Council has recently adopted its Local Plan (July 2015) which allocates housing and commercial sites for development in Bicester and covers the period from 2011- 2031. Bicester was designated as a Garden Town in 2014 under the government's Garden Cities initiative and is a strategic location for growth within the Oxfordshire Strategic Economic Plan.

The programme is a partnership initiative led by Cherwell District Council, Oxfordshire Clinical Commissioning Group, Oxford Academic Health Science Network, A2 Dominion (developer of the ecotown Elmsbrook at North West Bicester), and supported by a further 25 different community organisations, health and care providers and Bicester schools and businesses. In Bicester the two key priorities are:

- **To increase the number of children and adults who are physically active and a healthy weight. (In Bicester 1 in 4 of children aged 2-10 are overweight or obese and 58% of women and 65% of men are overweight or obese)**

- **To reduce the number of people who feel socially isolated or lonely in order to improve their mental wellbeing (17% of older people are in contact with family, friends and neighbours less than once a week).**

How can the built environment encourage healthy living?

The ***Neighbourhood Centre located in Barton*** is undergoing a major refurbishment, funded through pooling of 'section106 funding' (the money developers pay to contribute to new infrastructure like schools and road access), City Council funding from capital investment from the 'Investing in Barton' regeneration programme and from its maintenance programme. This will see the ***expansion of the medical practice***, which will ***triple primary care space*** from 74m^2 to 249m^2, providing enough capacity for existing and new residents in Barton. This is alongside the ***modernisation of the community and youth spaces***, including the installation of youth art, ***dementia friendly signage and improvements*** to the reception area. All of this will convert the Neighbourhood Centre into a ***Health and Wellbeing Hub***, with additional capacity to cope with the increased demands from the new population within six months of the first occupants moving in.

Over the last year Barton took part in the Town and Country Planning Association's (TCPA) Developers and Wellbeing project to look at how working with developers improves health. The project culminated with a parliamentary launch in February 2018 which featured a profile on Barton. This initiative was also featured by the Local Government Association as part of its 'Planning Positively through Partnership' publication.

As a result of the project, spatial planners now have a much richer understanding of how development can shape the health and wellbeing of future generations and the project has had a permanent impact on planning policy within the City Council including a policy within the Oxford Local Plan 2036 stipulating that '*for major development proposals of more than 9 dwellings or 1000m^2 the Council will require a health impact assessment to be submitted to include details of implementation and monitoring*'.

Other initiatives at Barton include *a* ***wayfinding project with three new dementia-friendly trails*****.** These provide opportunities for people to be more active, create routes between community facilities and link the new development with existing areas in Barton and neighbouring communities. These are due to be launched in spring 2019 when Barton's Park opens (a 3.84 hectare linear park) connecting Barton and Barton Park.

In Bicester ***three 5K circular Health Routes for walkers, joggers and runners*** have been marked out in blue in residential areas of the town to encourage people to get active. There is no cost to participation and it is suitable for a wide range of ages, at any time of the day. When ***'Bicester's blue lines'*** were launched they attracted over 50,000 views on Facebook, resulted in an increase in footfall of 27% along one of the routes, and are supporting community cohesion with people walking them with family and friends and using them to explore different parts of Bicester. ***They have been so popular that a new Discovery Walk is planned*** for Bicester town centre to encourage people to take a ***brisk 15 minute walk during their lunchbreak***. The graphic below gives the idea:

Other built environment initiatives in Bicester include the installation of ***wayfinding signs*** across the town which provide ***information on cycling and walking times*** to key local destinations, and the opening of ***a 'community house'*** at Elmsbrook, to provide an early facility for residents to support them to come together and run community events and activities and develop a sense of community in the eco development in Bicester.

Building social cohesion and enabling people to live healthier lives through 'Community Activation'

Community activation builds on the idea of actively engaging communities to be partners in the development of new ideas which will benefit both individuals and the whole community. The notion was floated in the NHS's 'Five Year Forward View' and, is about putting into practice the principles set out in the graphic below through the real and dynamic involvement of local people and communities:

fyfv@nationalvoices.org.uk 2016. Six principles for engaging people and communities

Over the last year ***Bicester's primary and secondary schools*** have been actively supporting young people in a range of ways to increase both their physical and mental wellbeing. ***Five primary schools have introduced the 'Daily Mile'*** into the school day with the result that 2,000 children now run a mile a day at school promoting not just their physical health but aiding concentration and mental wellbeing. All schools in the town took part in ***Walk to School Week*** in May to encourage parents and children to leave the car at home for their school commute and ***Cherwell's Sports Activators have trained play leaders to increase active play*** at break time providing more playtime equipment and activities.

Encouraging children to be active outside of school hours is equally important and ***St Edburg's school has successfully tested a family fun club*** in the early evening to get families together and take part in fun and healthy activities. Across the 10 week programme there was a total of 173 attendances with new friendships formed between families as well as enthusing them to have active family time. There has been a 50% increase in children attending the ***active fun clubs run in the school holidays*** by Cherwell District Council.

Addressing the ***mental health of young people*** is equally important and ***Healthy New Town Ambassadors in the secondary schools have provided input into the development of a website by the local mental health trust offering access to mental health advice and services for young people, parents and teachers.***

Training has also been provided to primary school teachers to promote the mental wellbeing of under 11s, with practical 'SATS relax' sessions provided in all schools to help reduce any stress felt by Year 6 children as they took their exams.

In Barton, there has been a particular emphasis on building and embedding community resilience using an 'asset-based community development approach'. In practice, this means working with local voluntary and community groups to use their strengths to address health issues in their community supported by small grants. Through the grants programme in year one, 11 pilot projects were funded, supporting over 1,800 people, with several project levering in additional external funding to continue the projects when NHS funding comes to an end in March 2019.

The funding was complemented with special training for 122 professionals and in community development skills to support directly those who need help the most. Skilling-up local people and professionals in this way will make the legacy of the project last longer than the end of NHS England's funding. The fruits of this are shown by the local Community Association having health and wellbeing as their number one priory in their strategy for 2017 – 2020.

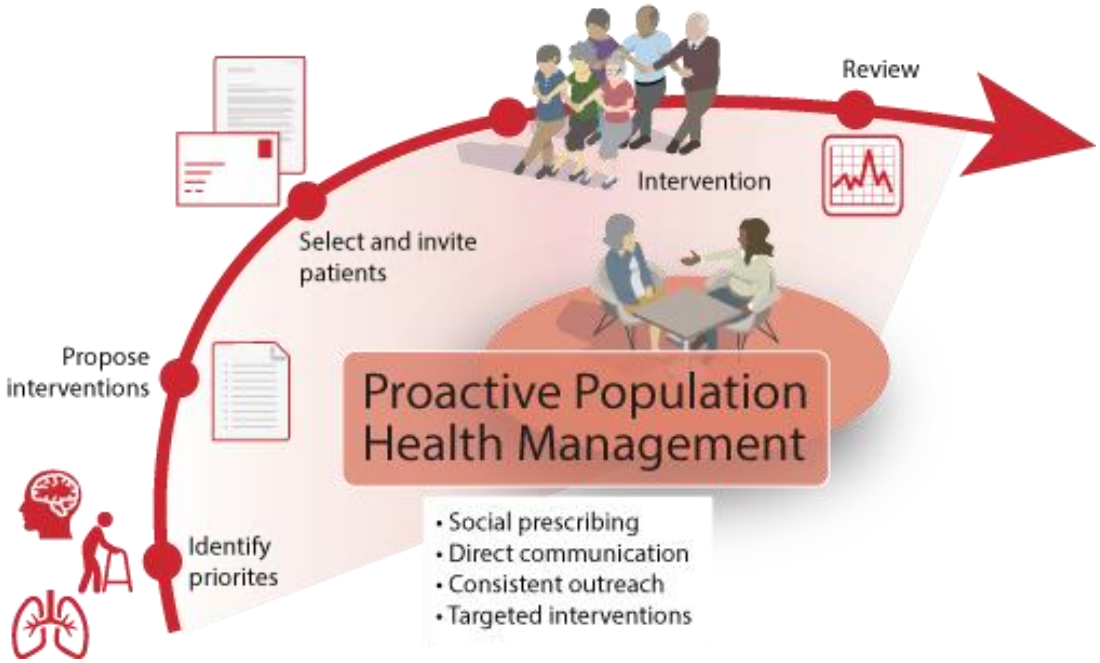
One of the local organisations funded was Getting Heard, which was piloting an 'Appointment Buddies' project. This project provided advocacy for older people attending a health appointment to ensure that they understood the information they received, especially around medication or any secondary care referral. The project was successful and went on to successfully apply for *£204,326* of Big Lottery funding to expand the project over a 3 year period.

Year two saw an increase in 'social prescribing' (prescribing activities like exercise and hobbies instead of the traditional 'pills and powders') and led to commissioning a range of physical activity sessions. For example, a Zumba session started in late 2016 in partnership with Barton Community Association and Oxford City Council's Sport and Physical Activity Team and has now been running for two years and attracts around 30 local residents each week.

Testing new ways of delivering health and social care

In both Barton and Bicester, a range of **service innovations** have been tested designed to ***prevent problems and to reach out to people before crises occur***. The emphasis has been on providing services in a community setting and promoting self-care.

In Barton an 'asset mapping' exercise was undertaken to understand current services, how well-used they are and service gaps. A range of new services started in January 2018 to fill those gaps. This included local GP Practices running a **Proactive Population Health Management** initiative (defined in Chapter 1). This involved the ***two GP surgeries which serve Barton sending proactive, direct invitations to patients with long term conditions inviting them to attend the practice for preventative and early interventions*** specific to their health needs. In schematic form it works like this:



A promising example is the prevention of falls which often lead to hospital admission in the elderly. In a small pilot project, local GPs sent out invitations to people at risk of falls to take part in dance sessions designed to improve their balance and coordination. In the three months this pilot project ran, 53 patients with long term conditions took part with 29 patients sustaining participation. This approach is now being scoped for replication in other Oxford localities, as part of a Health Inequalities Commission joint project between Oxford City Council and Oxfordshire Clinical Commissioning Group.

Other initiatives include:

- Oxfordshire Clinical Commissioning Group running the ***National Diabetes Prevention Programme*** and;

- ***coaching to 12 unemployed people experiencing mental health issues***, to support them back to employment.

The point here is to experiment with new ways of reaching out to people to improve health, prevent further deterioration and avoid crises. A key lesson is that the ***involvement of the voluntary sector*** can enhance health care and use the whole community's resources.

In year three in Barton, the programme has been specifically funded to develop and deliver a 'Team Around the Patient' (TAP) for frequent users of health and public services, linking in with

a city-wide health inequalities project. GPs will work with the local Accident and Emergency Department, Ambulance Service, Social Housing providers and other partners to identify individuals who place the highest demand on services. A TAP meeting is convened to find the root causes of their frequent use of services, and a support package is provided to address these root causes, which may be more social than clinical.

In Bicester there has been a focus on ***improving care for people with diabetes***. ***Digital technology*** is now being used by GPs to ***access expert advice remotely*** from consultant colleagues, ensuring that ***patients only travel to Oxford for specialist care when they really need it***. Patients have been encouraged to get active to help control their diabetes, with practices in Cherwell making the most referrals in the county to ***motivational coaching support*** services run by the District Council and Oxfordshire Sports Partnership so that people access activities that meet their interests. Practices have also been working closely with diabetic nurses and consultant colleagues to ***coordinate the care they provide with the result that there has been a 7% increase in people receiving all the care they need.***

For many people diabetes stems from being overweight and in efforts to prevent this Bicester has launched a ***'Healthy Bicester' Facebook Page to provide regular tips on how to be active and eat more healthily.*** It promotes self-care through the use of ***Public Health England apps*** and over the last year 414 people in the Bicester area have downloaded apps such as 'Active 10'.

Looking ahead to 2018/19

2018/19 is the last year of central funding from NHS England and so both sites will be focusing on completing delivery of planned short term initiatives, evaluating the impact of various interventions, sharing the learning from the programme and planning for development of creating further healthy communities in the next three years.

How do we keep this approach going?

We are reaching an important point for the Healthy New Towns. They have promised much, they have fulfilled their role as test-beds for innovation and the lessons learned are important. Realistically three years isn't long enough to demonstrate the full value of these trailblazing projects – Titanics take time to turn, engaging communities is a lengthy process and finding the initiatives that really fly all require a degree of experimentation.

The real gain will come from generalising the learning across the whole planning system – and this is precisely what the recent event held in Bicester described above was intended to do.

So, the question is how do we keep this learning and this initiative going in some form? The answer to that question will be taxing leaders across the County during this year and into next. In my view, these projects press so many positive buttons for future success that between all organisations we need to find a way – and that is the basis for my recommendation for this chapter.

Recommendation

Leaders of all organisations should continue to find ways of keeping the learning from these initiatives alive until the long-term benefits emerge, and they should continue to explore ways to

generalise the learning, making it an integral part of the planning system for new developments and for health services.

What did I say last year and what has happened since?

Last year I looked in detail at the health effects of poor air quality. There is little new health information about these effects during the year and last year's recommendation to see this as another way of 'getting health into planning' still holds good and reinforces the message of this chapter. If we can include health issues in planning, we can build in improved air quality too.

I also recommended close monitoring of progress for 'Healthy New Towns' and, as this chapter demonstrates, this has been achieved.

Chapter 3: Breaking the Cycle of Disadvantage

Part 1
Keeping the Torch aflame: The Health Inequalities Commission

What was 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.
- The idea was to take an independent look at inequalities across Oxfordshire and to make recommendations for action.
- It took two years of persistent effort to create it.
- 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.
- The report made 60 recommendations covering a very wide range of topics. The recommendations were just that – recommendations – they have no force apart from our willingness to consider them and make changes where appropriate.
- The practical work is being taken forward by a multiagency implementation group.

This was an important piece of work and I want to use this report to keep the torch aflame

Progress has been reported regularly to the Health and Wellbeing Board and the Health Overview and Scrutiny Committee (HOSC) for the last 18 months.

So what is happening?

- The Health and Wellbeing Board agreed that organisations need to adapt and develop existing ways of working to ensure that health inequalities were identified and addressed. This will form part of the to-be-revised Joint Health and Wellbeing Strategy.
- Rather than set up a range of new, possibly short-lived projects, the Implementation Group wants to see existing projects develop a stronger focus on tackling inequalities, maybe by targeting particular localities or groups of people instead of just taking a general approach for everyone.

- The Commission also highlighted the need to step up the whole 'prevention agenda' aimed at including people who are likely to have worse outcomes. This is now gaining traction and the Clinical Commissioning Group are working with the Public Health Team to join up their preventative action across the County.

Has anything changed?
There are some good signs of progress but entrenched health inequalities will not be eradicated overnight. This is a long haul and it is only by sustaining the effort and really embedding inequalities in all our work that lasting improvements will be seen – hence my desire to keep the torch aflame. We need to keep going. It is about considering inequalities in every one of our new strategies and plans that will make the difference.

Q: Universal or targeted?
A: Both!

There is an old question: should we aim to reduce inequalities right across the board, or should we start off with those who are the worst-off? The answer is both – we need a general approach to increase benefit for everyone – and narrow the gap between best and worst….. and target those at the very end of the scale.

The good signs so far include:

- The big-ticket item is that health inequalities and their reduction are now included in all our major strategies. Increasingly, vulnerable groups are having specific work focussed on them e.g. people suffering from domestic abuse.

- Establishment of a (very modest) Innovation Fund through the Oxfordshire Community Foundation which will be used to fund projects to have a measurable impact on health inequalities. Working with Oxfordshire Community Foundation has already meant more money can be added to the pot.

- Social prescribing initiatives (prescribing things like walks or joining clubs rather than having a prescription for medicine) are being developed across the county, including a project in North and West Oxfordshire with West and Cherwell District Councils which has won national funding. More people will be "prescribed" activities instead of medicine to help with their health problems and prevent them getting worse. (see chapter two on Healthy New Towns for further examples).

- A new analysis of areas of the county which have worse outcomes for some health issues has been published and is being used to target services.

- Well@Work activities in the NHS, local authorities and the private sector are being used to raise awareness of mental wellbeing and the benefits of physical activity

What else is still needed?

- Reporting success and good practice will fuel the flame and keep the momentum going – we need to learn from each other.
- Better data for use in needs assessments and equity audits is coming on-stream and needs to be used more widely.

- The new Joint Health and Wellbeing Strategy and other major strategies need to address inequalities issues and be explicit about what can be done.

- The 'population health management' initiative mentioned in Chapter 1 will help to combat inequalities and spread preventative activity.

Part 2

Report on the Basket of Indicators

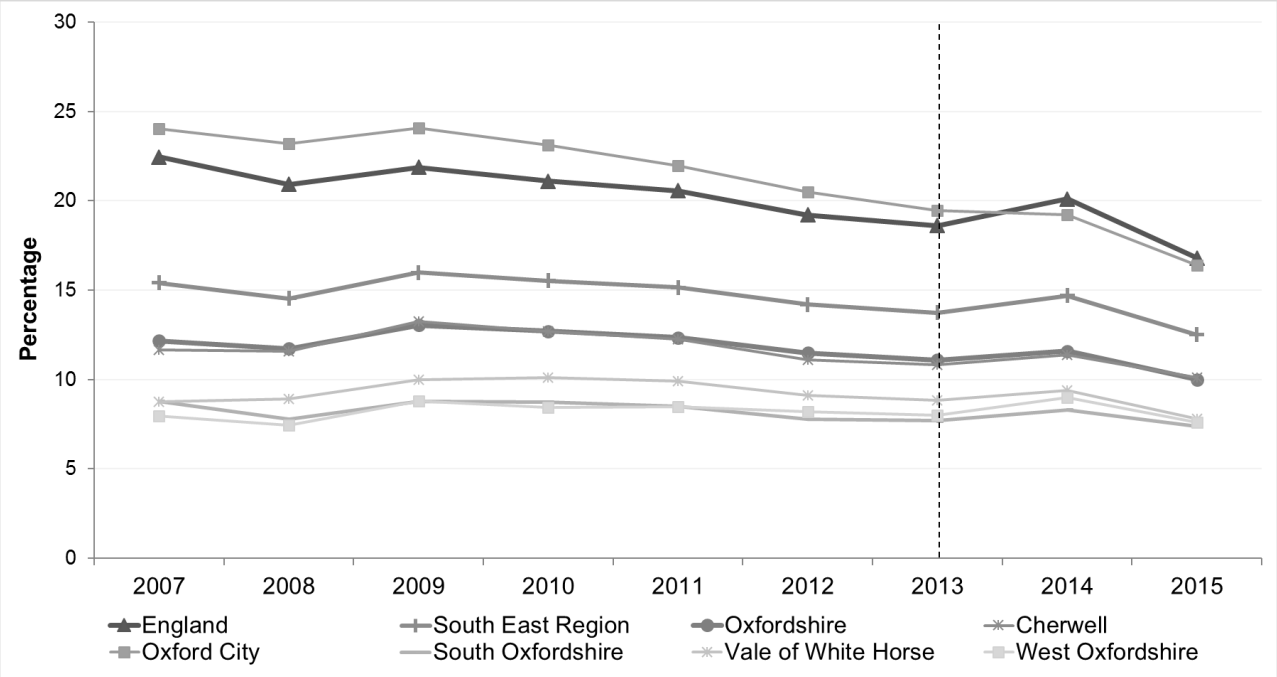
Two years ago I identified a basket of high quality indicators which would help us to measure progress in the fight against disadvantage. I set a baseline figure for comparison (shown as a vertical dotted line on the charts in this chapter) and will report on progress against these one by one.

Indicator 1. Child Poverty

The proportion of families classed as having 'children in poverty' fell both nationally and locally last year after a worrying upward' blip' last year. **This is good news.**

The correct name for this is indicator is 'relative poverty'. Poverty is not an absolute – it is a comparison of the best-off with the worst-off. Poverty in a 'wealthy' country might look like wealth in a 'poor' country. 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 classified as being in poverty are living in households where at least one adult is in work. The most up to date data comes from 2015.

Percentage of Children in poverty (Under 16 years)



Public Health Outcomes Framework, from PHE

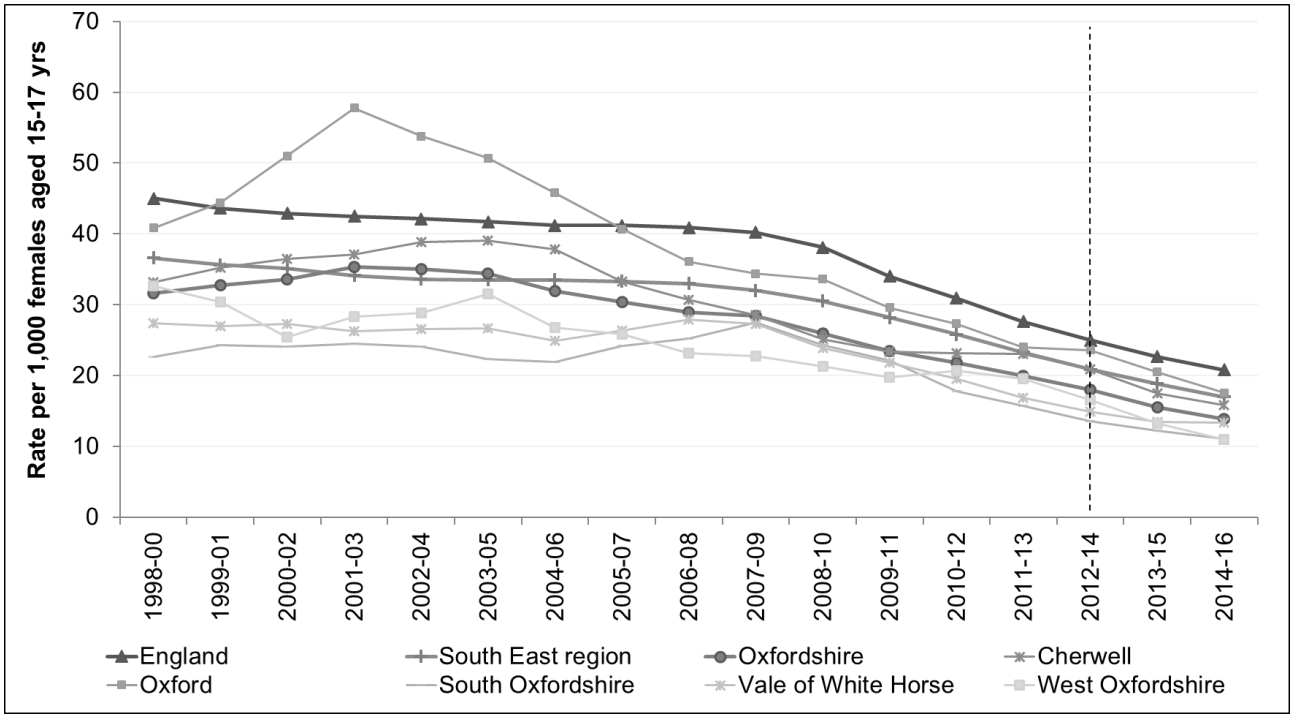
The chart shows that:

- There is a national and local trend downwards – this is very welcome.
- Overall Oxfordshire has a significantly lower percentage of children in low-income families than England. This is good news.
- Oxford City has had a significantly higher percentage of children in low-income families than England until more recently – it has been lower than or similar to the national figure for the last couple of years. This is encouraging.
- All other districts in Oxfordshire have significantly lower levels of children in low-income families.

Indicator 2. Teenage Pregnancy

This indicator measures all conceptions in females under 18 years of age whether the pregnancy ends in birth or termination.

Under 18 conception rate per 1,000 female population aged 15-17 years



Office for National Statistics

The chart shows that:

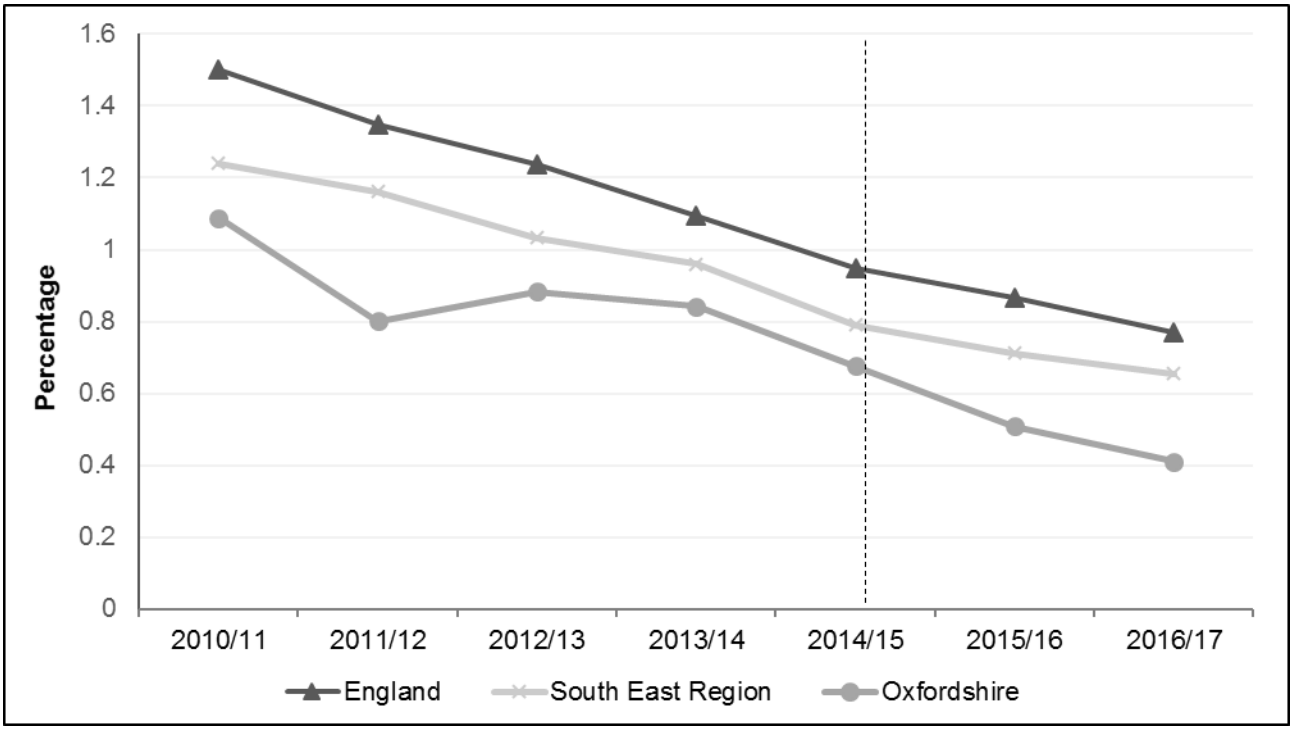
- The general downward trend in under 18 conceptions continues. More good news.
- The teenage conception rate in Oxfordshire is significantly lower than the national average and is decreasing broadly in line with national and regional trends.
- There has been a welcome sharp decline in Oxford City since 2001-03
- Most recent data (2014-16) continues on a downward trend across all geographies.
- This is a good result.

Indicator 3. Teenage mothers

Not all teenage conceptions end with a live birth. About half result in termination. This indicator measures live births to mothers under 18 as a percentage of all births. These children will, on the whole, be at risk of experiencing disadvantage and poorer life chances.

The chart below shows a percentage, but to give a more human context we are talking about 30 births to mothers in this age group in 2016/17 and this number has more than halved over the last decade.

Percentage of births where mother is aged <18 years



Hospital episode statistics (HES), from PHE

The chart shows that:

- In Oxfordshire, the proportion of births where the mother is under 18 is significantly lower than in the South East and England, and is decreasing.

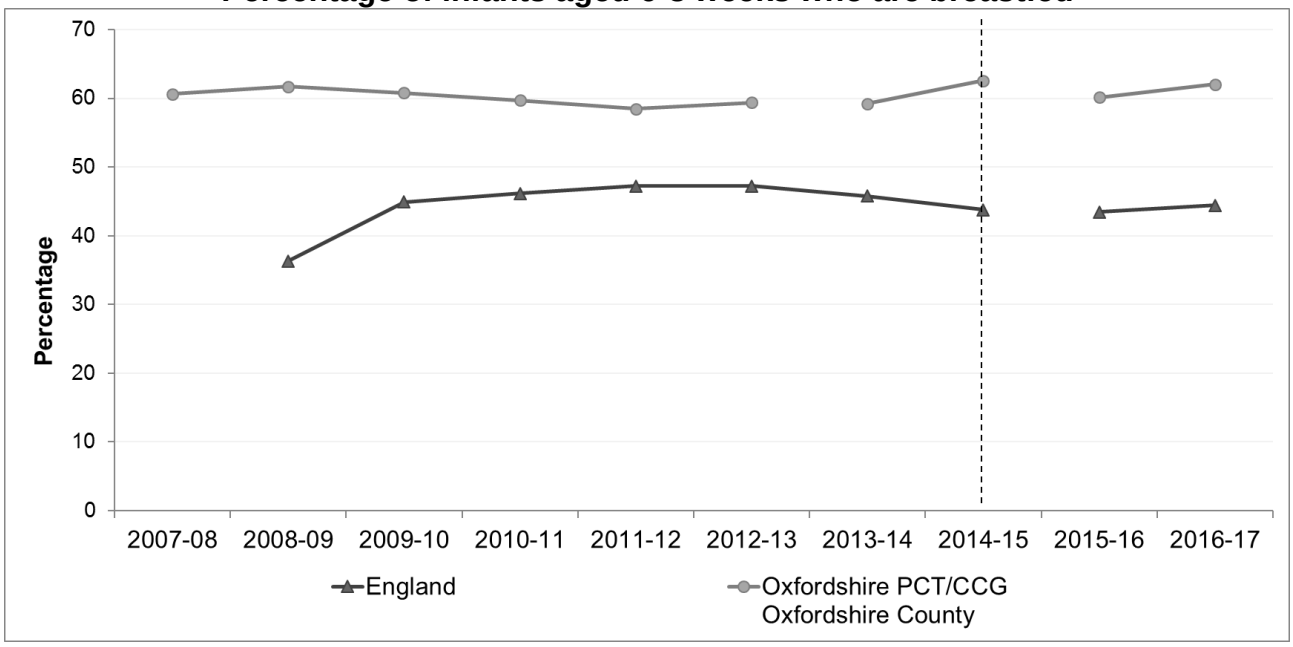
- This is very good news. It means that a lower proportion of children in Oxfordshire are at risk from this form of disadvantage.

Indicator 4. Breastfeeding at 6-8 weeks.

Breastfeeding gives children a great start in life. Its positive effects on health are long-lasting and as well as providing a perfect diet and providing immunity from disease. The breastfeeding rate at 6-8 weeks remains high in Oxfordshire compared to England at just over 60%. England's figure is 15 to 20 percentage points lower. We should remember however that despite best efforts not all mothers can breastfeed.

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 breastfed



Public Health England National Child and Maternal Health Intelligence Network

NB Breaks in the Oxfordshire line indicate that 1) reorganisation from PCT to CCG, and 2) change in methodology which has not yet been backdated – breastfeeding data is now reported by county (i.e. residence) rather than CCG (i.e. GP population).

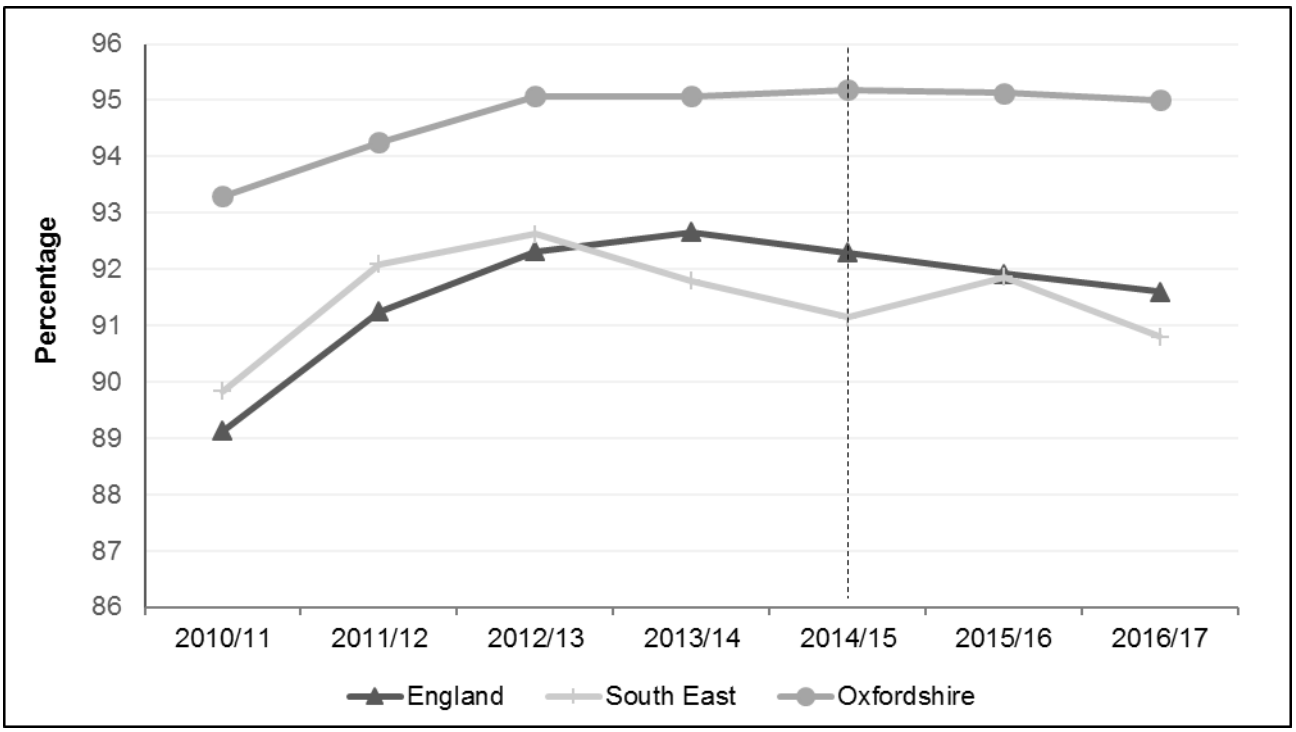
The chart shows that:

- Oxfordshire has a significantly higher percentage of infants breastfed at 6-8 weeks than the national and South-East averages.
- The Oxfordshire figure has increased slightly.
- Nationally the prevalence of breastfeeding at 6-8 weeks increased and now appears to be levelling off.
- This is another good result.

Indicator 5. Childhood Immunisation

Immunisation for Measles, Mumps and Rubella is a good proxy measure for the take up of all immunisations. Children should receive two Measles, Mumps and Rubella (MMR) vaccinations, the first by the time they are 2 years old and the second by 5 years old. All immunisation rates are monitored 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. The key is to monitor these figures really closely and respond to the smallest dip.

Percentage of 2 year olds that have received one dose of MMR vaccination



Cover of Vaccination Evaluated Rapidly (COVER) data collected by Public Health England (PHE). Please note axis does not start at zero.

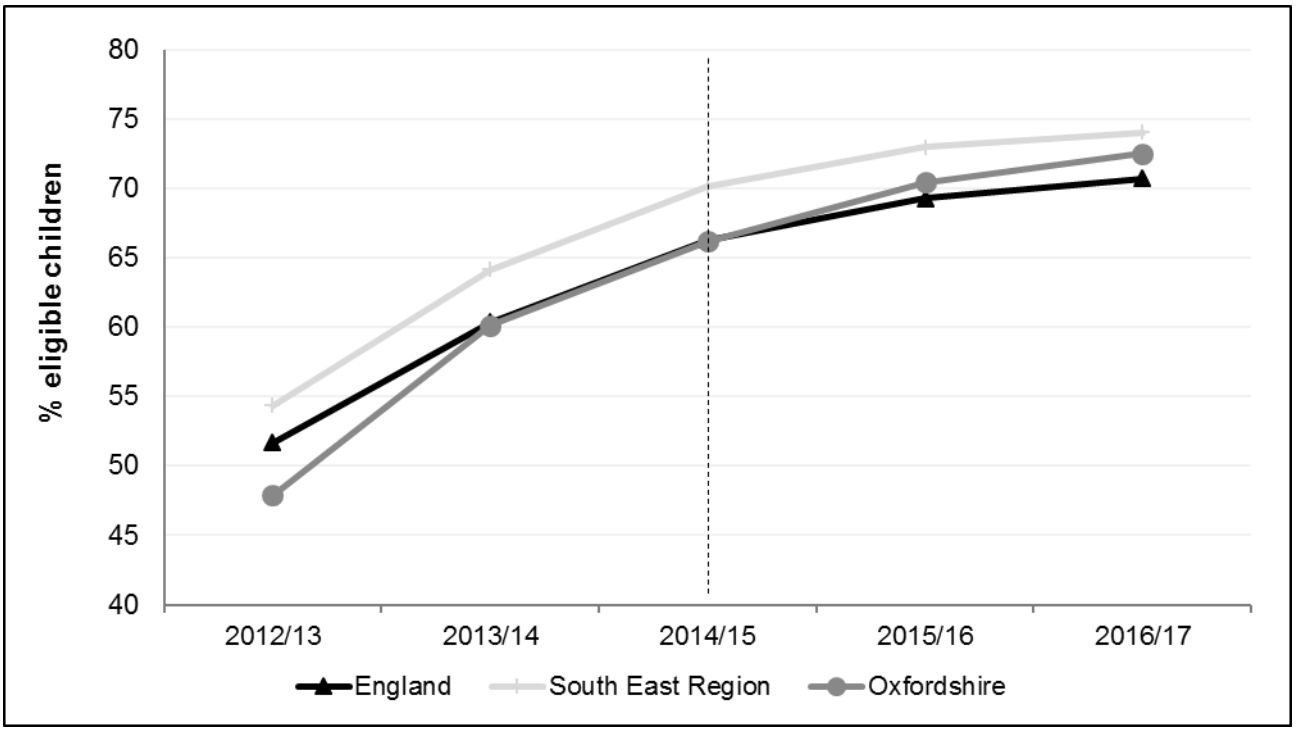
The chart shows that:

- The percentage of eligible children receiving MMR vaccination has consistently been better in Oxfordshire than in the South East and England overall.
- Vaccination coverage in Oxfordshire is among the highest in the region at 95% - the national target - which very few areas meet.
- Oxfordshire's coverage appears stable over the past five years, where regional and national coverage has decreased. This is due in part to the very close scrutiny we give to these figures quarter by quarter.

Indicator 6. School Readiness: the percentage of children achieving a good level of development at the end of reception year.

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. 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.

School Readiness: the percentage of children achieving a good level of development at the end of reception



Department for Education (DfE) EYFS Profile. Please note axis does not start at zero.

The chart shows that:

- Since 2012 Oxfordshire has been gradually 'catching up' with rest of our Region – this is very encouraging.
- In 'catching up', Oxfordshire's figure was 'lagging behind' the England figure but has now overtaken it – another good result.
- It should be noted that if one drills down into this data, the results for children in receipt of free school meals an indicator of disadvantage) are lower than the group who do not receive free school meals (see more detail below).

Indicator 7. School results

Educational attainment is a fundamental and profound indicator of disadvantage. **It is an indicator of a child's life chances.** How our children perform compared with all children nationally is important and helpful information.

The national system for measuring educational attainment is changing. Looking at our overall performance in GCSEs over the last decade shows two main trends:

1. Gradual improvement on an initially weak position compared with neighbours

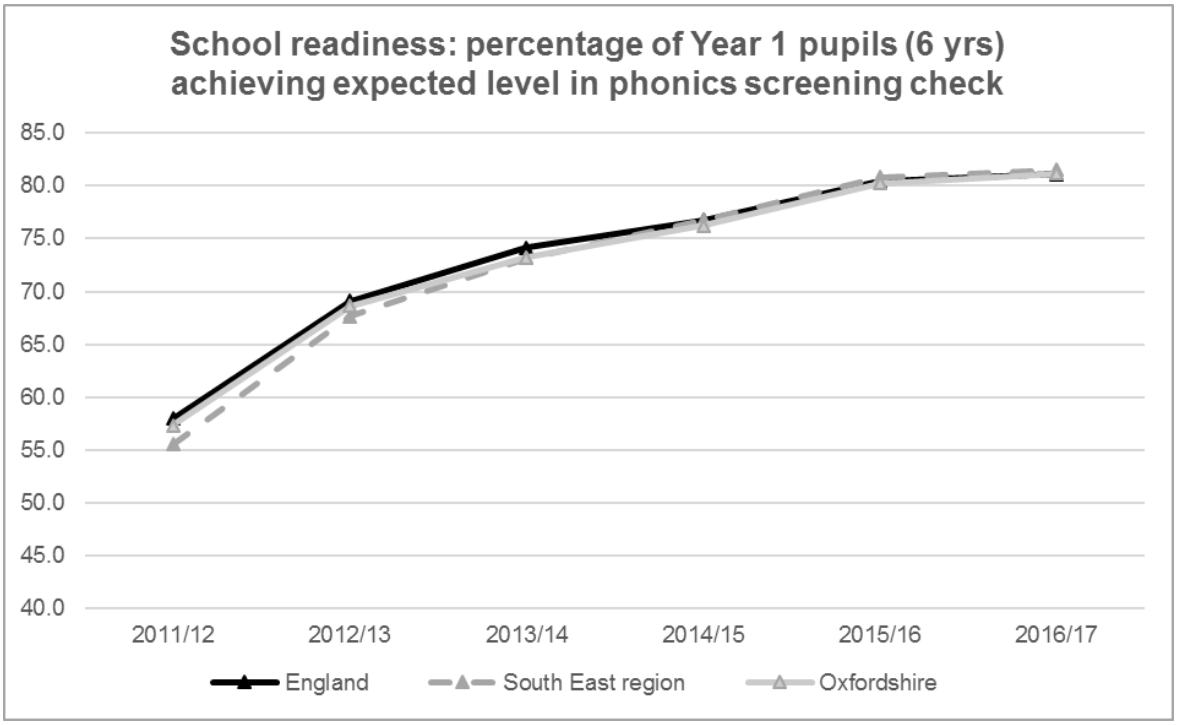
2. Concerns that (as elsewhere in the country) children identified as having a disadvantage either because of poverty or ethnicity performed less well on the whole.

The section below sets out some of the new ways of comparing our children's performance with elsewhere.

Because this is an important indicator I am going to explore the figures in some depth.

The first measure, in Year One (age 6), is the 'phonics screening check'. Phonics is a method of teaching people to read by learning the sounds that letters make. The test takes 5 to 10 minutes and tests children's ability to read short words or bits of words that form the building blocks for longer words e.g. cat, sand, windmill. It also includes nonsense words to make sure children can really link the writing to a spoken sound.

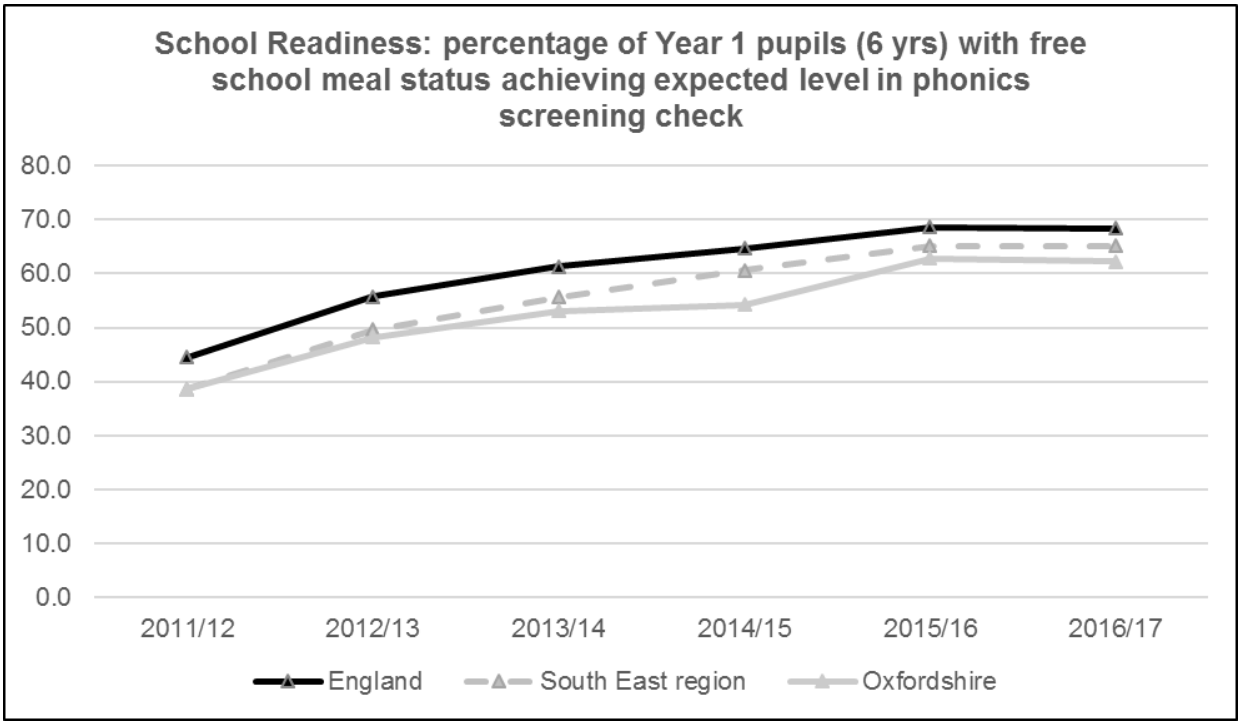
Oxfordshire's performance compared with regional and national figures looks like this:



Please note axis does not start at zero

The chart shows that there are no notable differences in the phonics test results across England, South East and Oxfordshire and all follow a similar upward trend.

However, if we look at the children who receive free school meals, we get the following picture:



The chart shows that:

- Oxfordshire's attainment for phonics for children receiving free school meals is lower than national and regional levels.

- This is a concerning result. It shows we have work left to do to at least catch up with, if not exceed, the national figure.

Ethnicity

The results for school readiness are not spread evenly across ethnic groups – highlighting a further source of potential inequality. Recent results are shown in the table below:

% achieving a good level of development	White	Mixed	Asian	Black
Cohort in Oxon.	6239	526	460	174
Oxfordshire	**74 (72)**	**74 (71)**	**68 (59)**	**68 (65)**
National	72 (70)	73 (71)	69 (68)	70 (68)
Similar Local Authorities (average score)	73 (72)	74 (71)	68 (70)	64 (63)

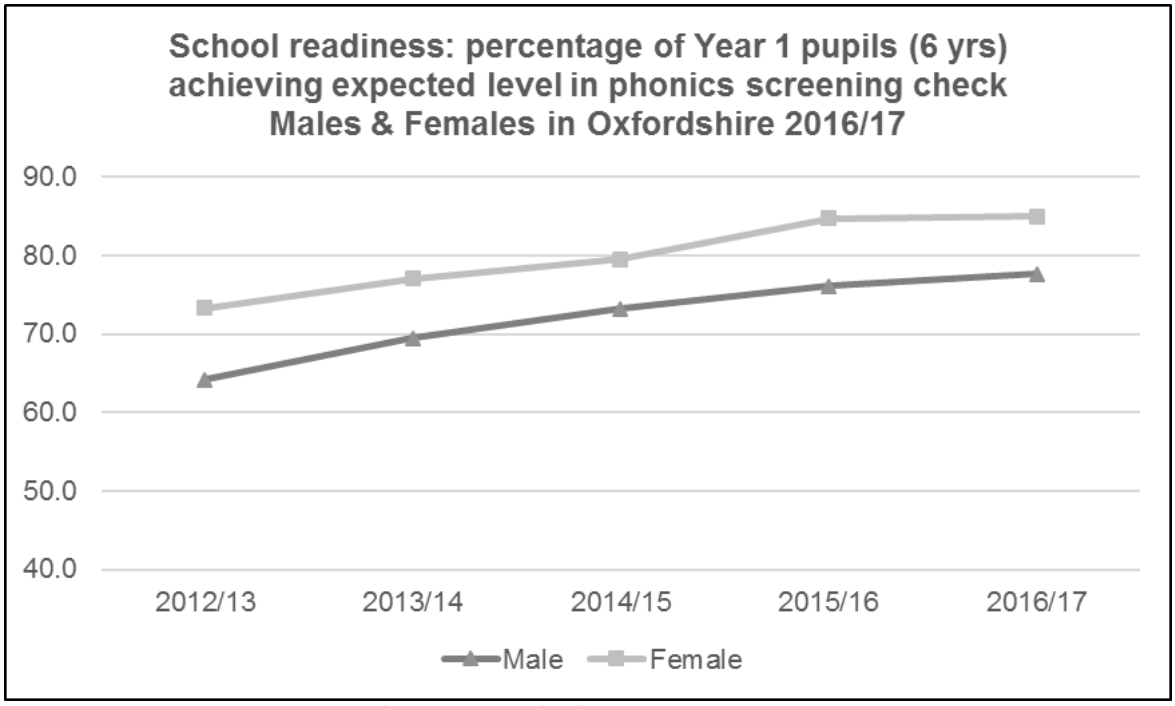
The figures in brackets show last year's results, so the picture is generally improving.

The table shows that a lower proportion of children from Asian and Black ethnic groups score lower on this measure.

This finding is similar to those seen in England and amongst similar Local Authorities and gives an indication of ongoing disadvantage.

Gender

There is a further inequality in this data regarding phonics – girls outperform boys overall. This may mirror underlying genetic and social differences in some way. The chart below shows the picture for measures of school readiness regarding phonics:



Please note axis does not start at zero

The chart shows that:

- Girls achievement stands at around 85%, boys' at around 78%
- Achievement for both genders has been steadily improving.

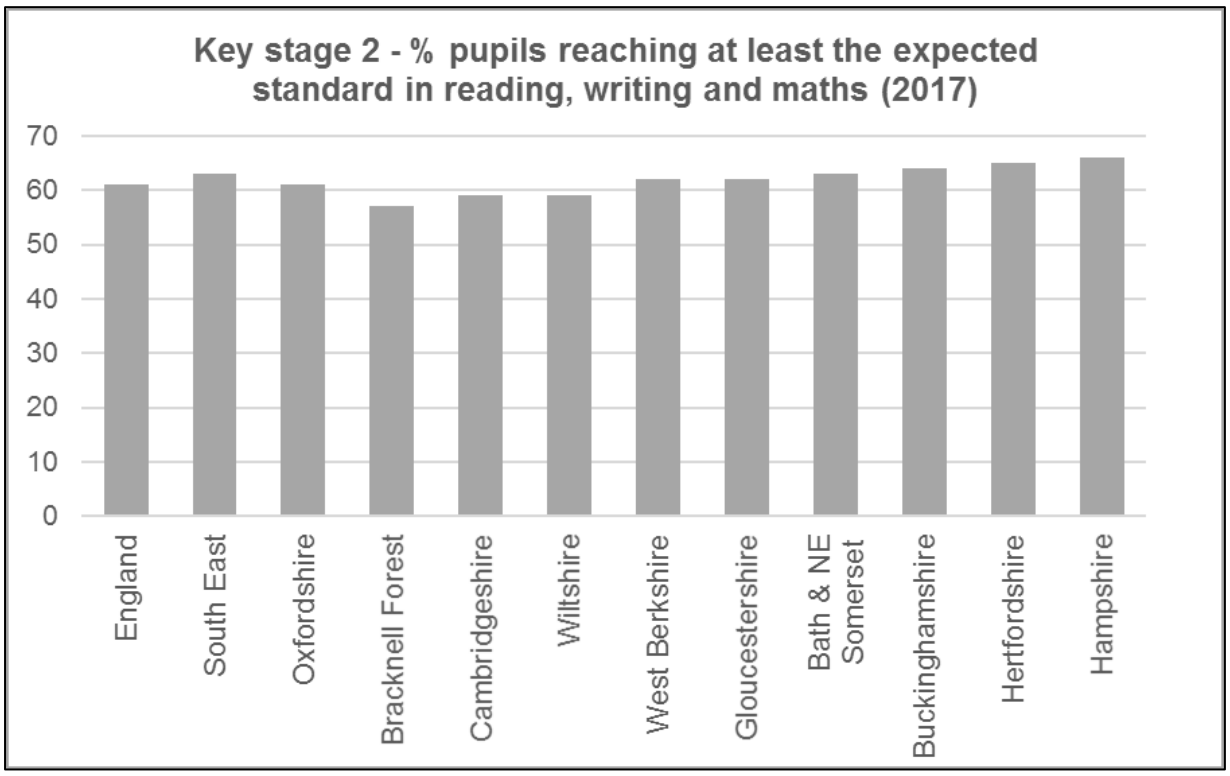
Other Key Stage 1 results

Summarising the other County's many other results at key stage 1 (6-7 years), in the interests of space, gives the following comparative position and shows mixed results. Taken as a whole, the figures are better than England and lower than in similar Authorities indicating again that there is room for improvement.

Test	Oxon compared to similar counties	Oxon compared to England
Maths	Just below	Just above
Reading	Just below	Above
Science	Similar	Above
Writing	Slightly below	Slightly below

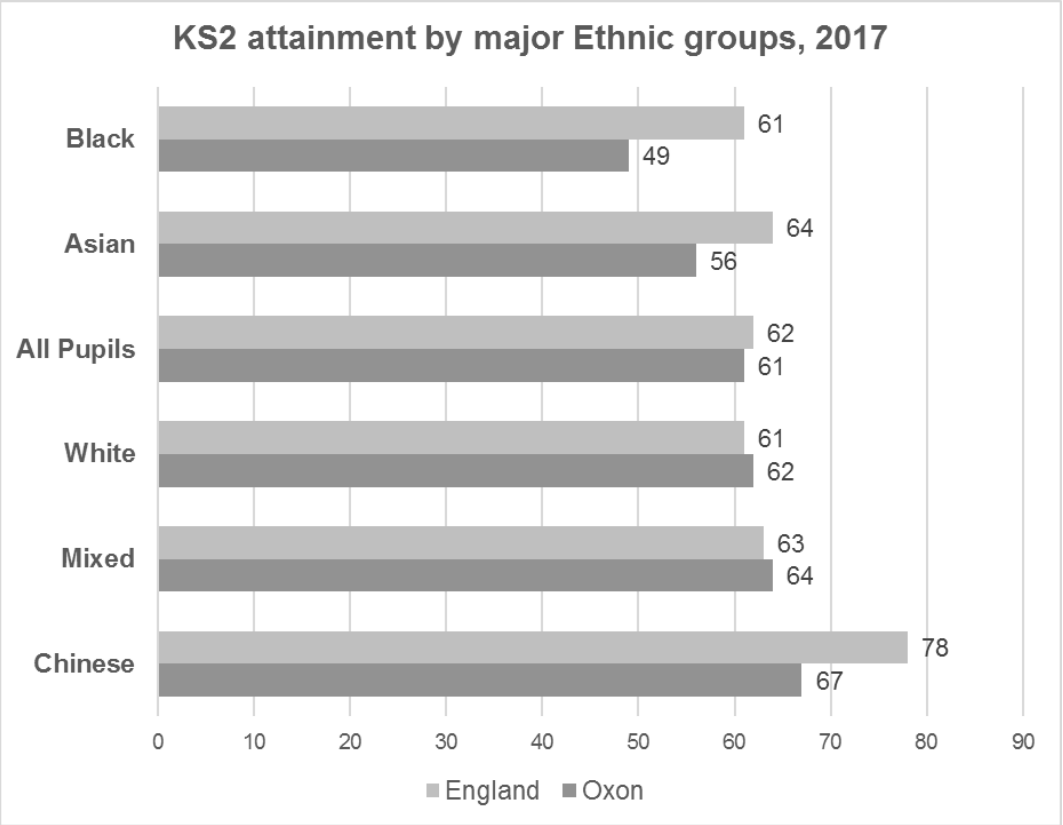
Results at Key Stage 2 (age 10-11 years)

At Key Stage 2 (10-11 years) the method of assessment has changed. Data for 2017 shows the following picture. It combines reading, writing and maths. The results look like this, comparing Oxfordshire with similar Local Authorities:



The chart shows that Oxfordshire's performance is around the national average and slightly below the regional average. The results for similar Local Authorities show a mixed picture with some performing less well than Oxfordshire and some better. It will be important to monitor these results to see what trend emerges over time.

Looking at Key Stage 2 results for ethnicity shows the following results:



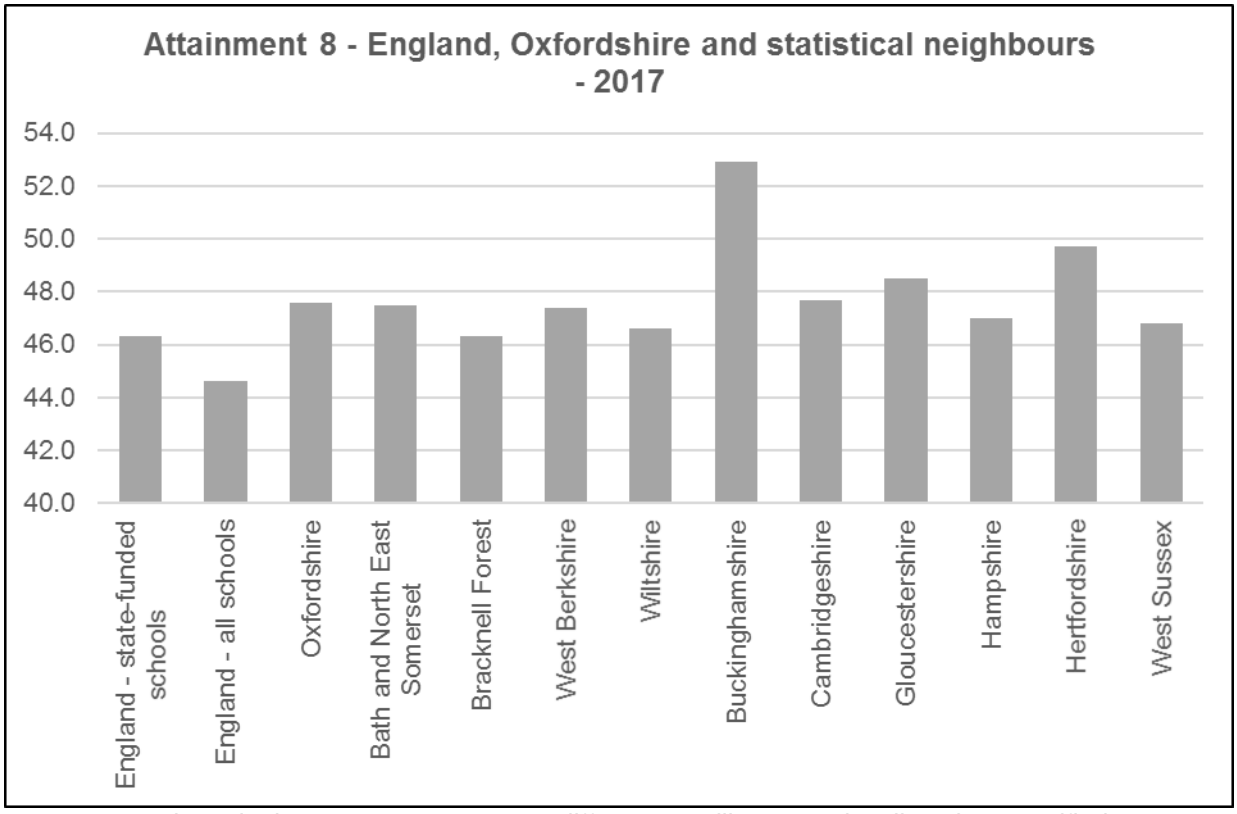
The chart shows that:

- Attainment at the end of key stage 2 varies between different ethnic groups. Chinese pupils are the highest achieving group in 2017 as in the last few years, although this cohort is only 13 pupils, and so the statistics are less reliable.
- Attainment of 'mixed', 'white' and all pupils is broadly similar to the national average.
- Pupils from Black and Asian background are lower in attainment than the England average and this is a source of inequality, although the numbers of students in Oxfordshire are small and so the statistics are less reliable.

Results at the end of secondary school

The new system aims to capture the progress a pupil makes from the end of primary school to the end of secondary school in measures called Attainment 8 and Progress 8. New GCSE qualifications will be added in 2018 and 2019 so measures may not be comparable over time.

Attainment 8 scores add up attainment in 8 subjects and average them. Results are shown below:



NB the axis does not start at zero so differences will appear visually to be magnified.

The chart shows that:

- Oxfordshire performs better than England and is comparable with similar Authorities, although some, such as Buckinghamshire score higher.

Progress 8 is a measure of improvement between key stage 2 and key stage 4 (i.e. during secondary schooling). Oxfordshire's children are compared with a similar national peer group to see if they do better or worse than the peer group. Oxfordshire scores 0 which means we do as well as the average. However, compared with similar authorities, five of our statistical neighbours have a below average score and three have an above average score.

Regarding free school meals, the attainment 8 gap in Oxfordshire is slightly wider in Oxfordshire than that recorded nationally and shows that this inequality persists throughout the 'school career'.

We need to keep a watching brief on these new scores as they develop and more data is added.

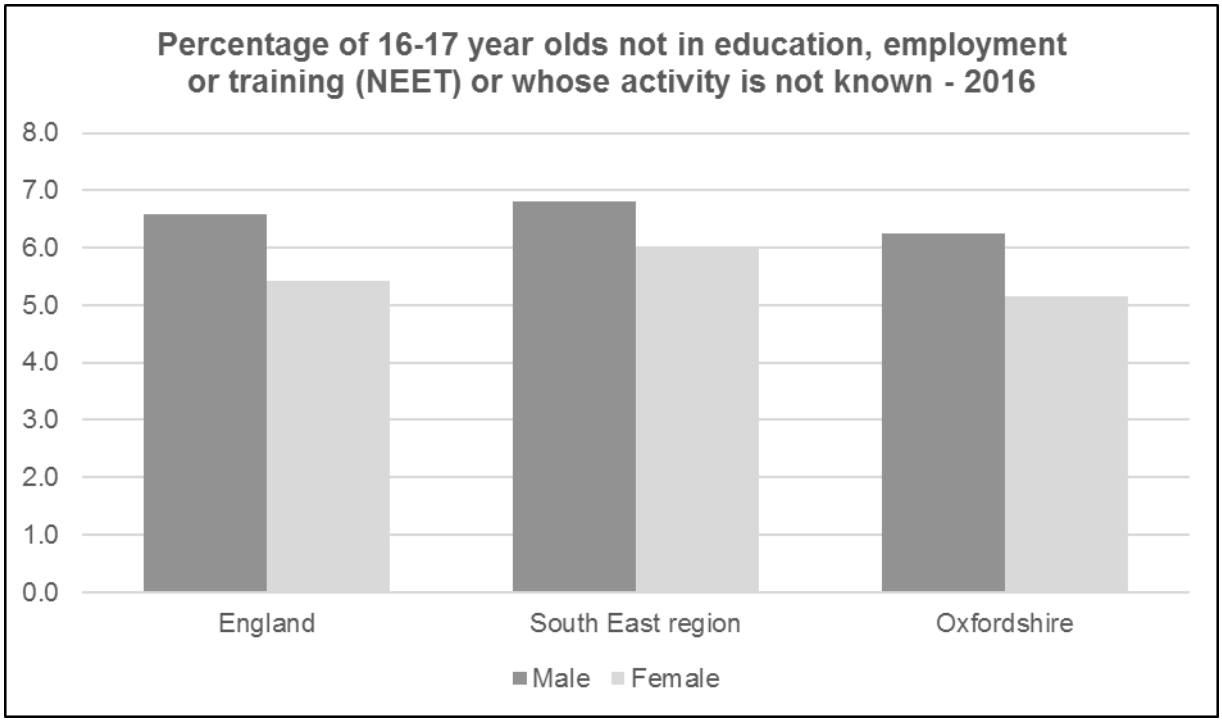
Overall for school attainment the themes are:

- Oxfordshire's scores are improving overall.
- However, inequalities are a cause for concern amongst children with free school meals and children from Asian and Black ethnic groups.

Indicator 8. 16-17 year olds not in education, employment or training.

From September 2016 the Department for Education changed the requirement on Authorities to track school age 18-year-olds. Local Authorities are now only required to track and submit information about young people up to the end of the academic year in which they have their 18th birthday i.e. academic age 16 and 17-year-olds. This means that accurate comparisons can't be made as before.

In the new system only one year of data is available, the results are shown below for males and females:

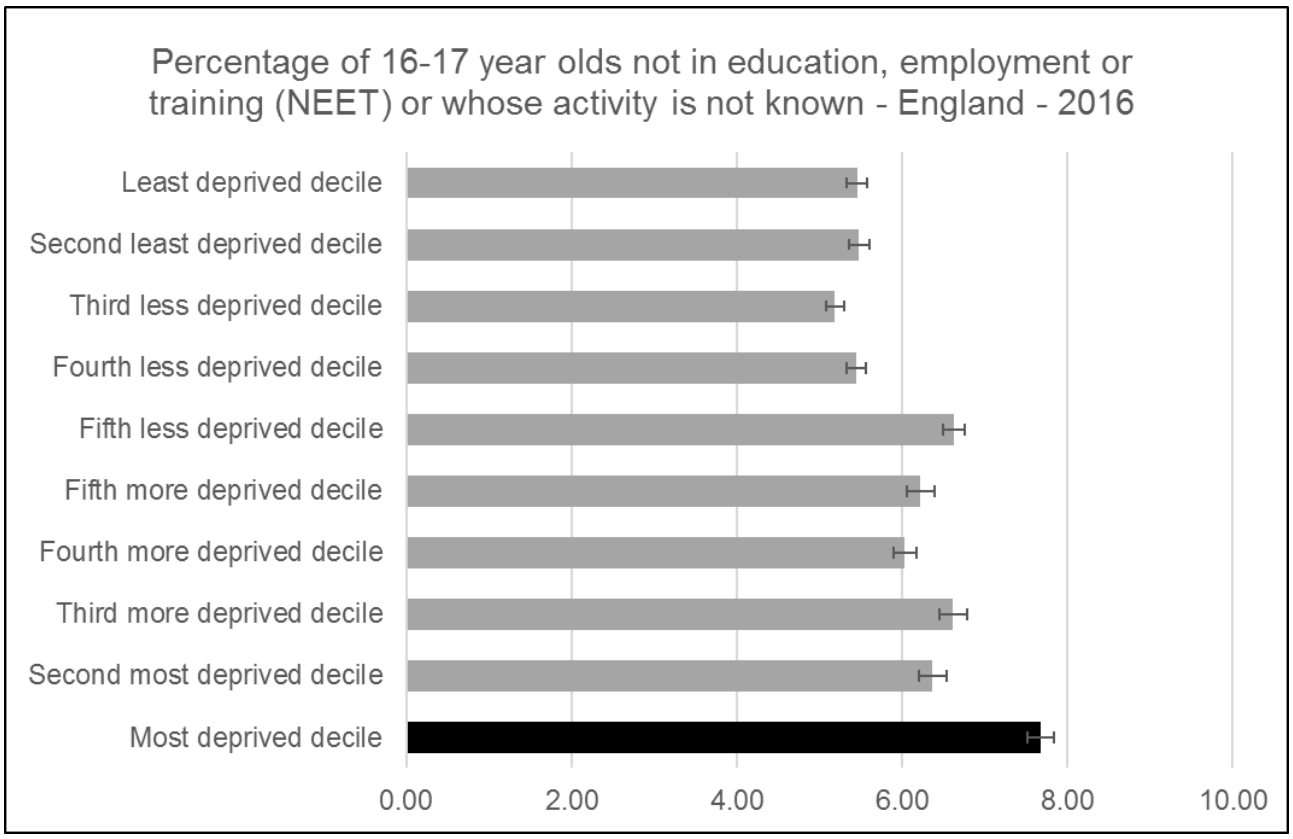


The chart shows that:

- Oxfordshire's figures for males and females are better (i.e. lower) than both the national and regional figures at just over 6% for males and just over 5% for females.
- This is a good result.

Improvement is possible however as some similar Local Authorities have lower figures – Hertfordshire for example is around 3% overall.

National figures show the following result:

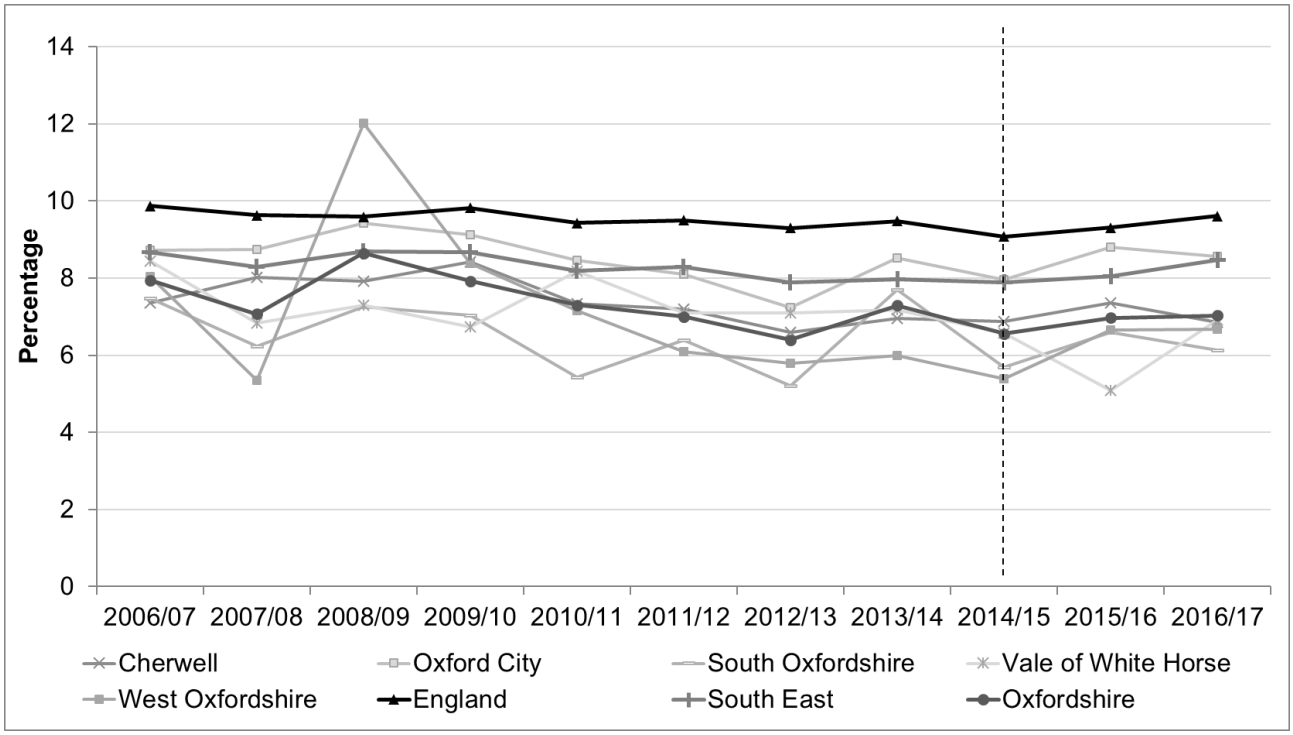


There is an 'inequalities gradient' at play here in the national data, with children in the most disadvantaged tenth of the population being about 2% more likely to be not in education, employment or training than those in the least disadvantaged tenth.

Indicator 9. Obesity in children in reception year.

Obesity is one of the biggest threats to health and wellbeing and it starts young. This indicator looks at children as they enter school. Obesity is more common in disadvantaged children.

Percentage of children in Reception Year who are obese



National Child Measurement Programme (NCMP)

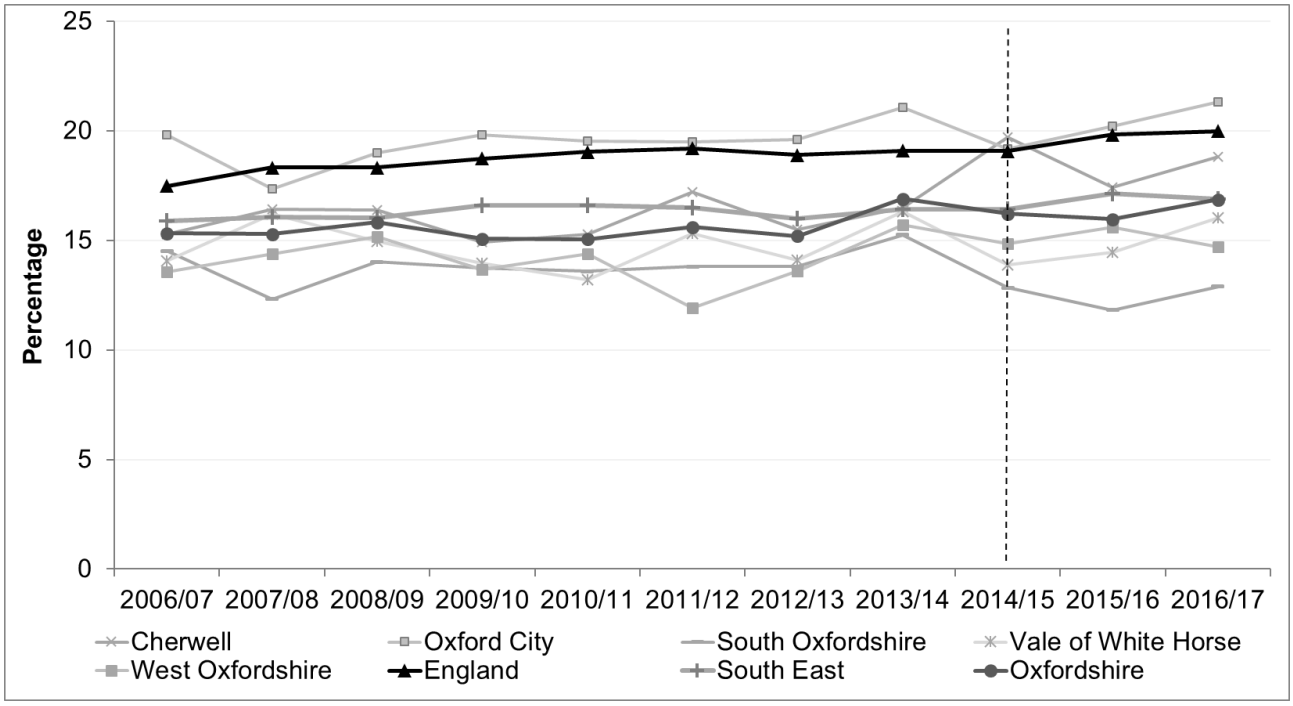
The chart shows that:

- Oxfordshire continues to buck the national trend, having obesity levels in reception year of around 7% compared with almost 10% nationally. Both these figures are too high – but it is a good result for Oxfordshire comparatively speaking.
- The trends are fairly static over time.
- Oxford City continues to have a higher rate – this will be due largely to higher levels of social disadvantage. The figure for more disadvantaged parts of the City will be higher still as the poor result is offset by very low levels in more affluent parts of the City.

Indicator 10. Obesity in year 6 (10/11 year olds)

The last indicator showed an average of 7% obesity for Oxfordshire's children in reception year. By the time children become 10-11 years old the Oxfordshire figure rises to around 17%. This is better than England's figure of 20%, but it is still a concerning increase in such a short time. This trend continues into adulthood when over 50% of people are overweight or obese.

Percentage of Year 6 children who are obese



National Child Measurement Programme (NCMP)

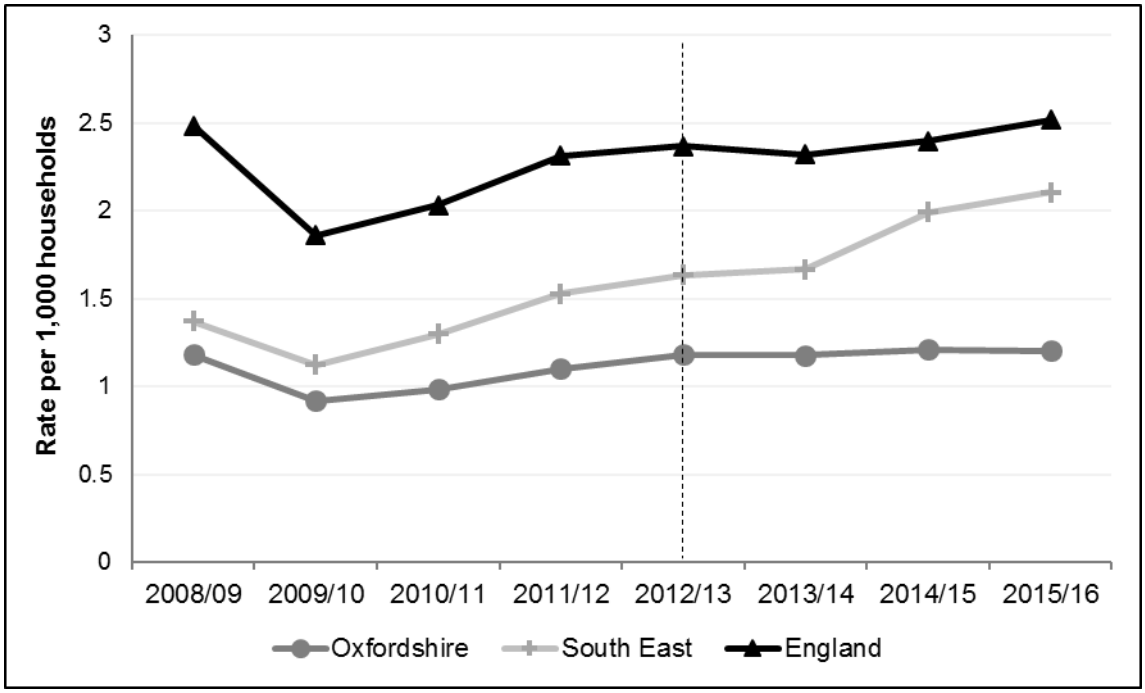
The chart shows that:

- Oxfordshire as a whole performs significantly better than the national average for prevalence of obesity in Year 6 children.
- Oxford City and Cherwell are the only districts which do not have significantly lower rates than England, and the City's figure is higher. This is a reflection of the fact that these areas have a greater number of disadvantaged children.
- Over time childhood obesity shows a slow gradual rise with some possible levelling off over recent years.

Indicator 11. Homeless Households

To be homeless is a direct measure of disadvantage and gives us a useful overall indicator.

Statutory homelessness: crude rate per 1,000 households, Oxfordshire, the South East and England.



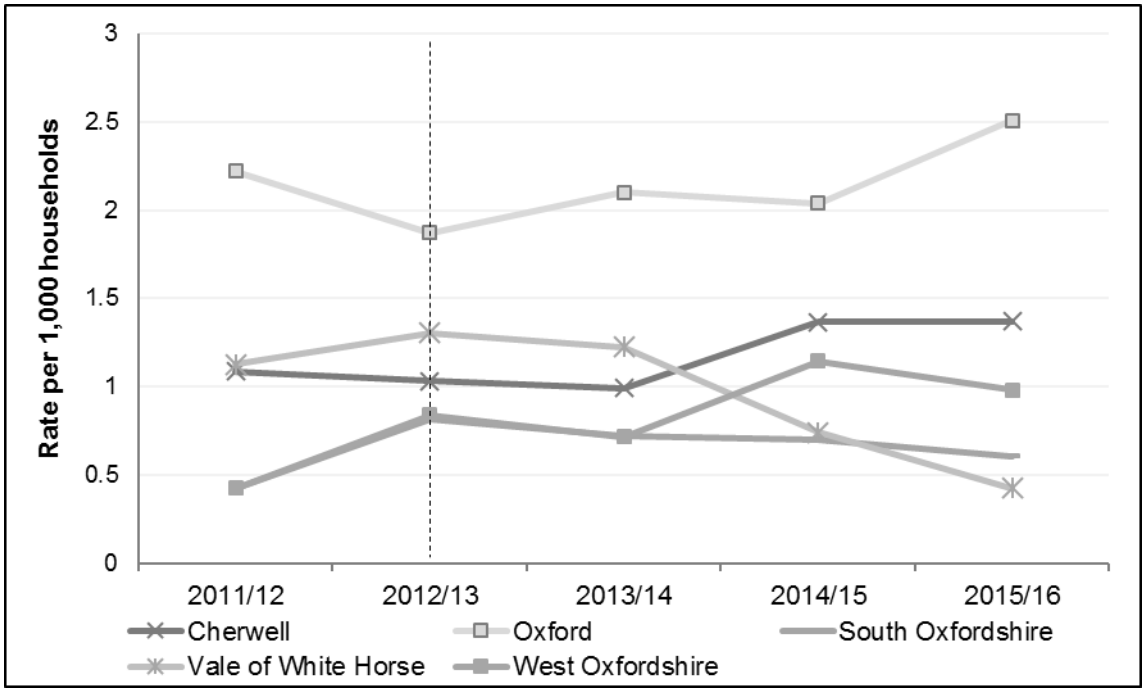
Department for Communities and Local Government

The chart shows that:

- The Oxfordshire figure is much lower than the regional and national average.
- The Oxfordshire rate is stable at just over 1% of households while national and regional rates are rising and more than double this figure.
- This is a good result which bucks the national trend.

If we drill down into the Oxfordshire data we get the following picture at District level:

Statutory homelessness: crude rate per 1,000 households, Districts in Oxfordshire.



Department for Communities and Local Government

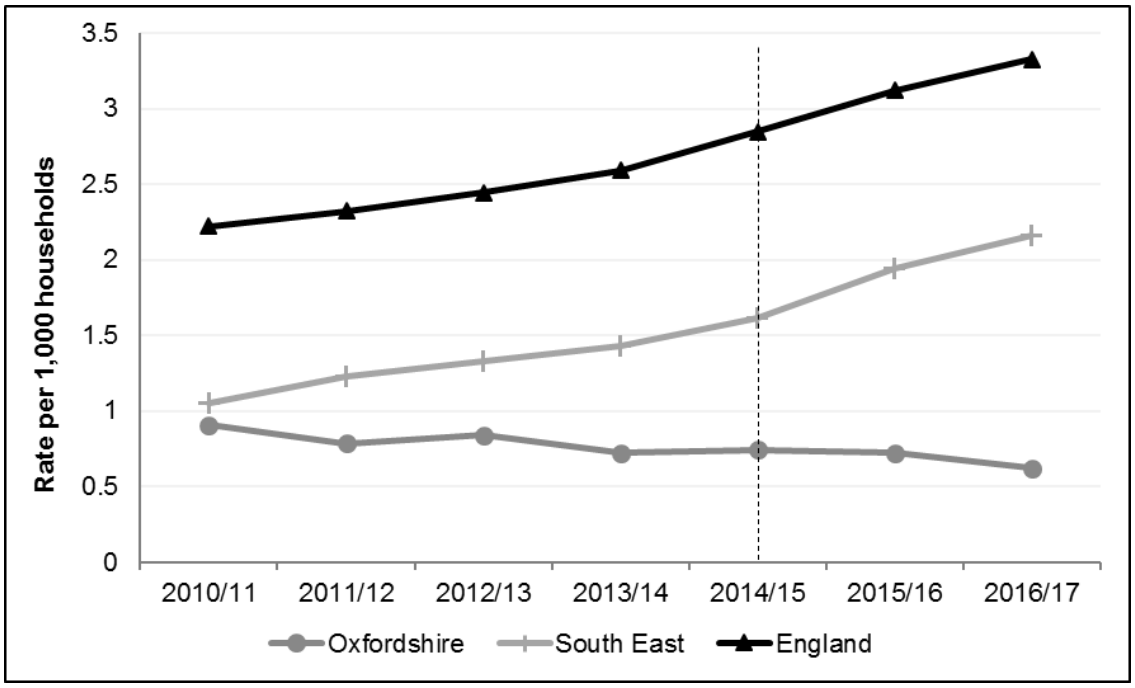
The chart shows that:

- Homelessness is most prevalent in Oxford City and is similar to the England rate.
- All other districts are significantly lower than England.

Indicator 12. Households in temporary accommodation

Placing homeless families in temporary accommodation is a means of preventing homelessness and provides a stop-gap. It is also an indicator of significant disadvantage. The first chart shows the big picture:

Households in temporary accommodation, Oxfordshire, the South East and England



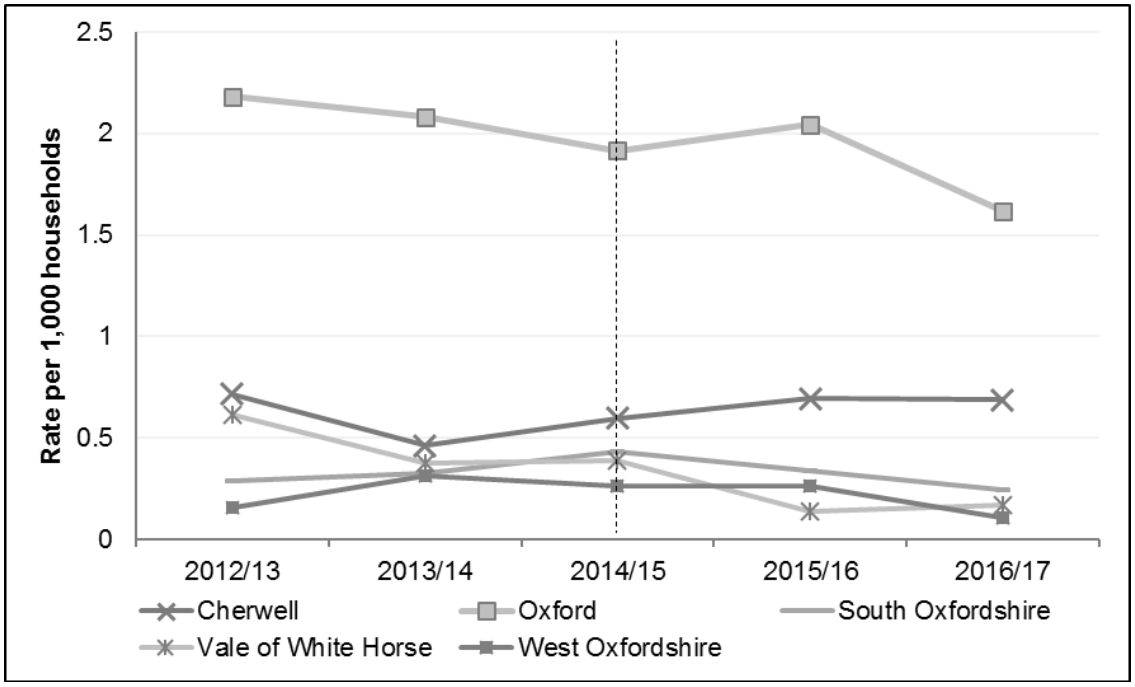
Department for Communities and Local Government

The chart shows that:

- Oxfordshire performs very well indeed on this measure. The rates are falling and are much lower than the national figures. In contrast the national figures are rising steeply.
- This is an excellent result.

The next chart shows the same data at District level:

Households in temporary accommodation, Districts in Oxfordshire



Department for Communities and Local Government

The chart shows:

- Another very good result over the last year's data overall.
- Rates in general are low.
- Rates in Oxford are higher but have fallen sharply and are lower than the national average.
- Rates in Cherwell are steady.
- Rates in Vale of White Horse, West Oxfordshire, and South Oxfordshire are among the lowest in the region.

Overall Assessment and Conclusion

Overall the indicators show a general reduction in these measures of disadvantage over the year which is a heartening result. However, inequalities are hard-wired into our society based on income, education, ethnicity and gender. We need to take a systematic and sustained approach to tackling disadvantage in Oxfordshire – we are on the right track at present, but vigilance is required.

Educational attainment among children with free school meals and from Asian and Black ethnic groups is a source of concern.

What did we say last year and what has happened since?

For convenience I have inserted last year's recommendations and have given an assessment of progress beneath each one.

Recommendations from last year

1. The Health and Wellbeing Board should ensure that the work of the Health Inequalities Commission continues to be taken forward.
   This is being achieved.

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.
   This has been achieved.

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.
   This has been superseded by the intervening review of the Health and Wellbeing Board outlined in Chapter 1. This recommendation is now being taken on actively by the Health and Wellbeing Board.

Recommendations

1. The Health and Wellbeing Board should ensure that dealing with inequalities features prominently in the new Joint Health and Wellbeing Strategy and that all health and social care and public health strategies plan for such reductions.

2. The basket of indicators of inequalities in childhood should be reported in the DPH annual report next year.

Chapter 4: Lifestyles and Preventing Disease Before It Starts

If you want to boost your odds of a long and disease-free life, your lifestyle really matters. I've said it before and I'll say it again.

We are what we eat, drink, breathe, think and do.

These things shape our whole lives.

In this chapter we're going to look at some lifestyle choices and their consequences, and we're going to start with the most important issue of the last decade or two: diet, exercise and obesity.

Obesity – why it matters.

Everything in our current culture pushes us towards obesity. We enjoy:

- Less physical labour
- A cornucopia of foods from across the world on tap
- Cars and public transport
- Relatively more cash to spend
- Every shape and size of restaurant
- A vivid advertising industry – now messaging us 24/7
- Many, many fast food options – delivered from armchair to front door if we want it – as close as the nearest app
- Cheap alcohol and relaxed licensing laws
- Electronic communication so we don't even have to go out to have company

The snag is that these things are a cocktail that tends to end up in one place – Under-exercised. Overweight. Obese.

It's been creeping up on us for years, just like it has already in a more extreme form in the USA.

And as a result, more than half of all adults are overweight or obese. And once it becomes the new norm, who notices?

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.'

So what's the catch? What's the problem?

Well, ***unfortunately obesity leads to more of all the long-term things we don't want.*** It increases our chances of heart disease, stroke, diabetes, cancer, dementia and makes any disability worse and it costs the national economy an estimated £27bn, the NHS £6bn and social care £350m each year.

Of course, it's also a big 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 showed in 2017, for example, that the higher a woman's educational level the less likely is it was her children will be overweight.

Definitions of Physical Activity and Obesity

Physically active*: Percentage of adults (aged 19+) who meet Chief Medical Officer recommendations for physical activity (150+ 'moderate intensity equivalent minutes' – which means doing enough to make you breathe a little harder - per week).*

Physically inactive: *Percentage of adults (aged 19+) that are physically inactive (less than 30 'moderate intensity equivalent minutes' per week).*

Excess weight: *Percentage of adults (aged 18+) classified as overweight or obese, based on Body Mass Index (BMI) which is your weight in Kgs divided by your height in metres squared. For most adults, a BMI of:*

- *18.5 to 24.9 means you're a healthy weight*
- *25 to 29.9 means you're overweight*
- *30 to 39.9 means you're obese*
- *40 or above means you're severely obese*

So why do we keep going in this direction?

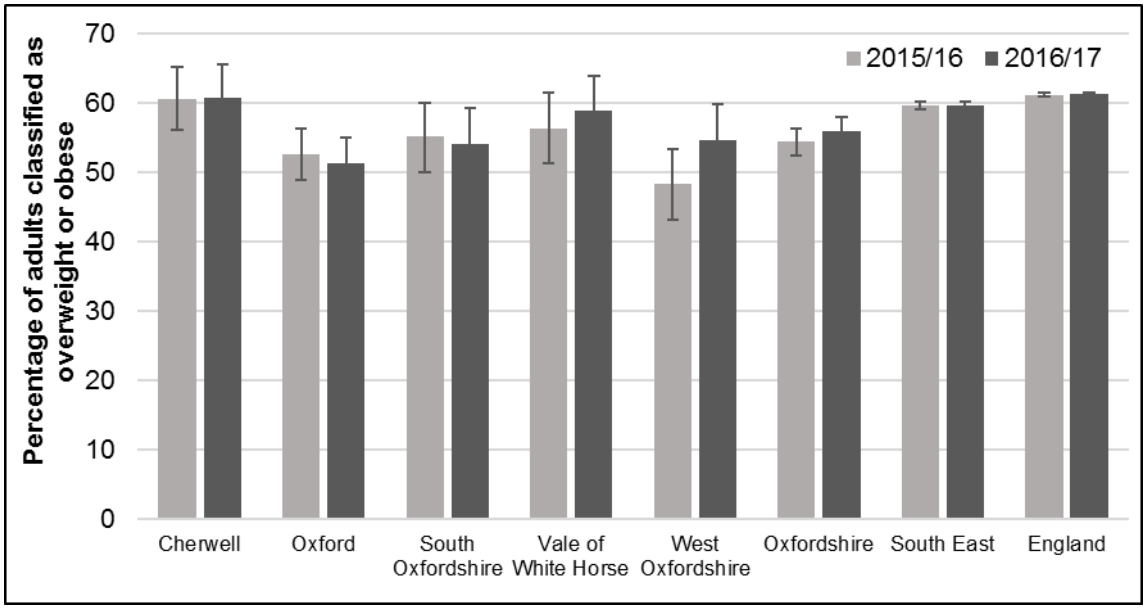
Well, lifestyles are hard to turn around. They are the warp and weft of what we are day to day and changing is difficult – we are programmed for short term pleasure rather than long term wisdom - and changing and sticking to a change in lifestyle is even more difficult…… ask anyone who has lost weight on a diet how easy it is to keep the pounds off long term – it isn't easy, is it?

What is the situation in Oxfordshire?

We have already looked at obesity in children in detail in Chapter 3 on inequalities. To recap, by the time they reach school, 7% of children are obese. More are overweight. By the time they are in Year 6, the figure is more like 17% and so it goes on increasing into adulthood.

The Active Lives Survey tells us that the picture for adults from who have 'excess weight' in our Districts and county looks like this:

Excess weight in adults (18+)



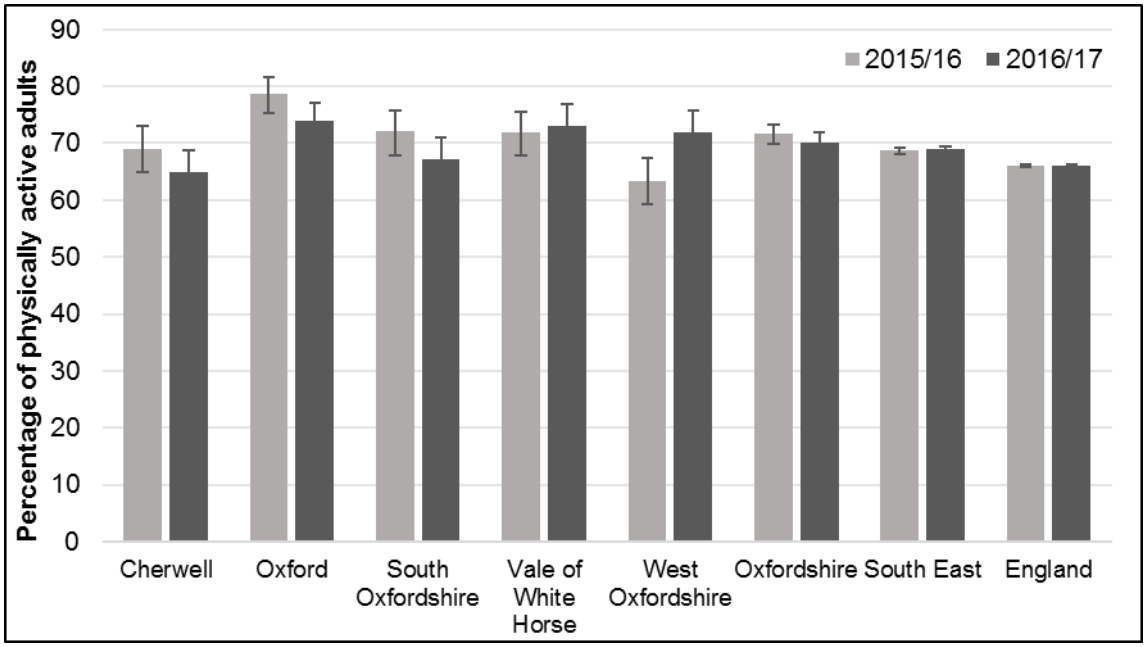
Active Lives Survey

The chart shows that:

- In Oxfordshire, over 5 in every 10 adults are either overweight or obese.
- Oxfordshire has had a significantly lower proportion of adults overweight or obese than in England overall. This is relatively good news.
- The chart reflects the different age-structures of the different Districts, the younger structure of the City keeping its figure lower.

Let's take a look at some of the factors underpinning obesity. Physical activity is very important as it burns calories and thus burns fat…… and any physical activity is OK, even standing instead of sitting, or taking one flight of stairs, or getting off the bus a stop early – it doesn't need to come clad in lycra!

Physical activity in adults (19+)



Active Lives Survey

The chart shows that:

- Oxfordshire has had a higher proportion of physically active adults than England in both survey years. This is good news.
- Again, the differences between Districts will mostly be due to different age structures – younger adults being more active than older ones.

Inequalities are at work in the realm of physical activity too:

- Those who are working are more likely to be active than those unemployed or economically inactive
- Those less disadvantaged are more likely to be active than those more disadvantaged
- Those of White or Mixed ethnicity are more likely to be active than those from Asian, Black, Chinese, or Other ethnicities
- Males are more likely to be active than females
- Participation in physical activity decreases with age. Nationally, 76% of 19-24 year olds were physically active in 2016/17 compared to 26% aged 85+

So what do we do about it?

The answer set out in last year's report holds good:

'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.'

To be more specific, I think the answer comes at 3 levels:

1. Government/ National

2. County/District

3. Personal

Government/ National level

Government can help to create an overall climate in which exercise and healthy eating become easier.

This has begun with initiatives such as the sugar tax, food labelling and starting a debate on protecting children from advertising. **This is gradual work.** It begins with voluntary agreements and ends in legislation. **It is for the long haul and Public Health England have done a good job in championing the debate**….. but…… ***we*** are the electorate and the consumer, and ***we*** have to want these changes too… which means that ***we*** have to understand the issues and want change. Once they become ballot-box issues we should see the pace of change increase. The ever-increasing demand on the NHS due in part to obesity-generated diseases may in time provide the fillip policy makers need.

Government can make changes in many other helpful ways too e.g. emphasising exercise in the curriculum and onto Ofsted's agenda; also through rewarding transport schemes which reward active travel and so reduce traffic congestion. These things are happening, but the pace is gradual.

The national campaigns on nutrition such as '5 a day' have been very effective in raising public awareness. You can tell when campaigns are effective as the message enters the vernacular.

At County and District level there is much we can do too - especially if Government supplies the framework and the incentives.

This is the level at which we plan the road schemes, put in the cycle paths, design the communities, and work with the schools and local organisations and assemble the Growth Deals.

This is where 'getting health into planning' comes in. Initiatives such as the Healthy New Towns initiative and all the other measures detailed in chapter 2 are excellent examples of how we can work together to reduce the threat of obesity, as well as reducing heart disease, cancer and reducing the impact of dementia (and thus demand on our hospitals). It is also the level at which

we work with schools on travel plans not involving cars, social prescribing by our GPs and enticing people into using parks and green spaces.

On a personal level.

If you cast your eyes back to the list of modern lifestyles that heads up this chapter, the changes we all need to make are pretty obvious and you don't need a Director of Public Health to tell you what to do. The point is,

This isn't nannying, it is enlightened self-interest. It is backing your own team in the game of life – and it's up to you.

We can all do a little more activity and we can all eat a little healthier, and it's those small daily changes that add up to make the difference…….

How are we doing overall in Oxfordshire?

There are three main points to make in summary:

- We are still better than the national averages on exercise and obesity measures – this is good progress.

- The Health Improvement board is taking a sound approach to coordinating effort – this needs to continue and the recent interest in prescribing activity for people is a great boost.

- The addition of a stronger 'getting health into planning' aspect of this work has tremendous potential if it can be tapped – this would be a major step forward. Chapter 2 is all about this.

On the strength of this assessment I would make the following recommendations.

Reviewing what I said last year, the recommendations have the same thrust but good progress on the Healthy New Towns and spreading their message more widely means that I am repeating these recommendations more emphatically this year.

Recommendations

1. The Health Improvement Board should continue to coordinate this work and ensure that the Health and Wellbeing Board retains an overview. The current emphasis on prevention within the NHS is very promising.

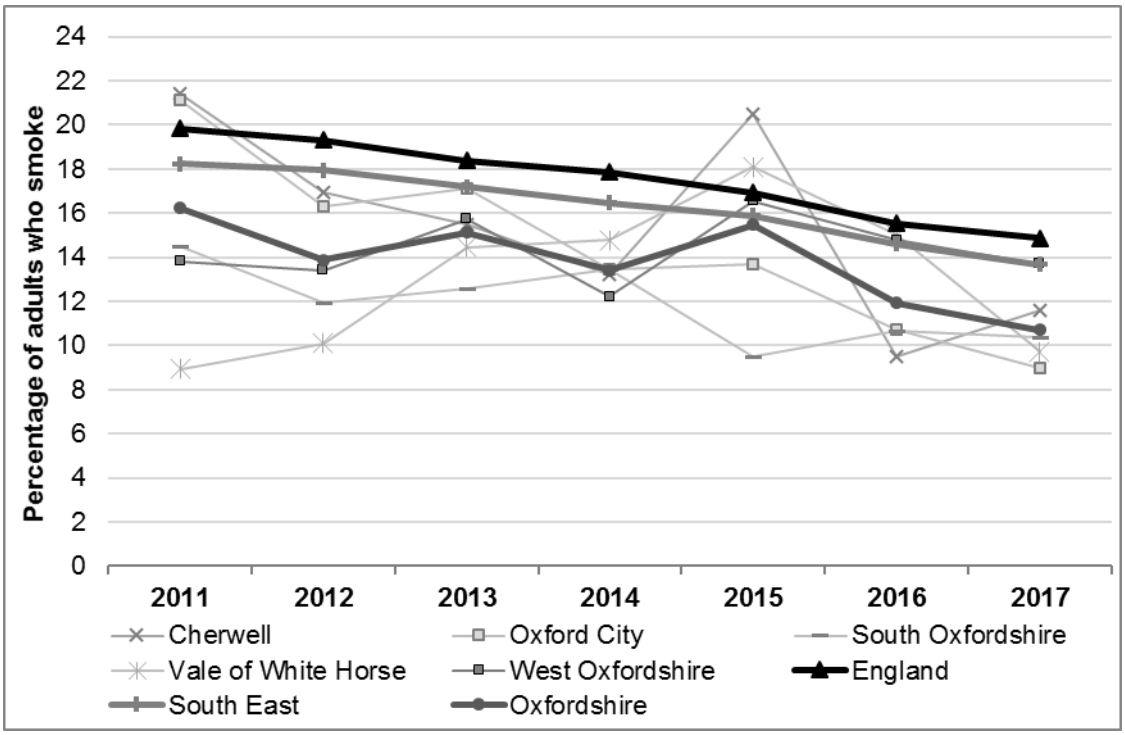
2. All organisations should work together to generalise the benefits of initiatives such as the Healthy New Towns and find a way to build health issues squarely into the planning process.

Smoking and Tobacco Control

Smoking tobacco continues to be the single most harmful thing you can do to damage your health. Smoking causes conditions ranging from cancers, heart attacks, strokes, rheumatoid arthritis and dementia.

In Oxfordshire, the prevalence of adult smokers has seen a continued decline in the past few years. This is excellent news. The decline is shown in the chart below. The prevalence of adults who smoke in Oxfordshire is currently estimated to be around 11% which is lower than the national prevalence of around 15%. **This is very good for the health of Oxfordshire.** The estimated rates in Districts will vary from year to year because the numbers are small.

Smoking prevalence in individuals aged 18+ by District in Oxfordshire



Active People Survey

The chart shows:

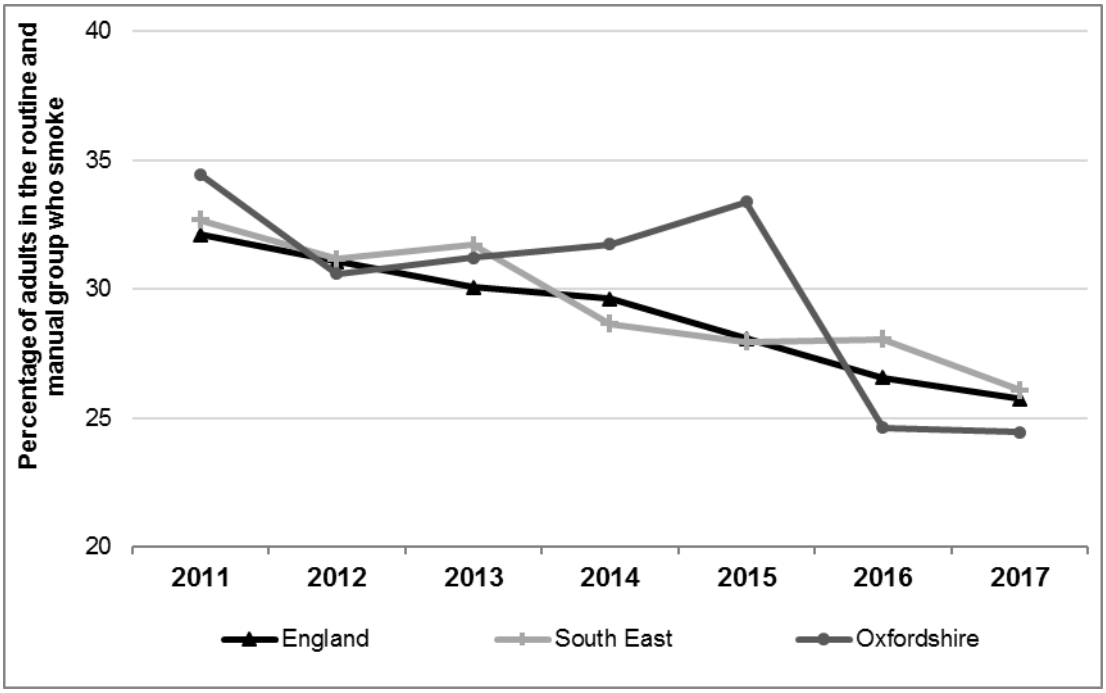
- The general decrease in the number of smokers at all levels. This bodes well for the future.
- The fact that Oxfordshire performs better than national and regional levels.
- The variation between Districts – caused mainly by the modest sample size of the survey.

While falling smoking rates in the County are what we want to see, there is no room to be complacent. ***There is still a large inequality in who smokes, with much higher levels of smoking found in more disadvantaged communities.*** **The level of smoking in routine and manual workers in the County is 24.4%, more than double the average.** To meet the need, services are being targeted at the groups who need it most.

The chart below shows the higher figures for smokers in manual groups across the County.

Adults smoking: 18+ in Routine and Manual groups

Active People Survey



Active People Survey

The chart shows:

- The higher levels of smoking in manual workers at all geographical levels.
- The same downward trend as for all smokers.
- Oxfordshire's figure showing variation year on year but currently lower than regional and national averages.

Tobacco Control

Tobacco control is an umbrella term used to describe a broad range of activities aiming to reduce smoking and the problems it causes. In 2017, the Government published a new Tobacco Control Plan, to pave the way for what they dubbed a 'smoke free generation'. Since the introduction of the last Tobacco Control Plan, smoking prevalence among adults in England has dropped from 20.2% to just 15.5%—the lowest level since records began.

The National Plan prioritises working with NHS organisations in reducing smoking in pregnancy, the harm to disadvantaged communities and the harm to people with mental health conditions.

Locally the County Council and other local stakeholders have a responsibility alongside central Government to help reduce smoking rates. To achieve this the Oxfordshire Tobacco Alliance has been established as a partnership between organisations to monitor the situation, advocate stopping use of tobacco, and coordinate activities across the County. This will help us to act as a single unit in the fight against tobacco.

Last year I recommended that a new stop-smoking service should be commissioned that targets stop-smoking effort at the groups with the highest smoking rates. This has been achieved. I also recommended that the Health Improvement Board should monitor the situation which has also been done.

Recommendations

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

- The Oxfordshire Tobacco Alliance should develop coordinated plans to reduce the use of tobacco in Oxfordshire.

NHS Health Checks

NHS Health Checks (commissioned from GPs by the County Council's Public Health team since 2013) 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 5 years (191,000 people). The 40- 74 years age range of the programme was set nationally because this is the group in which detection and prevention of heart and circulatory disease is most cost effective.

Since 2013 in the first five years of the programme in Oxfordshire, 190,000 invitations (98.7% of eligible population) were sent to residents. **There were 95,485 health checks given to residents -** 50.4% of those invited - which is a good result compared to other areas. The programme has achieved the following impressive results:

- **26,422 people were given advice about their weight**

- **21,173 people were informed they had high blood pressure**

- **9,072 people were given smoking cessation advice**

- **8,426 people were advised to increase physical activity**

- **4,522 people were given advice on lowering alcohol consumption**

- **3,494 people were told they were on the threshold of developing Type 2 diabetes**

- **1,357 people were informed they were Type 2 diabetic**

- **900 people were diagnosed with Chronic Kidney Disease**

What we said before and what we are doing about it

Last year I recommended that we should continue to market the NHS Health Check programme in new and innovative ways to increase its uptake. *This is being done and a comprehensive programme is in place.*

I recommended that we should continue to work with GPs to improve on the uptake of Health checks and investigate new ways to improve the way people are invited. *Currently plans are being developed to advertise Health Checks on-line, targeting the catchment areas of the local practices as invitations go out.*

I recommended that we should better identify and engage with high risk groups to take up the offer of a free NHS Health Check. *A health equity audit has identified groups in the community who are not taking up the offer of the free health check. We are working with minority groups to learn why they do not have a health check and what can be done to their take-up.*

I recommended that we should continue to work with partners to improve on the quality of the programme locally and to the knowledge base supporting the programme nationally. All the GPs have signed up to continue delivering the health check programme. *We are continuing to work with the practices on auditing services to deliver continued quality improvements.*

Recommendations for NHS Health Checks

The first five years of the NHS Health Check programme have been a success locally and is well embedded in the health system. While it is well received by the public, we cannot be complacent. 50.4% of people offered had their free health check which is commendable, but 49.6% of people didn't. We need to reach out to these people and do more to encourage them to have a free health check. The concerted efforts to raise the profile of this programme with the public and improve on the programme must be maintained. In order to achieve this the public health team should:

1. Continue to market the NHS Health Check programme in new and innovative ways which take advantage of emerging technologies.

2. Continue to work with GPs to improve on the uptake of the offer of a free NHS Health Check.

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

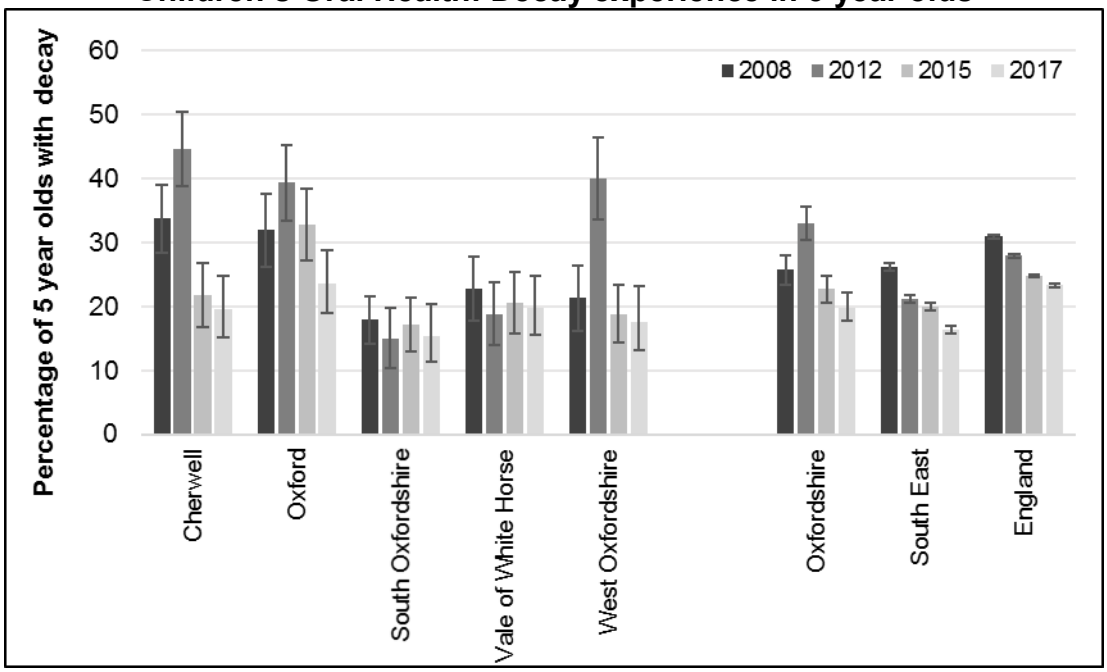
Oral Health The marked improvement in oral health and the number of adults keeping their teeth is a result of better brushing with fluoride toothpaste and more awareness of oral health. This is welcome. Tooth decay is one of the most easily preventable diseases.

The picture in children

Local data is based on national surveys whose sample size is really too small to draw firm conclusions beyond a County basis. 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 data from the 2016/17 oral health survey of five-year-old children shows that in Oxfordshire 80% of 5 year old children were free from any decay which is significantly better than the national average of 77%. This is a good improvement locally from 67% who were

free of decay in the 2012 survey. The range of decay is still unequal in the county, 76% of children in Oxford are decay free whereas in South Oxfordshire this number is 84%.

Children's Oral Health: Decay experience in 5 year olds



National Dental Epidemiology Programme for England, Oral Health Survey of five-year-old children

The chart shows that:

- These are estimated figures, making it hard to draw firm conclusions. The small bars at the top of the columns on the graph indicate the amount of uncertainty about the figures – they are best estimates. The taller the thin line, the bigger the uncertainty.

- There is an improving trend over time in Oxfordshire which mirrors improvement in the South East and in England.

- Oxfordshire performs better than England but not as well as the South East as a whole.

Last year I recommended that the oral health promotion service should continue its policy of training staff in oral health so that a small 'army' of professional can reach out to educate people about oral health in setting such as maternity, schools and care homes. *This has been achieved and these principles will inform the re-commissioning of the service.*

Recommendations re oral health

1. The Director of Public Health should continue to monitor trends in tooth decay.

2. A new oral health service should be commissioned which aims to train front line workers in oral health promotion

A word about alcohol

Alcohol consumption continues to fall nationally and locally. This is part of a secular trend. In its wake, indicators such as alcohol related deaths are also improving. At the same time, our partnership group working on reducing harm from alcohol has continued to make good progress, and so, apart from this update I am not going to report further on this topic this year.

Last year I recommended that opportunities should be taken to give people brief advice about drinking and alcohol related harm*. This is now also part of the 'Making Every Contact Count' programme. The work is progressing at a steady pace and is being led at Buckinghamshire-Oxfordshire-West Berkshire level.*

Chapter 5: Promoting Mental Wellbeing and Positive Mental Health

For the past 2 years I have looked in detail at the mental health of young people.

This year I want to devote a major part of this report to mental wellbeing, positive mental health and promoting mental wellbeing for all age groups.

It isn't an easy topic to capture for a number of reasons that are worth stating up-front:

- Mental wellbeing and mental health problems are less easy to define than physical health problems. The two often occur together and it is better to treat the whole person.

- The statistics reflect this – there is a notorious dearth of good hard data on mental health and wellbeing – it is quite different from physical health.

- We tend to know when we don't experience good mental health e.g. when we are anxious or depressed, but we tend to overlook it when we do have it.

- Talking about mental health problems can be stigmatising. Coming forward to seek help can be difficult leading to many problems staying undetected. This is less of an issue than 20 years ago, and our young people of school age are coming forward with problems much sooner than they used to.

So, let's look at some definitions.

The World Health Organisation defines positive mental health as:

'... a state of wellbeing in which the individual realises his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community.'

This is an interesting definition. It includes the concept of stresses of life as a cause of problems and has contributing to the community as a yardstick of positive mental health.

It's worth unpacking stress as something that makes us lose our sense of mental wellbeing. This seems to operate in 3 ways:

1. Stress early in life can predispose us to mental health problems in later life

2. Stress in the day to day sense can veil our sense of mental wellbeing leading to discontent or dissatisfaction…..something many people feel much of the time. This can be as simple as coping with the daily round – exams – young children – work.

3. Stress can also act as a trigger in those predisposed to serious mental illnesses such as schizophrenia and bipolar disorder.

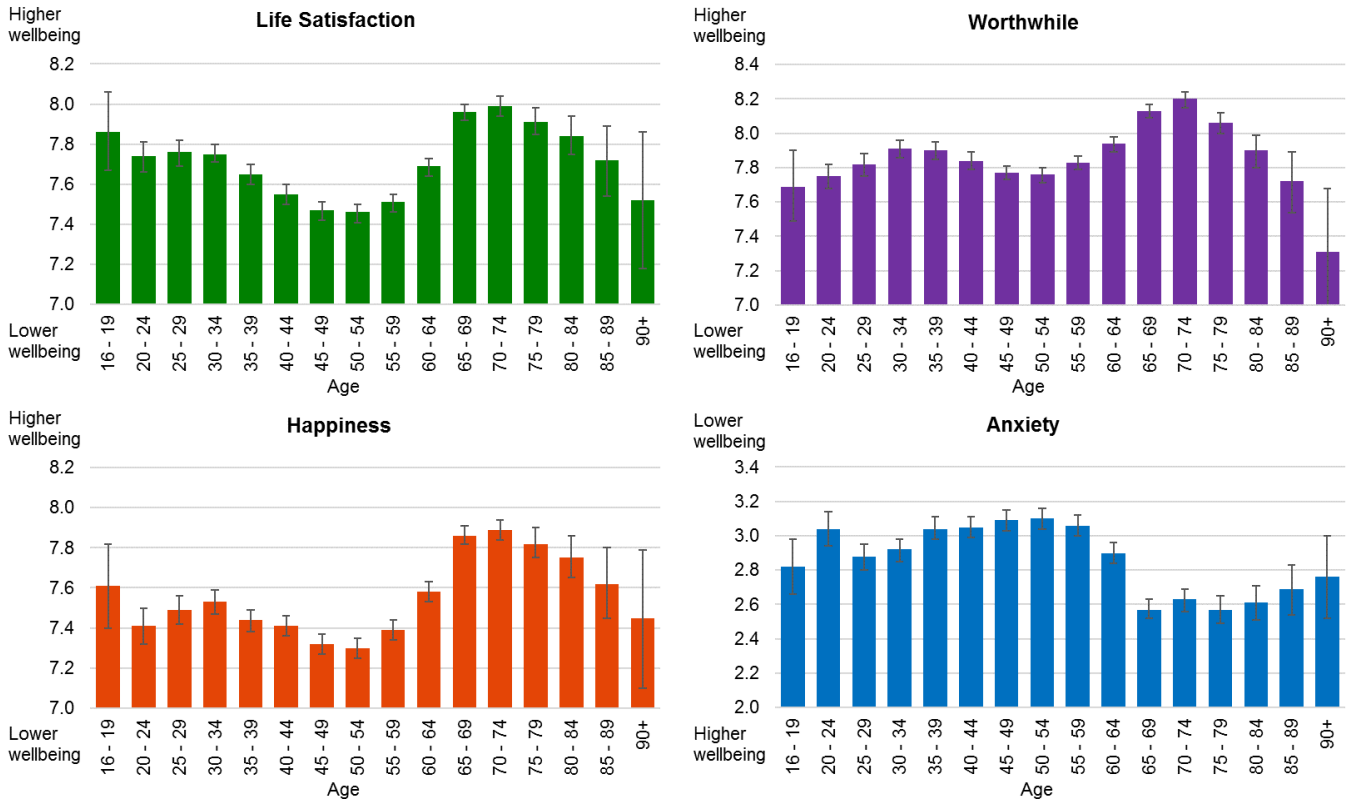
Looking at stress more closely in younger people led the Chief Medical Officer to evidence the following list of factors which build resilience in young people and so helps them withstand the stresses and strains of modern life. These are:

- 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

The reverse of this list leads to decreased resilience and vulnerability to stress.

We can get a handle on mental wellbeing in over 16s from a UK survey which asked about people's levels of satisfaction with life, happiness and anxiety. It shows some surprising results. The results are shown below in 5-year age bands from age 16 onwards below

Average personal wellbeing ratings in the UK by age, 2016-17



Source: Office for National Statistics

The results show:

- All measures of happiness and wellbeing tend to start well in one's teens and early twenties, dip rather steeply and progressively in the 30s, 40s and 50s and then improve dramatically around retirement age.

- Anxiety levels do the opposite – they are lower in the teens and early twenties, rise in adults of working age and then fall dramatically.

- As older age increases, life satisfaction and happiness do fall, and anxiety increases a little.

It is tempting to see this as evidence of the stresses of life mounting as jobs, families and mortgages add to responsibilities leading to increasing measures of mental unrest. This leads to a general period of wellbeing in the retirement years with some decline as the stresses of old age take effect.

Just how common are mental health problems across the age groups?

The following facts from Public Health England and Government sources tell the story – and the numbers are surprisingly high.

Children and Young People

- 1 in 5 children have a mental health problem of some kind. In Oxfordshire this equates to 28,700 children in the 0-17 age group

- In those suffering lifelong mental health problems, 50% have begun by age 14 and 75% by age 25.

- Children from the poorest 20% of households have a 3-fold greater risk of mental health problems than children from the wealthiest 20%

Mental health of all Adults

- 1 in 4 adults suffer from a mental health disorder at some point.

- 15 million working days were lost in England due to stress, depression and anxiety in 2014 – up 24% from 2009.

- 1 in 6 people of working age have a mental health disorder

- Mental health problems are the biggest single reported form of disability.

- Of people with long term conditions, 1 in 3 have a mental health disorder, usually anxiety or depression.

- People with mental health problems in England and Wales have a reduced life expectancy of about 10 years compared with those who do not.

Impact of work and impact on the economy

- 19% of long term sickness is due to mental health problems.

- Each year mental ill health is estimated to cost the economy £70bn in lost productivity, NHS costs and care benefits.

Women and Maternity

- Postnatal depression affects 1 in 10 women within a year of giving birth. In Oxfordshire this equates to around 700 women per year.

Learning Disability

- People with learning disabilities have six times the risk of developing mental health problems.

Older People

- Depression in over 65s affects around 22% of men and 28% of women. In Oxfordshire this equates to around 12,400 men and 18,700 women.

- 850,000 people are living with dementia in the UK – by 2020 the figure will top 1 million. In 2016-17 there were almost 5,500 GP-registered patients in the Oxfordshire Clinical Commissioning Group with a diagnosis of Dementia and Alzheimer's disease, up from 5,200 in 2015-16. The estimated total number of people living with dementia in Oxfordshire (diagnosed and undiagnosed) is thought to be around 8,000.

These facts give an eloquent picture of just how common mental disorders are and just what a prize mental wellbeing really is.

The facts and figures above refer to the general population. The figures are even higher in specific groups. This is set out in the section below.

Vulnerable groups and inequalities in those at risk of mental health problems

The Local Government Association reports that the risk of mental health problems is higher in the following groups of people experiencing:

- Poverty
- Homelessness
- Disability
- Long term illness
- Violence or abuse

The risks are also higher in the following groups:

- Veterans
- Lesbian, gay, bisexual and transgender communities
- Looked after children
- Refugees and asylum seekers
- Some Asian, black and minority ethnic groups.

Here we see the all too familiar impact of social disadvantage and inequalities. The take-home message has to be that,

'Tackling inequalities also reduces the burden of mental health problems and promotes positive mental health'

I would also add carers to the list of people particularly at risk – 57% of carers in the latest Oxfordshire survey reported general feelings of stress. Just under half reported feeling depressed.

Protecting ourselves and promoting good mental health

There seem to be several factors that nurture mental wellbeing and promote good mental health. Together these could be seen as a programme of 'mental health self-defence'. They are easy to list but rather more difficult to achieve in practice.

Protective factors are:

- A nurturing childhood.
- Good community design which fosters safety, communication, access to greenspaces, makes exercise easy and is 'dementia friendly'.
- Being more active in everyday life.
- Investing in one's 'life assets' i.e. maintaining a network of friends, maintaining hobbies and interests, contributing to the local community.
- Practising Mindfulness and the '5 ways to wellbeing' (see below)
- Achieving a healthy work-life balance.
- Being in steady work.
- Catching problems early.
- Reducing social inequalities.
- Proactive and early help for vulnerable groups.

So, reviewing these factors, how well are we doing in Oxfordshire?

This is a massive topic and there is only space to give a high-level overview in this report. My view would be:

A nurturing childhood

We are doing a lot to support families to achieve this through our Community Midwifery and Health Visiting Services, through our school health nurse service, through partnership work in the Children's Trust and through the Children's Safeguarding Board.

For example we can look more closely at the County Council's **Health Visiting** service provided by Oxford Health NHS Foundation Trust. It is rated by the Care Quality Commission as 'outstanding'. **Health Visitors assessed 7,253 new mothers for maternal mood last year by the time baby was 8 weeks old, this is 97.1% of the eligible population and is a very good result.**

Mental wellbeing is promoted at every Health Visiting contact and women with existing mental health problems receive additional support.

If there is a mild to moderate risk of mental health problems then the service uses the 'Knowing Me Knowing You' model which helps mothers to help themselves to find long term solutions and strengthen the all-important bond with their baby. There is also a focus on building a good social network through meeting other mothers and community groups.

The low figures for **teenage conceptions** in Oxfordshire mentioned elsewhere in this report are also a positive indicator of future mental wellbeing. Oxfordshire's high figures for **breastfeeding** are also helpful to the bonding process between mother and child.

Although still concerning, levels of **childhood poverty** are relatively low**,** providing another useful positive indicator.

Referral to children's social care gives us another side-light on children who are in difficulties. In 2016-17, 6,429 children were referred to **children's social care**. This number is increasing but is in line with similar Local Authorities and is part of a national trend.

Overall our Children's social care service is rated by Ofsted as 'good' which is an excellent result. Services are working with partners to offer **'early help'** to intervene before situations reach a crisis. This has been successful and early help assessments have risen steadily throughout the year. It is expected that over 1,300 of these assessments will be carried out in Oxfordshire this year. This is a good development aimed at solving problems early.

There is also a welcome emphasis on **children leaving local authority care**, aiming to build their resilience and maximise their life chances. This is a good development. By March 2017 there were 230 known care leavers in Oxfordshire. The County Council stays in touch with 94% of care leavers and takes an active interest in their lives. This compares with the England average of 90% - a good result.

Schools of course have a vital part to play in young people's mental wellbeing. The County Council's **school health nurse service** (run by Oxford Health NHS Foundation Trust and rated by the Care Quality Commission as 'outstanding') shows just how important this is. **In 2017/2018 school health nurses saw children for emotional wellbeing or psychological**

support on 7,665 occasions from a total of 33,276 interventions (22%). This was a rise from 7,224 occasions the previous year. Emotional and psychological problems were the most common reason young people saw a school health nurse. Our school health nurse service is more comprehensive than in neighbouring areas and this is a major weapon in our fight to detect and treat problems early. Our nurses are trained in common childhood mental health and wellbeing issues including self-harm, low mood, eating disorders and building resilience. They may help the child directly or signpost them on to other services.

Good Community Design

This is the subject of Chapter 2 of this report and it is of vital importance. If we can design communities to strengthen social interaction, make exercise easy, make access to good food easy and help people with conditions such as dementia, we are hard-wiring mental wellbeing into the fabric of our villages and towns.

The Healthy Towns initiative really does point the way forward. Please see Chapter 2 for more detail.

Exercising and increased physical activity

Exercising makes people feel good both mentally and physically and makes us more resilient to the stresses and strains of life. It also protects against anxiety, depression, heart disease, stroke, cancer and dementia - it is a real all-round winner!

We have high levels of exercise in Oxfordshire, but we still need to make it easier to stay active. A number of useful initiatives have been strengthened over the last year:

- Building in cycleways and walkways has become standard in transport planning – this is good news.

- Our Healthy New Towns have had success with their planned parks and 'blue lines' which map out 5 kilometre and 2 kilometre walks.

- Our Sports Partnership which aims to promote sport across the County has been re-branded and re-launched as Active Oxfordshire. Their mission is to Get Oxfordshire Active - Every person in Oxfordshire including sport & physical activity as an essential part of their daily routine.

- 21 Oxfordshire primary schools are participating in an initiative called 'WOW'. WOW is run by Living Streets, the UK charity for everyday walking, as part of their Walk to School Campaign and it has been proven to make pupils healthier and happier, as well as reducing congestion around school gates. The County Council's Public Health team have contributed funding towards this programme. The baseline rate of active travel amongst the 21 participating schools in September 2017 was 65%. In July 2018 this had risen to 86%.

- Oxfordshire School Sport Games, during the 2016-17 academic year, 95% of primary schools and 100% of secondary schools took part, involving nearly 30,000 participants.

- School Health / College Health Improvement Plans also focus on mental health and wellbeing and physical activity within the education community

- See chapter 2 for involvement of schools in Bicester in getting more exercise through the Healthy New Towns initiative.

Overall this is a positive story for Oxfordshire.

Social Prescribing

Social prescribing means prescribing exercise or participation in clubs and hobby groups instead of traditional prescribing. It is designed to support people with a wide range of social, emotional or practical needs, and many schemes are focused on improving mental health and physical well-being.

Social prescribing schemes can involve a variety of activities which are typically provided by voluntary and community sector organisations. Examples include volunteering, arts activities, group learning, gardening, befriending, cookery, healthy eating advice and a range of sports.

The City GP Locality of the Clinical Commissioning Group have an established programme and have 'care navigators' who link to GP practices and signpost people to activities.

North & West GP localities have won a national bid for funding of a social prescribing scheme and are working with Cherwell and West District Councils and Citizens Advice locally from September 2018. This is a good development.

Details of social prescribing as part of the Healthy New Towns initiative are detailed in Chapter 2

Mental health self-defence – 5 Ways to wellbeing

The excellent programme of what I call 'mental health self-defence' - the 5 ways to wellbeing - is becoming better known. This is something everyone can practise and I recommend it. Researchers have set out 5 practical and simple things anyone can do to improve mental wellbeing. They are:

According to the 'NHS Choices Moodzone' webpages they are:

- **Connect** – connect with the people around you: your family, friends, colleagues and neighbours. Spend time developing these relationships.

- **Be active** – you don't have to go to the gym. Take a walk, go cycling or play a game of football. Find an activity that you enjoy and make it a part of your life.

- **Keep learning** – learning new skills can give you a sense of achievement and new confidence. So why not sign up for that cooking course, start learning to play a musical instrument, or figure out how to fix your bike?

- **Give to others** – even the smallest act can count, whether it's a smile, a thank you or a kind word. Larger acts, such as volunteering at your local community centre, can improve your mental wellbeing and help you build new social networks.

- **Be mindful** – be more aware of the present moment, including your thoughts and feelings, your body and the world around you. Some people call this awareness "mindfulness". It can positively change the way you feel about life and how you approach challenges.

I've also seen this set out as 7 things you can do via the Mental Health Foundation and the Civil Servants' Charity website:

1. **Keep active** Physical activity does wonders for your mental health

2. **Talk about it** Get together with friends, family or colleagues and have a good old natter!

3. **Eat well** Good food is another great way to support your mental health. Vitamins and other nutrients can protect your mental wellbeing.

4. **Drink sensibly** Why not pass on the alcohol and have a mocktail party? By replacing alcohol with your favorite juices, you might discover a new favorite whilst having a healthy evening in.

5. **Keep in touch** Spending time with friends and loved ones, whether it's a BBQ or full on dinner party is a great way to open up and share your story with the people that matter most.

6. **Be mindful** Learn a technique called mindfulness to help yourself cope during stressful times.

7. **Be you** We're all different. Do what you're comfortable with. By talking about mental health locally, you will be helping to break down some of the stigma surrounding mental health issues.

The point I want to make here is that there is a growing awareness of these common things that improve people's sense of wellbeing in the broadest sense. It's something you do for yourself.

For example, there is a thriving workplace 'mindfulness' group which County Council staff run for themselves, and this sort of initiative is expanding rapidly…… try it!

Earlier this year the County Council's Public Health Team worked with MIND to run a 5 Ways to Wellbeing campaign which used social media, posters and Tea and Talk events in libraries all around the county to highlight mental health and wellbeing. Mind also used the launch event at event at County Library in Oxford to display their World Mental Health Day book – a collection of stories and contributions from their clients and supporters.

The campaign gained good coverage on social media and in the press. Overall more than 9000 people saw the campaign via Facebook and 8000 on Twitter, while others attended the library sessions to join in small group discussions.

Work-life balance

This is a difficult issue given the pace of modern life and the nature of working patterns. Duncan Selbie, Public Health England Chief Executive has said,

'Having a job is good for our health, but the quality of our jobs makes the difference. Ensuring people have a safe, encouraging and supportive working environment will help keep them well and in work for longer. This is something that all employers should take steps to achieve'

Good quality work is important for good mental wellbeing: The Health Foundation report that over 1 in 4 employees feel depressed when they work long hours. They also report that 61% of workers in insecure employment have worked when unwell for fear of losing their job or pay. The TUC report that in-work training and further education makes people happier and more effective at work.

This is a matter for individual employers but it begins close to home. In the County Council for example there has been a real emphasis placed on training and development of staff over the last year. It's good for the employee and good for the employer, and it promotes good mental health. We also have a long-standing programme of Health in the Workplace events led by our Human Resources team which promotes physical activity, health checks and mental health self-defence.

Being in steady work

Being out of work is decidedly bad for mental wellbeing. Chapter 3 reports on our very low levels of employment which is a boon, but, as Duncan Selbie points out above, the quality of the job also matters a great deal.

Domestic abuse

This topic covers a wide range of issues from domestic violence to controlling and coercive behaviour covering physical, psychological and sexual aspects. This is a major stress and puts mental health seriously at risk. An estimated 28,000 residents aged 15 + are thought to be affected altogether, around 1000 people access specialist services and around 300 individuals are classed as 'high risk'.

A major review of services for domestic abuse was carried out in 2016 and a new service was launched on the 4th of June 2018. This pulls together all services, County and District, into a single 'pathway' under a new service provider A2 Dominion. This is a major step forward. It is too early to evaluate the service yet and it requires a watching brief.

Armed Forces and Veterans

There are more than 8,500 military personnel and almost 5,000 family members living and working in the county. The nature of their work means that they are vulnerable to emotional pressures both in active service and as veterans. Partnership work is strong and Oxfordshire's close relationship with the military is cemented in the Community Covenant, which is a statement of mutual support between the civilian community and the local armed forces. An updated Covenant was signed by a wide range of partners in June 2018, signifying their willingness to continue to work together for the good of armed forces, families and local communities.

The County Council Armed Forces Champion co-chairs the Veterans' Forum which meets annually and oversees a wide range of work to ensure that veterans are able to get the services they need locally. Although a huge network of organisations supports the armed forces community, the Veterans Forum highlighted that finding the right service or assistance is not always easy. In response the 'Veterans' Gateway' was launched last year (June 2017) as a single point of contact for veterans and their families to enable them to get the right advice and support from local organisations both within and outside the armed forces sector: https://www.veteransgateway.org.uk/

Special consideration has been given to ensuring access to mental health services over the last few years not only for veterans but for families of serving personnel too. Local NHS providers have been able to fast-track individuals who need treatment for Post-Traumatic Stress Disorder, for example. Oxfordshire Mind have also delivered training and support services to families of serving personnel on the Oxfordshire military bases, helping them through times when members of their families were on active service in war zones and returning home. Grants from the Community Covenant Fund have enabled this work to expand. In addition, the Armed Forces Primary Care Services personnel regularly attend training set up by the Public Health team to help them identify and give treatments such as brief advice on alcohol use, which may be linked to mental health concerns.

Reducing inequalities

Any action to reduce health inequalities and reduce social disadvantage is highly likely to improve mental wellbeing and protect against mental health problems. Chapter 3 deals with this issue in more detail, but it is very clear that any programme of mental health improvement will also be a programme which reduces inequalities.

Preventing dementia

Dementia is estimated to cost the UK £11.6 Bn in unpaid care, £4.5 Bn on state funded social care and £4.3 Bn on health care. It is a massive issue with the number of cases set to top the 1 million mark in the UK by 2025.

The good news is that it can be prevented or delayed to some extent – how? Public Health England point to the following factors:

At societal level:

- By helping people to give up smoking or never start – some cases of dementia are linked to disease of the blood vessels.
- By improving environments where people can be more active – another boost for the healthy New Towns initiative.
- By promoting healthy eating
- By addressing loneliness and creating better community spaces

At an individual level (reminiscent of the 5 ways to wellbeing mentioned above):

- By volunteering and socialising
- By reading, doing puzzles and crosswords
- By learning new things such as a second language

The great work of the Voluntary and Community Sector and Faith Groups

The work of many charities is key to keeping people mentally healthy. Charites such as MIND RESTORE and Age UK do a great deal to improve the quality of people's lives and to improve their social networks. It doesn't stop with the big specific charities though – carers groups and the different condition-based support groups for sufferers and families have a major role to play too. Any organisation which promotes better connections, more activity and a sense of purpose is contributing to mental wellbeing.

Faith groups have a tremendous part to play too as does the scouting movement and groups like the WI.

All of these endeavours promote a really crucial sense of focus, purpose, creativity and belonging which is highly effective in promoting mental wellbeing. It protects the mental health of the users of these services and is also protective for those who organise them and take part.

The examples are too numerous to cover here – I would simply like to pay a heartfelt tribute to the work done by 1000s of (largely unsung) heroes and heroines across the County who carry out this work.

Mental Wellbeing: Conclusion

This a major public health issue now and increasingly in the future. Everyone has a role to play from individuals, to community groups, to organisations, to employers, to schools, to Government. We have many useful initiatives in place. We now need to take this work to the next level as organisations and coordinate our activities better. The recommendations below drive at this, but first I want to review what I said last year.

What the report said last year and what's been done about it.

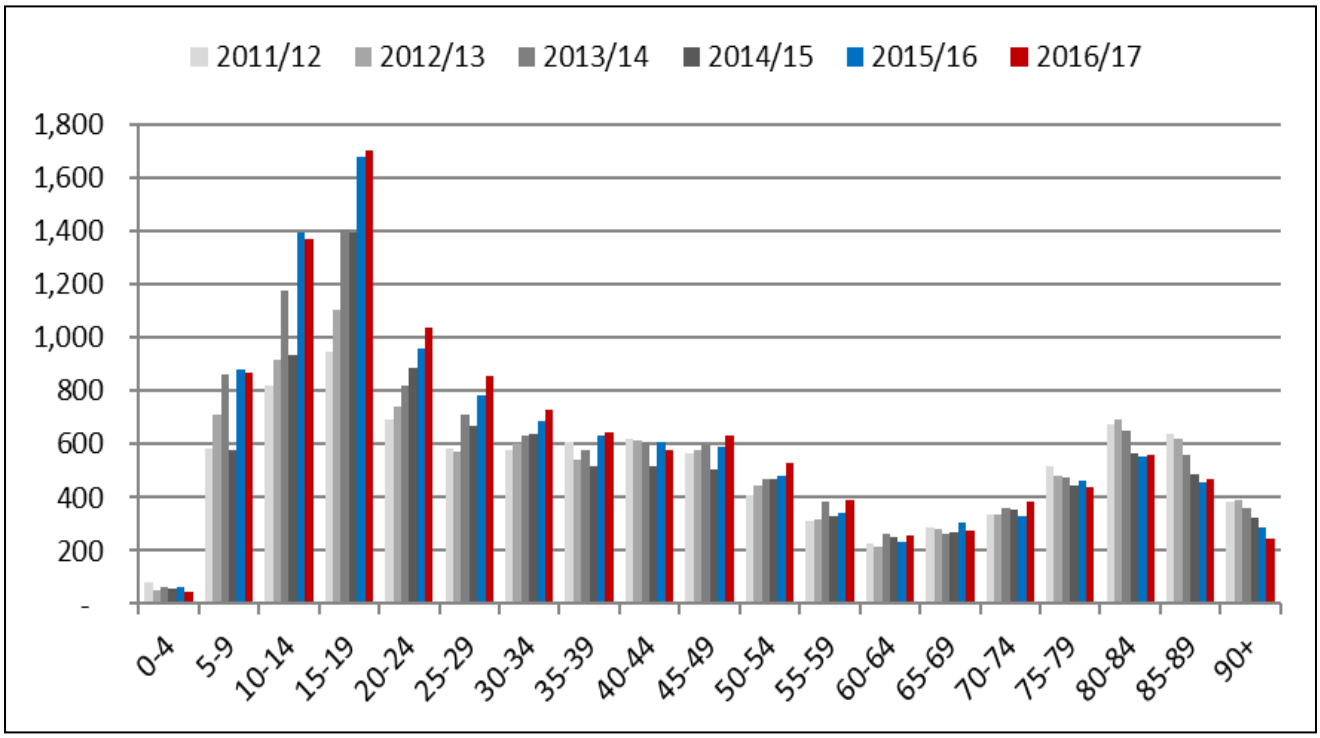
Last year I reported on children's mental health problems and self-harm. There was particular concern as the number of referrals to children and young people's mental health services were increasing and that services were under pressure to cope – this is part of a national issue.

The reality is that we are dealing with a new phenomenon – children and young people coming forward in increasing numbers seeking help with emotional distress. This is a good development. The question is, how should services cope?

The significant contribution our School Health Nurses are making has been highlighted earlier in the chapter.

The latest data on referrals looks like this:

Number of Oxfordshire residents referred to Oxford Health mental health services 2011-12 to 2016/17



This shows that:

- Referrals for 0-4s, 5-9s, 10-14s all fell slightly in latest data, and referrals for 15-19 rose slightly.

- Referrals in the 10–19 year age group are by far the highest in any age group and this is mirrored nationally.

In terms of action taken:

Waiting times for Children's mental health services remain a huge challenge locally and nationally as services try to cope with the ever-increasing number of referrals and the increasing number of children waiting for a first appointment.

The local service model implemented over the last year is sound, but it has taken longer to settle in than expected. Crucially, the overall service is supported as the model of choice by children and parents as well as by the professionals.

The aim now is to be more ambitious in trying to increase self-referral by young people rather than waiting for a professional referral. This is likely to increase demand further but is felt to be the right thing to do. This will allow assessment to be done 'live' and immediately on the phone and treatment begun immediately rather than waiting for cumbersome referral processes. This also helps to not medicalise and stigmatise these common emotional problems.

Oxford Health NHS Foundation Trust (which runs the service) is also putting together an improvement plan to reduce the number waiting by seeing if additional support can be brought in to help with initial assessments.

Time will tell if these initiatives are effective.

Regarding hospital admissions for self-harm, the figures remained broadly similar to last year and are broadly in line with national and regional trends. The specific numbers of admissions fluctuate year on year in the different age groups. In 15-19 year olds in Oxfordshire the rate has risen for the past three years, and is just above the England average. The rate is lower for 10-14 year olds. This fluctuation is to be expected as the numbers are statistically fairly small overall. The key fact is that this is a national trend.

In terms of specific action:

The County Council Public Health team commissioned the play 'Under My Skin' for the third year in a row. It is a play performed in schools by Pegasus Theatre to raise awareness of self-harm for Oxfordshire's young people, and access to support services. It was developed via the multi-agency self-harm network in collaboration with Pegasus Theatre. This was a response to an increase in self-harm rates in the north of the County.

Headline Outcomes for the play

- Year on year outcomes continue to be excellent
- 26 schools in Oxfordshire received the play with a total of 28 performances
- 5078 young people in Years 8 and 9 saw the play
- The cost was £3.94 per pupil
- 95% of young people said their awareness of self-harm had increased since seeing the play
- 90% know where to get support since seeing the play
- 87% felt using theatre was a good way of learning about difficult topics
- 69 young people saw their School Health Nurse on the topic of self-harm in the immediate two weeks post performance

The play will be commissioned again for 2018/2019 school year.

Recommendations regarding mental wellbeing and mental health promotion

1. There is good activity across the County. This now needs to be taken to the next level.

2. The Health Improvement Board should receive a specific Joint Needs Assessment on mental health issues alongside this annual report and should use these to direct planning by the end on 2018/19

3. The Health Improvement Board should coordinate this effort and should create a new framework for mental health promotion activity by the statutory sector and beyond.

Chapter 6: Fighting Killer diseases

Part 1. Epidemics, Flu and Antimicrobial Stewardship

The improvement in the quality of our living conditions and the advances in modern medicine have meant that threat of major illness and large numbers of deaths due to communicable disease are considered as a problem from the past or a problem for poor and developing countries.

Most people don't see or know about the efforts made to keep them safe from infectious diseases. There are still stark reminders of the continuing threat that can arise at any time and present a very real risk to us all irrespective of countries and borders, as seen with Ebola and Zika in recent years. The concerns about flu last winter is a reminder of the continued vigilance that is still needed to safeguard our population's health from communicable disease.

A lot of the work that goes on to protect the community from communicable diseases is relatively unseen and out of the public eye. This work must still be a priority and continue to be delivered every day of the year to make sure that suitable preparations are in place for the worst scenarios. Directors of Public Health and their teams have worked closely with Public Health England and the NHS across the Thames Valley to make sure we can respond when the need arises. **This cooperation and 'behind the scenes' effort is vital.**

The right response continues to be systemic and calm planning. We need to ensure that we are organised so we can respond when the need arises without fear or panic. The need to remain vigilant continues to hold true.

Last winter saw an increase in the level of flu compared to the previous few years of low activity. This put pressure on the health system and caused the cancellation of planned procedures nationally. This increased flu activity was expected and world-wide surveillance helped us in planning how to limit the effect of flu during the winter season. This included a concerted effort to encourage people who work as carers of vulnerable people in our community to take up a free flu vaccine.

The threat of **antibiotic resistance** and the rise of "superbugs" remains a cause for concern. Antibiotics are important drugs in the fight against bacterial infections which were once life threatening in animals and humans. Bacteria are highly adaptable and the widespread misuse of antibiotics and inappropriate prescribing of antibiotics continues to lead to increasing numbers of bacteria which have developed resistance to antibiotics which once were effective.

Failure for us all to act responsibly now could see antibiotics becoming ineffective and the return of people dying of once curable infections and 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 the public of their role as individuals in limiting antibiotic resistance.

Our work on this in Oxfordshire has been strong. 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)

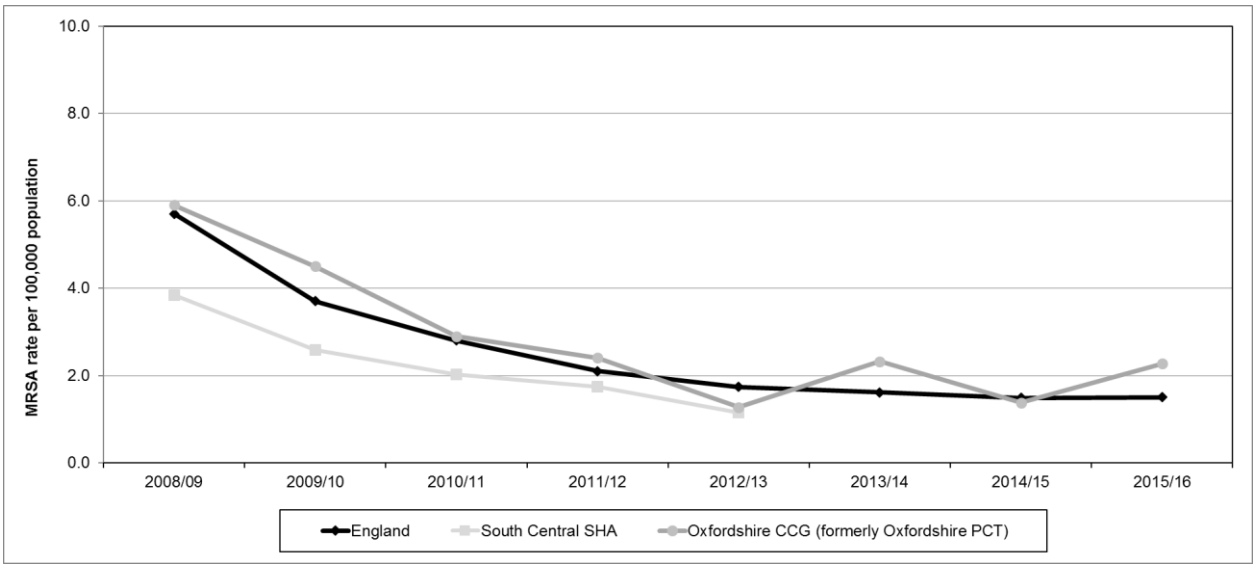
Infections caused by superbugs like Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium difficile (C. diff.) continue to be an important cause of avoidable sickness and death, both in hospitals and in the community. These infections do not grab headlines as they have in the past but they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

Infections can be limited by using traditional hygiene methods. Nationally there is a zero-tolerance policy and the rate of MRSA is still higher than we would like to see. The improvements over the past years in Oxfordshire have reflected the efforts to reduce MRSA and continued vigilance is still required by all hospital and community services to combat MRSA infections.

Methicillin Resistant Staphylococcus aureus (MRSA) - crude rate per 100,000 population (2008/09 – 2016/17)



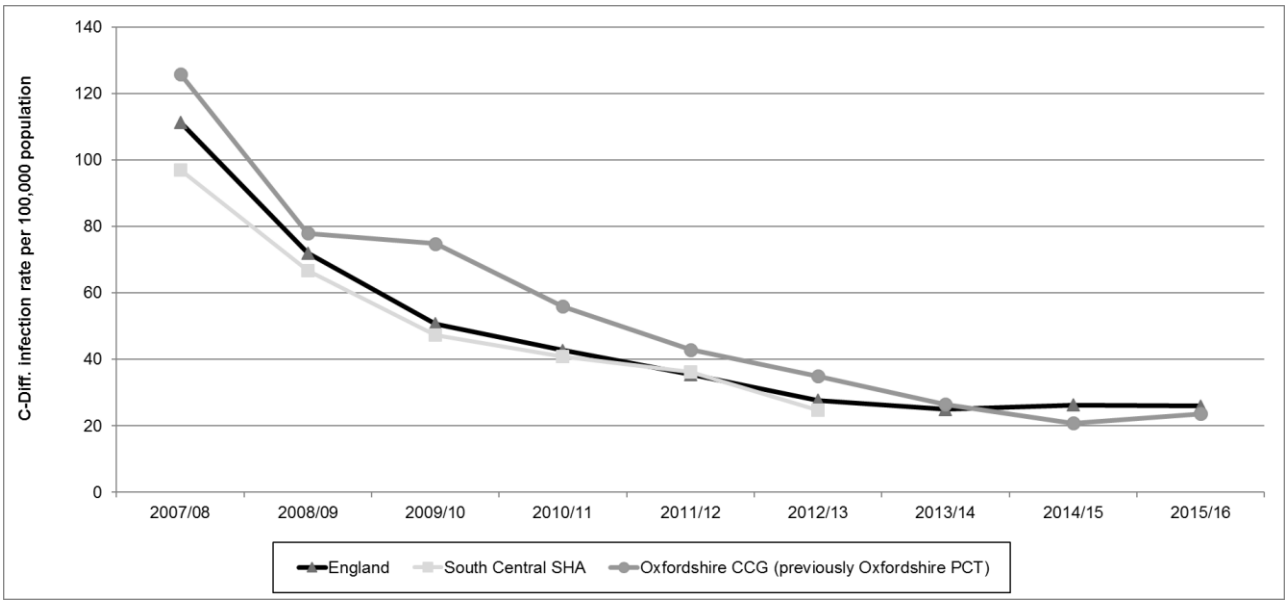
Public Health England (PHE), Health Protection Agency (HPA)

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.

The focussed approach on the prevention of this infection has resulted in the steady reduction of cases in Oxfordshire since 2007/08 as shown in the chart below which is in line with the national trend. This reduction in C. diff involved coordinated efforts of healthcare organisations to identify and treat individuals infected and careful use of the prescribing of certain antibiotics in the wider community.

Clostridium Difficile Infection (CDI) - crude rate per 100,000 population (2007/08 to 2016/17)



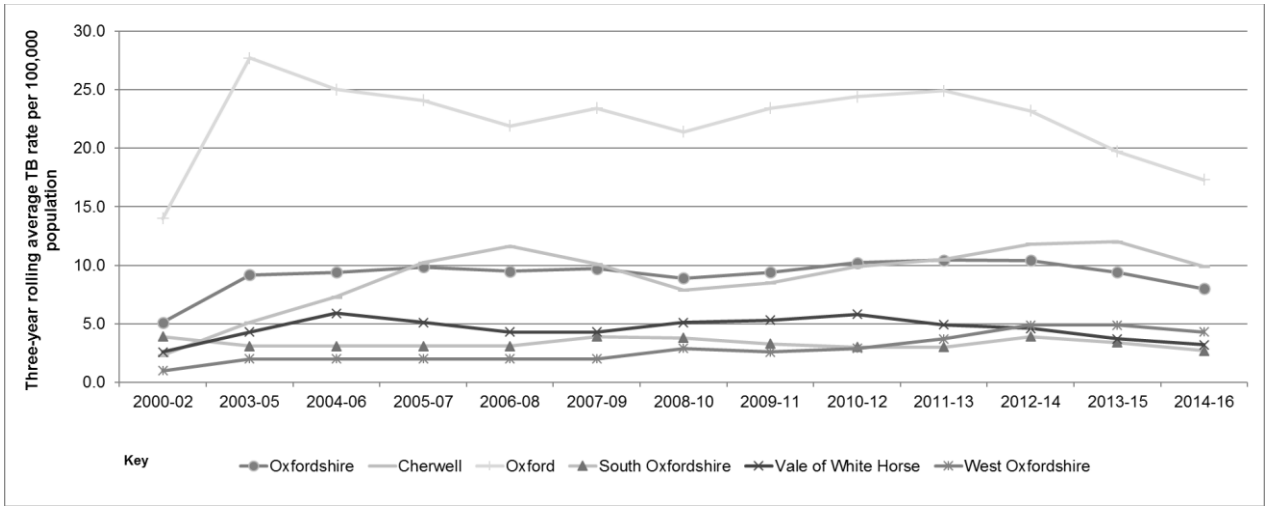
Public Health England (Health Protection Agency)

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 2014-16)



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

The levels of TB in the UK are continuing to show a reduction due to the ongoing coordinated efforts by TB control boards across England to improve TB prevention, treatment and control.

The rate of TB in Oxfordshire remains lower than the national average and is 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). This is reflected in the higher rate of TB in Oxford compared to other districts in the County.

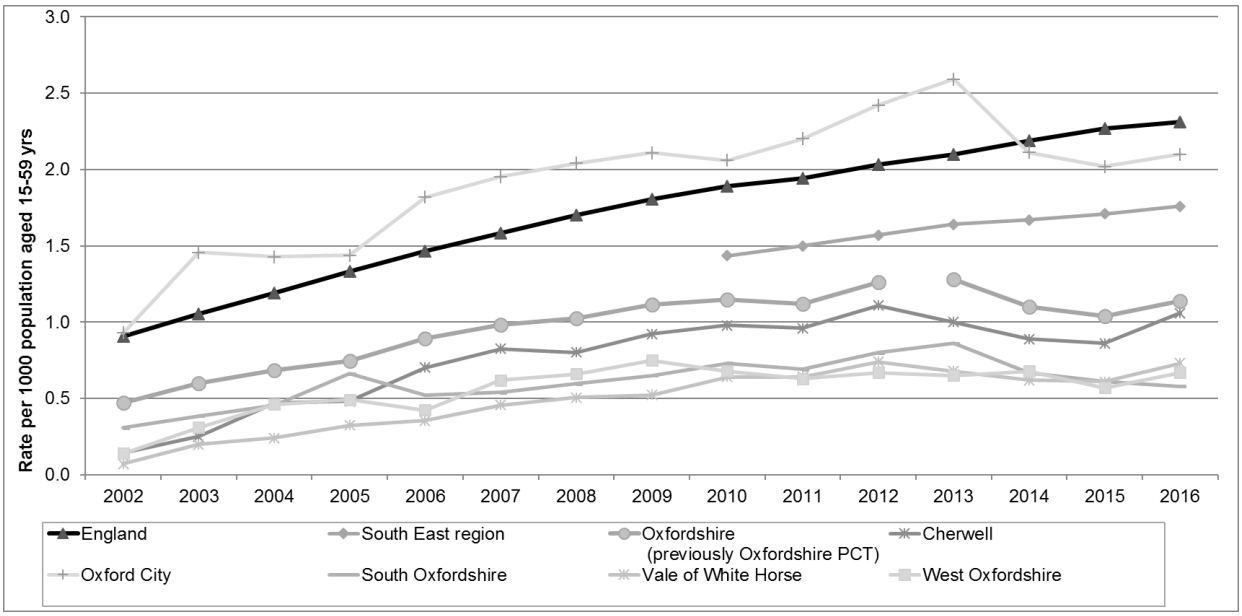
The National TB strategy which has been developed by Public Health England is beginning to realise a reduction in the levels of TB in England.

Sexually transmitted infections

HIV & AIDS

HIV does not raise public alarm like it did in the 1980s, but it 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 in health than previously expected by HIV carriers. As such we expect to have more people living with HIV long term. 2016 data shows that there were 463 people diagnosed with HIV living in Oxfordshire, 233 out of these 463 were living in Oxford City. This trend is shown in the chart below and shows another decrease this year across the County.

Percentage 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. 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. In 2017 the sexual health service provided 15,495 HIV tests.

- Through community testing. Local residents who are at high risk of HIV can now access a testing kit online which is part of a national service led by Public Health England. This increases convenience and accessibility of testing.

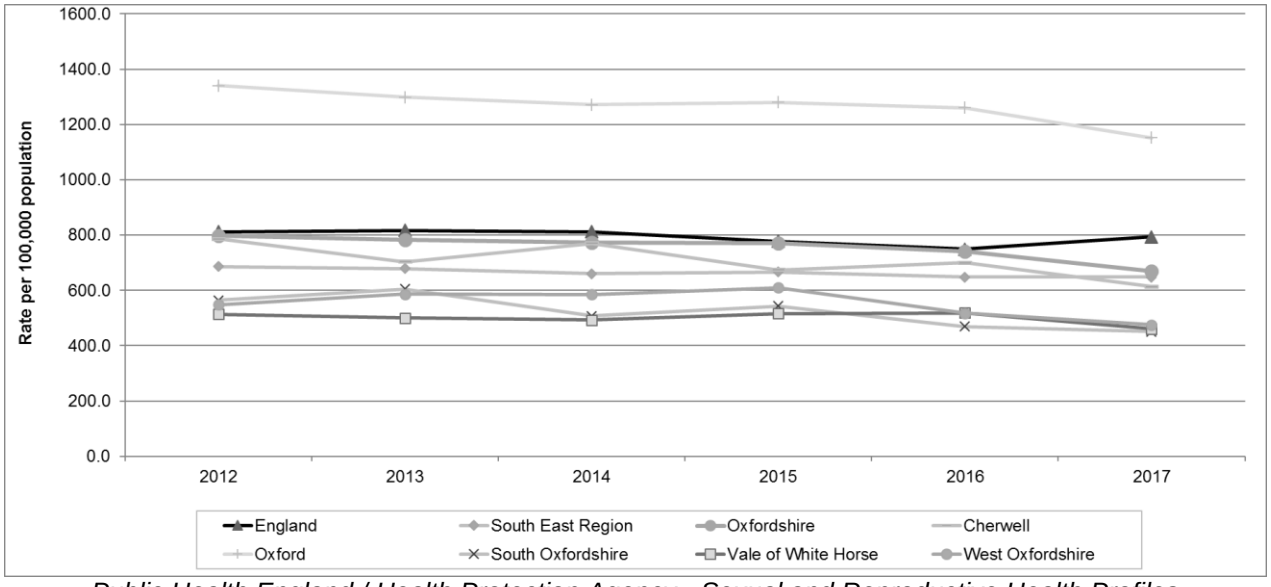
- Prevention and awareness. Educating the local population about safe sexual practices and the benefit of regular testing in high risk groups. The eligibility for accessing our condom scheme is available to men who have sex with men (MSM) and commercial sex workers, both groups being higher risk of contracting 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 decreased. The trial of using drugs to halt transmission in high risk groups (PrEP) is currently being conducted nationally by NHS England. Local services are part of this trial and residents who meet the criteria can take part. The outcome of this trial is expected in a couple of years.

Sexual Health

Sexually Transmitted Infections (STIs) are still fairly common 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 improved since 2013. The local picture is shown in the chart below.

All new sexually transmitted infections (STIs) rate per 100,000 population aged 15-64 years - 2012 to 2017



Public Health England / Health Protection Agency - Sexual and Reproductive Health Profiles

The different types of STI each show a mixed picture which is generally still good. Looking at each disease in turn gives the following picture.

- Gonorrhoea - Is below the national average for Oxfordshire overall and all districts except in Oxford City. The systems of testing which were introduced to reduce the number of false positive diagnoses has produced the expected decrease in the number of diagnosed cases.

- Syphilis - there was a slight increase which is in line with national activity. However, the rates are still below the national average in all Districts.

- Chlamydia - levels are lower than the National average in all Districts.

- 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 still declining rates. With Human Papilloma Virus vaccination programmes in place nationally we anticipate a decline in rates over the coming years.

- Genital Herpes – rates are similar to national average except in the City which has higher levels. Again, this reflects the predominantly younger population of the City.

The County Council's integrated sexual health service which began in 2014 continues to see good levels of activity and this is welcomed.

In addition to the integrated service our GP surgeries have provide contraception services and pharmacies have provide access to emergency hormonal contraception.

The established partnership of local organisations continues to work together to identify and address priorities locally to further meet the sexual health needs of Oxfordshire.

Recommendation

The Director of Public Health should report on progress of killer diseases in the next annual report and should comment on any developments.

Oxford Health
NHS Foundation Trust

REPORT FOR THE OXFORDSHIRE HOSPITAL OVERVIEW AND SCRUITNY COMMITTEE SEPTEMBER 2018

Situational Report Regarding Oxford Health Community Stroke Ward Co-Location

Summary

Following the decision to co-locate the stroke units onto a single site at Abingdon Community Hospital there has been improvement to the level of therapy provided to patients.
Workforce developments are continuing with the aim of providing a comprehensive workforce that aligns more closely with national recommendations. As anticipated, relocation to one site has provided the ability to recruit occupational and physiotherapists, and reduced vacancies. This has allowed us to treat more patients, enabling them to return closer to home sooner and is reflected in improved flow through the system.

Background

Oxford Health presented a case for change to the Health and Oversight Scrutiny Committee in late 2017. The change was proposed based on the premise that co-location of services from two, ten-bedded, stroke units based at Witney and Abingdon to a twenty-bedded unit at Abingdon, would provide a higher quality service for those patients requiring post-acute stroke rehabilitation in-patient care. The primary anticipated benefits broadly comprised:

- Dedicated geographical co-location to provide better focus on stroke rather than diluted with more general medical rehabilitation, and a more consistent approach to care

- Improved specialty stroke staffing levels by avoiding separation across two community hospitals in different towns
- Improved staffing increases the amount of therapy provided to patients, in turn leading to decreased length of stay and return closer to home more quickly.

Progress

Phase 1 of the project to manage the consolidation of the two stroke wards onto one site was completed on time and on budget by 15th February 2018. This included staff consultation across both wards and 16 beds were located on the original Abingdon stroke ward with four step down beds provided on Ward 2.

Phase two of the co-location project enabled the existing Ward 2 to be reconfigured internally to encompass all 20 stroke patients on one ward on July 13th 2018. Following completion of phase two the ward is now known as the Oxfordshire Stroke Rehabilitation Unit (OSRU).

The following tables and charts present data across several key quality standards and performance indicators to demonstrate the impact of the co-location. It should be noted that it is difficult to draw conclusions regarding statistical significance of this data due to the limited number of months available for interpretation.

Staffing levels

The number of vacancies across the staffing groups has dropped, except for nursing, where there is still a gap requiring substantive staff recruitment. This will be filled by long-term agency (agency staff who commit to working for a longer length of time). Whilst the position now looks more favourable, it should be noted that staff turnover required further recruitment and compromised the staffing of the ward in the short term. However, we anticipate that the situation is now more stable, especially in therapy.

During the staff consultation phase the Matron for Witney community Hospital wrote to staff informing them of the change and offering the opportunity to continue

providing stroke nursing by moving to the Abingdon ward. No nurses decided to transfer to Abingdon.

The Witney staff who did not move are working to provide nursing and therapy on the two wards that provide rehabilitation.

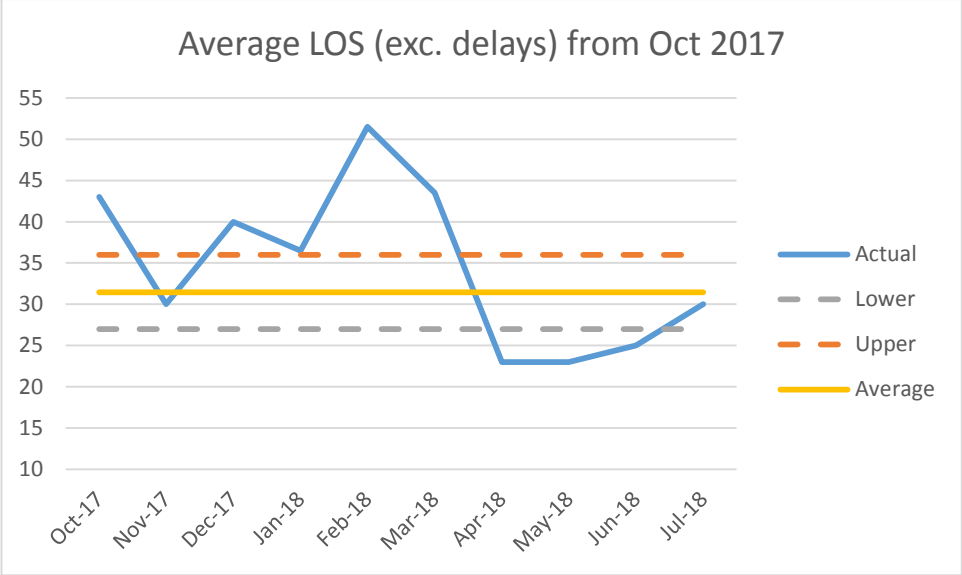
Staff group	Vacant posts prior to 16.02.18 (wte)	Vacant posts after 16.02.18 (wte)	Current vacancies
Nursing			
Registered nursing	3.22	3.22	5.2
Health care assistant	3.31	1.31	0.9
Therapy			
Physiotherapists	1.0	0.0	0
Occupational Therapists	1.1	0.5	0
Rehabilitation Assistant	1.0	0.0	0

There has been an increase in vacancies in registered staff. There are multiple factors related to this and reflects continued challenges nationally regarding nurse staffing. We are currently awaiting confirmation of offers to two non-registered staff that will remove the HCA vacancy gap.

Length of stay

Overall length of stay on the stroke ward (figure 1) has been reduced. Patients are receiving rehabilitation that enables them to reach their goals sooner, be discharged from a hospital bed and return to home earlier. The reduction in length of stay is mirrored by an increase in total number episodes of care delivered across this time period. Broadly, this suggests we have increased flow through the stroke unit by delivering more rehabilitation to more patients which in turn enables discharge of more patients from the ward.

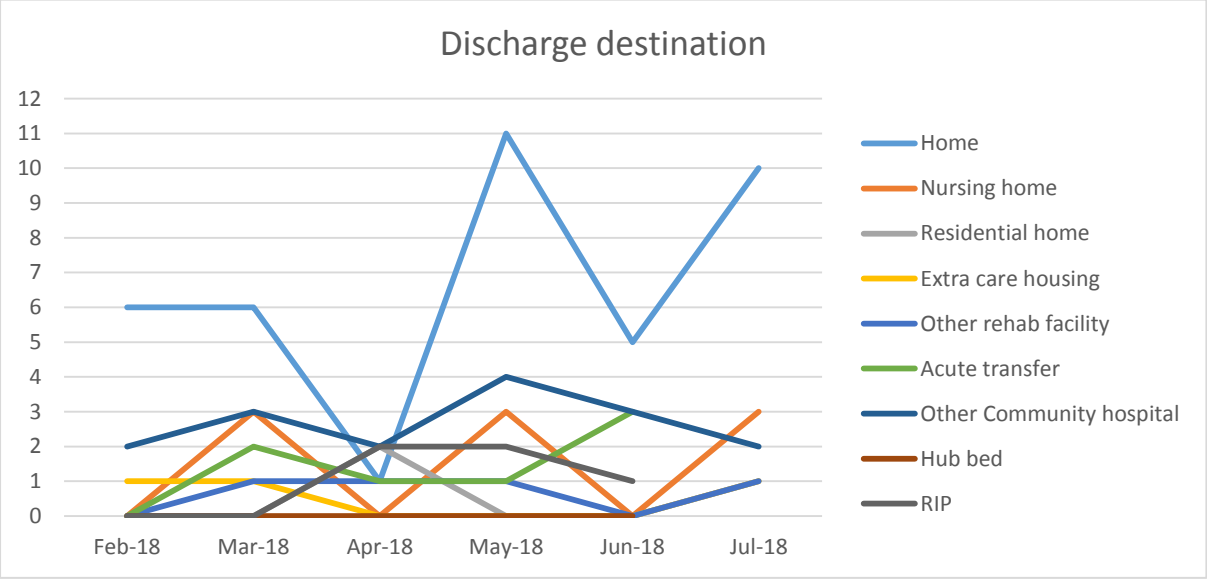
Figure 1.

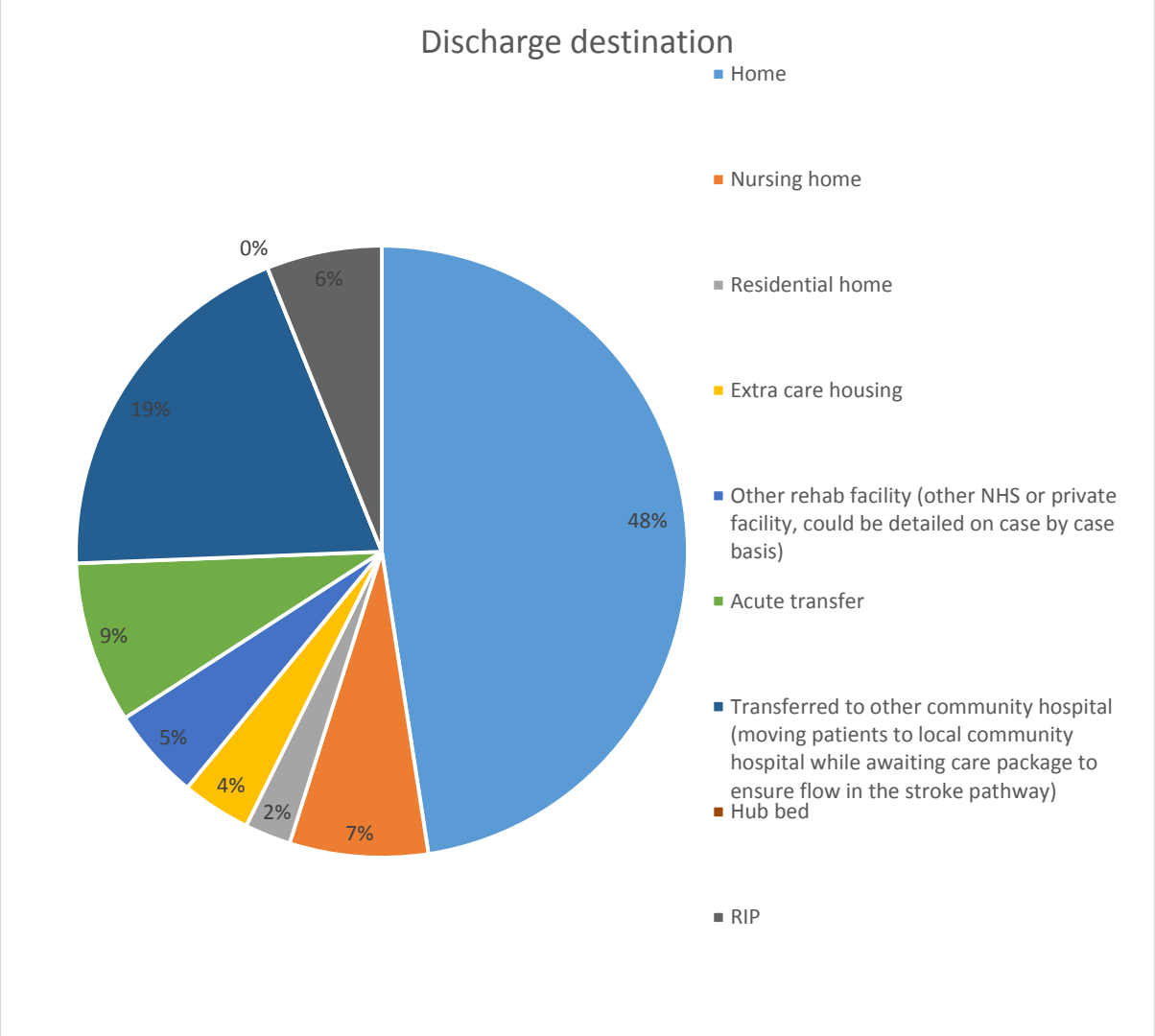


Discharge Destination

The following chart (figures 2 and 3) indicates the discharge destination for patients leaving the Oxfordshire Stroke Unit

Figures 2 and 3.





Outcome measures and quality of care

Barthel Index outcome measure

The Barthel Index (BI) consists of 10 items that measure a person's daily functioning, particularly the activities of daily living (ADL) and mobility. The items include feeding, transfers from bed to wheelchair and to and from a toilet, grooming, walking on a level surface, going up and down stairs, dressing, continence of bowels and bladder. The BI can be used to determine a baseline level of functioning and can be used to monitor improvements in activities of daily living over time.

The BI measure is used on the stroke unit to assess patients function on admission and at discharge. An increase in the score off 1.85 (out of 20) indicates an improvement in function. Evaluation of patient outcomes in the three months

following co-location has shown an improvement in the average increase of the BI score during admission. This indicates the patients are reaching a higher level of functional independence now as a result of increased therapy and rehabilitation focus on the ward (Figure 4 and 5).

Figure 4.

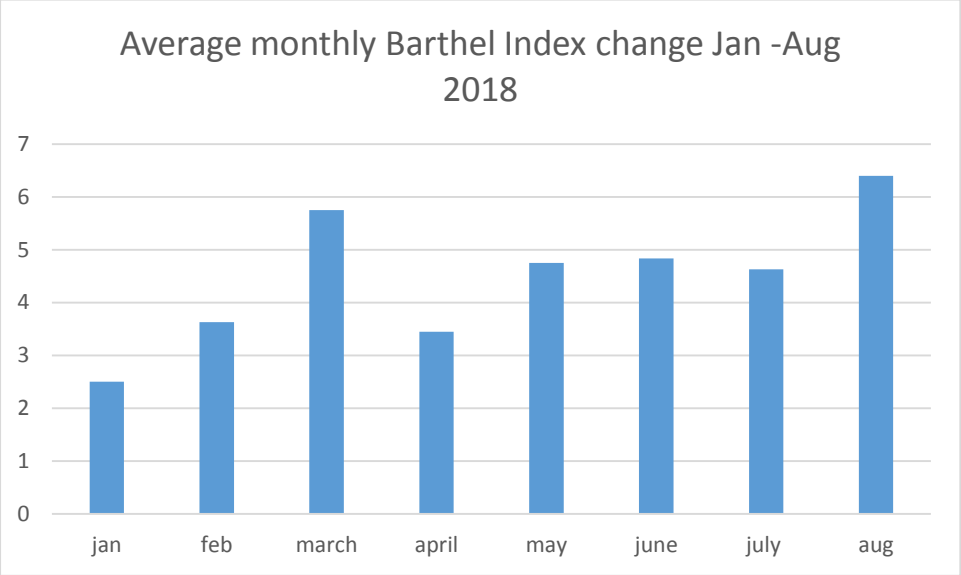


Figure 5.

Average improvement on Barthel index Jan-Feb 18	Average improvement on Barthel index Mar- Aug 18
3.06	4.97

Sentinel Stroke National Audit Programme (SSNAP) Performance

The SSNAP returns demonstrate overall rating of stroke care. Figure 6 below describes the latest SSNAP scores for the stroke unit at Abingdon April-June 18 alongside the previous scores. The most recent return shows an overall rating improvement from C to B

Figure 6.

Abingdon Community Hospital	Aug 17-Nov 17		Dec 17 - Mar 18		Apr - June 18	
	Patient centred	Team centred	Patient centred	Team centred	Patient centred	Team centred
SSNAP score	C		C		B	
Case ascertainment	A: 90% +		C: 70 - 79%		A: 90% +	
Audit compliance	D: 50 - 69%		B: 80 - 89%		C: 70 - 79%	
Total KI score	B	B	B	B	B	B
D1: Scanning	N/A	N/A	N/A	N/A	N/A	N/A
D2: Stroke Unit	A	A	A	A	A	A
D3: Thrombolysis	N/A	N/A	N/A	N/A	N/A	N/A
D4: Specialist Assessments	N/A	N/A	N/A	N/A	N/A	N/A
D5: Occupational therapy	A	B	A	A	A	A
D6: Physio therapy	B	B	A	A	A	A
D7: Speech and language	B	C	B	C	B	C
D8: Multidisciplinary team working	C	N/A	C	N/A	D	N/A
D9: Standards by Discharge	A	B	B	B	B	B
D10: Discharge process	E	E	E	E	D	

OCCG Key Performance Indicator Compliance

The following charts are extracted from the SSNAP team centred report and relate to the OCCG key performance indicators.

Figure 7.

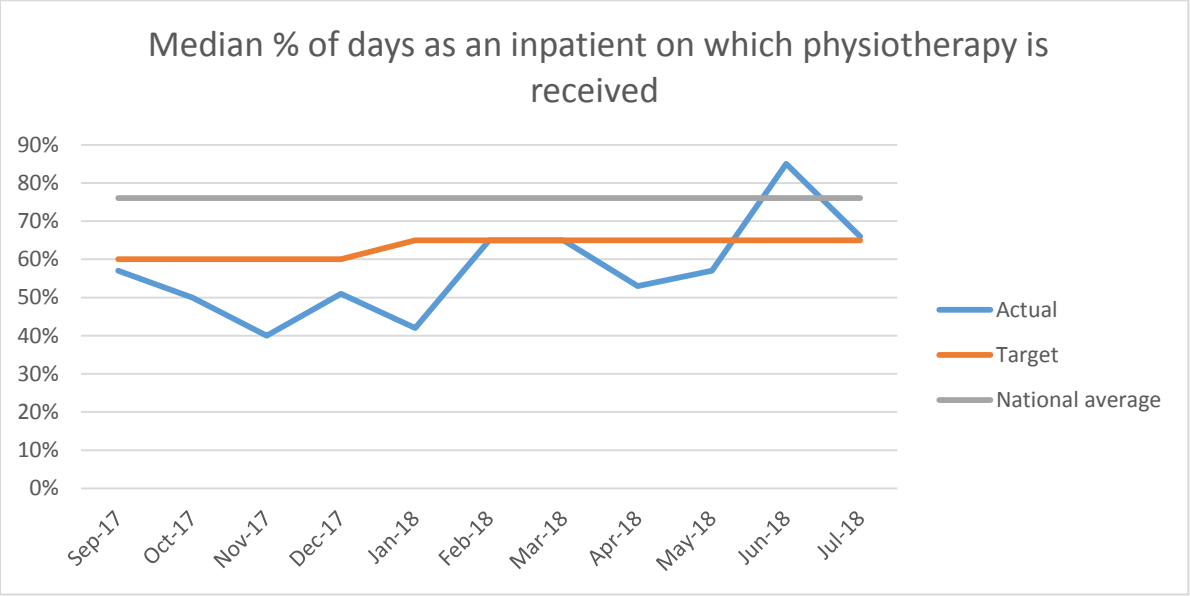


Figure 8.

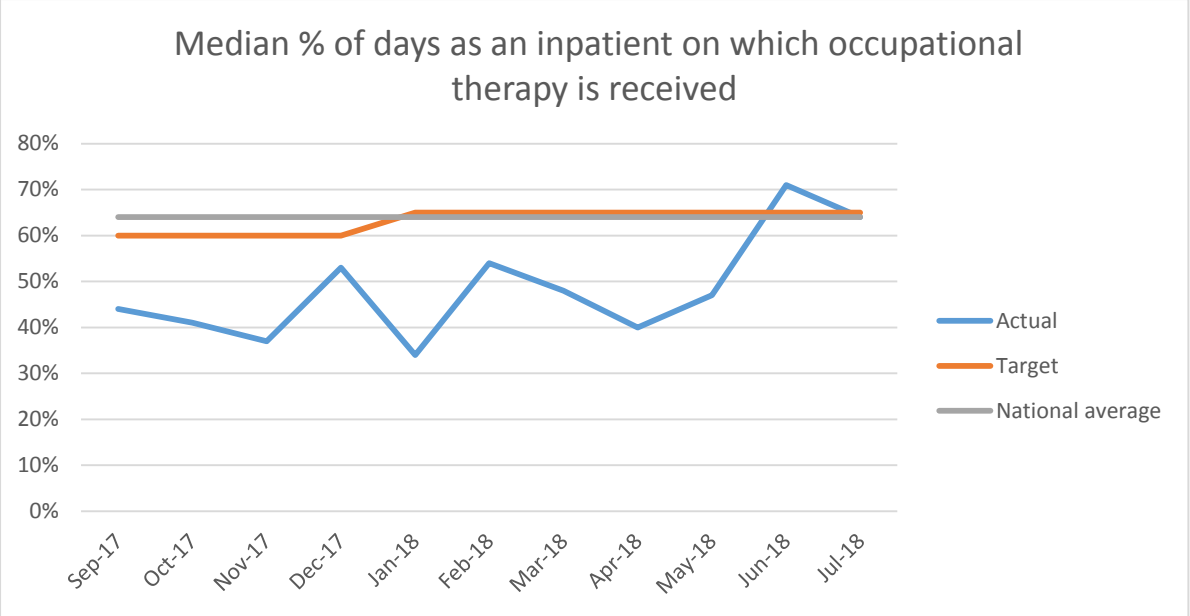
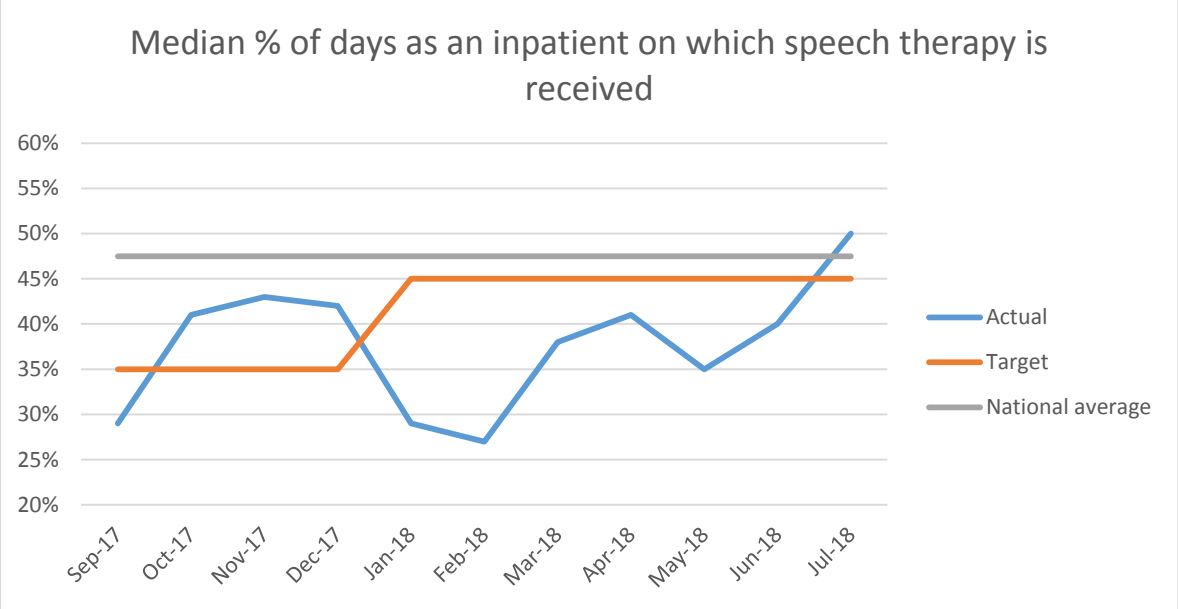


Figure 9.



The available SSNAP data indicates that the therapy teams are, in the majority, able to deliver the NICE Quality standard of 45 minutes of therapy but that the intensity (number of days delivered) needs to improve. The comparisons to national intensity for therapy in this reporting timescale is seen in Figure 10:

Figure 10.

Data from SSNAP Dec 17- March 18	Intensity of therapy (% number of days)		Median number of minutes treatment session	
	National	Oxford Health (Abingdon)	National	Oxford Health (Abingdon)
Occupational therapy	65	47.3	40	49
Physiotherapy	73	57.8	35	42.9
Speech Therapy	51	30.9	32	42.3

Patient feedback

The Trust collects patient feedback in the form of 'I Want Great Care' surveys. The latest feedback is attached as an appendix. The ward reviews this feedback in the team and quality meetings acting on any issues raised and shares all feedback with staff. In summary over 90% of feedback states recommendation of our stroke services, but with none stating that they would be "unlikely to recommend".

Analysis

The SSNAP return and the KPI data supports the clinically held view that the patients admitted to the stroke unit are complex and have high therapy requirements. The data demonstrates during that period there was improvement in the stroke therapy intensity and median minutes of treatment. The latest OCCG KPI data shows that this improvement continues and is likely due to the increased staffing profile and rehabilitation focus.

Future development

A multidisciplinary stroke improvement plan continues which aims to:

- raise the quality of clinical care
- improve patient outcomes
- increase performance of the team
- improve the overall SSNAP rating of the OSRU
- improve data collection/data clerk

The Stroke Quality committee meets monthly to review this plan and escalate as necessary to the senior clinical leadership. Close links already exist between the ward staff and the Stroke Association and further work is underway to strengthen the partnership working with carers and families. I Want Great Care is used to evaluate patient feedback and a summary of this feedback is in Appendix 1.

Conclusion

Following the co-location of the stroke units to Abingdon, we are able to rehabilitate more patients, with an increased flow through the ward, enabling patients to return home more quickly. Following our last attendance, evidence continues to demonstrate improvement, and confirms early findings. Patients are receiving more therapy in our beds than before, and this will continue to have a positive impact on outcomes. The co-location has allowed for a more sustainable workforce, albeit impacted by continued turnover requiring more cyclical recruitment than anticipated. This has particularly true for registered staff. A more settled staffing position and future plans will allow for continued service development improving quality of care further for the stroke patients of Oxfordshire.

We ask HOSCC to recommend that the provision of OHFTs stroke rehabilitation services provided at Abingdon community hospital is accepted as a substantive change.

Sara Bolton
AHP Professional Lead
Oxford Health NHSFT

Health Overview and Scrutiny Committee.
20 September 2018

Chairman's Report

1. HOSC Visit to the Churchill

1.0 On the 2nd of July 2018, four members of the Oxfordshire's Joint Health Overview and Scrutiny Committee (HOSC), took up an invitation from Oxford University Hospitals Foundation Trust (OUHFT), which was made at HOSC's February 2018 meeting, to attend the Churchill Hospital to visit its Cancer and Haematology Services.

1.1 HOSC's committee members were warmly welcomed at 'Maggie's Centre' at the Churchill Hospital, where they heard how the charity Maggie's offered non-clinical support and environment for cancer patients. Members noted how valuable these services are for Oxfordshire patients and that such support is not available in all places.

1.2 Committee members were shown around the Oncology and Haematology Outpatients service, the Day Treatment Unit, Radiotherapy Services and Early Phase Clinical Trail unit. All committee members noted the professionalism and humanity of the staff they encountered.

1.3 Members heard how the world-leading research of OUHFT and Oxford University is helping to understand more about cancer and cancer treatments; for patients now and in the future.

1.4 During the visit, committee members had the opportunity to understand more about some of the workforce challenges faced by the local health and social care system. This included uncertainty created by Bexit, the cost of living in Oxfordshire and local transport and parking issues. They also heard about some of the initiatives being used by OUHFT and partners across the system to tackle these issues. These included, investing in the back-office to free clinical and care staff from administration, using technology to help with more effective scheduling, being flexible with recruitment and where appropriate, increasing the use of chemotherapy at home.

1.5 All HOSC members in attendance personally thanked the team involved at OUTFT for the visit. The Deputy Chairman, Cllr Neil Owen then wrote a letter of thanks to the Chief Executive of OUHFT. This was duly acknowledged by Dr Bruno Holthof.

2. Letter from the Chairman

2.0 On the 31st of July, the Chairman wrote to request greater clarity by Oxfordshire Clinical Commissioning Group (OCCG) and Oxford Health Foundation Trust (FT) over the future options for Wantage Community Hospital and the likely timescale for such options to be available for public consultation. This letter is included in Appendix A.

2.1 The letter stated how at its meeting of the 21st of April 2016, HOSC recognised the closure of Wantage Community Hospital as a substantial change in service. The

Chairman recognised the changes regarding the planned transformation programme (as it was). However, given the committee's view of April 2016 and now having made that assessment more than two years ago and public consultation still outstanding on the issue, he requested greater clarity as a matter of priority.

2.2 The Chairman received a joint response from OCCG and Oxford Health FT (contained within Append B of this report), who committed to presenting a paper to the 20 September HOSC meeting that will set out the emerging framework they are proposing to follow in all localities in Oxfordshire; to determine the health and care needs of the population and how they can be met today and in the future. This approach will be evidenced based and include:

- population health and demographics review
- local assets mapping
- identification of good practice
- consideration of the impact of the Oxfordshire 'Growth Deal'
- options development and review.

.

2.3 OCCG and Oxford Health FT, recognise how public involvement and engagement will be critical throughout this approach along with the involvement of clinicians and care professionals. They intend to clarify that this work will be advanced and championed by commissioners and providers in Oxfordshire and owned by the Health and Wellbeing Board, with a strong sense of co-production at District level.

3. Health liaison

3.0 The Chairman and committee received briefings regarding the following issues, which are each summarised below.

Banbury Health Centre

3.1 This briefing was received from Oxfordshire Clinical Commissioning (OCCG) and circulated to the committee on the 28th of June 2018. It contained the following key information.

3.2 Banbury Health Centre, situated in Banbury town centre, provides services for its 6,186 registered patients and was providing bookable appointments for non-registered patients. It also provided extended hours 365 days each year 8am – 8pm.

3.3 The Health Centre is run by Principal Medical Limited (PML) under an Alternative Provider Medical Services (APMS) contract that was due to expire at the end of March 2018. This was subsequently extended until the end of June 2018 while Oxfordshire Clinical Commissioning Group (OCCG) and PML worked to ensure that there was continued provision of GP services from the Banbury Health Centre site after this time.

3.4 OCCG worked closely with the Patient Participation Group (PPG), listened to the views of local patients at Banbury Health Centre and conducted a travel survey. This engagement made it clear that the primary care services provided at Banbury Health Centre are highly valued by the local community and in a central location that benefits many patients.

3.5 OCCG worked with PML on how primary care services can still be provided from the same location for the foreseeable future. Subsequently OCCG let a new contract with PML from 1 July 2018 that means:

- From 1 July 2018, registered patients of Banbury Health centre will still be able to access primary care services at the Banbury Health Centre site during standard practice hours (08.00 to 06.30, Monday to Friday). They will also be able to access evening and weekend appointments in the same way that other practices do (extended hours and 'hub' appointments- some being commissioned from Banbury Health Centre until further services are developed at the Horton General Hospital- see below).

- As from 1 July 2018 Banbury Health Centre (BHC) will not be offering appointments to patients registered at other GP practices in Banbury. Therefore, patients registered to another GP practice who might previously have accessed Banbury Health Centre's extended hours or same day bookable appointments, will now be directed to contact their own practice where they are registered. They will still be able to access extended hours and hub appointments via their own practice. If they need help out of hours they will be advised to call NHS 111.

- Patients who are not registered with any GP in Banbury, and need to see a GP for urgent treatment, can be seen as a temporary resident at any practice in Banbury.

3.6 OCCG are now working with primary care, PML and the relevant partners in Banbury to explore the creation of a new, larger, unified General Practice in Banbury by integrating Banbury Health Centre with West Bar Surgery and Woodlands Surgery. If agreed, this change will occur later in the year.

3.7 OCCG are also seeking to bring NHS partners together to bring out of hours and A&E clinicians closer together at the HGH. Which may mean registered patients in Banbury are offered the choice of an appointment at their own practice, in a primary care access hub or, where appropriate, at the HGH.

3.8 Because there will be no significant changes for patients at BHC as once anticipated could be the case, a public consultation is no longer needed.

Cogges Practice

3.9 This briefing was received from OCCG and circulated to the committee on the 17th of July 2018. It contained the following key information.

3.10 Cogges GP Surgery is a small practice in Witney, with a patient register of approximately 7,700 people. Following the loss of two GP partners and without success in recruiting new partners, the with two remaining partners had been facing increasing difficulties in maintaining services at the practice.

3.11 The PPG and patients were reported to have been informed of the difficulties being faced by Cogges Surgery and its possible future.

3.12 OCCG stated that they were supporting Cogges in exploring their options, assisting in communications with the PPG and patients and until the partners made a decision about the future of the practice, they were unable to take any direct action. In the meantime, the CCG was undertaking background work preparing a thorough options appraisal, looking at the commercial case, strategic vision, service needs assessment, new models of care, state of the workforce and patients/public feedback.

3.13 The future of Cogges Surgery will be included in an update to the Committee at its meeting of the 20th of September 2018.

4. The Horton HOSC

4.0 Following an Oxfordshire CCG decision to permanently close consultant-led obstetric services at the Horton General Hospital, the decision was referred to the Secretary of State by Oxfordshire Joint Health Overview and Scrutiny Committee (JHOSC). As a result the Secretary of State and the Independent Reconfiguration Panel (IRP) deemed that further local action was required.

4.1 To respond to the IRP recommendations and establish a HOSC over the relevant patient flow area, Oxfordshire JHOSC agreed a proposal to establish a 'Horton Joint Health Overview and Scrutiny Committee' at its meeting on the 19th of April covering Oxfordshire, Northamptonshire and Warwickshire. All three county councils agreed the proposal in May 2018.

4.2 The first meeting of the new Committee will take place on **Friday the 28th of September 2018 at 2pm in Banbury Town Hall**. The membership of the new committee reflects the patient flow for the services under scrutiny and is politically balanced in-line with the upper-tier authorities with health scrutiny powers. There are ten places on the committee, with eight representatives (seven councillors, one co-opted member) being from Oxfordshire and one Councillor each from Northamptonshire and Warwickshire. The membership is therefore as follows:

Member	Member for	Party
Cllr Arash Fatemian	Oxfordshire County (Deddington)	Con
Cllr Alison Rooke	Oxfordshire County Council (Abingdon East)	Lib Dem
Cllr Barry Richards	Cherwell District Council	Lab
Cllr Fiona Baker	Northamptonshire County (Brackley)	Con
Cllr Kieron Mallon	Oxfordshire County Council (Bloxham & Easington)	Con

Member	Member for	Party
Cllr Neil Owen	West Oxfordshire District Council	Con
Cllr Sean Gaul	Cherwell District Council	Con
Cllr Sean Woodcock	Cherwell District Council	Lab
Cllr Wallace Redford	Warwickshire County (Cubbington & Leek Wootton)	Con
Keith Ruddle	Coopted	Non political

4.3 Oxfordshire HOSC will receive a summary from the first meeting of the Horton HOSC at its meeting in the Chairman's report for its November meeting.

5. Task and Finish Group

5.0 The HOSC Task and Finish Group on Musculoskeletal Services (MSK) met for the first time on the 13th of June. Due to timing of the publishing of papers for HOSC in June, the following was circulated to the committee via email to summarise the content and outcomes of that meeting.

- The Task Group met for the first time on the 13th of June, with Cllr Lovatt, Cllr Price and Dr Cohen from the Committee and representatives of OCCG and Healthshare (the existing provider of MSK services).
- The Terms of the Reference for the Group were confirmed, with the only change being in Cllr McHugh no longer being able to participate because of his new appointment on the Executive of Cherwell District Council.
- The meeting reviewed the history of MSK services, the development of a new service specification and a procurement process to appoint a new provider. Key messages within this are:

  - Services needed to change to address significant waiting times, to introduce an integrated approach and to improve patient experience and access.
  - Clinicians and patients were engaged in an extensive process to develop a new specification for MSK services.
  - The procurement process which followed was lengthy, complex and challenging. The process resulted in a new provider of MSK services in Oxfordshire.

- The transfer of services to the new provider has been impacted by legacy issues, including the hand-over of over 12,000 patient paper records.
- Early indications are that the new provider is reducing the wait for MSK services.
- Next steps for the Group will be:

- To hear evidence and stories from patients, patient representative Groups, GP's, an orthopaedic surgeon and previous providers to understand the full implications of the change in contract on patients.
- A further meeting with the CCG and Healthshare would be established in early November to allow the Task and Finish Group to see a full year's worth of performance information on the new contract.

- The output of the Task and Finish Group is proposed to be a jointly-presented item (HOSC Task Group and the CCG) at a full HOSC. The planned date for this is February 2019.
- The format will be a report written by the CCG on the MSK services contract background, existing service, evaluation and quality monitoring. The Task and Finish Group will also write a report on the findings of their evidence gathering. A third and jointly-agreed report will then pull together all of messages from the Group's work to make some clear recommendations to HOSC.

5.1 Following the meeting in June and the agreement to hear evidence and stories from patients, patient representative Groups, GP's, an orthopaedic surgeon and previous providers to understand the full implications of the change in contract on patients, two meetings have now been scheduled for the Task and Finish Group. During the meetings in September, the Group will be asking each party to reflect upon the following:

- Can you describe your current experience of MSK Services in Oxfordshire?
- Can you describe how your experience has been different in the past?
- From your perspective, what do you think works well about the service as it is being provided today?
- From your perspective, what do you think needs improving about the service?

5.2 Due to the timing of the publishing of papers for the September HOSC, a summary of the group's meeting on the 12th and 17th of September will be reported in the Chairman's report in November 2018.

Date: 31 July 2018

Oxfordshire Joint Health Overview and Scrutiny Committee
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Mrs Louise Patten
Oxfordshire Clinical Commissioning Group
louise.patten@oxfordshireccg.nhs.uk

Mr Stuart Bell
Oxford Health Foundation Trust
Stuart.bell@oxfordhealth.nhs.uk

Dear Mrs Patten and Mr Bell,

Re: Wantage Community Hospital

I am writing to request greater clarity by Oxfordshire Clinical Commissioning Group (OCCG) and Oxford Health Foundation Trust (FT) over the future options for Wantage Community Hospital and the likely timescale for such options to be available for public consultation.

On the 14th of April 2016, Oxfordshire Joint Health Overview and Scrutiny Committee (HOSC) members met with representatives to consider whether the following Oxford Health FT proposal contained within a toolkit assessment was a substantial variation in service:

- Temporarily close Wantage Community Hospital from June 2016 (due to the persistent recurrence of legionella in the hot water system in the hospital)
- Set aside the capital investment required for the plumbing works (in 2016/17 financial year)
- Delay commencement of the capital works until early 2017, once the public consultation is completed and the future use of Wantage community hospital is determined

Through the Chairman's report at its meeting of the 21st of April 2016, HOSC stated that it recognised the closure of Wantage Community Hospital as a substantial change in service. HOSC members noted the commitment by OCCG and Oxford Health FT and health organisations to a full transformation consultation which was planned for the autumn of 2016.

Wantage Community Hospital was closed for inpatient admissions from the 1st of July 2016. We understand this decision, taken by Oxford Health was on safety grounds in anticipation of a formal public consultation across the Oxfordshire health and care system which was due to conclude in spring 2017. On the 15th of September 2016, OCCG and

Oxford Health FT reported to HOSC that there would be a delay in launching the consultation and that the new date was early January 2017. By their meeting of the 17th of November 2016, HOSC were informed that consultation over proposals contained within the transformation programme would occur in two phases, with consultation over community hospital services, including the future of Wantage Community Hospital, coming in Phase Two of the programme. At this time, OCCG reported the consultation for Phase Two was planned for the beginning of May 2017.

It was not until the beginning of March 2018 that the NHS in Oxfordshire issued a joint statement from the System Chief Executives signalling a change to the approach to service transformation. This was reported to HOSC at its meeting on the 19th of April 2018 and was understood to have resulted from reflection on the experience of running Phase One of the Oxfordshire Transformation Programme and from CQC emphasis on better health and social care planning.

HOSC is supportive of the approach to better integration and the place-based approach outlined by OCCG during its meeting of the 19th of April 2018. The committee understands that local discussions to address the needs of the local population, taking into account geography and available services, is important to determine options for local provision. However, given the fact that in April 2016, the committee took the view that the closure of Wantage Community Hospital was a substantial service change and over two years has passed without public consultation on the issue, I am writing to you to address the future options for Wantage Community Hospital and the likely timescale for such options to be available for public consultation as a matter of priority.

At HOSC's meeting on the 21st of June 2018, the topic of Wantage Hospital was raised and OCCG tasked with outlining the timetable and framework for working with local communities to review local health needs, current and projected demographics and local assets to inform service change (including the physical assets, describing what population needs are, if significant change to services, have a duty to consult). There was also a request to outline how the closed beds in Wantage have been reallocated as was indicated would be the case to the committee back in April 2016.

I have asked that the above information be considered at HOSC's next meeting on the 20th of September 2018. During this item, I would like to understand the specific timeframe and consultation plan for developing options for the local area that includes Wantage Community Hospital.

I very much hope that you are able to share this information in September, so that we can ensure local health scrutiny continues to strengthen the voice of local people in the commissioning and delivery of health services in Oxfordshire.

Yours Sincerely

Cllr Arash Fatemian
Chairman Oxfordshire Joint Health Overview & Scrutiny Committee

Oxford Health NHS Foundation Trust

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20 August 2018

Dear Arash

Re Population Health Management approach to local planning (including Wantage Community Hospital)

Thank you for your letter of 31 July 2018 asking for greater clarity about the future options for Wantage Community Hospital and the likely timescale for such options to be available for public consultation. In the spirit of our integrated working we are happy to provide you with a joint response.

Your letter includes a useful summary of the history of the temporary closure of the beds at Wantage Community Hospital. As we have discussed before we think it is important that we move on in a different way and particularly ensure that this is taken forward by the NHS working with the Local Authorities through the Health and Wellbeing Board. In June we agreed to bring back to the September HOSC meeting:

Outline timetable/framework for working with local communities to review local health needs, current and projected demographics and local assets to inform service change (incl. physical assets – describing what population needs are – if significant change to services, have a duty to consult)

We will present a paper to the 20 September HOSC meeting that will set out the emerging framework we are proposing to follow in all localities in Oxfordshire; to determine the health and care needs of the population and how they can be met today and in the future. This approach will be evidenced based and include:

- population health and demographics review
- local assets mapping
- identification of good practice
- consideration of the impact of the Oxfordshire 'Growth Deal'
- options development and review.

Public involvement and engagement will be critical throughout this approach along with the involvement of clinicians and care professionals.

We will emphasise that this work will be advanced and championed by commissioners and providers in Oxfordshire and owned by the Health and Wellbeing Board, with a strong sense of co-production at District level. The 20 September HOSC meeting will be an opportunity to seek the views of HOSC members on this emerging approach. The paper will include an outline timetable for how this approach could be advanced in Wantage.

We are committed to providing safe services and we completely understand the frustrations of the local population but we have to balance getting this absolutely right in terms of analysis of both current and future population needs and public involvement. The approach we will follow in Wantage and needs based review will include analysis of bed requirements. We will emphasise that this can only be done as an integral part of the wider approach described above.

Our proposals are at an early stage; HOSC will have the opportunity to input before they are signed off by the Health and Wellbeing Board. We look forward to discussing this at the HOSC meeting on 20 September 2018.

Yours sincerely

Louise Patten
OCCG Chief Executive

Stuart Bell CBE
OHFT Chief Executive