Notice of Meeting Public Document Pack

Oxfordshire Joint Health Overview & Scrutiny Committee

Thursday, 8 July 2010 at 10.00 am
County Hall

Membership

Chairman - Councillor Dr Peter Skolar
Deputy Chairman - Councillor Susanna Pressel

Councillors:	Tim Hallchurch MBE	Neil Owen	Don Seale
	Jenny Hannaby	John Sanders	Lawrie Stratford
District Councillors:	Christopher Hood	Jane Hanna	Rose Stratford
Co-optees:	Ann Tomline	Dr Harry Dickinson	Mrs A. Wilkinson

Notes: ***There will be a pre-meeting for members of the Committee only at 9.00 am on 8 July.***
Date of next meeting: 16 September 2010

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 Dr Peter Skolar
E.Mail: peter.skolar@oxfordshire.gov.uk
Committee Officer - *Julie Dean, Tel: (01865) 815322*
julie.dean@oxfordshire.gov.uk

Tony Cloke
Assistant Head of Legal & Democratic Services

June 2010

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.

Health Scrutiny complements the work of the Patient and Public involvement Forums that exist for each of the NHS Trusts and Primary Care Trusts in Oxfordshire.

What does this Committee do?

The Committee meets up to 6 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 - 18)

To approve the minutes of the meeting held on 20 May 2010 (**JHO3**) and to note for information any matters arising on them.

4. Speaking to or Petitioning the Committee

5. Oxfordshire LINk Group – Information Share

10.15 am

To date, no items have been received.

6. Public Health (Pages 19 - 74)

10.45 am

This is the fourth Annual Report by the Director of Public Health (DPH) for Oxfordshire. It provides OJHOSC members with an opportunity to listen to and question the Director. Recommendations are made in the Report for all organisations and for the public. A copy of the report is attached at **JHO6.**

The aims of the Annual Report are:

1. To report on progress made in the last year and to set out challenges for the next year.
2. To galvanise action on five main threats to the future health, wellbeing and prosperity of Oxfordshire; and
3. To emphasise two strongly emerging threats to public health; namely those posed by dementia and alcohol abuse.

The five main long-term threats are:

- Breaking the cycle of deprivation
- An ageing population – the 'demographic challenge
- Mental health and wellbeing
- Increasing obesity
- Fighting killer infections

The threat posed by dementia is described in the chapter on an ageing population.

The threat posed by alcohol abuse takes its place as the sixth long-term threat to health.

Progress will be monitored in future reports. Long-term success will depend on achieving wide consensus across many organisations.

7. PCT Procurement Process - Townlands and Bicester Hospitals

11.45 am

Work has been going on for some time to develop new community hospitals in Henley and Bicester. This has included:

- Establishing a planning framework;
- Carrying out a number of surveys on the current sites;
- Looking at other site options in Bicester and work with key partners, including Cherwell District Council, on the wider developments in the area, such as the proposed eco town.

The PCT was going through the process of finding a developer to take on the work of re-developing the hospitals. However, legal advice led to a decision to restart the procurement process.

This item will give the Committee an opportunity to find out how this position was reached and what effect this delay will have on the future development of the hospitals.

Speakers will include:

Catherine Mountford – Director of Strategy & Quality at the PCT;

Councillor Ian Reissman, Chairman of the Townlands Steering Group (TSG). The TSG is the formal advisory Committee to the Henley Town Council. Membership comprises elected members; groups across and beyond Henley, business health groups, charities and church parishes around Henley; and

Dr Michael Curry, Chairman of the Bicester Community Hospital Engagement Forum

(CHEF) which was set up by the PCT to enable local people to have their say in the development of the new Bicester Community Hospital.

8. Dementia Diagnosis Pathway (Pages 75 - 132)

12.45 pm

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

In Oxfordshire, Quality and Outcomes Framework (QOF) data shows that 34% of people currently receive a diagnosis of dementia. Memory clinics exist , provided by both Oxford Radcliffe Hospitals Trust (ORHT) and Oxfordshire & Buckinghamshire Mental Health Foundation Trust (OBMHFT). There is currently no clear pathway and no agreed service specification, leading to uneven levels of service and post diagnostic support. There is confusion amongst GPs around where to refer a patient with suspected dementia.

Building on recommendations in the National Dementia Strategy, the proposal is to commission an integrated Memory Assessment Service involving both providers working together to maximise the strengths of both. The need for an increase in the numbers receiving a diagnosis and current capacity issues would be partially addressed by enabling a specialist dementia nurse to undertake routine follow up appointments, moving to follow up appointments into community settings, such as GP surgeries; and freeing up consultant time for diagnosis and more complex cases. Agreed information and support would be provided at, or shortly after, diagnosis.

Duncan Saunders, Service Development Manager for Older People's Mental Health at the PCT will present the business case, which is attached at **JHO8(a)),** and describe what consultation has taken place to date **(JHO8(b)).** The proposed Care Pathway for early diagnosis in Dementia, is also attached at **JHO8(c)).**

9. Chairman's Report

13.15 pm

The Chairman will report on the following matters:

- South central Ambulance Service NHS Trust review;
- Keeping People Well project group.

10. Information Share

13.25 pm

No items have been received to date.

Declarations of Interest

This note briefly summarises the position on interests which you must declare at the meeting. Please refer to the Members' Code of Conduct in Part 9.1 of the Constitution for a fuller description.

The duty to declare …
You must always declare any "personal interest" in a matter under consideration, ie where the matter affects (either positively or negatively):

(i) any of the financial and other interests which you are required to notify for inclusion in the statutory Register of Members' Interests; or

(ii) your own well-being or financial position or that of any member of your family or any person with whom you have a close association more than it would affect other people in the County.

Whose interests are included …
"Member of your family" in (ii) above includes spouses and partners and other relatives' spouses and partners, and extends to the employment and investment interests of relatives and friends and their involvement in other bodies of various descriptions. For a full list of what "relative" covers, please see the Code of Conduct.

When and what to declare …
The best time to make any declaration is under the agenda item "Declarations of Interest". Under the Code you must declare not later than at the start of the item concerned or (if different) as soon as the interest "becomes apparent".
In making a declaration you must state the nature of the interest.

Taking part if you have an interest …
Having made a declaration you may still take part in the debate and vote on the matter unless your personal interest is also a "prejudicial" interest.

"Prejudicial" interests …
A prejudicial interest is one which a member of the public knowing the relevant facts would think so significant as to be likely to affect your judgment of the public interest.

What to do if your interest is prejudicial …
If you have a prejudicial interest in any matter under consideration, you may remain in the room but only for the purpose of making representations, answering questions or giving evidence relating to the matter under consideration, provided that the public are also allowed to attend the meeting for the same purpose, whether under a statutory right or otherwise.

Exceptions …
There are a few circumstances where you may regard yourself as not having a prejudicial interest or may participate even though you may have one. These, together with other rules about participation in the case of a prejudicial interest, are set out in paragraphs 10 – 12 of the Code.

Seeking Advice …
It is your responsibility to decide whether any of these provisions apply to you in particular circumstances, but you may wish to seek the advice of the Monitoring Officer before the meeting.

OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 20 May 2010 commencing at 10.00 am and finishing at 3.25 pm

Present:

Voting Members:	Councillor Dr Peter Skolar – in the Chair
	Councillor Tim Hallchurch MBE Councillor Jenny Hannaby Councillor Neil Owen Councillor John Sanders Councillor Don Seale Councillor Lawrie Stratford Councillor Susanna Pressel (Deputy Chairman) District Councillor Dr Christopher Hood District Councillor Jane Hanna District Councillor Rose Stratford Ann Tomline Dr Harry Dickinson Mrs A. Wilkinson
Co-opted Members:	Ann Tomlin Dr Harry Dickinson Mrs Anne Wilkinson
Other Members in Attendance:	Councillor Alan Davies (West Oxfordshire District Council) as an observer.
By Invitation:	Councillor Aresh Fatemian
Officers:	
Whole of meeting	Julie Dean and Roger Edwards (Corporate Core)

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.

25/10 ELECTION OF CHAIRMAN AND DEPUTY CHAIRMAN FOR THE 2010/11 COUNCIL YEAR

(Agenda No. 1)

Councillor Dr Peter Skolar was elected Chairman and Councillor Susanna Pressel was elected Deputy Chairman, for the 2010/11 Council Year.

26/10 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS
(Agenda No. 2)

There were no Apologies for Absence and Temporary Appointments. Councillor Alan Davies, West Oxfordshire District Council, was present as an observer, Councillor Richard Langridge having submitted his resignation by virtue of his appointment to the Cabinet of West Oxfordshire District Council and there being no replacement appointment for him as yet.

The Committee congratulated Councillor Langridge on his appointment and thanked Councillor Langridge both for his very active and valued service on the Committee and in his capacity as Deputy Chairman for the previous two years.

27/10 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE
(Agenda No. 3)

Councillor Jane Hanna declared a prejudicial interest in Agenda Item 8 by virtue of her partner being a Finance Director of one of the voluntary bodies affected by the proposals. She remained in the room in order to make a statement relating to the proposals being scrutinised and then left for the duration of the discussion.

Dr Harry Dickinson declared a personal interest in Agenda Item 8 by virtue of him being Chairman of 'Mental Health Matters', a charitable organisation.

Councillor Jane Hanna declared a personal interest in Agenda Item 10 by virtue of her being Director of 'Epilepsy Bereaved', a charitable organisation.

28/10 MINUTES
(Agenda No. 4)

The Minutes of the meeting held on 11 March 2010 were approved and signed as a correct record.

Matters Arising

Minute 19/10 – Public Health – Immunisation Targets - in response to a question as to whether Public Health had reached a 100% target in respect of immunisation targets for killer diseases, Dr Habibula commented that the department had reached all of its targets for this area, but that 100% was 'almost impossible'. Dr McWilliam added that compared with other counties, Oxfordshire was performing well and that more stringent targets were planned for next year.

Minute 19/10 – Public Health – Screening for Bowel Cancer – In response to a request for an update on the bowel cancer screening programme, Dr Habibula reported that the programme had been rolled out from 26 April to the whole of Oxfordshire. Uptake had been quite slow at this stage with 8,300 invitations having been sent to date, with an uptake of 3,200. However, it was very early in the programme and the Department were planning an extensive planning campaign to raise awareness and improve the uptake.

Minute 20/10 - Oxford Drug Rehabilitation Project – Recommendation (b) – Mr Edwards reported that a letter had been sent to Oxfordshire PCT and the DAAT and that they had confirmed that the re - provision was to proceed. Members asked that they be kept informed of progress at each meeting until the matter has been resolved.

29/10 SPEAKING TO OR PETITIONING THE COMMITTEE
(Agenda No. 5)

The Chairman had agreed to the following people speaking to the Committee:

- Jacquie Pearce-Gervis representing 'Patient Voice' (a patient involvement body focussed on the Oxford Radcliffe Hospitals NHS Trust) (Agenda Items 5 & 9);

- Councillor Jane Hanna (Agenda Item 8);

- Dr Peter Agulnik representing a group of voluntary sector organisations (Agenda Item 8);

- Councillor Hilary Biles (Agenda Item 9);

- Dr Nixon, senior partner, Shipton under Wychwood Surgery (Agenda Item 9);

- Mrs Catherine Hitchins, spokesperson for the Patient Involvement Group, Shipton under Wychwood Surgery (Agenda Item 9);

- Councillor Larry Sanders (Agenda Item 12).

At this juncture Jacquie Pearce-Gervis addressed the Committee raising the following points:

- She informed the Committee that Patient Voice had been commissioned by the Oxfordshire LINk to carry out a survey of discharge procedures. To date they had received 42 responses, but would like more. She appealed to the Committee to encourage their constituents to support the survey as the delays were causing concern. Their findings were to be presented to the LINk on 24 June;
- With regard to Agenda Item 12, Oxford City Community Hospital, she commented that Patient Voice were concerned that the present accommodation was adequate, but rather 'squashed' and urged Community Hospital Oxfordshire and Oxfordshire Radcliffe Hospitals Trust to proceed towards a final proposal as soon as possible.

30/10 OXFORDSHIRE LINK GROUP – INFORMATION SHARE

(Agenda No. 6)

Adrian Chant, Oxfordshire LINk Locality Manager, together with two members of the Stewardship Group, Alderman Dermot Roaf and Richard Lohman, gave an update on recent Oxfordshire LINk activities. They reported as follows:

- The LINk had commissioned 'Patient Voice' to conduct a survey of discharge procedures at the John Radcliffe, the Horton and at the Churchill Hospitals (see Agenda Item 5 above) . A full report was expected by 24 June 2010;
- The recommendations emanating from the 'Hearsay' event planning process were currently being prioritised. The majority of the work concerned Social & Community Services and a report would be submitted to the Adult Services Scrutiny Committee on 6 June 2010. This could lead to a further event next year;
- In the meantime other projects in their programme were underway;

Richard Lohman, on behalf of the Oxford Drugs Rehabilitation Project, thanked the Committee for the letter which was sent to DAAT and to the PCT, as set out in Minute 20/10 of the last meeting. However he pointed out that the question relating to the lack of public consultation on the closure had not been addressed by the Committee. He added that Andrew Smith MP had written to the PCT to ask if consultation had taken place and they had responded that it was not justified because the Unit only treated 15 – 20 people per annum. It was **AGREED t**hat Roger Edwards be asked to write to Oxfordshire PCT requesting confirmation that the Unit would re-open by October of this year.

The LINk were asked to give Roger Edwards and Julie Dean early notice of the items to be discussed in their regular slot on the agenda, so that the appropriate Health officials could be invited to respond to the matters raised.

31/10 PUBLIC HEALTH

(Agenda No. 7)

Dr McWilliam brought the following topics for information:

- Vulnerable groups within Oxfordshire – Health Services for the Armed Forces and their families

  Officers were meeting with families, identifying any vulnerable groups, such as those needing dental care, those with post natal depression etc. He undertook to request one of his deputies, Jackie Wilderspin, to brief the Committee further on this liaison work;

- Cleanliness of Oxfordshire's Community Hospitals

  The Care Quality Commission had carried out an unannounced visit to Witney, Wallingford and Abingdon Community Hospitals on 19 May 2010 and had found that there were no breaches of standards. Apart from very minor improvements required, all the hospitals had been given a clean bill of health;

- Preview of the Director of Public Health's Annual Report – the following issues would receive prominence within this year's report:

    - Alcohol Abuse;
    - Work in progress between the Armed Forces on Oxfordshire and the Health & Well-Being Liaison Committee;
    - Diabetes.

Dr McWilliam was thanked for his report.

32/10 KEEPING PEOPLE WELL - RE-COMMISSIONING OF DAY SERVICES PROVIDED BY VOLUNTARY AND COMMUNITY SERVICES FOR ADULTS WITH MENTAL HEALTH PROBLEMS
(Agenda No. 8)

Prior to consideration of this item, the Committee were addressed by Councillor Jane Hanna and by Dr Agulnic. They each made the following points:

Councillor Hanna

- She spent four years as mental health lead during the course of her duty as non-executive director of one of the Oxfordshire PCT's. During this time she endeavoured to accrue as much information as possible on this highly vulnerable group of society;
- This Committee had a reputation for very careful scrutiny and she therefore hoped that its members would ensure that they were fully informed about the outcomes of service change for future and existing service users, when financial details were known;
- It was difficult to take a view at this time because there was an absence of key information in the form of the value of contracts going forward. It was understood that the specification for service suppliers was to be approved on 13 May;
- She hoped that an evaluation of the existing services would take place and that this would be an independent evaluation.;
- Much of the voluntary sector requires statutory funding; and
- A timeline with regard to the management of this process would be useful.

(Councillor Hanna left the room at this point for the duration of the consideration of this item)

Dr Agulnic (accompanied by Patrick Taylor, Chief Executive, MIND and Benedict Leigh, Director of Oxfordshire RESTORE)

- Was a retired psychiatrist who had worked for the Trust for 32 years, based at Littlemore Hospital;
- He had had a keen interest and involvement within the voluntary sector and had worked to represent some of the organisations listed on page 13 of the report;

- The county's voluntary services were lead agencies of a very high quality comprising models of good practice and innovation;
- Particular applications, such as day services which promote recovery and rehabilitation should be regarded as front line services as they have to meet some exacting standards of governance;
- A critical mass of core activity was maintained to meet objectives. Thus, small cuts in funding would threaten the survival of the organisation as a whole or, at best, would take years to repair;
- The above would put increased breakdown pressure on an already stressed service. It would serve to prolong illness, which would result in increased costs to the NHS service;
- A feature of Oxfordshire was close, collaborative working of which there was a strong voluntary contribution;
- He urged the Committee to support at least the maintenance of the current level of voluntary service.

Patrick Taylor and Benedict Leigh were invited to comment. Patrick Taylor commented that he had found the tendering process talks encouraging and that the current services were valued. Benedict Leigh added that one of the aims of his organisation was to help people back into employment, which ultimately saved the Government money. Any cuts would result in a small saving, but the long term implications would be dire.

In response to a question asking what the £2m funding was spent on, Mr Taylor referred to the services listed in the report, together with information services and Mr Leigh commented that the vast majority of the spend was on staff (80%).

Alan Webb, Director of Service Redesign, Fenella Trevillion, Head of Joint Commissioning for Mental Health and Ian Bottomley, Service Development Manager, Oxford PCT were invited up to the table. Alan Webb, introducing the report commented as follows:

- The PCT were committed to working with the voluntary sector who worked both in a complementary capacity and in the delivery of other services;
- The Health & Well-Being Partnership had produced a paper 18 months ago which described the current provider services and, whilst recognising that they were good, also recognised that they were not necessarily as integrated as they might have been. The PCT were therefore looking at a wide range of services, whilst keeping the wider Mental Health Strategy in mind.

Fenella Trevillion presented the main points of the report for the Committee. Members of the Committee asked a number of questions, some of which are included below:

Comments made by members of the Committee during the course of the discussion included the following:

- There is insufficient information. It would be useful to know the value of the contracts which are going forward;

- It may be a retrograde step that the new service will see the demise of some very good local services, particularly in the smaller towns and villages;
- Concentration on the geographical profile may be a red herring. The reason why they are concentrated on the Cowley Road is because that is where the users are situated;
- Mental Health sufferers can often feel quite isolated and the day centres help them with their communication skills and cooking skills etc;
- The Chinese Advice Service has a large membership;
- Most of the current funding focuses on the severe end of the illness. These proposals appear to be a change in focus to help those with milder illnesses – but would funding be redirected from the former to the latter. If this should happen the outcomes would be disastrous ;
- Poor service links to BME people and to the primary care sector do not appear to have been picked up in the proposals as they stand at the moment;
- If one FTE post is lost, then many more volunteers would be lost to the service.

The Director of Public Health commented that anything which improved services with regard to well-being and education would be a positive move. He added that one could not argue with commissioning on outcomes as long as one is commissioning for the right results. Although he gave the proposals, as far as they were known, a cautious welcome, he wondered where the 'human factor' would be in the light of the new 'business like' stance of the NHS and their partners. He praised Fenella Trevillian for her close work with the voluntary sector.

Alan Webb reported that the contract value had been reduced from £2m to £1.7m, adding that the PCT needed to work with the voluntary sector on what that would mean to the services and to give additional support if required. The intention was to increase throughput and people accessing voluntary services for a reduced amount of money. The focus of the services would be on local delivery, building on the Needs Assessment already carried out and also based on the Community Strategy. He added that there were significant numbers of volunteers in Oxfordshire, particularly in the Mental Health sector. With regard to the Committee's anxiety around the possible loss of smaller providers , sub-contracting would be actively encouraged and also joint bidding would be encouraged. It was hoped also that grant money would be accessed.

In response to concerns that money might be taken away from those with severe mental health difficulties in order to establish public health/community services, Mr Webb assured the Committee that funding for the acute mental health care services would not be affected.

Fenella Trevillion commented as follows:

- Very key service users were involved. Ian Bottomley had visited all current users who had expressed a wish to be involved. Moreover, carers and users sat on the Programme Board in order to feed in their views;
- People were aware of the changes and had been sympathetic to the adverse financial environment;

- The proposals encompassed a recognition that the geographical spread of services needed to be improved. Work was being done to assist people to retain their links with their community. There were a significant amount of services being delivered on the Cowley Road in Oxford which were very similar and therefore not a good use of resources;
- There would be a continuation of linkage to other services , however, there some dovetailing of services and linkage to key mainstream services would occur;
- Services for older people were being looked at within the aegis of 'Ageing Successfully' ie prevention.

Ian Bottomley responded to issues raised by the Committee concerning:

- Gaps in service for the Bangladeshi community and people of black minorities and ethnic background have been identified. There will be service specifications to state how that process will be managed. It was expected, however, that not all the services will be going to a community service provider;
- With regard to day service provision, there was no intention to abolish the peer support function. New buildings will not be commissioned, but creative thought will be given into different ways in which this could be given.

Whilst welcoming the very detailed discussions which had taken place with service users, members of the Committee continued to express their concern about the 20% reduction in funding for these services and the lack of information about where the cuts, reductions or reconfigurations would fall. It was this is mind that the Committee **AGREED** to

(a) thank Councillor Jane Hanna and Dr Agulnic for their addresses;
(b) thank Patrick Taylor and Benedict Leigh for attending the meeting;
(c) thank Alan Webb, Fenella Trevillion and Ian Bottomley, Oxfordshire PCT for their presentations and for making themselves available to respond to questions; and
(d) form a working group, comprising Dr Dickinson and Councillors Rose Stratford and Jenny Hannaby to work with the PCT commissioners to ensure that:

(1) the Keeping People Well service level outcomes were equitable, there was equity of access and that the current level of service was maintained and/or improved;
(2) that the process had been transparent throughout; and
(3) whether a full public consultation was required.

33/10 PHARMACEUTICAL NEEDS ASSESSMENT - COMMISSIONING PHARMACEUTICAL SERVICES ACROSS OXFORDSHIRE

(Agenda No. 9)

The Chairman invited Jean Nunn Price and Mary Judge up to the table to comment on behalf of Oxfordshire LINk. Jean Nunn Price reassured the Committee that the LINk continued to challenge the PCT, where appropriate, with regard to the proposals. Indeed, both herself and Mary Judge had been involved in service changes over the last two years which had included carrying out a Pharmacy Survey (which had been presented to this Committee by the PCT's Patient & Public Involvement Group) and sitting on a PNA Steering Group where challenges had been made on quantity outcomes, equity of location, opening times etc. Mary Judge commented that one of the issues from the survey had been the need for patients to have the appropriate facilities with which to discuss their needs privately.

Ginny Hope, Head of Primary Care Contracted Services, Oxfordshire PCT , introduced the paper (JHO9) on PCT commissioning intentions for pharmaceutical services and the revised Control of Entry Regulations process, which PCTs were required to apply to new applications when opening a new pharmacy. A consultation on the Pharmaceutical Needs Assessment was required prior to submission to the Board. The Committee were asked if they found the consultation process acceptable.

Prior to discussion on the above the Chairman invited Councillor Hilary Biles, local member for Chipping Norton, Dr Ahmed, Pharmacist, Shipton under Wychwood GP Surgery, Catherine Hitchins, spokesperson for the surgery's Patient Involvement Group and Dr Nixon, senior GP partner, Shipton under Wychwood Surgery, up to the table. At the same time he advised that it was not within the remit for the Committee to be involved in individual applications for the development of new pharmacies, it being more strategic in nature. However, whilst the matter was not directly within the Committee's sphere of activity, the PCT representatives had been advised that it may be raised at this meeting as an example of the complexities of planning pharmacy provision. It related to a recent decision of the PCT to give permission for the development of a new pharmacy in Shipton under Wychwood. At present, there was no pharmacy in the area, but the local GP surgery contained a dispensary. If the pharmacy were to be opened the, under current regulations relating to dispensing in rural areas, the surgery would lose the right to provide medicines to patients living within a 1.6km radius of the new pharmacy. They would still be able to dispense to any patients who were deemed to be in a rural area outside of the 1.6 km radius of the pharmacy. In this context the concept of a 'rural area' is one that has a population within 1 mile of the pharmacy amounting to more than 2750 people. Below 2750 was considered to be a 'reserved area' and the 1.6km regulation did not apply. The population of Shipton under Wychwood was 2,796.

Councillor Hilary Biles made the following points:

- The application affected 5k patients in what was a rural area;
- The PCTs decision meant the loss of a GP dispensing service to people living within 1.6kms of the surgery and a loss of income to the surgery;

- In her view the decision constituted a major service change and no consultation had taken place;
- She urged the PCT to look at current provision for patients living in the area, to conduct a patient survey and to reconsider their decision;
- She asked why the PNA had not been sent to district councils for their views;
- In her view the surgery's pharmaceutical provision would far outweigh the benefits which a new, independent pharmacy would bring, for example, the current provision offered a needle exchange service. She added that any profits were ploughed back into services for the community; and
- The support that current pharmacy gave to members of the community served to avoid the need for patients to go into acute care.

Dr R.Ahmed, Pharmacist, addressed the Committee stating that the proposed change would directly affect his business. The Pharmacy had introduced a number of changes and were working together with the PCT as a team in order to bring about the changes in the best possible way.

Catherine Hitchins put forward the following points:

- She understood that it was the duty of the PCT to provide Health and Social Care to the local community and to respond to local demand. It was also their duty to make the service accessible to residents;
- Currently, both able bodied and disabled residents had ease of access to the service. The surgery reorders medicines for collection at 8.15am or at 6.30pm each day. There was no closure for lunch. This helped to cut down on transport problems for older people or for young mothers in an area which has sparse public transport facilities;
- No discussion had taken place within the Parish and District Council and the local Patient Involvement Group. Furthermore those living outside the designated area had been ignored;
- The whole community and in particular the Local Patient Involvement Group, were gravely concerned at the potential loss of the facilities offered at the surgery; and
- The Patient Involvement Group were also concerned at the lack of attention given by the PCT to the views expressed by the public.

Dr Nixon commented as follows:

- There is a large proportion of high priority groups served by the current Pharmacy, which include older people and young mothers;
- The Pharmacy undertakes risk assessments on medicines and also gives health advice;
- The service given is confidential and staff often have a personal knowledge of the patients;
- The Pharmacy offers exceptional access to patients covering a 25 mile distance;
- He expressed his confidence that the service it gives results in lower referral rates;
- The Pharmacy also offers enhanced diabetic care.

At this juncture, Alan Webb and Ginny Hope informed the Committee that the application was not subject to appeal with the PCT, rather, to an independent organisation, namely the NHS Litigation Authority – Family Health Services Appeal Unit. The PCT was therefore unable to comment on individual applications. The DoH PNA regulations were due to come into force on 24 May 2010 and the PCT was thus bound by the current regulations. They pointed out that any decisions made by PCTs were subject to a strict formal process to accord with a Statutory Instrument, Pharmaceutical Regulations 2005. These also determined regulations for rural surgeries. They added that although dispensing income at GP practices had to be separate from GMS; in practice there were links, but they were not co-dependent.

In response to a question seeking information on whether there were regulations enforcing who to consult on applications, Ginny Hope responded that there was a requirement to notify interested organisations about applications. As a matter of course, notifications were sent to parish and town councils, to the LINk and other representatives of the public. Unsolicited responses were received from members of the public and these were taken into account when the PCT made their decisions.

Following a further question and answer session and discussion with regard to the PNA process and consultation, the Committee **AGREED** to:

(a) thank Jean Nunn-Price, Mary Judge of the Stewardship Group, Oxfordshire LINk, Dr R. Ahmed, Pharmacist, Shipton under Wychwood, Ginny Hope, Head of Primary Care, Contracted Services and Alan Webb, Director of Service Redesign, Oxfordshire PCT for attending the meeting;
(b) thank Councillor Hilary Biles, Catherine Hitchins, Patient Involvement Group spokesperson and Dr Nixon, senior partner of Shipton under Wychwood surgery for addressing the Committee;
(c) note that the Committee had no remit to intervene in the appeal process with regard to individual applications to set up a pharmacy; and
(d) note the project plan for the Pharmaceutical Needs Assessment process and consultation.

34/10 PARKINSON'S DISEASE - SERVICES TO OXFORDSHIRE PATIENTS
(Agenda No. 10)

Prior to the question and answer session with the invitees, namely Philippa Muir, Head of Specialist Commissioning and Clinical Networks, Alan Webb, Director of Service Redesign, and Sue Barnden, Service Development Manager, Oxfordshire PCT; and Dennis Morgan, Chair, Oxford Neurological Alliance, members of the Committee were addressed by Mrs Dickinson, mother of John Dickinson, who had made representations to the Committee on 16 July 2009 (Minute 42/09 refers) about alleged deficiencies in the service given in Oxfordshire Health services.

Mrs Dickinson informed the Committee that since July 2009, her son's treatment had not improved. She informed the Committee of a number of problems her son had encountered with the service and that they had lodged a formal complaint against the PCT and the ORH alleging a lack of leadership from within the Department, a lack of

support staff and that the wrong drug had been used during a Drug Challenge test. She summed up by stating the following:

- Despite reviews of the service extending over two years, there was still no specialised Parkinson's Disease nurse working exclusively for patients in the South and West Oxfordshire area;
- The part-time nursing post had not been extended to a full-time post;
- It was good news that the PCT had given £145k of funding for the neurological services, but it has come 3 years too late for her son;
- Her son had been refused a refund for travel fares to London for his treatment;
- Her son had disassociated himself from the services offered by Oxfordshire NHS , believing them to be of no relevance to the most vulnerable people of Oxfordshire.

Alan Webb, Philippa Muir and Dennis Morgan were invited up to the table. They put forward the following views:

- The PCT were aware of the anxiety and distress caused to Mr Dickinson had suffered and his views on the services in Oxfordshire;
- Discussions had followed questions raised by Mrs Dickinson at PCT Board meetings and there had followed an independent review and conciliation process;
- New information had now been brought forward with regard to the Drug Challenge Test and the PCT was working with Mr and Mrs Dickinson on it. There had been some progress made to improve these services but there was a need to ensure that services were available to all patients;
- Part of the Health Needs Assessment was about learning how many people were in treatment. This had been complemented by a service review which had been delegated to representatives from Health & Social Care and the voluntary organisations to do. A draft copy of this review had been presented to the Neurological Group last week;
- Funding had now been directed to the treatment of existing services and also to the commissioning of new services;
- On 12 May, the Local Implementation Group (LIG) comprising users, carers, voluntary and charitable groups looked at the draft service review. This Group, would be considering each commissioning model in July;
- There would be a formal consultation process carried out on the business plan.

The Committee asked a number of questions of Alan Webb, Philippa Muir and Dennis Morgan, some of which are included below:

Q <u>Is Mr Dickinson to receive some community support?</u>
R (AW) stated that he would if it is appropriate. There would be community staff support in the future.. The PCT was looking at how many services could be re-designed to become community based. They were looking to provide services where they were required and where there was no out-patient source.

Q Are there long delays for out-patients in hospital settings?
R (PM) was not aware of the numbers, but they are within the standard NHS requirements. She undertook to look at the Service Level Agreement and to report back to the Committee via Roger Edwards.

Q A Parkinson's Disease nurse appears to be the key player with regard to assisting patients and assessment, but the post is only part-time. Will more hours be given to the post?
R (AW and PM) stated that the nurse was engaged on a full-time basis, but 0.5 fte was devoted to research. The PCT were looking to address community support and assessment. This would be included in the Service Level Agreement which would be circulated to members of the Committee. The PCT were involved in genuine debate with service users about how best to spend the money to ensure that patients were within commuting distance.

Q The LIG meets in July, which is exactly 12 months since the issues relating to the service were scrutinised at this Committee. Do you have any concrete proposals for support Mr Dickinson? How quickly can you start the recruitment process?
R (PM) stated that a business case would be worked up, adding that the sooner the Neurological Group could produce a model, the sooner it would be that the service could be commissioned. The recruitment process could be started by the end of July if approval was given by the LIG.

Q If your data is not available, how will you reach the correct recommendations?
R (PM) stated that it had been decided on 12 May that the service review was not complete. The problem was that data on the numbers of patients was not recorded easily. The PCT were using the data from the North East Public Health Observatory, which is 200 pages long. There was very little information on hospital admissions, episodes etc. There was a need to get better in the future at collecting information.

The Chairman summed up by stating that the PCT had gathered a large amount of information to date over a significant period of time, but still nobody was in post. He added his hope that the PCT would look at the commissioning of Neurology services at the ORH in light of the lack of provision of appropriate services. Alan Webb responded that there was no clear cut answer to that as yet, though acknowledging that there was a need to 'push on' with efforts to get a service to work across the whole spectrum. To do this, knowledge from the neurological alliance was required. The Committee had been assured by Philippa Muir that this could be supplied.

Dennis Morgan assured the Committee that his organisation had been discussing service requirements with Philippa Muir and service users. The PCT had attended these discussions and had fed information back. The priorities identified were those which had been identified by the Oxfordshire LINk. His organisation were looking at models which would benefit patients at all stages, rather than at only one.

Philippa Muir was asked what would happen if no agreement was reached at the LIG meeting on 14 July. She responded that, to date, there had not been sufficient time to think about different models. The PCT did not wish to take a directional approach, but it was hoped that a decision would be made on that day.

The Committee **AGREED** to:

(a) thank Mrs Dickinson for her address;
(b) thank Philippa Muir, Sue Barnden; Alan Webb and Dennis Morgan for attending the attending the meeting and for responding to members' questions; and
(c) request Philippa Muir to communicate to Roger Edwards the outcomes of the Local Improvement Group's deliberations as soon as possible following the meeting and that he, in turn, be requested to relay these to members of this Committee.

Alan Webb undertook to develop some proposals on how to take this forward and to share them with the Committee.

35/10 FUTURE ORGANISATIONAL FORM OF COMMUNITY HEALTH OXFORDSHIRE (CHO)

(Agenda No. 11)

Matthew Tait, Director of Finance Oxfordshire PCT; Geoff Rowbotham, Chief Executive of Community Health Oxfordshire (CHO); and Julie Waldron, Chief Executive, Oxfordshire & Buckinghamshire Mental Health Care Financial Trust (OBMFT), attended the meeting in order to explain the situation with regard to a proposal to merge OBMFT and CHO as part of the Transforming Community Services (TCS) process. A report which had been prepared by Matthew Tait was before the Committee (JHO11).

Matthew Tait, Julie Waldron and Geoff Rowbotham all gave brief presentations on the paper.

Matthew Tait undertook to provide the Committee with a report, at the appropriate time, indicating whether the proposals would entail a major service change.

Matthew Tait was asked if CHO planned to involve the district councils in the creation of a Housing Programme. He was also asked what further action was required of the TCS process. He reported that currently they were still in the process of developing and reviewing where they wished to go in the future. To date they had seen effective engagement with OCC and the wider GP practices in relation to the prevention agenda. They now needed to go to the next stage, to the wider stakeholders to get further buy in.

Matthew Tait was also asked if he was expecting a similar thing to happen in Oxfordshire as had happened in London where the Secretary of State had halted the re-structure. He responded that Oxfordshire's was a major reconfiguration programme, but that it was not yet at the stage where there was a need to consider the full vision – also whether there would be reconfiguration programmes in certain localities. He added that currently they were taking a general approach to enhance the community services close to home to enable secondary care services.

The Committee **AGREED** to:

(a) thank Matthew Tait, Geoff Rowbotham and Julie Waldron for attending their attendance and for responding to members' questions; and
(b) request a further update on the situation in the new year.

36/10 OXFORD CITY COMMUNITY HOSPITAL (CITY COMM)

(Agenda No. 12)

Prior to consideration of this item the Committee received an address by Councillor Larry Sanders, a local member. He stated that the following issues should be given consideration in relation to Ox Comm. These were:

- With regard to medical cover, the staff were concerned about the rapid re-tendering which was required. He added that if the outcome of this was to hire cheaper suppliers, there would be less expertise available, less time available and the service could be less conveniently situated;
- Assurances should be given that there would be good continuity of service into the community;
- The situation with regard to the premises appeared to have been solved with the signing of a 7 year contract. The staff did not feel that this was a perfect solution, but that it was manageable. He was aware that many places that were suggested were not manageable;
- He declared that he was not 100% clear with regard to the delivery of a full service to the population of Oxford when 21% of patients would be non Oxford citizens. This was not a small figure. He asked if the situation could continue to be reviewed;
- Most community hospitals had lovely, communal gardens, something this hospital did not have, being urban in nature; and
- He asked if somebody would take the lead in the setting up of a functioning friends/supporters group.

Geoff Rowbotham, Chief Executive of CHO, Jonathan Coombes, and Dr James Price, Lead for Gerontology, Oxfordshire Radcliffe Hospitals NHS Trust, attended the meeting in order to present the paper JHO12 and also to respond to any question the Committee may have had.

Geoff Rowbotham introduced the paper commenting that a number of colleagues and organisations, including local GPs and the Oxfordshire LINk had all played a part in the proposals. They had challenged with three major questions:

- Would the quality of provision be improved, in light of the Oxcomm experience?
- Are 20 beds sufficient?
- Was there long term commitment to having a permanent community hospital within the City?

He took each in turn, commenting as follows:

Quality of Provision

Very good feedback had been received from patients and other links. There had also been very good support from colleagues at the ORH. The scores had indicated that they considered the environment to be good. The quality would be judged on whether they would be successfully rehabilitating patients and were getting them home within a particular period. Over 95% were within the period set for them.

Is 20 beds sufficient?

This had been discussed within the paper. He stated that it was currently it was believed that 20 was sufficient. On the privacy issue, male and female wards had been separated.

Commitment to having a community hospital within Oxford City environs

It was believed that it was the right thing to do to commit to a 7 year contract for people in the City. With regard to the question about whether it was in the right place, ideally it could be on a lower floor so that there could be direct access to the gym, but this could be worked around.

With regard to GP cover for the hospital, ideally local GP support would be best, but ORH facilities do give direct access to GP support. There is an intention to look at how the GPs might interface.

Comments put forward by members of the Committee, and responses received from the Panel, included the following:

- Is a capacity of 20 sufficient? There is still a problem with delayed discharge in the JR Hospital and there is also the problem of the ageing population. The Committee has already heard that the current accommodation is squashed. Geoff Rowbotham responded that 20 beds were considered to be right at the moment. A home environment was the preferred place for patients where they could be provided with the appropriate care. Dr Price added that some work previously delivered in the acute sector could safely be done in the community. Work done with some patients in their own home could free up the capacity to treat some patients in the community hospital who would previously have had to be admitted to the JR;

- City Comm might not be able to offer specialist facilities compared with the bigger community hospitals such as Abingdon – Geoff Rowbotham commented that there will be more opportunity to send people to other community hospitals for more specialised care;

- In Thame, local GPs had been priced out of the bidding for GP bed cover in the Thame Community Hospital, might this happen in Oxfordshire? Geoff Rowbotham assured the Committee that this would not happen. There was a standard approach in Oxfordshire to have a weighted tender process giving an obligation for the provider to use

local GP provision. He added that there was to be an announcement during the following week of who had won the tender contact for provision. Jonathan Coombes also added his assurance that the contract would ensure that a high quality medical cover would be delivered at the time that it was needed;

- What about future provision following 7 year contract? Geoff Rowbotham responded that there was indeed a 7 year commitment with the ORH, however a 1 year break clause had been included in the contract in case there was a need to relocate, within the City;

- Have you plans to set up a League of Friends, or similar? Jonathan Coombes undertook to ensure that a member of staff was tasked to set up a staff link between the staff and a League of Friends body.

In conclusion, assurances were given to members of the Committee that this was the correct model. City Comm had excellent diagnostic facilities and was a good, strong model overall. There was an aim to deliver the greater proportion of admissions locally, though there was a need to weigh up the pros and cons of this in relation to the condition of the individual concerned.

The Committee **AGREED** to:

(a) thank Councillor Larry Sanders for his address;
(b) thank Jonathan Coombes, Geoff Rowbotham and Dr James Price for attending the meeting and for responding to questions from members on progress in developing the new Oxford City Community Hospital.

37/10 CHAIRMAN'S REPORT

(Agenda No. 13)

The Committee noted reports given by the Chairman in relation to meetings attended with the following Health organisations:

- 'Catch Up' meeting with Sonia Mills, the new Chief Executive of Oxfordshire PCT and colleagues;
- Meetings relating to the Joint Review of the South Central Ambulance Service;
- Better Healthcare Programme Board meeting.

38/10 INFORMATION SHARE

(Agenda No. 14)

There were no matters shared under this item.

The meeting closed at 3.25 pm.

..... in the Chair

Date of signing .....

This page is intentionally left blank

Final version: 15 June 2010

DIRECTOR OF PUBLIC HEALTH FOR OXFORDSHIRE

ANNUAL REPORT IV

Reporting on 2009-2010
Recommendations for 2010-2011
Produced: May 2010

SUMMARY

This is the fourth Annual Report by a Director of Public Health for Oxfordshire (jointly appointed by the NHS and the County Council). The recommendations are made for all organisations in Oxfordshire and for the public.

The aims are simple:
1. To report on progress made in the last year and set out challenges for the next year
2. To galvanise action on five main threats to the future health, wellbeing and prosperity of Oxfordshire
3. To add an emphasis on two strongly emerging threats, namely those posed by dementia and alcohol abuse.

The five main long-term threats are:
- Breaking the cycle of deprivation
- An ageing population – the "demographic time bomb"
- Mental health and wellbeing: avoiding a Cinderella service
- The rising tide of obesity
- Fighting killer infections

The threat posed by dementia is described in the chapter on an ageing population.

The threat posed by alcohol abuse takes its place as the sixth long-term threat to health.

Progress will be monitored in future reports. Your comments are welcome as long-term success will depend on achieving wide consensus across many organisations.

Please direct comments to: ruth.fenning@oxfordshirepct.nhs.uk

I hope you enjoy the report and act upon it.

Dr Jonathan McWilliam
Director of Public Health for Oxfordshire
May 2010

CONTENTS

INTRODUCTION

What is the purpose of a Director of Public Health's Annual Report?
The purpose of a Director of Public Health is to improve the health and wellbeing of the people of Oxfordshire. This is done by reporting publicly and independently on trends and gaps in the health and wellbeing of the population in Oxfordshire and by making recommendations for improvement to a wide range of organisations.

The role of the Director of Public Health is to be an independent advocate for the health of the people of Oxfordshire.

The Director of Public Health's Annual Report is the main way by which Directors of Public Health make their conclusions known to the public.

This is the fourth Annual Report by a Director of Public Health appointed jointly by local government and the NHS. This report attempts to build on the momentum generated by the first three which were generously received by a wide range of audiences.

What is the thrust of this particular Annual Report?
This report aims to keep the spotlight firmly on the five main long term threats to public health by reporting on progress made in the last year and by making recommendations for next year. The main threats are:

- Breaking the cycle of deprivation
- An ageing population – the "demographic time bomb"
- Mental health and wellbeing: avoiding a Cinderella service
- The rising tide of obesity
- Fighting killer infections

Sound progress is now being made across the county on these five areas.

It is now timely to emphasise two new threats which are emerging, namely those posed by dementia and alcohol abuse.

The threat posed by dementia is described within the chapter on an ageing population.

The threat posed by alcohol abuse is set out in a new chapter 'Alcohol: What's Your Poison' making it the sixth current major threat to the public's health.

Public Health – everyone's business
Good health and wellbeing are not created in a vacuum. Good health is closely related to a wide range of factors such as employment, quality of neighbourhoods, quality of schools and having a part to play in society. These factors are, in turn, linked to issues of housing, skills and employment and all contribute to the general economic prosperity of the county. **In addition, to make a difference, it is necessary to focus on the same topics for a number of decades to make sustained change.**

For these reasons, the recommendations made in this report are long-term and wide-ranging and are not confined to traditional areas such as health services and social care.

The Contents of this Report
The first chapter takes an overview of general progress made during the last year.

The following six chapters concentrate on progress made on the six major threats. Recommendations for improvement are made at the end of each chapter.

Progress against recommendations will be reported each year and, in this way, this document has been designed as a tool to be used and built upon the year on year. I hope you enjoy it and act on it.

Dr Jonathan McWilliam
Director of Public Health for Oxfordshire
May 2010.

CHAPTER 1: Progress Report 2009/10: A Year In The Life Of The Public's Health

2009/10 was a momentous year for the public health of Oxfordshire. Among many other highlights, we tackled the flu pandemic, took active steps to tackle deprivation, completed work to give our immunisation systems a much-needed overhaul and made steady progress on all of the major threats to the public's health and wellbeing.

This chapter summarises gains made and areas of concern in improving public health and the areas of concern in Oxfordshire during the year 2009/10. It starts with the gains and then describes the concerns.

Evidence of Gains in the Public's Health

The Battleships are lining up!

Previous reports have stressed the fact that all of the major threats to the public's health require joined-up action by statutory agencies because **no one organisation can do it alone**. This has been likened to lining up battleships so that all move in a single direction as a single fleet against a common enemy.

Reviewing evidence of progress made over the last 3 years shows clearly that this is happening. In particular, gains have been made over the past year on work to help older people and the mentally ill as well as tackling long term problems such as deprivation and dementia. This is encouraging. It will take more years of determined perseverance to make a lasting difference, but gains can clearly be seen and are noted throughout this report. The challenge now is to keep this focus, develop clear action plans and define clear milestones so that we can measure our progress en route to long term success.

The Swine Flu Pandemic

It may seem strange to see the flu pandemic as a gain, given the suffering caused. There were, however, undeniable gains made in our ability to get organised to fight major public health threats. For example, we now know our emergency plans work; we now know how to run national call centres in health emergencies and we now know how to run mass vaccination programmes. All these things are significant gains. The flu pandemic forced the grasping of many nettles at national level with good success. This is to all our benefit. More detail is given in chapter 6.

Immunisation of children continues to improve

During the year the proportion of children vaccinated against serious infections continued to rise, with Oxfordshire's rates some of the best in the country. For example, for children aged two, most vaccination rates in the county were among the top 20 in England (out of 152 Primary Care Trusts), with over 9 in 10 children immunised. The increase in rates has been helped by significant improvements in the way data are collected so that individual children who miss their injections can be followed up more easily. For most vaccinations it is important to reach as many people as possible to reduce the risk of the infection spreading in the community.

Bowel Screening

Bowel Screening began in Oxfordshire. A service for residents living around the Horton General Hospital became operational in January 2010, followed by the rest of the County in April 2010.

About one in 20 people in the UK will develop bowel cancer during their lifetime. It is the third most common cancer in the UK, and the second leading cause of cancer deaths. In Oxfordshire around 93 new cases are diagnosed each year in 60-69 year olds. Regular

bowel cancer screening has been shown to reduce the risk of dying from bowel cancer by 16%.

The programme offers screening every two years to all men and women aged 60 to 69 with 40,918 people in Oxfordshire due for screening between 22/01/2010 and 21/01/2012.

Screening consists in the first instance of a postal test kit for blood in the stool. Around 98 in 100 people will receive a normal result and will need no further investigation. Around 2 in 100 people will receive an abnormal result. They will be referred for further investigation and usually be offered a detailed examination of the large bowel using a flexible hi-tech camera (colonoscopy).

Superbugs in decline

Methicillin Resistant Staphylococcus Aureus **(**MRSA) infections of the bloodstream continued to fall. Over the last 3 years the number of cases fell from 50 cases, to 43 cases, to 32 cases. During the year, people going to hospital for surgery have had their skin tested for MRSA before admission. If MRSA was found, people were given an antibacterial wash to get rid of the bugs. This has helped bring the number of cases down. Tightening up on the use of catheters has also helped.

Infections caused by *Clostridium difficile* (*C.diff*) have also reduced dramatically with 325 fewer cases occurring in 2009/10 compared to 2007/08. (2007/08 826 cases; 2008/09 533 cases; 09/10 500 cases) This has been brought about by improving antibiotic prescribing, improving the speed of isolation of suspected cases and improved cleanliness in hospitals.

More pregnant women say 'I quit'

Giving up smoking is the single best thing you can do for your health. The Oxfordshire Smoking Advice Service has strengthened its service to pregnant women to good effect. A specialist now provides intensive one-to-one support for pregnant smokers and their partners. Support continues throughout the pregnancy and up to six months after the baby is born. Alternatively pregnant smokers can access NHS stop smoking services in GP practices, Children's Centres and some pharmacies. In addition a weekly stop smoking clinic is held at the Horton Hospital in Banbury. Details are given in chapter 3.

Praise from the (former) Home Secretary for work to reduce alcohol related harm.

The use of information from the Emergency Department in the John Radcliffe to help police and others to reduce City Centre violence won plaudits from the former Home Secretary in a visit to Oxford in February 2010. Alan Johnson praised the strength of partnership work and commended Oxfordshire as a national leader. Information on where and when people get injured in fights or accidents is now collected alongside Ambulance pick-up data and crime statistics to help action planning. Direct results have included closure of some pubs and clubs or changes to licensing conditions requiring drinks to be served in plastic glasses. Taxi queues are now marshalled at particular times to prevent flare-ups. There was also extra praise for work done in following up people who had been injured when drunk – an effective way of helping them to change their behaviour and prevent repeat incidents

'6 Chiefs' fight deprivation in Banbury and Oxford

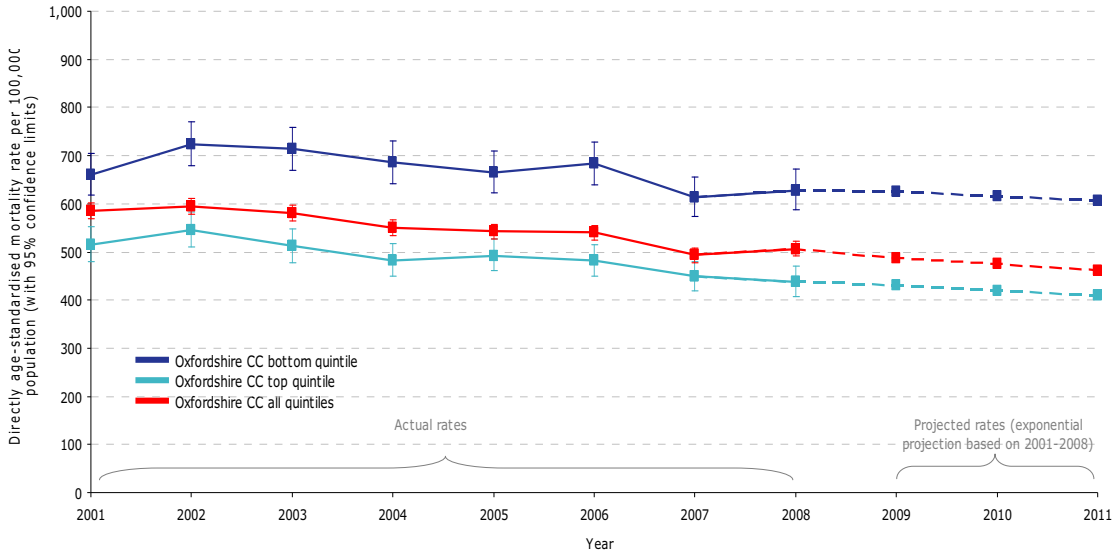
The Chief Executives of Oxfordshire County Council, Oxford City Council, Cherwell District Council , Oxfordshire PCT, Thames Valley Police (Oxfordshire) and Oxford and Cherwell Valley Colleges joined together to find a lasting way to tackle deprivation in small areas of Banbury and Oxford (see Chapter 3). The work will include a focus on helping families with young children to get a better start in life. The initiative was awarded £1 million of grant money to kick start the work…….. but there is a long way to go and final success will take years rather than months.

Areas of Concern in the Public's Health

The Inequality Gap widens slightly

Each year we measure what we call the inequality gap in Oxfordshire. The graph below compares death rates in the populations who live in the most deprived 20% of localities in Oxfordshire with those who live in the least deprived 20% (i.e. roughly the best and worst off).

Figure 1.1: Trend in all-age, all-cause mortality rates for Oxfordshire CC most and least deprived quintiles of Lower Super Output Areas, 2001-8 (actual) and 2009-11 (projected)



The solid top line on the chart shows the trend in death rates for the worst off up to the end of 2008. The dotted line predicts what might happen in the future. Overall death rates for this group are falling, though in the last year there was a slight upturn.

The bottom line on the chart shows the trend in death rates for the best off 20% of areas. Here too you can see a general reduction in death rates, and these continued to fall in 2008.

The middle line on the graph shows the average for the whole County.

The gap between the top and bottom lines is the 'inequality gap' and we can see that this latest data shows that, **the inequality gap in Oxfordshire widened**. This data is limited as it only reflects the position 18 months ago It may be a 'blip' and the measures put in place during the last year may improve the situation, but we need to continue to monitor these trends vigilantly.

Rates of cervical screening in younger women are too low

Cervical screening is an effective way of detecting and treating cancers of the womb neck at an early stage, significantly reducing the chance of illness and death among women taking part in the programme. Although the overall uptake rate for women eligible for cervical screening – around 4 in 5 women (80%) – is satisfactory, the rate in women aged 25-49 is around 10 per cent lower. We are working hard to raise awareness of the benefits of screening in this age group, to reduce women's risk of developing cervical cancer in the county.

Childhood Obesity is on the increase

Data collected on Oxfordshire's schoolchildren showed that the 2009 cohort of children is more overweight and obese than 2008's cohort. The data shows a significant rise in reception age children being overweight and obese compared to 2008 Oxfordshire data. This is also the first time that our local data has been worse than the national figures. The detail is given in chapter 3 and the proposed action is in the chapter 5 which is dedicated to the topic of obesity.

CHAPTER 2: Older People and the Demographic Time Bomb

What is the Issue and Why Does It Matter?

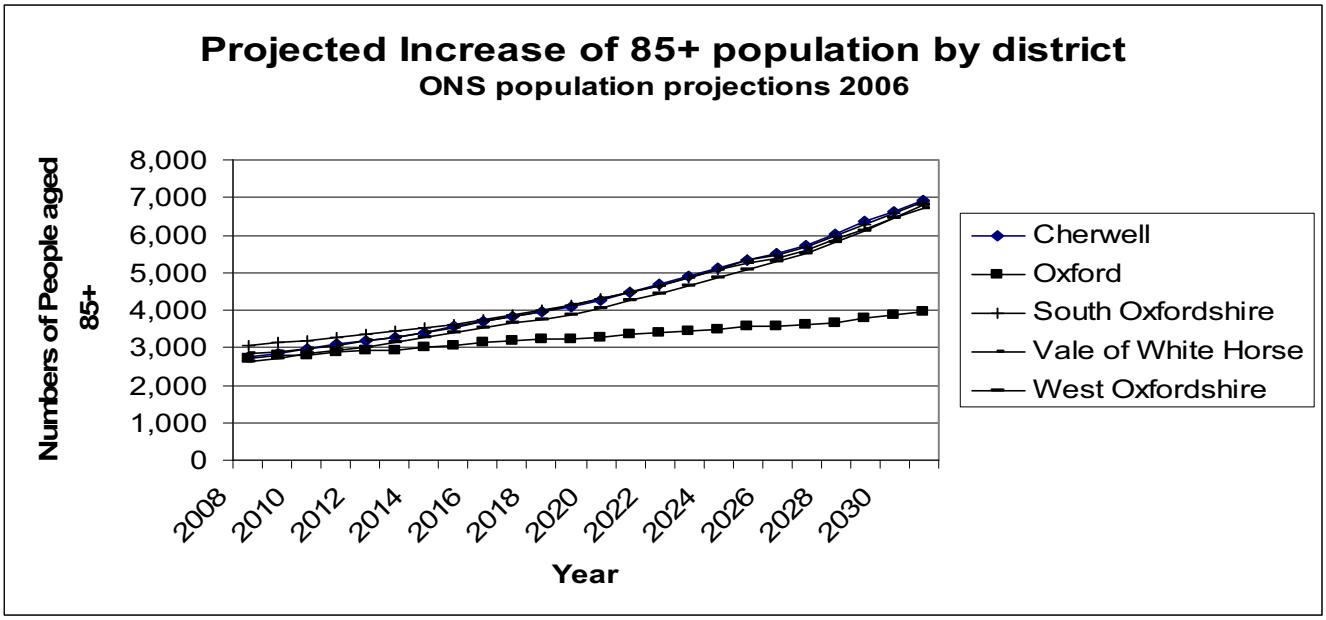
The growth in the number of older people in Oxfordshire is now universally accepted as one of the major challenges to the wellbeing of this county.

The reasons for this are well worth repeating. They are:

- The number of older people is increasing, particularly over 85s.
- The proportion of older people in the population is increasing. The working population will be increasingly stretched to fund public services for the retired.
- The increase will be uneven across the county. By 2029 people aged 85+ will increase in number by around 150% in Cherwell, Vale and West Oxfordshire, by around 125% in South Oxfordshire and by around 70% in Oxford City. This is an example of an inequality that hits rural areas hardest.
- The impact on services will be severe. The current range of services we provide will simply not be affordable.
- Because the proportion of younger people in Britain is falling compared with older people, demand for informal care for older people is predicted to exceed supply within the next ten years – by 2017.
- **There is increasing concern at both national and local levels about the challenges posed by the growing number of people with dementia in an ageing population. The issues are set out in a separate section within this chapter.**

The effect of the 'timebomb' is illustrated in the graph below. It shows the rise in the numbers of people aged 85 and over in the 5 Districts of Oxfordshire. The number of people in this age group more than doubles over the 22 years from 2008 to 2030, by around 4,000 people in four out of five Districts in Oxfordshire. It is noteworthy that the effect is much less pronounced in the city because of its younger overall age profile. The increase here is around 1,000 people.

Figure 2.1:



What recommendations were made last year?

The thrust of last year's report was to recommend that:

- A clear map of services should be produced setting out a clear direction forward for older people. **This has been achieved.**

- Preventative work for older people should be grouped together. **This is being achieved**.

- Clear outcome measures should be identified. **This has not yet been achieved but has begun**.

- A senior, dedicated, joint commissioner for older people and healthy ageing should be appointed. **This has been achieved.**

- Carers should be actively supported, particularly by the NHS**. A good start has been made**.

Older People: Progress
This section will cover overall progress followed by a report on support for carers and then a new section on dementia.

A. Overall progress made

OPINION: Good progress has been made in grouping and organising work for older people across the County, given the huge size of the task. We have done well to include younger age groups in an all-embracing healthy ageing strategy. The strategy needs to be tightened, process and outcome measures identified and clear action plans implemented which will make a difference for older people on the ground.

The good progress made over the last year is tempered by the growing realisation of the sheer size and complexity of older peoples' issues in the County. During the year the decision was made to tackle the whole topic of "ageing successfully". In effect this means it has been decided to include preventative work for people in their 40s and 50s and 60s. This is the right decision to make so that problems are prevented in later years, but it does increase the scope and scale of what has been taken on. Preventative work in this context means helping people with chronic disease to stay well as well as more traditional preventative work around exercise, diet and smoking.

A single long-term strategy called "Ageing Successfully" has been produced and is undergoing consultation having been agreed by the Health and Well-Being Partnership Board. The strategy is broad and ambitious in scale, ranging from prevention through to end-of-life care and also includes vitally important issues for well-being such as housing and transport. **This is the first time this has been achieved in Oxfordshire**.

Overall progress is good but more now remains to be done. We need in particular to have a clear sense of where we are going. This can be achieved through defining clear results to be achieved in the future (outcome measures) and also by defining clear milestones along the way so that we know we are going in the right direction (process measures). This work has begun, and needs to be completed during the next year.

Better organisation of existing work across agencies brings some of the 'first fruits' of partnership working to early ripeness. There are numerous examples of this across the County, two of which are given below.

- **Falls** are common in older people, particularly those who are taking a mixture of medications and who have eyesight problems. Oxfordshire is acknowledged as having one of the leading Falls Prevention services in England. Improvements have recently been made to improve services for people who have fractures from falls in the John Radcliffe Hospital.

- We now have an improved "pathway of care" for **people who have had a stroke.** The pathway joins up all aspects of care, including prevention, care by people themselves, home care, GP services, community services, specialist hospital services and community hospital services. There has also been investment in rehabilitation in the community. As a result more people are being treated in services dedicated to those who have had strokes.

B. Caring for our carers

Most people prefer to be cared for by their family or other informal carers as this is often the highest quality of individual care that can be given. This type of care is continuing to shore up health and social care services. We will rely increasingly on informal care as the population ages.

In last year's report the need for Oxfordshire PCT to take a more strategic approach to supporting informal carers was recognised. There were three main areas for action:

- Strengthening the GP's role in identifying carers and championing their needs. **This was partly achieved.**
- Identifying current money spent and investment over time in support of carers in the NHS. **This was partly achieved.**
- Strengthening the NHS contribution to the Joint Carer's Strategy. **This has been achieved**.

Progress in detail:

OPINION: Since the need to care for our carers was identified as a major issue last year a good start has been made. There is much still to do but we are now on the right track. We need to build on this.

The thrust of last year's recommendations was to improve the NHS contribution to work on carers to bring this up to the level of the work of Local Authorities. This is now being achieved. In particular:

(i) Oxfordshire PCT increased the budget available for support to Carers by £250,000 from 2009-10. This money has been invested in:
    - Local implementation of the National Carers Strategy,
    - Piloting the prescription of carers' breaks by GPs
    - Commissioning training programmes to make the task of caring easier and to help carers find the support they need more readily.

In addition:

(ii) A document called "The Carers' Protocol for Primary Care" has been revised and distributed to general practices. This sets out expectations for best practice and enables primary care teams to make this part of what they do.

(iii) 6,800 people are now known to their GPs as Carers and can therefore be offered services such as an annual health check. However, there are an estimated 60,000 carers in the county so there is still a long way to go.

(iv) A contract is in place with an organisation called "Rethink" for running support services for carers of people with mental health problems.

(v) The PCT now has a high quality Carers Action Plan 2009-2012 which was agreed by the PCT Board in April 2009. This dovetails with the Oxfordshire Carers Strategy which sets out the partnership approach across the county.

C. The Growing Threat of Dementia

What is dementia?

Dementia is not a single illness. It is a group of symptoms caused by specific brain disorders. The most common cause is Alzheimer's disease, but dementia can also be the result of a stroke or mini-strokes.

Dementia is progressive – the symptoms will get worse over time. Although there is no cure, treatments can slow the progression of the disease, and there are ways of helping to keep it manageable.

What is the issue?

Dementia presents a huge challenge to society, both now and increasingly in the future. There are currently 700,000 people living with dementia in the UK. Dementia costs the UK economy £17 billion a year and in the next 30 years the number of people with dementia in the UK will double to 1.4 million, with the costs predicted to treble to over £50 billion a year.

Dementia is therefore a demographic timebomb within a demographic timebomb

In addition, recent national reports and research have highlighted the shortcomings in the current provision of dementia services in the UK.

While the numbers and the costs are daunting, the impact on individuals with the illness and on their families is profound. Dementia results in a progressive decline in multiple areas of function, including memory, reasoning, communication skills and the skills needed to carry out daily activities. Alongside this decline, individuals may develop behavioural and psychological symptoms such as depression, psychosis, aggression and wandering, which complicate care and can occur at any stage of the illness. Carers of people with dementia are often old and frail themselves, with high levels of depression and physical illness and a diminished quality of life. Dementia is a terminal condition but people can live with it for many years after diagnosis.

What is the position in Oxfordshire?

The estimated number of people with dementia in Oxfordshire is almost 7,000. The Oxfordshire Older People's Health Needs Assessment (2007) showed a total of 2,400 people with a definitive diagnosis of dementia recorded by Oxfordshire GPs in 2007. This is in line with the national estimate of between only 20% and 40% of people affected by dementia receiving a diagnosis.

The estimated number of people with dementia by Local Authority in Oxfordshire is set out in the table below alongside the percentage increase expected by 2016. Overall, an increase of around 20% is expected over ten years.

Again, this is an issue which will have the greatest impact on more rural parts of the county.

Table 2:1: Predicted prevalence of dementia in Oxfordshire, 2007 and 2016
(Source: POPPI & PANSI data systems)

Local Authority	People aged Over 65 estimated to have dementia in 2007, showing current numbers and predicted % increase by 2016
Oxfordshire	6,828 to increase by 19.3%
Oxford City	1,249 to increase by 4.1%
Cherwell	1,376 to increase by 24.1%
South Oxfordshire	1,496 to increase by 20.8%
Vale of White Horse	1,391 to increase by 23.1%
West Oxfordshire	1,316 to increase by 23%

Dementia is also the second largest contributor in the county to lengthening a hospital stay. Recently discharged patients with dementia also manage more poorly in the community and are more commonly readmitted than patients discharged with any other condition.

Progress in detail

OPINION: Dementia is an important topic. A good start has been made. The Dementia Strategy and individual projects now need to become part of mainstream work on older people.

Nationally
The National Dementia Strategy was published on the 3rd February 2009. It aims to provide a framework which can be adapted locally. In effect it improves awareness and services for dementia by grouping all the issues together in one place and recommending good practice.

The national strategy identifies 17 objectives to improve dementia services, which have been grouped into three broad themes:

- Raising awareness
- Early diagnosis
- Living well with dementia

Locally
In Oxfordshire, the 17 objectives of the National Strategy have been grouped into 5 work streams with a number of programmes and projects being delivered within each. The work streams include:

1. Improved quality of life for people with dementia and their carers
2. Early diagnosis and complex care
3. Early onset dementia – Including learning disability and alcohol related dementia
4. Provision of information
5. Making change happen

Local progress in detail:

- A draft Dementia commissioning strategy has been written and a Dementia Development and Implementation Board has been set up to make the strategy a reality.

- From May 2010 a programme of support and training for carers of people with dementia will be put in place. Carers will have a choice of 3 training courses or a one-off payment to support their needs.

- Specific services designed to help people with memory problems are well established in Oxfordshire but two different models co-exist. Work is underway to develop a single system.

- Oxfordshire is one of the Demonstrator Sites for a Dementia Advisory service. To date, four Dementia Advisors have been recruited by the County Council and are linked to specific GP surgeries to provide an 'information prescription' to patients who are newly diagnosed. Dementia advisors will also signpost people to support services. Following this Dementia Advisors from the voluntary sector will be recruited.

- A national campaign will be implemented, aimed at improving public and professional awareness and understanding of dementia. This will begin in March 2010.

- The 'Careforce Oxfordshire' project has been established to ensure that all staff working with people with dementia receive specific training, both as part of basic training and as ongoing professional development.

Recommendations

Recommendation 1
By December 2010 the Ageing Successfully strategy should be completed with agreed overall direction and clear outcome measures, process measures and action plans, through the PCT Director of Service Redesign and County Council Director for Social and Community Services.

These outcome measures and process measures should be monitored vigorously by the Health and Wellbeing Partnership Board.

The Oxfordshire Health Overview and Scrutiny Committee should also consider scrutinising progress made as part of its annual plan.

Recommendation 2
By December 2010 Oxfordshire PCT, through its Director of Public Health, should have identified 20% more carers in primary care.

Recommendation 3
Work on Dementia in Oxfordshire should be formalised in a joint strategy, led by Oxfordshire PCT and Oxfordshire County Council through their Directors of Service Redesign and Director of Social and Community Services. It should include on the identification of people with dementia and support of carers for people with dementia. It should contain clear outcome measures, process measures and a clear timescale for implementation. This strategy should be completed by March 2011 and should be monitored vigorously by the Health and Wellbeing Partnership Board.

The Oxfordshire Health Overview and Scrutiny Committee should also consider scrutinising progress made as part of its annual plan.

CHAPTER 3: Breaking the Cycle of Deprivation

What is the Issue and Why Does It Matter?

We are now tackling areas of stubborn inequality in this county, where poor life prospects and poor health have been handed down from one generation to the next. This has been recognised as an important priority for Oxfordshire's public services, and work to tackle this problem has begun in earnest and is showing promise, although the final results will take time to show through in the data we collect.

The statistics show that there are specific areas of the County which experience poor school attainment, excessive ill health, higher crime rates, higher levels of teenage pregnancy, higher unemployment and, ultimately, an early death. There is also early evidence from across the country that the impact of the recession is falling most heavily in these areas, particularly through unemployment rates. This is how the cycle of deprivation perpetuates itself and underlines the fact that long term resolve will be needed break the cycle.

Paying for these problems through additional public services adds to the drain on the public purse for the whole county: **This is an issue of concern for everyone**.

Tackling the Issues: The Oxfordshire Approach

We have agreed to tackle this problem on two fronts

1. **A countywide approach to breaking the cycle of deprivation in children, young people and families** led by the Children's Trust, focusing on Banbury, Oxford City, Abingdon/Berinsfield and smaller rural areas.

2. **A specific focus on the most deprived wards of Oxford and Banbury covering all age groups,** involving all organisations and led by the Oxfordshire Partnership (the partnership-of-partnerships where community leaders meet to create an overall strategic plan for Oxfordshire).

This chapter reports on progress and makes recommendations for each of these two topics in turn.

1. Breaking the Cycle of Deprivation in Children, Young People and Families

The issue

Over the last 3 years the need to break the cycle of deprivation in this County has been well recognised.

What recommendations were made last year?

- That the existing work on 'deprivation and narrowing the gap' should be drawn into a single comprehensive workstream. **This has been achieved.**
- That commissioning of children's services should be drawn together more tightly within Children's Trust arrangements. **Good progress has been made.**
- That work to encourage breastfeeding should improve and that the inequality gap between wards with the highest and lowest rates should be reduced**. Improved services are in place and modest progress has been made to narrow the inequality gap.**

Progress made in detail

OPINION: Breaking the cycle of deprivation in children, young people and families is now firmly mainstream business for organisations in Oxfordshire. New determination is evident and the new joint plans are the best yet. Outcome measures have not yet improved as this will take a number of years to achieve. We should focus on developing 'process measures' to make sure we are achieving steady progress towards the ultimate goal.

This work has now entered a transitional phase; the statistics below show that we have not yet broken the cycle of deprivation, but on the other hand current work shows that we are en route. This is evidenced by a palpable new determination to tackle these issues at root, evidenced as follows:

- The production of a new Children and Young Peoples' Plan containing a major section on tackling inequalities called 'Narrowing the Gap', demonstrating the commitment of the Children and Young People's Trust to tackle these issues.
- The personal commitment of the Leader of Oxfordshire County Council to improve educational attainment results and to reduce the number of people who are not in employment, education or training (NEETS) as stated at the Oxfordshire Partnership and Council meetings.
- The personal commitment of the Deputy Leader of the County council to improve educational attainment results as stated at the Public Services Board
- A number of targeted initiatives cited in this report which focus selectively on areas of longstanding social deprivation in this county.
- The '6 Chiefs' initiative in Banbury and Oxford described later in this chapter- this work contains a strong commitment to help those families who are worse off.
- The appointment of a new Director for Children, Young People and Families in the County Council committed to resolve these issues through partnership working led by the Children's Trust.

Examples of good progress made in more detail are:

1. A revised Oxfordshire Children and Young People's Plan 2010 – 2013 was published in January 2010 and it is heartening to see that Narrowing the Gap for our most disadvantaged and vulnerable groups is one of only 3 strategic priorities for Oxfordshire Children's Trust.

2. The Children's Trust commissioning subgroup has focused on improving services for some of the county's most vulnerable children and young people including children with disabilities and young people who abuse drugs and/or alcohol.

3. Three Area Trust Boards have been established and are being developed to drive forward actions to deliver the priorities in the Children and Young People's Plan based on local information and needs.

4. Breaking the Cycle of deprivation is a strategic priority in the PCT Operational Plan and a detailed programme of work is in place for 2010-2011.

5. A new community-based infant feeding support service has begun which will deliver intensive support in the first 2 weeks of life to women living in areas with the lowest breast feeding initiation and duration rates.

The facts about children in Oxfordshire

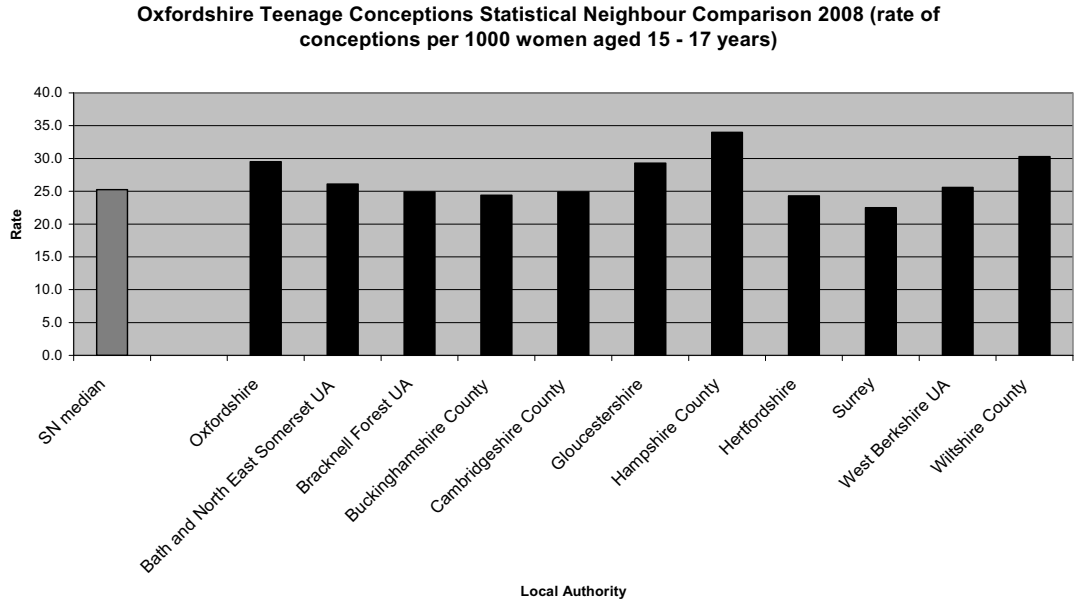
Measure 1: Child Poverty.
National data has not been updated on this measure since 2007 and it is therefore inappropriate to report on it. Further data will come from the 2011 census. The findings were that overall the county ranks highly for child well being, BUT there was wide variation across the county with Oxford City in the bottom third of all districts. 10 wards were among the 10% most deprived wards in the country, 9 of which were in Oxford and one in Banbury.

Measure 2 Teenage pregnancy and sexual health
It is appropriate to take a different approach to teenage pregnancy targets this year. The national way of measuring teenage pregnancy is not very satisfactory as it only measures how fast the number of pregnancies falls. This also tends to hide the real problem as follows:

As a largely affluent county, Oxfordshire's teenage pregnancy rates are among the lowest in the country and so on the whole we do well (currently we are 19th best in the country). However there is considerable variation across the county with some small areas having persistently high rates. We have 18 wards in the county which have teenage pregnancy rates in the highest 20% in England. Of these, 13 wards are in Banbury and Oxford and the solution has to lie in targeting those small areas with the highest rates - and this is what we are doing. There is evidence that **focused work in deprived parts of Oxford over the last 5 years is now working well, and the overall teenage pregnancy rate in Oxford (though still higher than other Districts) is falling year on year.**

A comparison with Local Authorities which are similar in terms of size and demographics shows that there is still room for improvement. All of these Local Authorities are near the top of the class nationally. (These are called in the jargon our 'Statistical Neighbours'). The following chart shows that Oxfordshire does better than Hampshire and Wiltshire but can still do more to catch the likes of Buckinghamshire and Surrey, although there are some question marks about whether the comparison is totally fair given lower levels of deprivation in Buckinghamshire.

Figure 3.1:



During October 2009 Oxfordshire Children and Young People's Trust reviewed and revamped its plans for teenage pregnancy. Much good practice was found and new services were put in place to target some of our most vulnerable young people at highest risk of becoming pregnant. For example:

- Since 2008 we have made significant investment in health visitors and school health nurse services. We have increased the number of school health nurses working in teenage pregnancy hotspots in Oxford and Banbury. As a result, a school health nurse is available 52 weeks a year in person or on the phone.

- A special service was commissioned to provide advice and support to under-18s following the birth of their baby or after a termination of pregnancy. The service also works closely the Youth Offending Service and Social Services to offer 1 to 1 support for young people at high risk of becoming pregnant

- In January 2010, a home visiting programme began targeting first time mothers aged under 20. This service will be offered to 100 families living in Oxford and Banbury. Specially trained nurses visit young families starting during pregnancy and continuing until the child is aged 2 years.

Measure 3: Breastfeeding

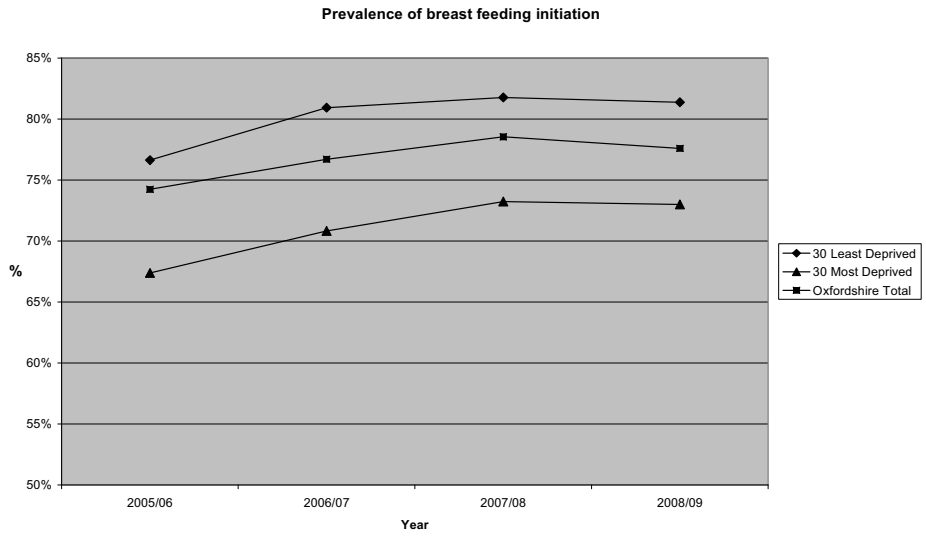
Breastfeeding is one of the best ways of getting a healthy start in life. It provides the perfect food for babies and protects against disease and obesity in later life.

The data shows that we have had some modest success in narrowing the gap in initiating breastfeeding between our most deprived and our least deprived wards since 2006/07- but we need to do more. This was a requirement of last year's report. The 'gap' can be seen as the distance between the top and bottom lines of the graph below. **The really good news is that all of the rates are steadily climbing which is a gain for the public's health long term.**

Despite this we know that in some wards, particularly in Banbury, less than half of mothers choose to breast feed their baby.

Overall in Oxfordshire around 80% mothers choose to breast feed their baby. By the age of 6-8 weeks less than half of all babies are fully breastfed. To address this gap a new community Infant feeding service was commissioned, with the aim of providing intensive support to women during the vital first 2 weeks when long term breastfeeding is established. The service will be delivered in Oxford and Banbury in communities where we know breast feeding rates are particularly low.

Figure 3.2:

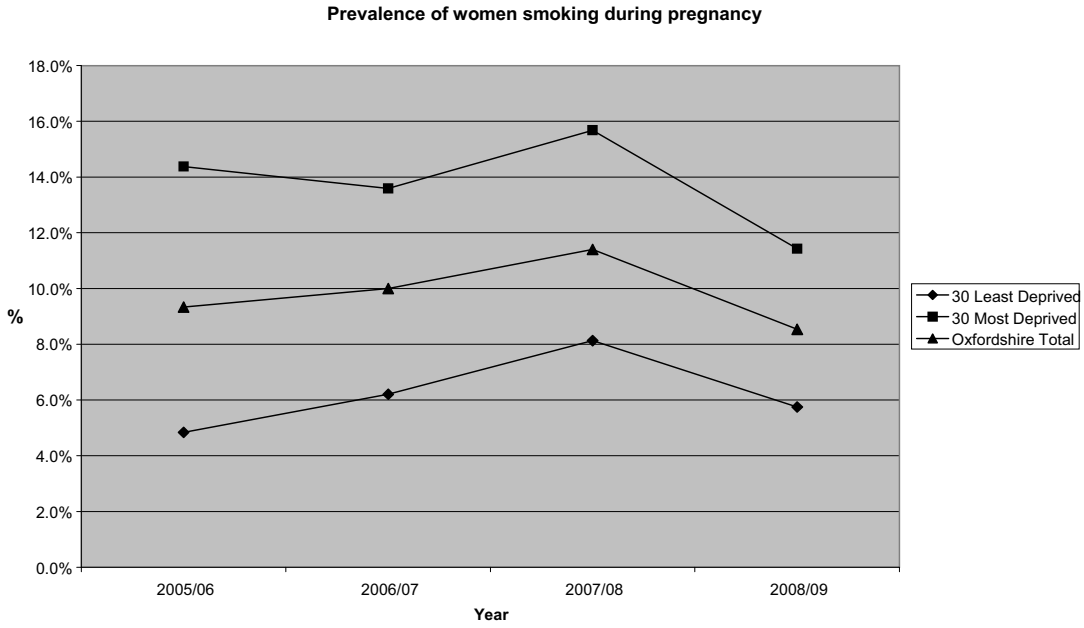


Measure 4: Smoking in pregnancy

Following a concerted effort from our smoking cessation service the percentage of pregnant women who smoke has fallen during the year, reversing the trend of the previous two years. **This is a good achievement.**

Because of careful targeting, the gap between those best and worst off in the county has narrowed, making 2009/10 a doubly successful year. The proportion of women living in deprived wards who smoke throughout their pregnancy is still roughly double those in better off areas (around 6% vs. around 12%). The graph below shows trends over the last 4 years in Oxfordshire.

Figure 3.3:

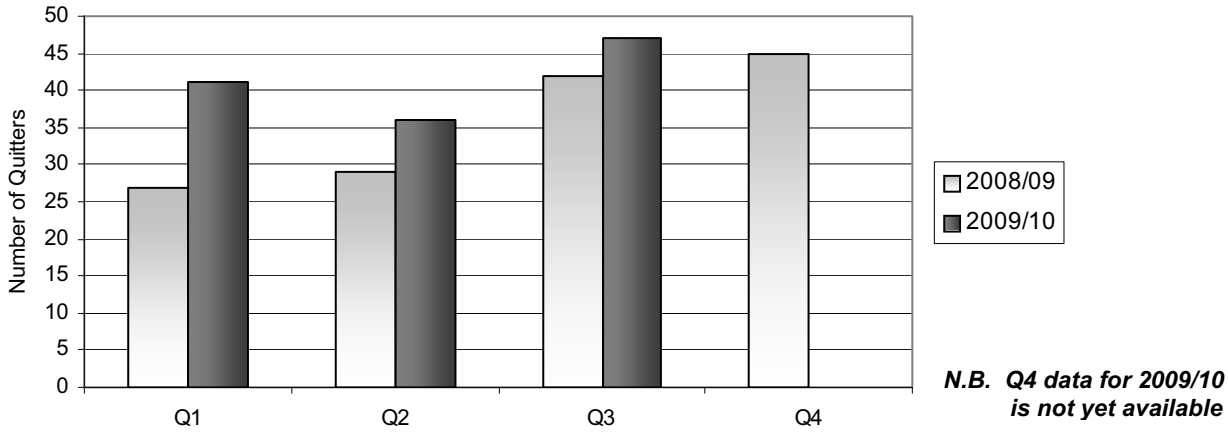


In England as a whole, the number of women smoking in pregnancy was 14.4% in 2008/09.

Additional stop-smoking services for pregnant women were described in chapter 1.

The Chart below compares the last two years, quarter by quarter and shows the increased number of smoking quitters achieved last year. Around 25 additional pregnant women were helped to stop smoking in the first 9 months of the year, compared with the previous year.

Figure 3.4: Pregnant Four Week Smoking Quitters



N.B. Q4 data for 2009/10 is not yet available

Measure 5: Obesity

We are continuing to improve our local data on childhood obesity through the National Child Measurement Programme. This year we weighed and measured 11,256 children in Oxfordshire.

The stark fact is that the 2009 cohort of Oxfordshire children are more overweight and obese than 2008's cohort. Data collected in 2009 shows a significant rise in reception age children being overweight and obese compared to 2008 data. This is also the first time that our local data is worse than the national figures.

This is a clear signal that we need to get 'back to basics' in terms of preventing obesity. This theme is elaborated in chapter 5.

Figure 3.5

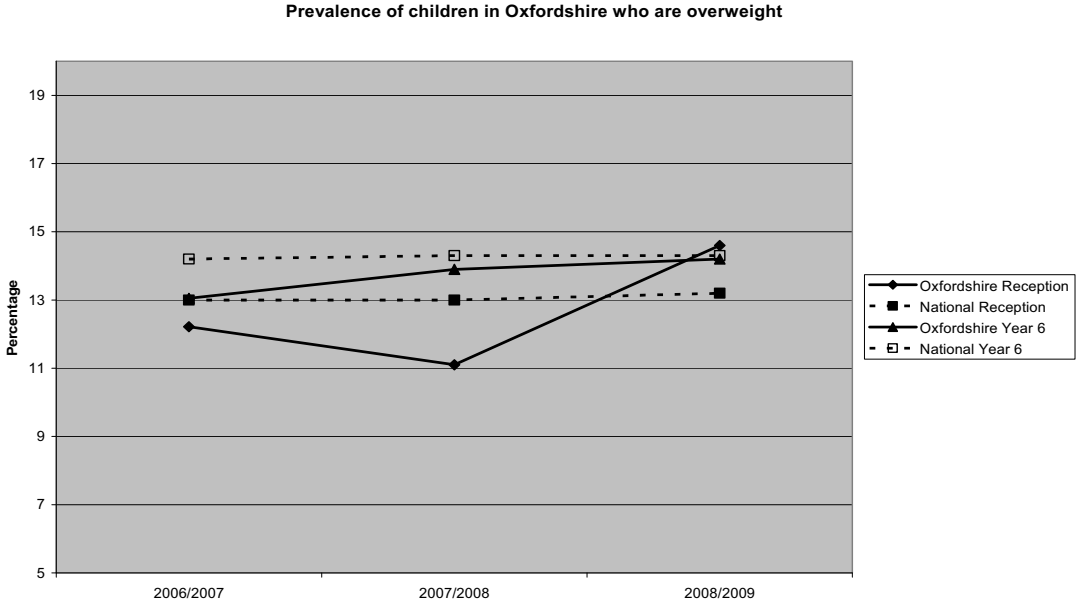
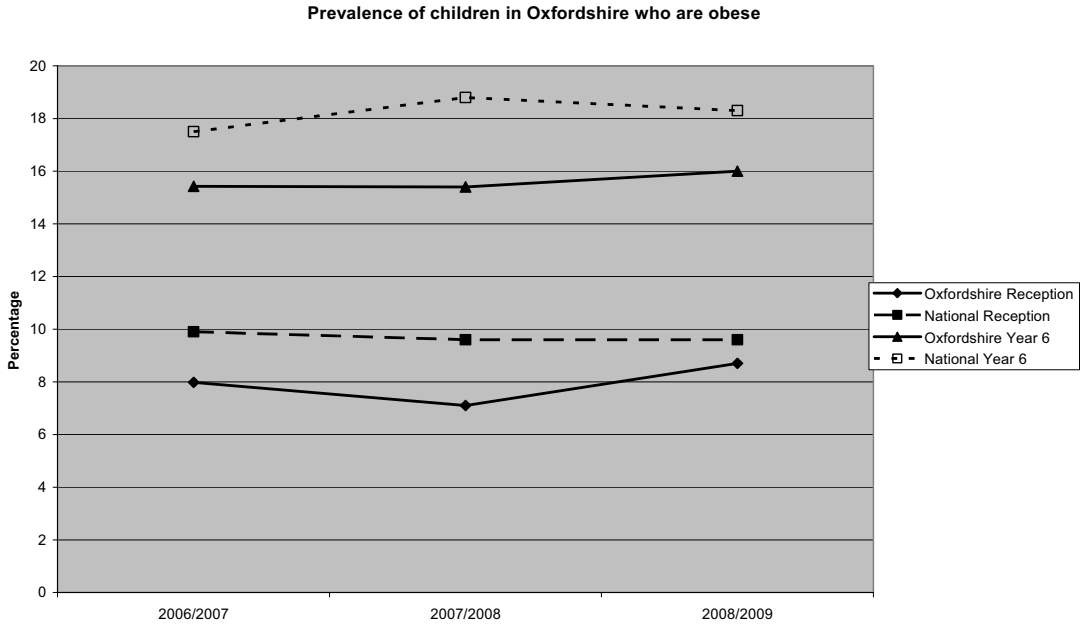


Figure 3.6



Measure 6: GCSE Attainment

It is important that educational attainment is carefully monitored each year.

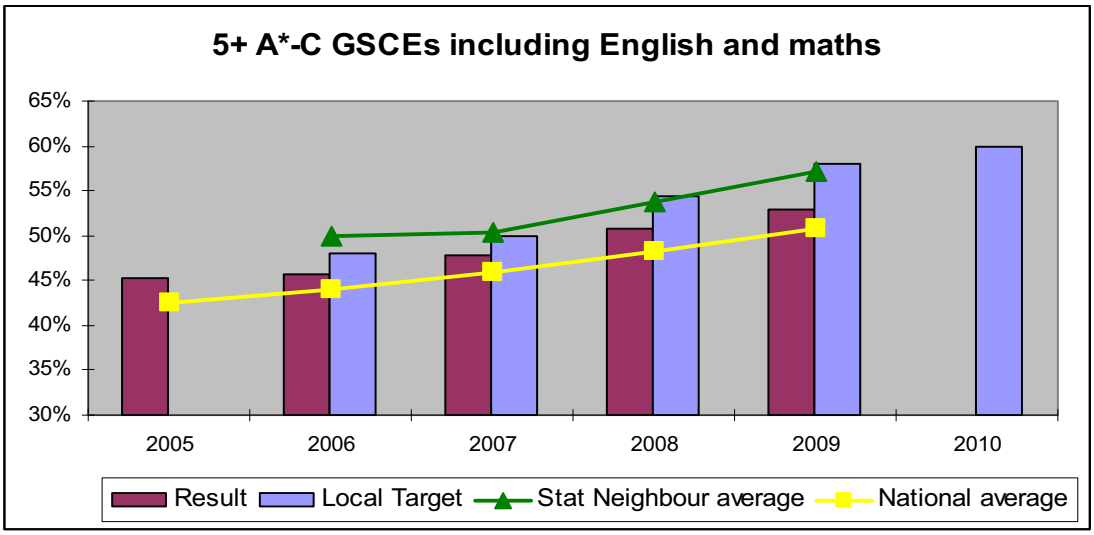
Educational attainment is a useful summary indicator of underlying problems in a society. All organisations have some responsibility for remedying this situation as educational attainment is a product of many family and social factors as well as the quality of our schools.

In this section the key performance measure used is a National Indicator called NI 75 which measures the percentage of Year 11 pupils achieving 5 A-star to C grades including English and Maths at GCSE (5 GCSEs A*-C inc English and Maths).

a. Overall attainment compared with national results

The percentage of children in year 11 achieving 5A*-Cs including English and Maths in Oxfordshire has improved consistently since 2005 to 52.9% in 2009. In 2009 Oxfordshire's results were 2.2% above the national average for maintained schools, a slight decrease on 2008. However, performance still remains below the local target of 58% and is lower than similar Local Authorities shown by the top line on the graph below. Despite the improved results therefore, this indicator remains a cause for concern and is a priority for the County Council and partners. A comprehensive set of actions is in place to remedy the situation.

Figure 3.7



	2005	2006	2007	2008	2009	2010
Oxfordshire	45.3%	45.6%	47.9%	50.7%	52.9%	
Local Target		48.0%	50.0%	54.3%	58.0%	60.0%
Statistical Neighbour average		50.0%	50.4%	53.7%	57.1%	
National average	42.6%	44.1%	45.9%	48.3%	50.7%	

Source: DCSF statistical first releases Dec 2009

b. Comparison with statistical neighbours

This information allows us to benchmark the attainment of our young people against similar local authorities. The data shows that Oxfordshire performs below its statistical neighbours. The percentage of Oxfordshire children gaining 5A*-Cs including English and Maths was 4.4% lower than the average score of statistical neighbours in 2006. The

Oxfordshire average improved to be only 2.5% lower than statistical neighbours in 2007 but the gap has widened again to 4.2% in 2009 and remains a cause for concern.

c. Inequalities in attainment between schools.
In 2009, all 32 maintained secondary schools in Oxfordshire reached the government's 'floor target', which requires at least 30% of a school's Key Stage 4 pupils to attain 5 A*-C GCSEs including English and Maths.

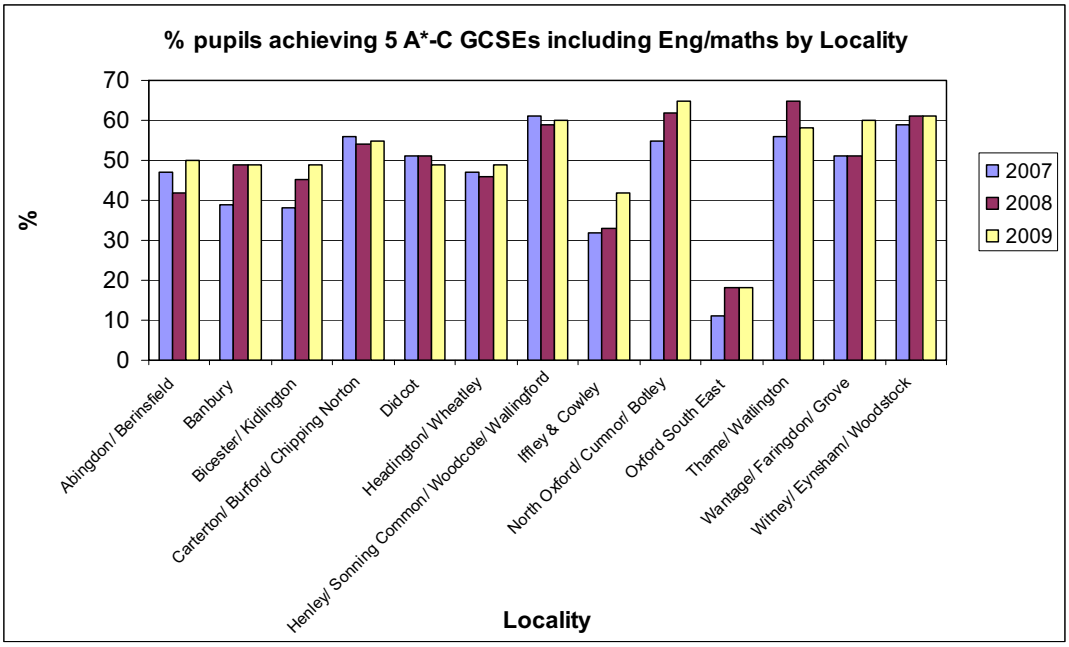
The range of pupils achieving 5 or more GCSEs A*-C including English and Maths in 2009 varied widely across the county, from Matthew Arnold School (70%), Bartholomew School (66%) and Gillotts School (65%), to Oxford School (35%), North Oxfordshire Academy (25%) and Oxford Academy (18%).

In 2009, 11 schools (32%) had 50% or fewer pupils achieved 5+ GCSEs A*-C including English and Maths, an improvement from 13 schools in 2008. These results need to be used to target services and resources by all organisations.

d. Inequalities in attainment by locality
The overall shape of GCSE results achieved by pupils attending schools situated in the 13 agreed localities for children's services has changed little overall during the year. There have been welcome increases in Iffley/ Cowley (9% increase), Wantage/Faringdon/Grove (9% increase) and Abingdon/Berinsfield (8% increase). Banbury and Oxford South East localities which both showed welcome increases in 2008 have maintained these results.

The percentage of pupils achieving 5+ A*-C inc English and Maths obtained by pupils attending schools in Oxford South East (including Blackbird Leys and Rose Hill – the area served by the Oxford Academy) and Iffley & Cowley remains markedly lower than the rest of Oxfordshire.

Figure 3.8

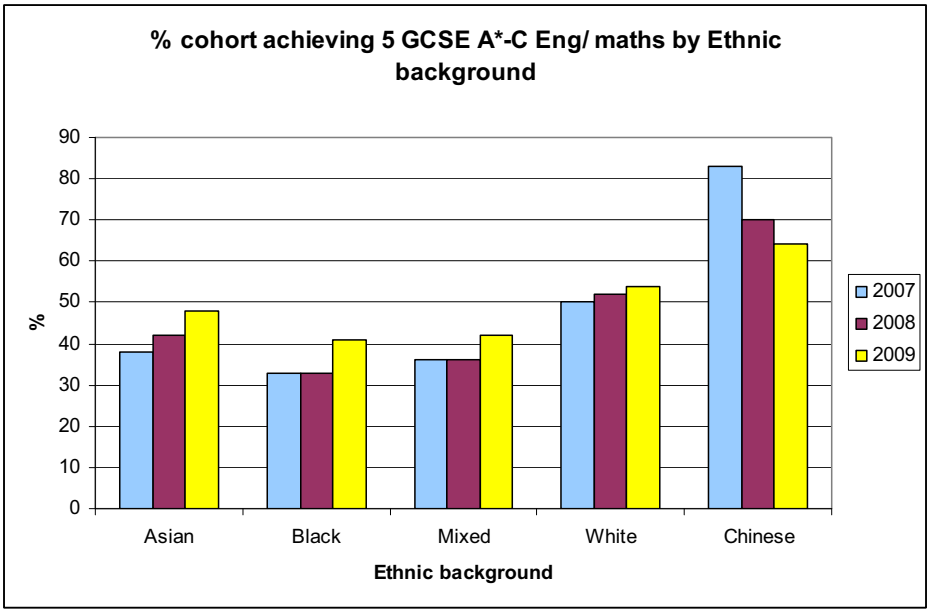


Source: DCSF statistical first releases Dec 2009

e. Attainment in black and minority ethnic groups
The chart below shows that over the previous 3 years the proportion of pupils from Asian, Black and Mixed backgrounds achieving 5A*-Cs including English and Maths has been consistently below the Oxfordshire average**. However in 2009 the proportion of pupils**

reaching 5A*-Cs from all 3 of these groups increased noticeably (pupils from Black backgrounds improved by 8%, Asian and Mixed backgrounds improved by 6%). The results also show that the proportion of children from Chinese backgrounds achieving 5 A*-C including English and Maths has fallen in recent years. The performance of Black and Minority Ethnic (BME) groups has improved overall which is to be welcomed, but there is room for improvement and this remains a cause for concern.

Figure 3.9

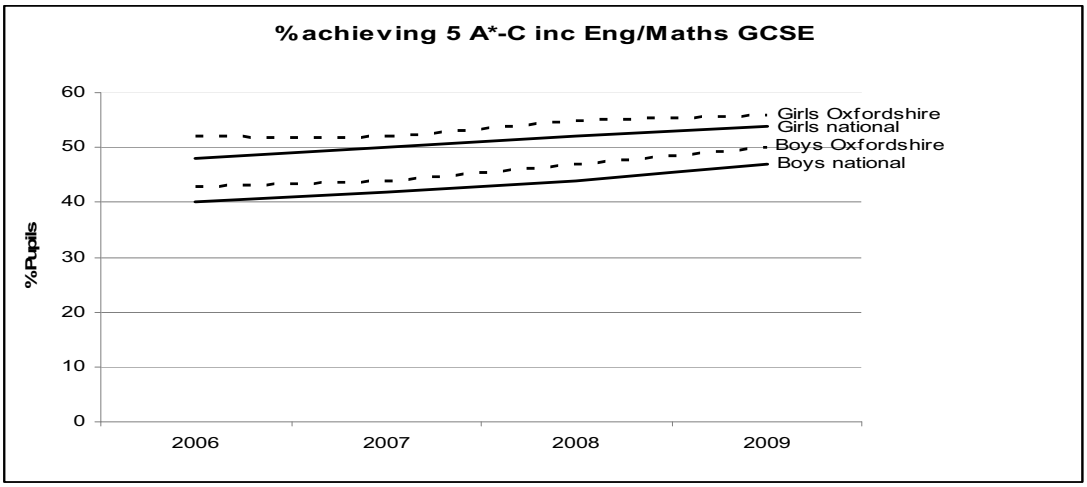


Source: DCSF statistical first releases Dec 2009

f. Differences in attainment between boys and girls

The data below shows that girls consistently out perform boys by around 6-8 percentage points in GCSE performance. This mirrors the national picture and represents a further inequality to be investigated by the Children's Trust. The picture is more complex when looking at individual subjects, however. For example, girls consistently outperform boys in Science and in English, whereas in Maths performance is more evenly balanced.

Figure 3.10



Percentage of pupils achieving:		Results							
		National				Oxfordshire			
		2006	2007	2008	2009	2006	2007	2008	2009
5+ A*-C inc GCSE En & Ma	Boys	40	42	44	47	43	44	47	50
	Girls	48	50	52	54	52	52	55	56

Measure 7: Oral health

Oral health in children is an important marker of general health, inequality and deprivation.

Dental decay significantly compromises health and well being throughout life as well as causing pain and discomfort. Oral health problems in children are largely preventable. Oral health has improved over the last 30 years but there is still a long way to go

The last national survey of 5 year olds (2007/2008) indicated that although the County as a whole was better than the England average, children living in Oxford and Cherwell had higher than the National average levels of tooth decay (measured in decayed, missing or filled teeth - DMFT), 1.32 and 1.2 teeth decayed, missing or filled per child respectively, compared to children in other areas of the county. This underlines the familiar pattern of inequality seen in Oxfordshire.

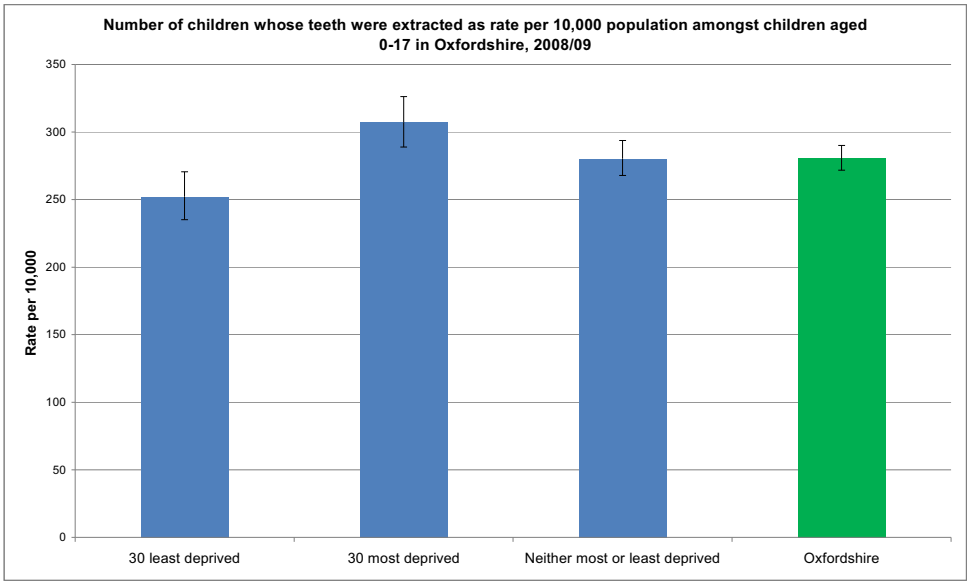
Table 3.1

Local Authority/PCT	**Average number of decayed missing or filled teeth.**
Cherwell	1.20
Oxford	1.32
South Oxfordshire	0.47
Vale of White Horse	0.59
West Oxfordshire	0.63
PCT Average	0.86
England	Average = 1.11. Range for all PCTs = 0.48 to 2.50

Another indication of inequalities in our children's oral health is the number of children who had teeth extracted under general anaesthetic in primary care dental services in the community. This is demonstrated by the graphs below. There is a statistically significant difference in the rates of extraction between the 30 most and the 30 least deprived wards.

In 08/09, 486 children aged 0-17 had dental extractions. Again, many of these would have been preventable given good oral hygiene.

Figure 3.11



To try to improve this situation, in the last year NHS Dentistry provision in Blackbird Leys and Banbury has been increased. Following the opening of the new practice in Blackbird Leys the percentage of the local population seen by an NHS dentist has increased from 47% to 62%. Over 3000 patients have been seen by the new practice since August 2009.

An oral health education programme has also been commissioned to address the health needs of vulnerable children in Oxfordshire. This includes training professionals to be oral health educators. A pilot project in two schools in Oxford City and Banbury will aim to measure the effectiveness of health education, screening and the application of fluoride varnish in a community setting to help improve the oral health of children.

Recommendations

Recommendation 1
Oxfordshire County Council, Oxfordshire PCT and Local Authorities should continue to drive forward plans to further integrate children's services planning and commissioning across the county under the Children and Young People's Trust through the Directors for Children, Young People and Families and the PCT Director of Service Redesign so that clear process and outcome measures for commissioning plans are agreed by March 2011.

Recommendation 2
The Oxfordshire Children and Young People's Trust should ensure that all community services and community resources for children living in localities with high levels of social deprivation (including schools) are better coordinated so as to target those who need the services the most, with the aim of bringing the areas with the lowest outcome measures up to the county average. This work should show demonstrable progress by March 2011.

Recommendation 3
The Children and Young People's Trust should review initiatives aimed at preventing and treating obesity in children across Oxfordshire and should consider re-directing resources towards primary prevention of obesity by March 2011.

Recommendation 4
The Oxfordshire Children's Trust Board should receive regular progress reports from the '6 Chiefs' work (described below), which overlaps with the Children's Trust programme of work called 'Narrowing the Gap', with a view to integrating this work into Children and Young People's Trust planning by March 2011.

2. Breaking the Cycle of Deprivation in the Most Deprived Wards of Banbury and Oxford

What recommendations were made last year?
The thrust of last year's recommendations was that:

- Organisations should join forces to break the cycle of deprivation **because no one organisation can do it alone. This has been achieved.**
- Priorities identified for change should be identified and action plans should be produced. **This has been partly achieved.**
- The chief officers of Oxfordshire County Council, Oxford City Council and Cherwell District Council should join forces with the chief officers of Oxfordshire PCT and the Police Force in Oxfordshire to steer and direct this work, which is consequently now known as the "five chief's project". **This has been achieved.**
- The Oxfordshire Partnership should actively oversee this work and ensure that concrete action happens. **This has been achieved and is ongoing.**

Progress in Detail

OPINION: Good progress has been made. A clear strategy with clear outcome measures and action plans now need to be finalized so that we can drive on to make lasting change.

This initiative has had a successful year. All of last year's recommendations have been achieved or partly achieved. Since this issue was first brought to prominence two years ago it has now become a mainstream priority across Oxfordshire. Positive developments are described below.

The 5 Chiefs met in May 2009 and agreed how they wanted to run this project, focusing on 4 major priorities. These are:

1. Giving children a good start in life by supporting vulnerable families
2. Improving employability by focusing on improved skills and increasing job opportunities
3. Improving the physical environment including housing and housing policy
4. Reducing health inequalities e.g. by identifying those at risk of heart disease

It was agreed to develop an "Oxfordshire Model" through careful evaluation of this first stage of work. This is important: If we can prove we can make lasting change then we can use this model elsewhere in the County.

Work began in Oxford as part of a broader piece of work to regenerate parts of the city. Priorities for Blackbird Leys, Greater Leys, Rose Hill and Littlemore and Barton wards have been set.

Following thorough analysis of the local situation, work in Banbury is focusing on parts of Neithrop, Ruscote and Grimsbury wards.

A bid to the Public Service Board for £1 million of one-off 'reward grant' money was successful. This money will be used to start work off in the target localities.

Because of the importance of developing peoples' skills, a sixth chief officer has been added to the steering group from Oxford and Cherwell Valley Colleges making it the "six chiefs' project". This move is designed to reduce the number of people not in education, employment or training (and so reduce the level of NEETS mentioned earlier in this chapter).

Ways of working in the next year which will help us to break the mould for the long-term are:

- Building solutions by **joining up existing services** which are already part of core funding rather than relying on temporary add-ons from the reward grant and other short-term funding - ***we want to eat the whole cake, not just the icing.***
- **Keeping it simple** so that we can really measure the impact of a few key changes.
- **Making sure we can measure not only the end results, but also the milestones along the way.**
- Taking a scientific approach and **evaluating the degree of success** in a small area or for a small group of families so that we can definitely say whether this approach works or not.

Recommendations for 2010/11

Recommendation 1
By March 2011, the six chiefs should ensure that this project has work plans in place which concentrate on:

- joining up existing core services
- identifying simple and definable service improvements that can be measured, focused primarily on getting a better start in life
- beginning to evaluate this work.

Recommendation 2
By October 2010, the 6 Chiefs should have agreed a clear 'basket' of measures which will tell them accurately whether or not this work is on track to break the cycle of deprivation in the long term.

Recommendation 3
By December 2010 The Oxfordshire Partnership should have received a specific progress report on this work and should seek evidence of progress in line with the three points in recommendation 1 above.

Recommendation 4
By December 2010 Oxfordshire Partnership and/or Public Services Board should have considered whether this work could be part of a **"Total Place"** initiative (or a similar approach under the new Government) focusing on increasing the number of people in education, training or employment **(and thus reducing NEETS**). This work should seek to coordinate the effort and spending of public sector organisations to achieve more while being more efficient. The focus could be either on specific wards or on specific families who have particularly high needs.

CHAPTER 4: Mental health in adults: avoiding a Cinderella service

What is the Issue and Why Does It Matter?

Last year's report explained why mental health matters. To recap:

- Mental health problems are common: **one in six of the adult population** has a mental illness at any one time. This could happen to any one of us.
- Mental health accounts for a quarter of all disease suffered at any one time.
- Mental health problems strike at economic productivity - nationally mental health problems cost £77 billion a year
- We need to work in partnership to tackle these problems. Factors such as the quality of the physical environment, poverty, inequality, social cohesion and economic prosperity all combine to cause or exacerbate mental health problems.
- There is a high social cost to the individual, their relationships, their families, the wider society and thus the economy: mental health problems affect us all.

What recommendations were made last year and what progress has been made?

OPINION: Real progress has been made during the last year to improve commissioning of mental health services. Effort must now focus on agreeing clear outcome and process measures to drive this work forward.

Last year's recommendations focused on four points:

- That commissioning should be strengthened by the appointment of a senior joint commissioner. **This has happened.**
- That a clear strategy should be produced with clear outcomes. **This is well on the way.**
- That commissioning of services for older peoples' mental health should not be forgotten and should be well developed. **This has not yet happened and remains a high priority**. The section on dementia in chapter 3 sets out part of the problem.
- That issues affecting carers remained a priority for mental health as well as for older people. **Good progress has been made.**

This body of work is now well on track to make a real difference. The issue has been accepted as a major priority, a single strategy is in place and clear priorities have been set. More specific plans are now being drawn up so that progress can be monitored. A mental wellbeing component is also now well embedded in this work which is breaking new ground in Oxfordshire.

A practical example of progress made

A longstanding gap in Oxfordshire - access to psychological therapies (counselling, behaviour therapy and the like) - was filled by a new service which began in May 2009. The number of patients seen from across Oxfordshire is shown in the table below and has increased from 2,300 per year to 4,300 per year, planned to rise to 9,000 per year by 2011/12. The service has not been without teething troubles – demand has far exceeded supply for example – but nonetheless, this is an excellent step forward.

Table 4.1: Oxfordshire Residents seen by the new psychological therapies service plus service plans 2008-2012

Year	Actual or planned	Number of patients
Pre 2008	Actual	2,300
2008	Actual	2,700
2009/10	Actual	4,300
2010/11	Planned	7,000
2011/12	Planned	9,000

What happens next?
The success of joint work so far on mental health will inevitably bring into view a new set of challenges to be overcome if this work is to deepen. This is typical of any large programme of work in partnership and is in effect a measure of maturity and success. The next set of challenges to be faced will include:

- Making 'pooled budgets' work efficiently, especially when public sector funds are squeezed. (Pooled budgets contain money that is formally combined by the PCT and County Council for a specific purpose).
- Moving from health and social services planning to more complex issues around housing and independent living for people with Mental Health problems – this will involve closer working with District Councils.
- Collecting accurate information about patients' experiences and using this to shape service planning.

Recommendations

Recommendation 1
The PCT Director of Service Redesign should continue to drive progress forward until improvements to outcomes are achieved. Further demonstrable progress should be in evidence by March 2011.

Recommendation 2
The Director of Service Redesign and the Director for Social and Community Services should ensure that a commissioning strategy for older people's mental health is produced by March 2011 and this should form a part of the Ageing Successfully strategy. This should include a section on the care of people with dementia.

CHAPTER 5: The Rising Tide of Obesity

The importance of preventing adult obesity

Britain is in the grip of an epidemic. **Almost two-thirds of adults and a third of children are either overweight or obese** and it is estimated that, without clear action, these figures will rise to **almost nine in ten adults and two-thirds of children by 2050.**

Because there is a need to revamp our strategic approach to obesity in this County, the case for working on obesity as a priority is set out in more detail than in previous years.

It has been well documented that being overweight or obese increases the risk of a number of diseases. The risks rise the heavier you are and so are greater for people who are obese. For example:

- 10% of all cancer deaths among non-smokers are related to obesity
- the risk of Coronary Artery Disease increases 3.6 times for each unit increase in BMI
- 85% of high blood pressure is associated with being overweight
- the risk of developing type 2 diabetes is about 20 times greater for people who are very obese (BMI over 35), compared to individuals with a BMI of between 18 and 25

A Note on Jargon and Definitions of Obesity and Overweight

Obesity is defined as a body mass index (BMI) of 30 or more. Body Mass Index is measured by weight in kilogrammes divided by height squared. Overweight is defined as BMI of 25 to 29.9.

For example, a man aged 30 who weighs 13 stone 6lb (85kg) and is 6 feet tall (183cm) will have a BMI of 25.4, just in the overweight category; if he weighed 16 stone(101kg), he would enter the obese category with a BMI of 30.2.
For those of you who like maths:
Height squared = 1.83 X 1.83 = 3.34
Therefore BMI at 85Kg = 85/3.34 = 25.4
Therefore BMI at 101Kg = 101/3.34 = 30.2

A women aged 50 who weighs 10 stone 8lb (67kg) and is 5 foot 4 inches tall (163cm) will have a BMI of 25.3,again in the overweight category; if she weighed 12 stone 10 lb(80kg), she becomes obese with a BMI of 30.2
For those of you who like maths:
Height squared = 1.63 X 1.63 = 2.65
Therefore BMI at 67 Kg = 67/2.65 = 25.3
Therefore BMI at 80 Kg = 80/2.65 = 30.2

In the worst case scenario, current levels of child obesity mean that today's parents could outlive their children.

It has been calculated that approximately 116,600 adults in Oxfordshire (almost ¼ of all adults) are obese. Adult obesity is an issue across the whole county; however it is likely to be more prevalent in areas with high levels of deprivation.

The case for action

The price of obesity
Obese and overweight individuals place a significant burden on the NHS. Direct costs are estimated to be £4.2 billion nationally and these will more than double by 2050. The costs to Oxfordshire PCT of treating diseases related to overweight and obesity are set to increase by approximately £1 million each year. If current trends continue the estimated annual costs to Oxfordshire NHS of diseases related to overweight and obesity are set to rise from £143 million in 1997 to £159 million in 2015.

A reduction of 10% in body weight has been demonstrated to result in:

- A 20% fall in the total death rate,
- A 91% reduction in the symptoms of angina
- A reduction in blood pressure (of 10mmHg) sufficient to prevent a significant number of heart attacks and strokes.

- Substantial reductions in cholesterol and fats carried in the blood which lead to heart disease and stroke
- A 40% reduction in obesity-related cancer deaths

By 2020 obesity could lead to an additional 6,900 cases of diabetes in Oxfordshire alone, costing an additional £9.8 million each year and/or an additional 1,776 cases of Myocardial Infarction (heart attack) costing an additional £8.5 million each year.

The benefits of healthy eating

Diet-related ill health is responsible for about 10 per cent of deaths in the UK, and is estimated to cost the NHS some £6 billion every year. This is more than double the cost to the NHS of tobacco use. If diets matched the nutritional guidelines on consumption of fruit and vegetables, saturated fat and added sugar and salt intake, around 70,000 fewer people (10% of current annual mortality) would die prematurely each year in the UK. The benefits of meeting the national nutritional guidelines have been estimated to be as high as £20 billion savings each year.

Improving a person's diet by increasing consumption of fruit and vegetables can significantly reduce the risk of many chronic diseases. It has been estimated that eating at least 5 portions of a variety of fruit and vegetables a day could reduce the risk of deaths from chronic diseases such as heart disease, stroke, and cancer by up to 20%.

It has been estimated that diet might contribute to the development of one-third of all cancers, and that **eating healthily is the second most important cancer prevention strategy, after reducing smoking.**

Research suggests that there are other health benefits too, including delaying the development of cataracts, reducing the symptoms of asthma, improving bowel function, and helping to manage diabetes.

Good nutrition is vital to good health. While many people in England eat well, a large number do not, particularly among the more disadvantaged and vulnerable in society. There are many inequalities in nutrition and health that need to be addressed. For example, consumption of fruit and vegetables varies markedly between socio-economic groups. 27% of men and 33% of women in the managerial and professional groups consume the recommended five portions per day compared to 16% of men and 17% of women in routine and semi-routine occupations.

Poor nutrition and inequalities in nutrition are a major cause of ill health and premature death in this county.

The benefits of being active

Getting more people more active is one of public health's best buys. Primary and secondary care costs attributable to physical inactivity have been estimated to cost Oxfordshire PCT £8 million each year.

Almost ¾ (73%) of Oxfordshire's population still do not participate in enough activity to benefit their health.

Inactive lifestyles in England are twice as prevalent as smoking. Evidence shows that **the health impact of inactivity, in terms of heart disease, is comparable to that of smoking and almost**

Recommended physical activity levels

Adults: 30 minutes of moderate intensity physical activity at least 5 days a week. (Should make you slightly breathless and sweaty!)

Children: 60 minutes of moderate intensity physical activity each day

Targets can be achieved with 10-minute bursts of activity spread throughout the day.

as great as having a high cholesterol level. On average, an inactive person compared with an active person spends 38% more days in hospital, has 5.5% more GP visits, needs 13% more specialist services and has 12% more nurse visits.

There is a clear causal relationship between low levels of physical activity and early death. People who are physically active reduce their risk of developing heart disease, stroke, cancer and diabetes by up to 50%, and the risk of premature death by about 20–30%. Inactivity also has far-reaching implications for the wider public sector. Increased activity promotes independent living in older adults, and thereby reduces the cost of social care.

Oxfordshire has already made good progress in getting more people more active. Since 2006 an extra 20,000 more adults are now more active as a result of increased physical activity opportunities across the county. However a great deal still needs to be done to promote activity further.

Conclusion: Making modest improvements to your diet and physical activity really can really benefit your health as an individual, <u>but</u> these changes have to be made by the majority to prevent the growing spend on obesity-related diseases. The main focus of work must be on making it easier for the majority to adopt healthier lifestyles.

<u>What was recommended last year?</u>

In last year's Annual Report, 3 recommendations were made as follows:

- Progress against the County Obesity Strategy should be formally reviewed and reassessed. **This has been done (see below).**
- All public sector organisations should identify an obesity champion. **This has not been achieved and the immediate need for it is superseded by the results of the review of the strategy**.
- True levels of obesity can be measured in Oxfordshire's population. **To report BMI for the population of a single county has proved to be a more complex task than envisaged and remains a priority for the new strategy. To do this meaningfully will take time as the science is complex.**

Progress in Detail

OPINION: A good start has been made over the last 3 years and the coordination of work across the County is the envy of our neighbours BUT we need to take a step back during the next year and re-focus our effort on 'an ounce of prevention' for the majority of people by revamping our strategy and focusing on what really works. All organisations will need to play a part.

An appraisal of the existing strategy confirms that we have made a good start on grouping together work and coordinating current efforts. We have improved levels of physical activity, but childhood overweight and obesity are on the increase. **(See chapter 4 which shows that our children are now more overweight than the national average and that we are less far ahead of the national average than last year for childhood obesity).**

The review of our existing work shows both the good work done and the scope for further achievement. The main points of the review are summarised below.

Ownership of strategy
There is a perception that this is largely a PCT strategy not one "owned" by key partners. Consequently responsibility for tackling obesity rests with the PCT. Action plans should be drawn up collaboratively and signed off by all key partner agencies (especially by the PCT and Local Authorities).

Accountability
We need to make sure that "children's" initiatives join up with "adult" initiatives as one is reported to the Children's Trust and the other to the Health and Wellbeing Partnership Board.

Physical activity initiatives
In general there is a co-ordinated approach to these interventions countywide, although the focus is on sport rather than everyday physical activity such as walking and using stairs instead of lifts.

Healthy Eating initiatives
A more strategic approach to healthy eating is required. There is lots of good practice countywide but it is patchy and not joined up.

Health and Social Care settings
The primary focus of the strategy to date has been to develop a high quality care pathway for people who are overweight and obese. We now have a clear pathway from early intervention to surgical treatments. More focus also needs to be given to weight management for people with long term conditions. Interventions in social care settings are not clearly mapped and work needs to be undertaken to strengthen these services.

Primary prevention (i.e. preventing obesity in the first place)
The revamped strategy needs to place greater emphasis on primary prevention and early identification. GPs and Local Authorities will have a major role to play in this.

Getting thinking on diet and exercise into planning decisions at all levels
There are more questions than answers here …. For example, we need to attempt to influence planning decisions and influence supermarket chains to make healthy food more attractive and available. Who is going to buy apples when you can get 5 Mars bars cheaper? (5 Mars bars cost £1.68; a bag of gala apples (approx 6-8) costs £1.75) Which young person is going to eat salad when they can get chips from the shop next to the school/college etc? What can we do to influence food policy at a national level and how can we ensure sports facilities do not get cut in spending reviews as these will impact on what we can achieve? There is some comfort in the fact that the latest long term plan for roads in Oxfordshire (called, in the jargon, Long Term Plan 3 or LTP3) contains things like provision of footpaths and cycle paths within its structure. Health promotion staff from the Public Health team are also part of the planning group.

Recommendation

The County strategy for prevention of obesity should be reviewed and refreshed by March 2011 through the Director of Public Health. The new strategy should be a true partnership effort and should have an emphasis on the prevention of obesity rather than its treatment. It should include a focus on the important role of GPs. Work with children and adults should be seamless. Those at increased risk should be targeted.

CHAPTER 6: Fighting killer diseases

The issue

Killer diseases remain a threat to the population of Oxfordshire. However their impact can be reduced by good surveillance and information, early identification and swift action, basic cleanliness, hand washing and good food hygiene.

By far the biggest event in 2009-2010 was the worldwide flu pandemic, which saw the emergence of swine flu caused by a new type of influenza A virus – H1N1.

This chapter reports on the recommendations from the 2008/09 DPH Annual Report and highlights the work around the flu pandemic. It also sets out the current state of play around important diseases and makes recommendations for action.

Progress report on 2008/09's recommendations

All the recommendations from the last DPH annual report have been addressed met as follows:

- Hepatitis C infection has been reviewed and a strategy and action plan drafted (see below);
- The PCT has invested in infection control and health protection;
- Investment has continued in Tuberculosis (TB) with new funding being directed to improving access to vaccination against TB for children at increased risk.

Progress in detail:
This section sets out the current position on the killer diseases which most threaten the health of the people of Oxfordshire.

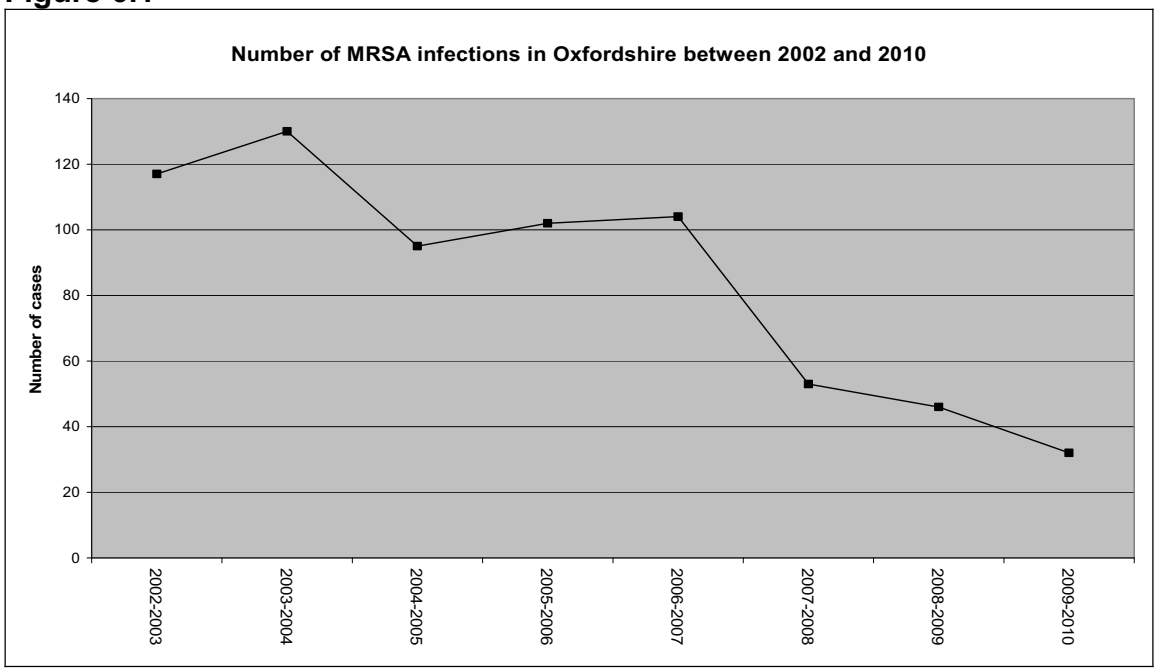
OPINION: Killer diseases are well managed in Oxfordshire but remain an ever-present threat. Constant vigilance is required.

1) Health Care Associated Infections

Infections caused by superbugs like Methicillin Resistant Staphylococcus Aureus (MRSA) and *Clostridium difficile* (*C.diff*.) remain an important cause of sickness and death, both in hospitals and in the community. However numbers of infections **can** be reduced and considerable effort has been put into tightening all our systems to reduce the numbers of cases. As a result, we are seeing a reduction in the numbers of infections associated with hospital settings and now need to work to get a decrease in the community.

a) Methicillin Resistant Staphylococcus Aureus (MRSA)
MRSA is a bacterium found commonly on the skin. If it gains entry into the blood stream (e.g. during surgery or other invasive procedures) it can cause blood poisoning (bacteraemias). It can be difficult to treat as it is resistant to commonly used antibiotics. MRSA bacteraemias continue to fall during 2009/10. The graph below shows the impressive achievement of the last 7 years.

Figure 6.1



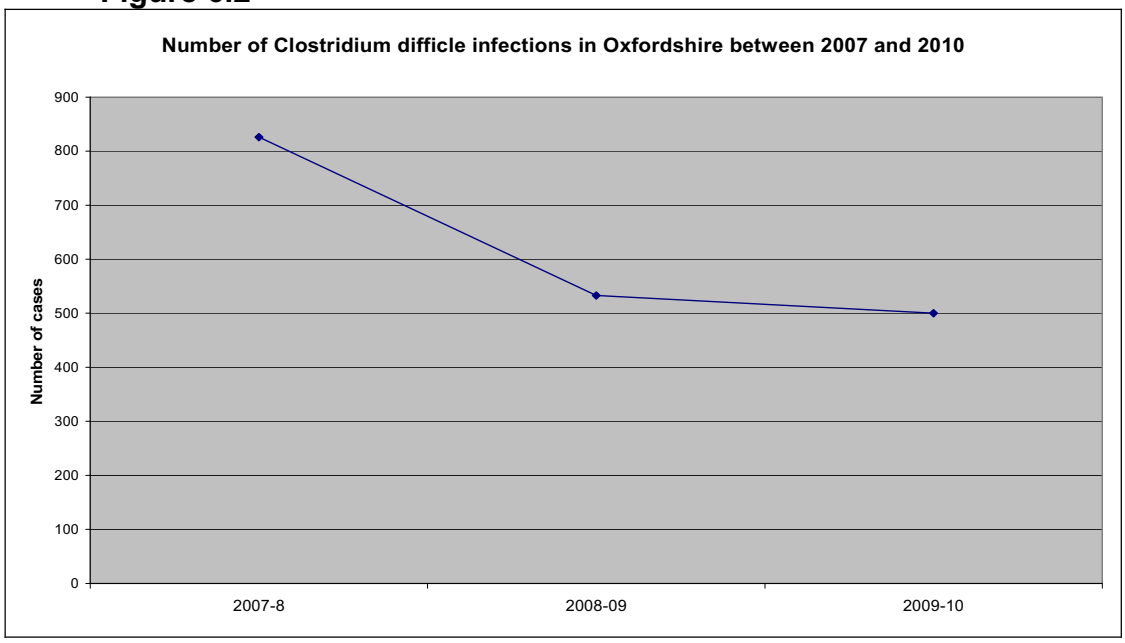
Approximately a third of MRSA bacteraemias are diagnosed within 48 hours of admission. These cases are reviewed by the PCT and a significant number are due to long term indwelling urinary catheters. As a result a countywide project is ongoing to reduce this cause. All planned admissions to our specialist hospitals are now screened for MRSA and if necessary patients are treated to remove the bacterium from their skin.

b) *Clostridium difficile* (*C.diff*)

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

Cases of *C.diff* are thought to have started outside hospital if they are diagnosed within 72 hours of hospital admission. These account for about half of all cases. No one can say for sure how these cases arise, but general practices with high numbers of cases have been reviewed by the infection control team and a pharmacist to check prescribing of antibiotics and the quality of infection control. The data below shows the reduction in cases since 2007/08. Work continues on reducing inappropriate antibiotic use, improving the speed of isolation of suspected cases and improving cleanliness in hospitals.

Figure 6.2



2) Tuberculosis (TB) in Oxfordshire

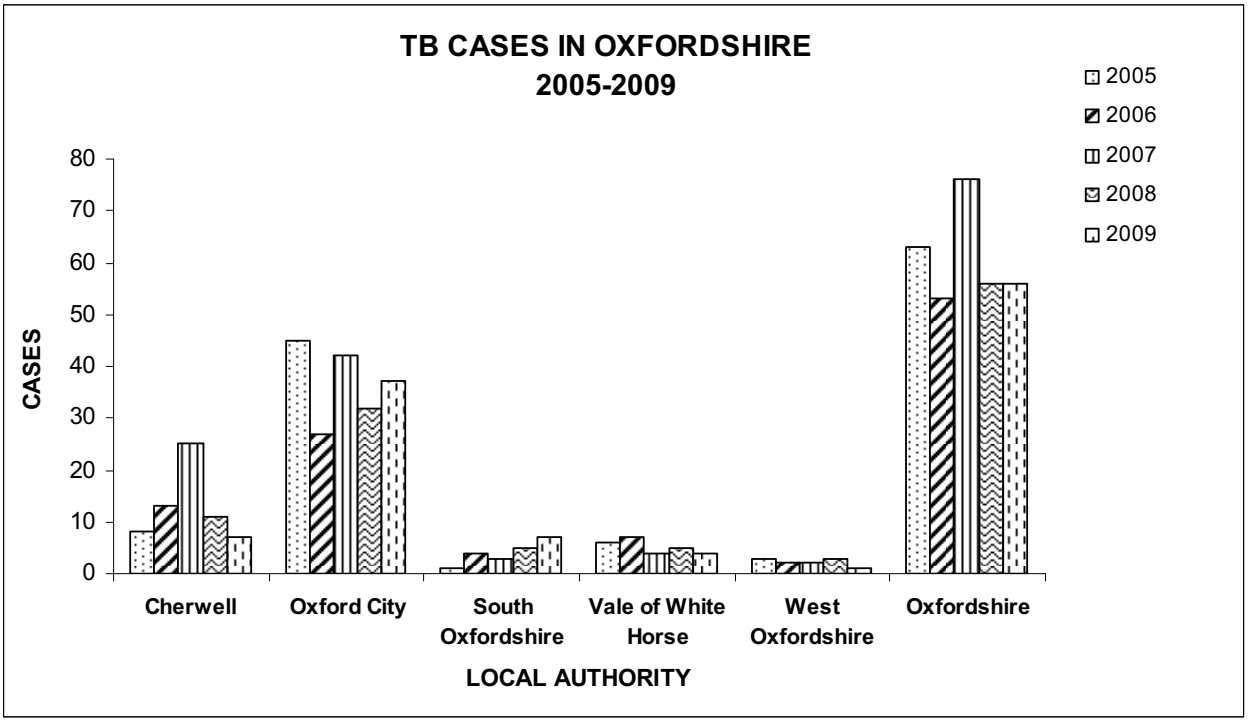
The latest data shows that TB rates in Oxfordshire fell compared with rates in 2007. Rates have remained highest in Oxford City and Cherwell District Council over the last five years (Fig 6.3). The substantial drop from 2007 to 2008 in the Cherwell District Council population follows the detection and successful treatment of a cluster of linked cases in this area during 2007.

Table 6.1: Tuberculosis incidence rate in Oxfordshire

Year	Number of cases	Rate per 100,00 population
2005	63	10.3
2006	53	8.4
2007	76	12
2008	56	8.8
2009	55	8.8

The Oxfordshire incidence rate of TB is consistently lower than the UK rate which provisional data suggests is 14.9/100,000 for 2009 across the UK. **This is a good achievement.**

Figure 6.3: Tuberculosis cases by local authority in Oxfordshire, 2005-2009



In Oxfordshire 55 TB cases were reported in 2009.

The Chief Medical Officer set local services a target of recording all TB cases and completing successful treatment in 85% of cases. Oxfordshire successful treatment rates have risen to 89.3% in 2008 (above the Thames Valley average) compared with 83.3% in 2006 and 84.2% in 2007.

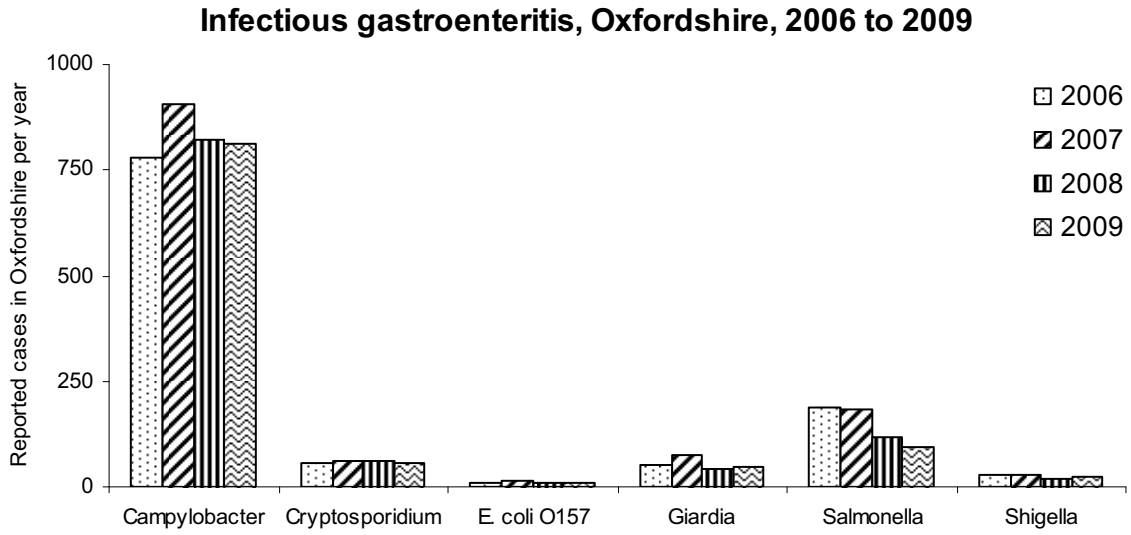
3) Gastrointestinal Disease

Food poisoning and other forms of infectious gastroenteritis continue to be a substantial burden of disease on the population of Oxfordshire. National regulations and standards are implemented locally by the environmental health staff of district councils. This year the five district councils in Oxfordshire collaborated to launch the excellent "Scores on the Doors" project where restaurant hygiene ratings are displayed prominently in restaurants and on the internet at http://www.scoresonthedoors.org.uk/fac.php?area=SE&county=OX . This is part of the ongoing work to ensure that safe food is served to the Oxfordshire population and visitors to the county. The need for continued public health work to assure safe food is shown by substantial numbers of cases of food borne disease in the County.

Surveillance data

There were over 1,000 reported cases of infectious gastroenteritis in 2009. This was an improvement on the previous year and shows satisfactory progress, apart from campylobacter infection which remains a cause for concern (see below).

Figure 6.4



More information on infection control is available from the health protection unit tvhpu@hpa.org.uk.

All of these infections can spread from person to person but this is usually easily prevented by hand washing and avoidance of preparing food for others while infected. For *Cryptosporidium,* infected children swimming in pools appear to be an important ongoing risk and all reported cases now receive advice to help with this.

The large number of cases of *Campylobacter* gastroenteritis is near to record highs, and with an estimated 8 cases occurring for each of the 811 that were confirmed by laboratory testing, we estimate that over 6,500 people suffered from this infection in the county in 2009, with young children being particularly affected. The main protection that is available to reduce this risk locally is to ensure that chicken is always well cooked and that raw chicken is not allowed to come into contact with other foods.

4) Vaccine Preventable Diseases

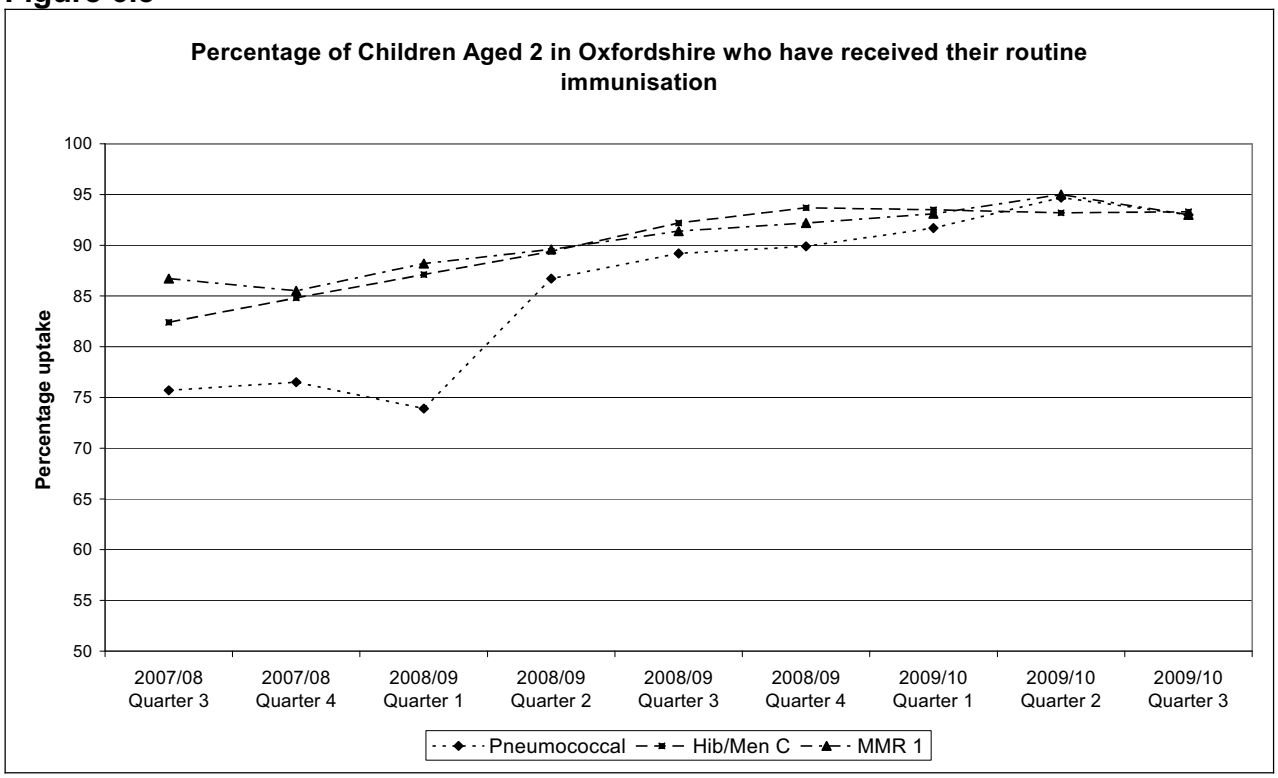
a) Childhood immunisations

Vaccination is the most cost-effective medical public health intervention. Levels of immunisation for childhood diseases in Oxfordshire have improved steadily over the years. A huge amount of work has been done to improve the way data is collected and recorded resulting in much more accurate information held by GP practices and the PCT. Practice staff, community staff and the PCT have been working together to achieve this – and this work was recognised nationally when the team were 'highly commended' at the Health Service Journal awards in November 2009.

A new Child Health Information System went 'live' in mid February 2010; this is an absolutely essential tool for keeping information accurate and quality high. This small number of children who are unimmunised can now be followed up individually and offered immunisation.

From the data up to February 2010 we anticipate that Oxfordshire will achieve the national targets set for immunisation. The graph below shows progress made.

Figure 6.5

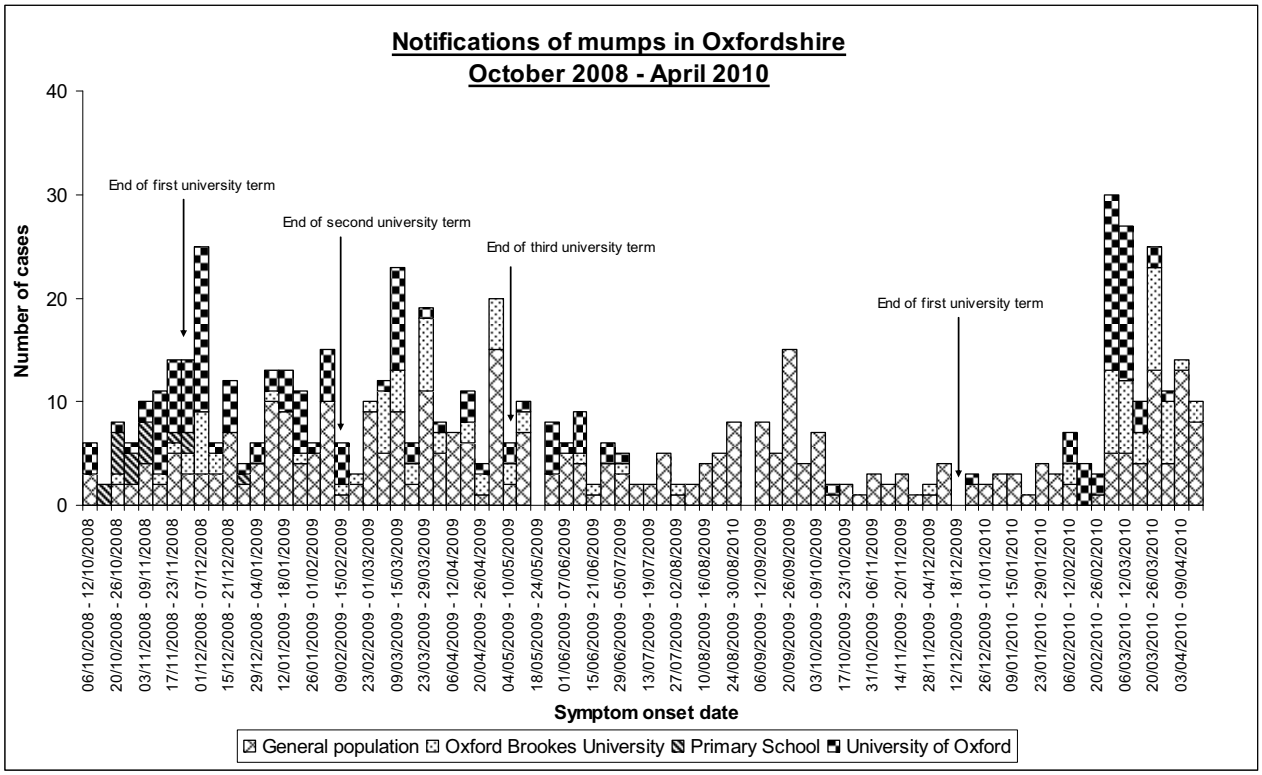


b) Measles Mumps and Rubella vaccine (MMR)

Two doses of Measles Mumps and Rubella vaccine (MMR) provides 99% of people with long term protection against measles (and 100% protection to the whole population if coverage is sustained at in excess of 95%). In the absence of vaccination there would be approximately 8,000 cases of measles per year on average in Oxfordshire. Of these, approximately 40 people would suffer convulsions as a complication, 8 encephalitis and an average of 1 person per year would die. However, the very success of vaccination programmes can lead to complacency, a fall in vaccination levels, and the recurrence of diseases. This has happened nationally with the resurgence of measles leading to over 1,100 cases nationally between January and September 2009, including 40 in the Thames Valley. Because we have prioritised vaccination in Oxfordshire, there were only 2 cases between January and October 2009 and 1 in 2008. Nonetheless, because the stakes are so high, the PCT has begun a major programme to improve performance further.

The relatively low rate of measles in Oxfordshire over the past year contrasts with an increased number of cases of mumps due to spread among university students in Oxford arriving from out-of-county (Figure 4). This involved students in an age group who had received only one dose of MMR and one of MR (measles and rubella but lacking mumps) in the 1994 MR campaign.

Figure 6.6



Provision of vaccination by general practitioners and information e-mailed to university students during the 2008/2009 academic year partly closed this gap in protection. Information highlighting this problem was provided to new students for the 2009/2010 academic year before coming up to university in an "MMR vaccination: it's not just for children" information sheet allowing them to ensure with their usual general practice that they were protected before leaving home.

c) Human Papilloma Virus vaccine (HPV): preventing cervical cancer

Genital human papilloma virus (HPV) is the most common sexually transmitted infection. It is so common that at least 50% of sexually active men and women get it at some point in their lives. There is no treatment for the virus itself but a highly effective vaccine is available that protects against HPV types 16 and 18, the types most commonly associated with cancer between them cause over 70% of all cervical cancers. **HPV vaccination will save the lives of an estimated 400 women each year in the UK with 4 lives saved per year in Oxfordshire.**

The first cohort to be immunised were girls in school year 8 in 2008/09, who were offered a three-dose course of HPV vaccination in school, over six months. A very impressive 90% of the girls took up the offer to have the three doses of HPV showing a highly successful start to a new vaccination programme. A catch up programme, the next phase of the HPV programme, started in September 2009 offering HPV to all girls up to the age of 18 years at 31 August 2009.

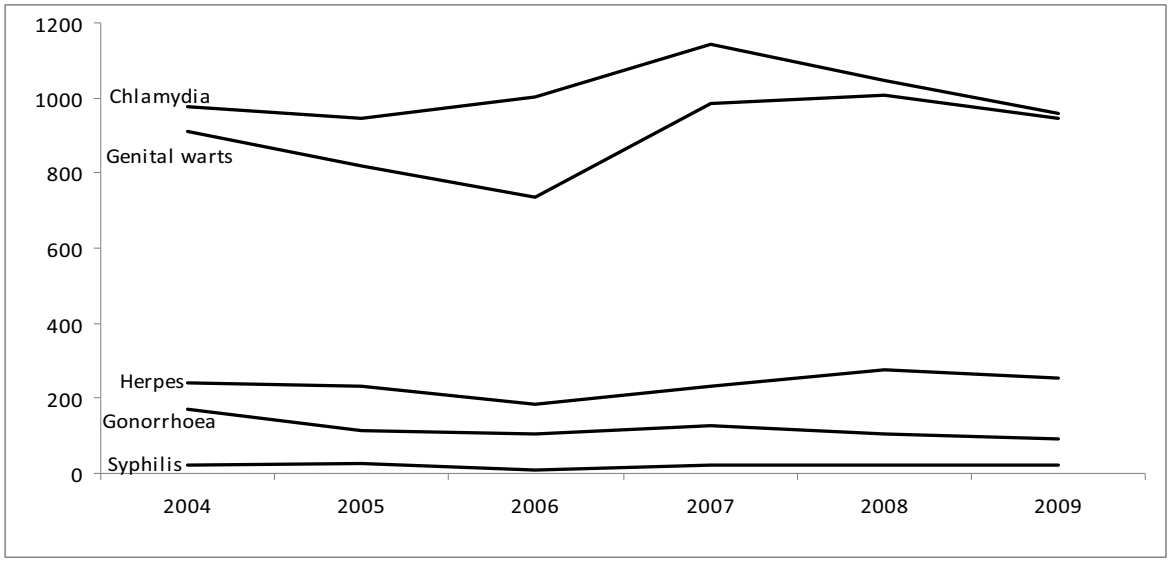
This new vaccine is a significant step forward in the prevention of cancer.

5) Sexually transmitted infections

It is important to monitor sexually transmitted diseases carefully to watch for increases in disease, the vast majority of which are preventable through taking basic 'safe sex' precautions.

Overall sexually transmitted infections diagnosed at genitourinary medicine clinics in Oxfordshire show a largely stable picture over the long term although there is some year to year variation. It is heartening to see that all the major sexually transmitted diseases fell during the last year. Chlamydia and genital warts remain the most common although there have been decreases in Chlamydia cases over both 2008 and 2009 from a high in 2007.

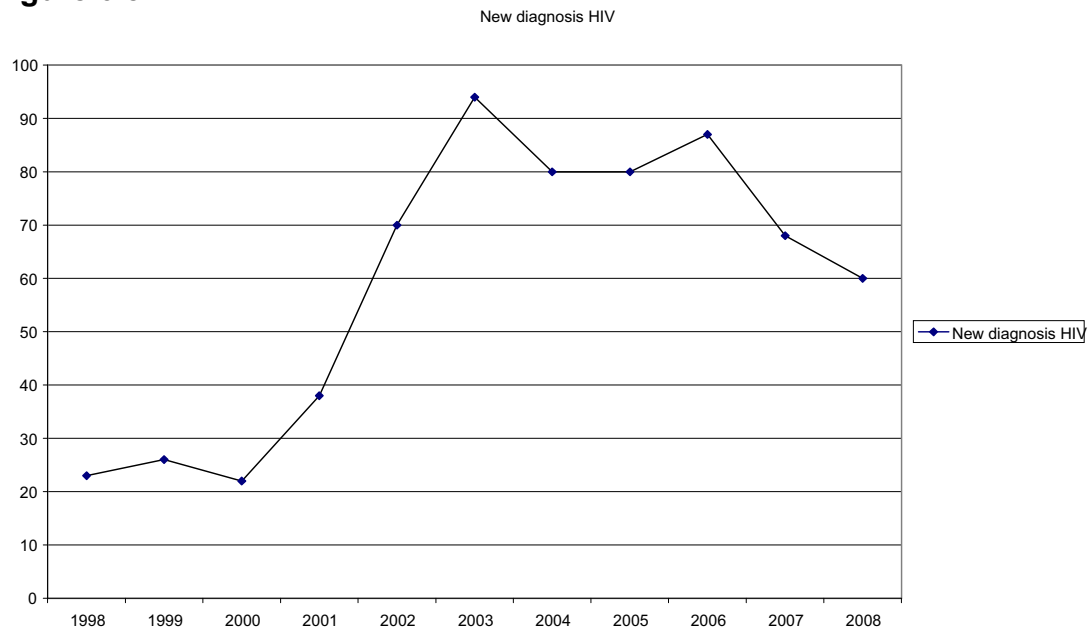
Figure 6.7: Sexually transmitted infections diagnosed at genitourinary medicine clinics in Oxfordshire, 2004-2009



HIV & AIDS

In 2008, there were 60 new HIV diagnoses across Oxfordshire and 267 across the Thames Valley, continuing the welcome downward trend begun the previous year. Work continues with vulnerable groups, delivered through partnerships with Terence Higgins Trust and Oxfordshire County Council.

Figure 6.8



6) Hepatitis C virus infection (HCV)

HCV is a blood borne virus that causes liver disease. A small proportion of cases go on to develop cirrhosis of the liver and a small proportion of these will contract liver cancer and die of the disease. HCV is contracted if a small amount of blood from an infected person gets into someone else's bloodstream. Most cases are injecting drug users, people who received blood transfusions in the UK before screening began in 1991 and people who have had transfusions in parts of the world where quality controls are poor. Many people will remain symptom-free and so will be unaware they have it.

The number of people estimated to be infected with HCV in Oxfordshire is around 2,000. 52 people were offered treatment in 2009/10.

Last year's DPH annual report called for the situation to be improved.

Oxfordshire PCT has worked productively with partners throughout 2009 to understand the current picture, identify the gaps, and draft a strategy to prevent this disease and improve treatment. This work is ongoing.

7) Influenza A (H1N1) – The Swine Flu Pandemic

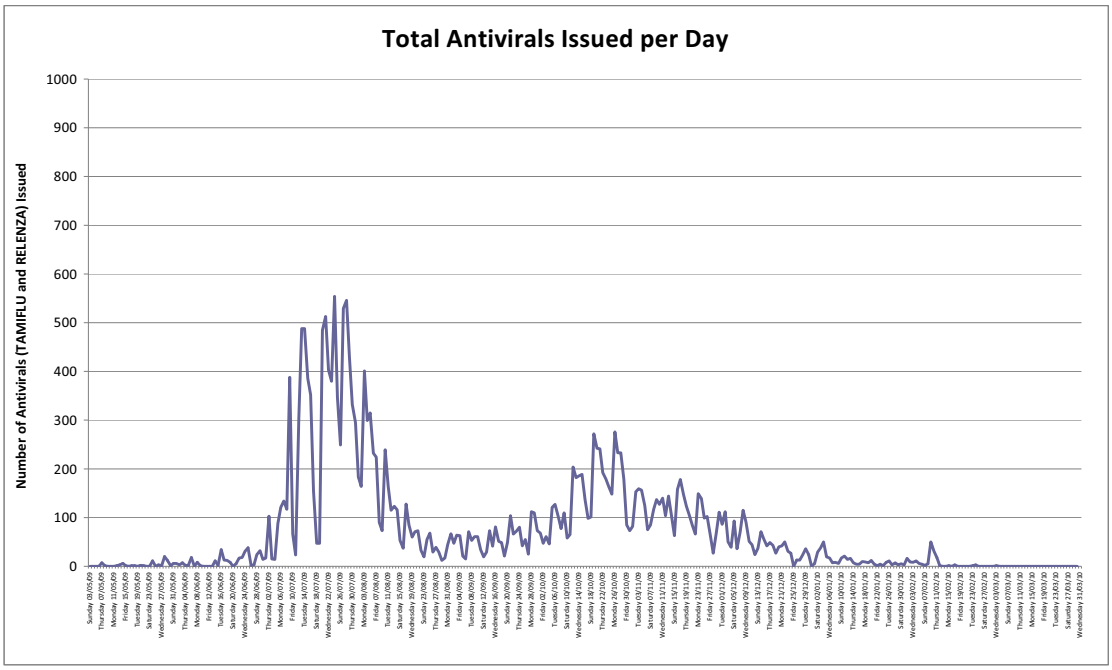
Influenza A (H1N1) was first identified in Mexico in April 2009. In June 2009 the World Health Organisation declared that it had become a pandemic, which meant that the virus had spread around the globe. It spread quickly because it was a new type of flu virus to which few people have full resistance. In most cases the virus has proved to be mercifully mild, however around the world hundreds of people have died. The confused picture in the early days in Mexico led the world to expect a virulent pandemic and so a full emergency response was triggered.

Oxfordshire has spent the last 4 to 5 years carefully preparing for a pandemic and this meant that the NHS and Local Authorities were able to respond very quickly. The multi-organisational response was excellent and all organisations played their part. Support from and teamwork with the Health Protection Agency, the Police, and a wide range of organisations were crucial to success.

In addition, Oxfordshire successfully took an overall lead for health services across the Thames Valley. In the first stages the PCT was able to support the Health Protection Unit and primary care in swabbing and treating individuals with confirmed disease and providing prophylactic antiviral drugs to slow down the spread of the infection in people who had contact with those with suspected swine flu.

As the numbers of individuals with suspected swine flu increased, the PCT opened antiviral collection points around the county to enable individuals to get their antiviral drugs. Numbers peaked at around 500 doses given per day. As numbers reduced access to antiviral drugs came from community pharmacies. The graph below shows the number of courses of antiviral drugs that were issued during the pandemic.

Figure 6.9



In June 2009 guidance was received from the Department of Health (DH) regarding the vaccination against swine flu and Oxfordshire PCT implemented a vaccination programme. This included making vaccination available to frontline health and social care workers and to priority groups including those that were pregnant, immunosuppressed or at higher clinical risk and to those between 6 months and 5 years. Data shows that Oxfordshire PCT achieved a high rate of uptake in health care workers thus protecting themselves and those patients with whom they have contact.

Table 6.2: The total number of frontline health care workers that have been vaccinated by each PCT in the Thames Valley as at 28 February 2010

Organisation	Eligible	Vaccine administered	%
Milton Keynes PCT	1,164	480	41.2
NHS Oxfordshire	3,343	1,350	40.4
Buckinghamshire PCT	3,017	921	30.5
Berkshire East PCT	2150	721	33.5
Berkshire West PCT	2,373	641	27.0

No Oxfordshire resident died of swine flu throughout the pandemic.

The question arises, was it all a storm in a tea cup? The answer is an emphatic no! Because of this pandemic we have learned much and improved services in new ways as follows:

- We know our joint plan works and it can now be improved
- We know that organisations in Oxfordshire and Thames Valley can cooperate well in a long drawn out emergency.
- We now know that we can slow down the spread of a pandemic through cough etiquette and handwashing
- We now know how to set up mass local and national phone-in services
- We now know how to give mass treatments to hundreds of people day after day
- We now know how to immunise thousands of people at short notice

- We know more about patterns and speed of spread around the globe and how these can be slowed down
- We now have a much better-linked network of intensive care services across Thames Valley.
- Improved planning also has wider benefits. Lessons learned during the flu pandemic helped the County deal better with the heavy snowfalls last winter.

OPINION: We are performing well in the fight against killer diseases in this County. There is no room for complacency and we need to refocus our efforts year on year to stay abreast of these diseases.

Recommendations

Recommendation 1
The Director of Public Health and the local Health Protection Agency must work closely to maintain surveillance of communicable diseases during 2010/11 and take appropriate steps to control these diseases and any new emerging killer diseases.

Recommendation 2
Oxfordshire PCT should continue to be ready and prepared to make investment in infection control services and health protection, through 2010/11.

Recommendation 3
The Director of Public Health should report on killer infections and infectious diseases in the DPH annual report in April 2011.

CHAPTER 7: Alcohol: What's your poison?

Why is it time to take Alcohol seriously as a major Public Health issue?

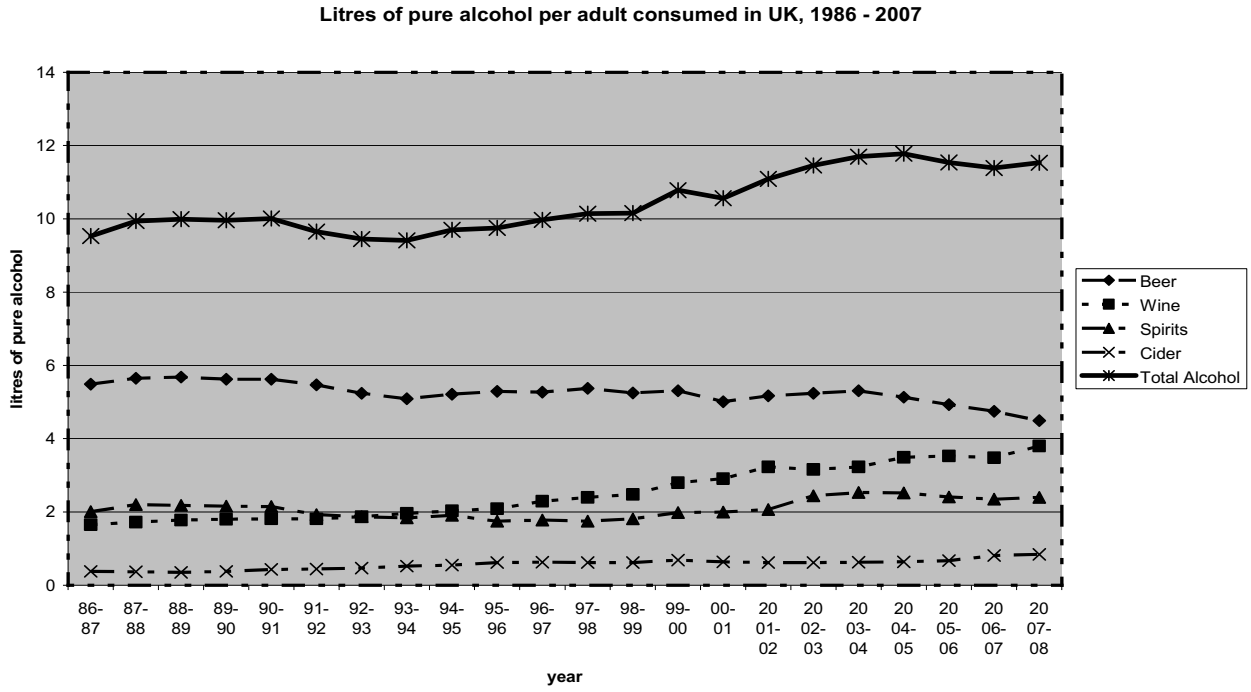
Alcohol is perhaps the last major gap in Oxfordshire's Public Health defences.

Despite good, innovative work in the county over recent years, this issue is not yet sufficiently in the mainstream of Oxfordshire's policy making, and it needs to be. Why? Alcohol is a deeply ingrained part of British culture. It is widely used in the home as a relaxant and its effect in lowering inhibitions is valued in social gatherings. Indeed, to many, the presence of alcohol is a social signal that says 'party'. Indeed, the majority of adults in our society do control their drinking and 9% abstain altogether. So, what is the problem? The list is as follows:

Alcohol consumption has risen in the last 40 years

In England, average adult alcohol consumption has risen by 40% since 1970. The graph below shows the recent trends in consumption.

Figure 7.1



Source: Institute of Alcohol Studies Factsheet "Drinking in Great Britain" www.ias.org.uk

A comprehensive summary of definitions relating to alcohol use and abuse are provided at the end of this chapter.

Many Adults exceed recommended drinking levels and one in five drinks at hazardous levels

- In 2006, almost half (48%) of British men and 4 out of every 10 British women exceeded recommended daily guidelines on at least one day in the previous week.
- Similarly, British men and women aged 25 to 44 were more likely than other age groups to have drunk heavily on at least one day during the previous week, followed closely by those in the 16 to 24 age group.
- Individuals in managerial and professional occupations are more likely to have drunk alcohol in the previous week, and to drink more frequently than those in routine and manual occupations

- In 2008 one in every five of over 16's consumed alcohol at hazardous levels.
- Only 9 per cent of the White British population are non-drinkers, but the proportion is higher among some ethnic minority groups, rising to 90 per cent or more among those of Pakistani and Bangladeshi origin.

Alcohol consumption in young people has increased with heavy drinking and binge drinking a concern in this group and consumption among girls has been increasing rapidly.

Between 1990 and 2006, drinking in UK's 11-15 year olds roughly doubled from an average of around 5 units per week to around 11 units per week.

In addition to this there are proven links with risk taking behaviour which may result in:

- Teenage conceptions
- Sexually transmitted infections
- Mental health problems
- Alcohol related accident and injury
- Poorer school attendance and lower attainment
- Involvement in anti-social behaviour and crime

Alcohol without doubt causes disease and early death. It is a poison.

- In England in 2006, 16,236 people died from alcohol-related causes.
- The number of deaths from alcohol-related liver disease has almost doubled in the last decade.
- Alcohol causes cancers of the liver, bowel, breast, throat, mouth, larynx and oesophagus; it causes osteoporosis, reduces fertility and causes accidents of all kinds.
- Alcohol is responsible for around 950,000 unnecessary admissions to hospital nationally per year, and this is rising (an increase of 70% in the 6 years between 2002/03 and 2008/09).

Alcohol is getting cheaper and more easily available

- The real cost of alcohol has fallen: a unit of alcohol cost 67% less in 2007 than in 1987.

The health benefits of alcohol are overstated

- The potential health benefits of alcohol tend to be greatly overstated.
- Above the age of 40 years, drinking a small amount of alcohol may reduce the risk of heart disease and stroke.
- For those who drink above this low level, and for those under 40 years who drink any amount, alcohol **increases** the risk of heart disease and stroke.
- For those of any age, drinking any amount of alcohol increases the risk of cancer – there is no safe limit.
- Across England, alcohol results in over 13 people being admitted to hospital for every one that it prevents.

Alcohol damages the family and social networks

- Living with somebody who misuses alcohol can be a horrendous ordeal. Alcohol can make a partner's behaviour unpredictable, aggressive and erratic.
- Marriages in which one or both partners have an alcohol problem are twice as likely to end in divorce.
- British Crime Survey figures for 2007/08 suggest that 125,000 alcohol-related instances of domestic violence occurred over this one-year period.

Alcohol fuels antisocial behaviour and changes the character of our towns, especially in the evening at weekends

- Local Councillors have frequently stated their unease about the drinking culture apparent in towns across Oxfordshire, particularly among young people in the evening at weekends.
- Nationally, aggressive behaviour resulting from alcohol misuse, in particular binge drinking, is a major cause of street violence. The British Crime Survey found that almost half of the 2 million victims of violence thought that their attacker was under the influence of alcohol, with 39,000 reports of serious sexual assault also being associated with alcohol consumption.
- The effects of crime extend beyond those who are directly attacked, creating an environment of fear.

Alcohol damages front-line services and the economy and places a huge financial burden on the taxpayer.

- Half of all assaults on staff in hospital emergency departments are committed by those under the influence of alcohol.
- There are over 8,000 alcohol-related assaults on police officers every year in the UK.
- This makes it difficult to deliver community services in areas where staff feel threatened, demoralising front line healthcare staff and other professionals.
- One in every four accident and emergency attendances is related to alcohol
- The total cost to the NHS is estimated to be £2.7 billion per year and rising - almost double the cost in 2001 when the cost was £1.47 billion.
- At least 14-17 million working days are lost per year in the UK because of alcohol, costing up to £6.4 billion per year.
- The National Social Marketing Centre estimated that the total annual societal cost of alcohol misuse to the nation to be £55.1billion.

In 2008 the Chief Medical Officer summed up the problem well:

"*Drinking alcohol is a deeply ingrained part of our society; each year the average intake per adult is equivalent to 120 bottles of wine. Since 1970, alcohol consumption has fallen in many European countries but has increased by 40% in England.*

The consequences of drinking go far beyond the individual drinker's health and well-being. They include harm to the unborn fœtus, acts of drunken violence, vandalism, sexual assault and child abuse, and a huge health burden carried by both the NHS and friends and family who care for those damaged by alcohol. "

<u>The position in Oxfordshire:</u>

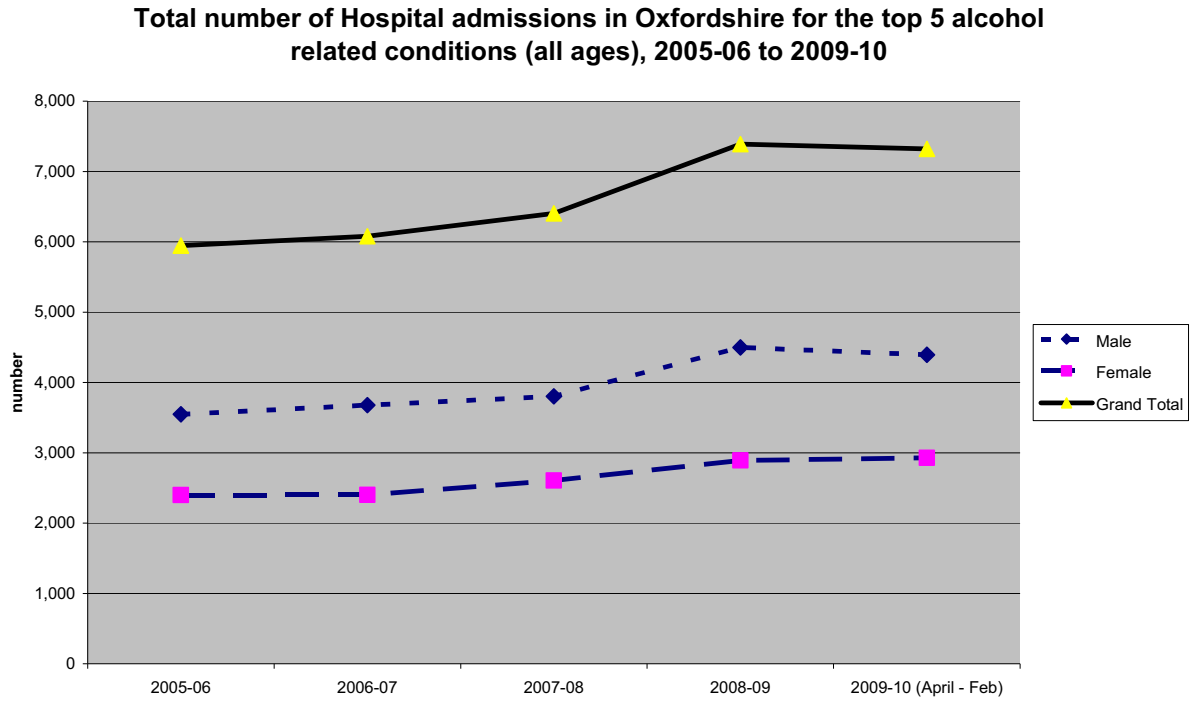
Hospital admissions for alcohol related harm in Oxfordshire

Local statistics show the burden of disease related to alcohol in Oxfordshire.

The graph below shows how hospital admissions due to alcohol related conditions have been rising steadily from 2005 to 2010. This calculation takes 5 common conditions and records the proportion of each one that is caused by alcohol.

The top five alcohol related illnesses are breast cancer or other related illness, heart rhythm problems, rectal cancer, heart disease related to artery deposits and other unspecified chest pain.

Figure 7.2



Source: SUS (U-R) data analysed by Decision Support, NHS Oxfordshire April 2010

Self reported under-age drinking in Oxfordshire

The Big Voice survey was carried out in Oxfordshire between March 2008 and June 2009. An online survey was completed at school by almost 5000 young people aged 4 – 19 with additional on-street interviews for 16-19 year olds. This gave the following results which many may find shocking.

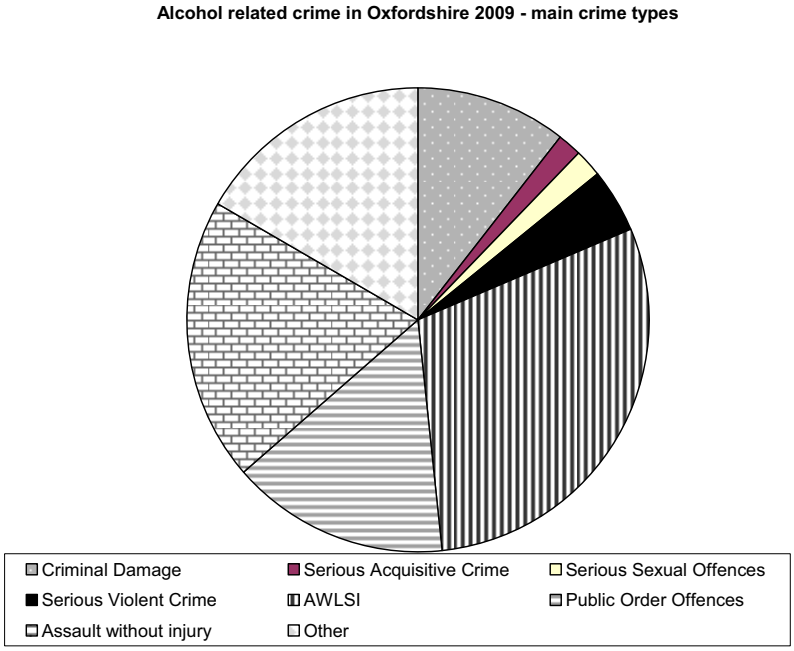
- 72% of young people aged over 11 have drunk alcohol,
- 9% regularly drink,
- 51% have been drunk
- 9% are regularly drunk.
- 5% agree that there is a lot of pressure to drink alcohol.

Under age sales of Alcohol in Oxfordshire

Police Licensing Teams and Trading Standards officers carry out checks of sales of alcohol to under age young people. Results of the police led operations in 2009-10 showed:

- 50 out of 207 premises tested sold alcohol to underage customers (24%)
- Over a third of these failed again when re-tested
- Seven premises were prosecuted for repeated failures

Figure 7.3: Alcohol related crime in Oxfordshire



Source: Thames Valley Police, March 2010 (Note – AWSLI stands for Assault with Less Serious Injury)

- **Over 11% of all crime in Oxfordshire last year was related to alcohol consumption**
- **This absorbs a substantial proportion of taxpayers' money spent on police services**
- Assaults make up the largest proportion of crimes which are committed under the influence of alcohol,
- Public order offences make up a high proportion of these crimes including being drunk and disorderly and using threatening words or behaviour. This behaviour often leads to other criminal behaviour including assault or the causing of criminal damage.

The cost of alcohol related crime can be estimated. For example, the crime figures from Oxfordshire last year indicate that:

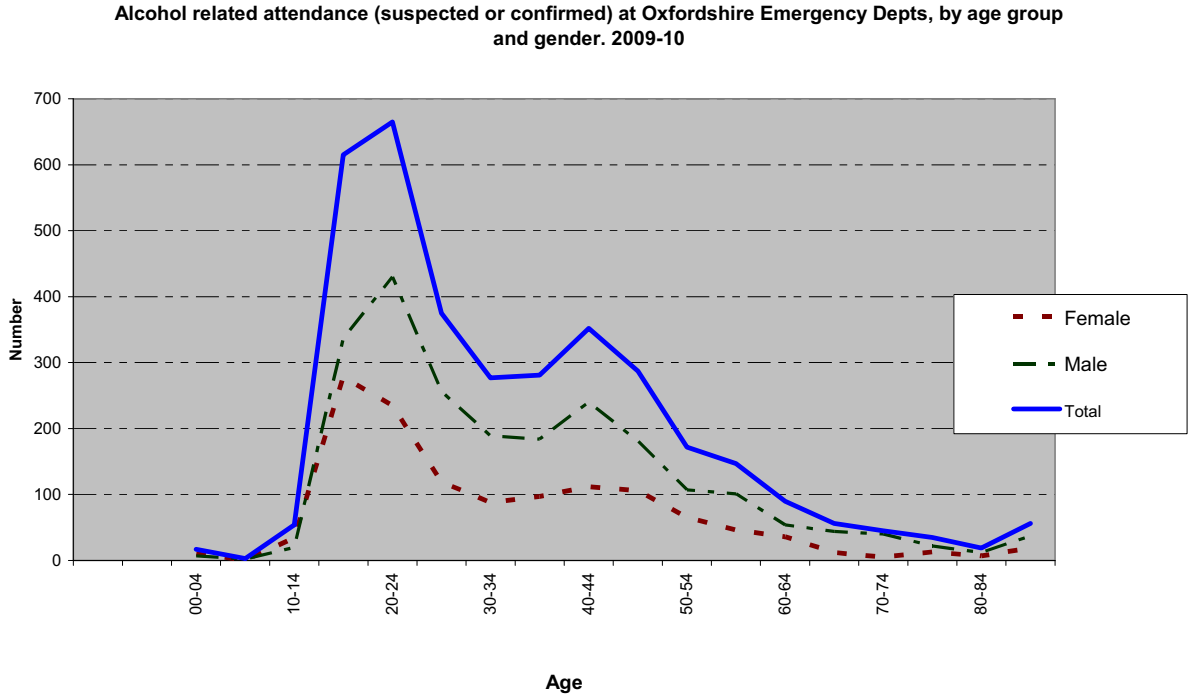
- Alcohol related criminal damage cost approximately £4.5m (over 5,000 incidents at an indicative cost of £890 per incident)
- Violent assaults fuelled by alcohol in Oxfordshire cost approximately £1.5m (149 offences at an indicative cost of £10,409 each)
- Serious sexual offences linked to alcohol use cost approximately £3.1m (99 offences at an estimated cost of £31,438 each)

Accident and Emergency (A & E) attendances caused by alcohol in Oxfordshire

3,500 A and E attendances were related to alcohol in 2009/10. This is expensive to the taxpayer and inefficient for our services, especially when our emergency departments struggle to see patients within the national 4 hour standard. These 3,500 attendees mean longer waits for everyone. The predominance of young people and young adults, especially young men, is simply a reflection of the drinking culture society permits, aided by liberal licensing laws around opening times. In Oxford at the weekend it is easy to carry on drinking until 3 o'clock in the morning.

National statistics indicate that 70% of emergency admissions on a Friday and Saturday night are due to alcohol consumption.

Figure 7.4



Source: Data from Oxford Radcliffe Hospitals Trust, analysed by Decision Support, NHS Oxfordshire.

Ambulance call-outs related to crime and disorder incidents in Oxfordshire

The further cost of alcohol to society is reflected and is shown in ambulance call outs to crime and disorder incidents. One quarter's data shows the pattern of activity, often focusing on built up areas in Oxford and Cherwell, resulting in 4,000 to 5,000 call outs a year.

The Oxford Nightsafe Partnership maps this data by location of the pick-up on a regular basis. They particularly look at the ambulance attendance where there is a record of assault / sexual assault, overdose / poisoning or stabbing or gunshot wounds. A high proportion of these pick-ups are made at licensed premises.

Table 7.1: Records of ambulance call outs to crime and disorder incidents in Oxfordshire July – Sept 2009

	Month (2009)			
LA district	**Jul**	**Aug**	**Sep**	**Total**
Cherwell	83	92	87	**262 (21%)**
Oxford	165	184	147	**496 (41%)**
South Oxfordshire	39	52	28	**119 (10%)**
Vale of White Horse	78	57	45	**180 (15%)**
West Oxfordshire	52	48	42	**142 (12%)**
Total	**417**	**433**	**349**	**1199 (100%)**

Source: South Central Ambulance NHS Trust (Oxfordshire)

Summary

The British Medical Association summed up the position well in 2008, and also criticised the effectiveness of our current national policies to control alcohol.

"*Alcoholic beverages consumed in moderation are enjoyed by many. Although socially accepted, alcohol can be an addictive drug. Alcohol misuse can be harmful foremost to the individual but also places a substantial burden on families and society. The levels of alcohol-related disorder, crime, morbidity and premature mortality in the UK are*

unacceptably high. Despite this, the strategy to reduce alcohol-related harm in the UK has seen an over-reliance on popular but ineffective policies, as well as liberalisation of the major drivers of alcohol consumption: availability and price. This represents a significant shortcoming in the political drive to improve public health and order."

What are we doing about it?

Our current strategy is a good start and provides a solid foundation.
The Oxfordshire Alcohol Strategy 2008-11 has made a very good start. Put together by an impressively wide range of organisations, its key priorities are to:

- Reduce alcohol related disorder
- Increase the consistency and quality of alcohol awareness for all ages
- Develop key health initiatives and commission alcohol treatment
- Develop a balanced sustainable leisure economy for the benefit of all ages
- Reduce young people's demand and supply of alcohol and its associated harms

This strategy is now due for renewal, and that gives us an opportunity to move forward faster.

Evidence of green shoots and good practice
New actions which have been carried out as part of this strategy include:

- A campaign to raise awareness of the safe drinking levels
- A wide range of organisations coming together including the police and ambulance services to keep our City and town centres safer at night time (the Nightsafe partnerships)
- Joining up work between the public health department and the John Radcliffe A and E Dept to follow up people with alcohol related injuries with the aim of reducing alcohol intake.
- Checks on shops selling alcohol to underage drinkers leading to successful prosecutions and greater awareness.
- A special theatre production for schools aimed at raising awareness of alcohol problems and limits called Last Orders.
- Brief Advice training for schools and Health Trainers (people working in the community to offer help on health issues to those who are the hardest to reach) so they are confident to raise the issue of drinking.
- A new alcohol treatment service procured by DAAT as mentioned above.
- Revising the Children and Young Peoples' Plan to include better action plans which will bring more joined up action from a range of organisations
- Carrying out the Oxfordshire Voice Survey of alcohol consumption and attitudes showing that levels of awareness are quite high.

What should we do next?
The direction of travel on tackling alcohol issues is good and we need to build on this success. The focus of this work, our understanding of the issues and the delivery of initiatives have increased enormously in the last few years. From a position where tackling alcohol related harm was not "owned" by anyone we now have a shared vision and a plan which is being implemented by several partners. The Alcohol Strategy has brought people together and given leadership to this issue.

OPINION: A good start has been made to tackle alcohol issues in this county. Given the size of the threat posed, this topic should be given a higher priority in the County. The preparation of a revised County alcohol strategy is an opportunity to do this which should be seized.

How do we get there?

We have to be realistic. Some of the actions needed to change attitudes and behaviour in connection with alcohol have to be carried out at a national level. Campaigns, information and regulation are important. The debate will continue on whether the Government should set a minimum price for a unit of alcohol and many would say that tax is already high, but it is undeniable that price does have an influence on consumption.

We have to shift the emphasis to prevention and give people the right information to help them take responsibility for their health. It is only changes in individual behaviour that will lead to reductions in overall consumption and this disease.

We have to use 'brief advice'. Many professionals could take the opportunity to raise the issue of alcohol consumption and give brief advice if required**.** There is good evidence that this works. Early detection and increased awareness are the best tools in the prevention agenda. The role of GPs and primary care are crucial in this. This work should be stepped up and made consistent across the county.

Recommendation

The revision of the Alcohol Strategy in the next year will give a great opportunity for a further step-change. We need a strong strategy which should include the following key elements by March 2011.

1. Powerful and far reaching information about the potentially toxic effects of alcohol to health, community safety and family life that make it a personal issue for all of us.
2. Further reductions in alcohol related crime and disorder in our towns and City with targeted approaches and a firm resolve to enforce action against premises and people causing problems. This is a lead area for Nightsafe partnerships around the county who should continue to develop their role.
3. Joined up and effective advice and treatment services are needed, including in primary care. The NHS and Drug and Alcohol Action Team should work together to commission prevention and treatment services proportionate to the size of the issue.
4. Involvement of young people is essential in devising and rolling out campaigns and activities to tackle the youth drinking culture. This will need to be part of the planning carried out by the Children's Trust.
5. Enforcement of the law to prevent sales of alcohol to under 18s (or people buying it for them). Trading Standards and the Police Licensing Officers can work together to ensure consistent coverage on this issue across the county.
6. A comprehensive set of process and outcome measures should be set monitored and reported regularly so that the impact of this step change can be seen. This responsibility should fall to the Alcohol Strategy Group who should make sure their results are reported to the Health and Wellbeing Partnership and the Children's Trust as well as to the Community Safety Partnership
7. The Health Overview and Scrutiny Committee should consider scrutinising progress made as part of their work plan for 2011/12.

Alcohol: a note on terms used

Looking closely at the subject of Alcohol requires some special jargon. The key terms are defined in this box.

Unit
In the UK, alcoholic drinks are measured in units (10 millilitres (ml) of alcohol.) One unit of alcohol is about half a pint of ordinary strength beer, lager, or cider (3-4% alcohol by volume), or a small pub measure (25ml) of spirits (40% alcohol by volume). There are 1½ units of alcohol in a small glass (125ml) of ordinary strength wine (12% alcohol by volume). There is substantial variation in the measures used in bars and restaurants and measures poured in the home tend to be larger.

Recommended drinking guidelines
In the UK, it is recommended that men should not regularly drink more than three to four units per day, and women should not regularly drink more than two to three units per day. In terms of weekly limits, men are advised to drink no more than 21 units per week and women no more than 14 units per week i.e.:

- **for men**, an **average** per day of 1½ pints of beer, 3 shorts of spirits or 2 **small** glasses of wine
- **for women** an **average** per day of 1⅓ **small** glasses of wine, 2 shorts of spirits or 1 pint of beer

Harmful drinking: drinking that causes harm
Harmful drinking is a pattern of alcohol use that causes damage to physical and/or mental health. Harmful use commonly has adverse social consequences.

Hazardous drinking: drinking that puts the individual at risk of future harm
Hazardous drinking is a pattern of alcohol use that increases the risk of harmful consequences for the individual. In contrast to harmful drinking, hazardous drinking is of public health significance despite the absence of any current disorder in the individual use as it is likely to lead to future problems.

Heavy drinking: drinking in excess of what is considered moderate
A pattern of drinking that exceeds some standard of moderate drinking. In the UK, heavy drinking is defined as consuming eight or more units for men and six or more units for women on at least one day in the week.

Binge Drinking: heavy drinking in one session
Binge drinking is defined as drinking at twice the recommended levels or more in one session. This would be 8 or more units for men and 6 or more units for women in one go.

ACKNOWLEDGEMENTS

Thanks are due to colleagues across the County for their generosity of time and talents in the preparation of this report

Angela Baker
Dawn Beechey
Jean Bradlow
Alison Burton
Paul Cann
Stephen Capaldi
Tim Chapman
James Clark
Jim Couchman
Julie Dandridge
Ian Davis
Ruth Fenning
Shakiba Habibula
Anna Hinton
Fred Hucker
John Jackson
Huw Jones
Juliet Long
Noel McCarthy
Val Messenger
Sonia Mills
Keith Mitchell
Catherine Mountford
Ronan O'Connor
Brendan O'Dowda
Jan Paine
John Parry
Tom Porter
Stephen Richards
Geoff Rowbotham
Sue Scane
Joanna Simons
Paul Smith
Meera Spillett
Matthew Tait
Patrick Taylor
Fenella Trevillion
Alan Webb
Jackie Wilderspin

This page is intentionally left blank

Ref: **Current Stage:** *Ver 0.1* **Author:** *D Saunders*	Business Case Dementia Early Diagnosis	NHS Oxfordshire

ITEM JHO8(a)

Proposal:	Early Diagnosis in Dementia service
Document Reference:	
Version:	1.0
Issue Status:	1st Draft
Date Last Updated:	26/ 04/ 2010
File Reference:	*will be set by PMO
Author:	Duncan Saunders
Directorate:	PMO

ITEM JHO8(a)

Contents List

ITEM JHO8(a)

Distribution List

PMO **must** review all Business Brief and Business Cases

Role	Name	Position	Scope
SDM	Duncan Saunders	SDM; Older Peoples Mental Health	Memory assessment service redesign

Issue/Amendment Record

Status	Version	Release	Issue Date	Reason For Issue/Changes Made
Draft	0.1	No	26/04/2010	First Draft
Draft	0.2	No	15/05/2010	Changes following discussion with John Walton
Draft	0.3	No	2/6/2010	Changes following discussion with Suzanne Jones
Draft	0.4	No	7/6/2010	Changes following discussion with Pauline Smith

Executive Summary

Executive Summary

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

In Oxfordshire, Quality and Outcomes Framework (QOF) data shows that 34% of people currently receive a diagnosis of dementia. Memory clinics exist, provided by both Oxford Radcliffe Hospitals Trust (ORHT) and Oxfordshire and Buckinghamshire Mental Health Trust (OBMHT). There is currently no clear pathway and no agreed service specification, leading to uneven levels of service and post diagnostic support. There is confusion among GPs around where to refer a patient with suspected dementia.

Building on recommendations in the National Dementia Strategy, the proposal is to commission an integrated Memory Assessment Service involving both providers working together to maximise the strengths of both. The need for an increase in the numbers receiving a diagnosis and current capacity issues would be partially addressed by enabling a specialist dementia nurse to undertake routine follow up appointments, moving the follow up appointments into community settings such as GP surgeries and freeing up consultant time for diagnosis and more complex cases. Agreed information and support would be provided at, or shortly after, diagnosis.

Background

The National Dementia Strategy was published in February 2009, containing 17 objectives. The implementation of the strategy is overseen by the Dementia Development and Implementation Board, and involves a commissioning team from both Oxfordshire PCT and Oxfordshire County Council. Early Diagnosis in Dementia is objective 2 of the National Dementia Strategy and forms one of the priority areas for Oxfordshire. Lead responsibility for this project is with Oxfordshire PCT.

A review of memory assessment services was undertaken in 2008, which underpins this document and the wider project.

There are many reasons for robustly commissioning a memory assessment service for the early diagnosis of people with dementia. In its guidance on Commissioning Memory Assessment services, NICE lists some of the potential benefits as increasing the number of people seen for early diagnosis and intervention, reducing total care expenditure by delaying the time to nursing home admissions and other costly outcomes, breaking down the stigma of dementia and improving the quality of life of people with dementia and their carers by promoting and maintaining independence. According to the NICE guidance, “Early detection and intervention enables more timely access to treatments and ultimately reduces total care expenditure by delaying the need for long-term care and other costly outcomes.”
“It is…well recognised that dementia has a significant economic impact on the health care system, on patients, on family and friends who provide unpaid care, and on the wide economy and society.” (Dementia 2010 report, Alzheimer’s Research Trust 2010)

Currently, the level of dementia diagnosis in Oxfordshire is 34% based on the estimated population with dementia and QOF data, so only around 1/3 of people with dementia have a diagnosis.
There are tensions in this locally; memory clinics currently undertake diagnosis and follow up monitoring of dementia; capacity issues mean that follow up is commonly less frequent than NICE guidance suggests. Also, Oxfordshire’s population is ageing and Community Mental

Health Team (CMHT) resources are likely to decrease with pending reorganisation, thus exacerbating these issues.

The 2008 report reveals some examples of good practice but significant variation exists between clinics across the county. There is variation in staff resources between clinics, leading to variation in service and follow up support. There is also inequitable access to structural imaging, which often falls short of NICE clinical guidelines.

There is currently a dual system in place with two providers; OBMH and ORH both provide memory assessment services for dementia. There is an identified need for a clear point of access and single service across the county, alongside a clear care pathway.

Proposed Solution

The proposal will build on existing good practice within Memory Clinics in Oxfordshire. The proposal would see the establishment of a single Memory Assessment Service within the county, providing an integrated service between the providers with a clear pathway and a single point of access for Memory assessment services in Oxfordshire.

The single point of access for both providers will receive referrals from GPs, removing current confusion around where to refer, building on recommendations from the National Dementia Strategy that “such services would need to provide a simple single focus for referrals from primary care, and would work locally to stimulate understanding of dementia and referrals to the service.“ Triage will be provided at this point, with referrals assigned according to clinical criteria. Domiciliary visits will take place as required at this point, to assist in triage.

Patients will have access to a structural imaging appointment to assist in assessment if clinically required. An appointment will then take place in a diagnostic memory clinic; this will be at the closest clinic geographically, unless the patient has requested otherwise. Home visits for diagnosis will be available if necessary. It is proposed that there would be 5 memory clinics for diagnosis occurring within the county on a weekly basis, in suitable locations around the county.

If a diagnosis is given, this will be communicated according to NICE guidance at the clinic. A letter detailing this diagnosis will be sent to the patient’s GP, with a copy sent to the patient if requested. Post diagnosis follow up and ongoing monitoring will take place in the community; either at GP surgeries or another suitable location. Initial follow up will include information provision and referral to appropriate services.

Given the current capacity issues, the need to increase levels of diagnosis and future demand for the service, it is anticipated that Consultant Psychiatrists would no longer be involved in all follow up appointments. This work would be undertaken by a registered mental health nurse (memory clinic nurse), operating in a community setting such as a local GP surgery. Referral to the CMHT for more complex cases would then be based on clinical criteria.

The possibility of involving GPs with Special Interest (GPSI) in diagnosis and follow up support is also included within the pathway. Currently, there are no such GPs within Oxfordshire.

Development funding of £116,000 has been included within the PCT operational plan for the support of this pathway. This is recurring funding, so would be available to support the service in future years.

Current Memory Clinic provision:

OBMH:
Didcot: 4 clinics
Witney: 2 clinics
Banbury: 12 clinics
Abingdon: 1 clinics
Henley: 4 clinics
Oxford: 7 clinics

ORH:
OXMAC: 8 clinics
Total: 38
These clinics are used for diagnosis and follow up.

Under the proposed pathway, the number of clinics per month would be 22; 5 clinics happening weekly = 20 per month, plus equivalent work outside clinic (domiciliary diagnosis, etc) for 2 more per month. Locations for these will be confirmed in discussion with providers. These clinics would be used for diagnosis.

Follow up would take place through appointments equivalent to 24 clinics per month, in community settings. Routine follow up would be undertaken by memory clinic nurses.

Investment:
The proposed use of the £116,000 is as follows:

£31,350.4: Band 6 Memory Clinic Nurse (4 day post)

If we were to commission three such posts as part of the service:

£94,051.2: 3 Band 6 Memory Clinic Nurses (4 day posts)

£9,400: Training and on-costs (10%)

£103,451.2

This leaves £12,548.8 for service costs; this will offset the costs of training other professionals such as GPs, additional venue costs, publicising the new service and recruitment costs.

The assumption is that the remainder of the service is “cost neutral”; in other words, that the existing number and grades of staff will continue to operate within the memory clinic system, that the venue costs will be comparable with current costs, that the current arrangements with regard to the provision of scans will continue to be sufficient and that administrative / support costs will remain at current levels.

The additional staff will be located within the existing CMHT structure, and will thus receive management support and clinical supervision from the existing support arrangements within the CMHT.

Assumptions

The following assumptions have been made:

- Early diagnosis and appropriate support for people with dementia and their carers has been shown to reduce the overall long term care costs in national evaluation
- Managers and clinicians support exists to deliver the project and the changes that will

accompany it

- Early diagnosis will result in fewer crisis interventions and delayed admission to intensive support services in the longer term
- Any future restructuring due to the integration of OBMHT and Community Health Oxfordshire will not have an impact on the service.

Risks

The following risks have been identified for the project:

Risk	Mitigation
Risk that there may be opposition by clinicians to the service specification and procurement strategy developed by the group resulting in disengagement and failure to support the changes to the service.	This is being managed by the presence of primary and secondary care clinicians on the project group, and the engagement of clinicians more widely in the project as part of the consultation.
Risk that planned service developments may be hindered due to a lack of resources.	This is partially mitigated by planned investment of up to £116,000, and by planned service redesign to increase capacity. However, future planning will need to look at this issue carefully given the population profile and anticipated increases within the county. Regular reviews of capacity and resources will be required for the service to meet projected demand.
Risk that project will not deliver the required outcomes.	This should be offset by the incorporation of clear, evidence based practice into the redesigned service. There will also need to be appropriate KPIs built into the service through a clear, structured service specification, with regular review of the service against these indicators. Training for professionals within the healthcare system and awareness programmes among the general public will be needed to help increase diagnosis levels.
Risk that memory assessment services will be unable to cope with increased demand.	The planned service is designed to include current and increased demand; however, this will need to be monitored on an ongoing basis, as mentioned above.
Risk that there will be significant user or public opposition to the planned developments.	The presence of a carer representative on the project group, and the wider consultation involving users and carers helping to shape the new service should ensure that the service takes the views and needs of users into account. As the planned developments also seek to provide a clear pathway of care and equitable access to service provision, major opposition to the redesigned service is not anticipated.

Key Stakeholders

The following have been identified as the key stakeholders for the project
NHS Oxfordshire
Oxfordshire County Council
Older Adult CMHTs,
Memory Clinic staff; both OBMH and ORH
GPs
Voluntary sector organisations working in the field of dementia, and with older people more generally
People with dementia, their carers and families

Project Sponsor: Suzanne Jones
Project manager: Duncan Saunders

Communications

The project team has held monthly meetings since the project launched; these have been documented, and the notes distributed to group members. The project sponsor has received monthly highlight reports tracking progress of the project and of the project status. A Communication strategy for the project has been created; a user involvement event was held on May 18th, where the draft pathway was examined. A web based consultation on the proposals was launched May 7th, following the General Election purdah period. Further user and stakeholder involvement was sought through the dementia awareness day on May 23rd and further involvement will be sought prior to implementation of any significant changes to the service.

Supporting Information

Scope

The project **INCLUDES** the following as part of its scope:

- Organisational Scope: primary care, public health, community health and social care services, acute providers of service, voluntary organisations as interest groups
- Client Group: People with dementia or suspected dementia, carers and families of people with dementia
- Funding Streams: health and social care commissioning of dementia care
- Information for staff, service users and carers, through a communication strategy
- Public and patient involvement in dementia developments
- All age groups

The project **EXCLUDES** the following as part of its scope:

- Organisational Scope: generic older peoples services
- Organisational restructuring into workforce required to support new pathway
- Provision of long term care home placement, intermediate care, continuing care
- Marketplace Redesign
- End of life – this will be covered in the end of life project work

Critical Success factors/ KPI's

The critical success factors for the proposal are as follows:

- An increase in the rate of diagnosis for dementia in Oxfordshire
- Diagnosis provided earlier in the course of dementia and a related reduction in the numbers of "crisis diagnoses"
- An equitable service provided countywide to agreed standards

Dependencies

The areas below have an impact on the project work, as work is happening at National or SHA level on dementia development and support, or generic work currently underway will inform the pathway outputs. The pathway can be developed and delivered without them; however they will enhance the pathway delivery. In the case of the DOH Dementia Advisor demonstrator site work, this will impact on the information and support provided to people with dementia and their carers in the mid to long term. In the case of the Dementia Workforce Development Project, this will impact on the delivery of training to allied healthcare professionals, such as GPs.

1. DOH Dementia Advisor demonstrator site phase 2 work
2. Dementia information prescription project work, tied in with (1), above
3. Dementia Workforce Development Project
4. Vascular prevention e.g. Vascular checks for adults at high risk
5. Older people's prevention strategy in Oxfordshire
6. Extra care housing developments
7. Delayed Transfers of Care (DTOC) demand and capacity work

Procurement

It is not anticipated that procurement will be required. However, advice will be sought if this is unclear at the implementation stage.

Constraints

There are possible impacts on the project and on the NHS more widely after the Emergency Budget; these are currently unknown but could have a significant impact on the project delivery in this and future years.

Approach

As suggested in the OBMH Review report, a phased implementation may be appropriate, with providers working together more closely prior to full implementation. If the business case is accepted, the proposal is to establish an implementation group to oversee the implementation of the redesigned service. This will be a time limited group, working towards the implementation of the proposal through a series of milestones to an agreed timescale.

Timescales

Following acceptance of the business case, timescales for implementation need to be established; full implementation is expected by April 2011.

Equality Impact Assessment

An EIA has been completed for this project; an action plan has been drawn up to address potential inequalities. Addressing potential inequalities identified in the EIA will form part of the implementation phase of the project.

Consideration of Green Issues- "Saving Carbon, Improving Health"

While the proposal will reduce the number of diagnostic clinics and potentially require users to travel slightly further to these clinics, there will be fewer appointments at the diagnostic clinics, with follow up support being delivered closer to home. Environmental impact is anticipated to be negligible.

IT Requirements

Diagnostic memory clinics will require internet access, at a suitable bandwidth to enable clinicians to access the ORH PACS system, in order to view patient scans as required. Access will also be required for appropriate databases, such as PCIS and DEEPARC.

Information Governance Impact

The service will use existing secure databases and information systems. There are therefore no anticipated impacts with regard to security of information.

Alignment with WCC – Health outcomes

The proposal aligns with WCC competencies 1; Locally lead the NHS, 4; Collaborate with clinicians, 8; Promote improvement and innovation and 10; Manage the local health system. Strategically, the project forms part of the implementation of the National Dementia Strategy, a key commissioning priority of the Ageing Successfully strategy for Oxfordshire, 2010-2015.

Quality Controls and Audit

Key Performance Indicators will be agreed as part of the contract for the service. These will include but not necessarily be limited to:

- Number of appointments within the service, to be broken down by location, first appointment / follow up and referral source. The number of home visits for assessment and diagnosis will also be recorded.
- Number of diagnoses given by the service, to be broken down by dementia sub type (including Minimal Cognitive Impairment), location and GP practice.
- Number of missed appointments: Cancellations / DNAs
- Staff absence and vacancies within the service.
- Average referral time from referral to assessment, and assessment to diagnosis.
- Percentage of diagnoses notified to GP within 5 working days.
- Results from patient satisfaction survey.
- Patient Gender / Ethnicity breakdown against all of the above.

The above measures will be measured by month and cumulatively for each year.

Post Implementation Review

Following implementation, there will be a review after 6 months and a further review after one year; subsequent reviews will take place on an annual basis. This will look at how far the overall pathway has been implemented against key milestones, any significant obstacles encountered and changes to the agreed timescales, including reasons for these. Action plans will then be updated to reflect the new position, with reports provided to stakeholders; this process will be managed under the governance of the Dementia Development and Implementation Board. KPIs and user satisfaction information will be used to ascertain performance against agreed targets on a monthly, quarterly and annual basis.

Measuring Success of Project Performance

The measures of success are mostly captured within the KPIs. The key metric is the rate of diagnosis for the county; currently at 34%, year on year increases to this will be agreed.

Project Team and Clinical Leads

Public Health lead	Kate King
Communication & PPI lead	Sara Price
Finance Lead	Julia Boyce
Clinical lead - OBMH	Dr Rupert McShane
Clinical lead - OBMH	Dr Carol Bannister
Clinical lead - ORH	Dr Gordon Wilcock
Social care lead	Liz Maughn
Community lead	Claire Du Feu
GP lead	Dr Mary Akinola
Management lead - OBMH	Sam Gillanders
Carer / User representative	Meg Barbour
Age Concern Oxfordshire	Andy Buckland

Service Options

Option 1- Do Nothing, Continue with the Current Services

The impact of the ageing population in Oxfordshire, alongside the current capacity pressures on the service mean that taking no action will not lead to an increase in the numbers of people who receive a diagnosis of dementia; it is far more likely that these numbers will reduce as a percentage of those within the county who have dementia. This will in turn have an impact on services for those with more severe dementia, as services will receive an increased demand.

Option 2 - Improve Current Services with this proposal

Details of the proposal are as listed above; this is the preferred option for improving Memory assessment services within Oxfordshire and increasing the rate of diagnosis. Early diagnosis for people with dementia has been shown to reduce the need for residential services by significant amounts; more detail is contained within the cost analysis, below. The Department of Health Operating Framework for 2008/9 said "…providing people with dementia and their carers the best life possible is a growing challenge, and is one that is becoming increasingly costly for the NHS. Research shows that early intervention in cases of dementia is cost effective and can improve quality of life for people with dementia and their families…"
As a key example of this,
"early provision of support at home can decrease institutionalisation by 22%" (Gaugler JE, Kane RL, Kane RA and Newcomer R (2005). 'Early Community-Based Service Utilization and Its Effects on Institutionalization in Dementia Caregiving'. The Gerontologist, 45, 177–185.) However, achieving this is reliant on early diagnosis. The above proposal would facilitate this.

Option 3 - Outsourcing

The current service is provided by OBMH and ORH; the potential for joint working to improve the overall service is accepted by both sides, as documented in the review of Memory Assessment Services undertaken in 2008 and repeated during the work of this project. Evidence, including that gathered nationally from GPs themselves suggests that a specialist service is necessary for diagnosis of dementia as opposed to GPs providing this diagnosis; as the current providers have worked over many years to develop expertise in this area, there is no real benefit to be gained by doing so, as opposed to the uncertainty that such a move would cause. Additionally, as the current arrangement provides good links to the support provided by Older Adult CMHTs, the breaking of this link would be to the detriment of the patient and suggests against altering the provider.

Implementation Milestones

A phased approach to implementation would be important for the sustainability of the service and to ensure that there is minimum disruption in the provision of the service to current and new patients.
The following key milestones would need to be met in the implementation of the new service pathway:

1. The establishment of an implementation group. Membership of this group would need to include representatives of provider organisations (management and clinicians), PCT commissioners, voluntary sector representatives and users/carers.

2. The creation of a detailed implementation plan, based on this specification and outline milestone plan. This would include target dates and lead areas of responsibility.
3. The establishment of the agreed point of referral across both providers.
4. The employment of the additional Memory Clinic Nurses, to increase capacity.
5. Increased integration between providers, leading to
6. A programme of training and awareness raising for allied health professionals such as GPs.

All of the above will lead to full implementation; the initial target date for this is April 2011.

Cost Analysis

Potential Investment:

Capital: n/a

Revenue: £116,000 recurring, in addition to current memory clinic costs

Please describe the investment required and expected funding source:

The investment is included within the operational plan 2010/11. This will be used to fund the single point of access / triage, and the increase in activity required over and above the service redesign in order to achieve the increase in numbers of people with dementia receiving a diagnosis.

Potential Annual Savings:

Capital: n/a

Revenue:

Please describe how it is anticipated that these savings will be achieved, i.e. will they be derived from a reduction in activity or a transfer of activity from one setting to another:

Savings will be whole system savings and will be realised in the longer term. Savings are as identified in "The clinical and health economic case for early diagnosis and intervention services in dementia", published by the Department of Health in 2008[1] . This document contained three potential levels of saving; by comparing these to the known and projected picture within Oxfordshire, we obtain the results shown here.
A 6% reduction in the number of people with dementia entering a care home would result in savings in Oxfordshire of £1,620,000, based on current costs.
A 10% reduction would result in savings of £2,700,000.
A 20% reduction would result in savings of £5,400,000.

While these savings are only partially offset by the need for other services such as home care, they do not take account of potential reductions in uptake other acute or intensive services, such as NHS continuing healthcare.
Given that the average length of stay in a care home is 2.5 years, the above savings would be achieved over a similar period. If one takes the smallest figure, a saving of 6%, this provides a saving of £648,000 per year. Removing the additional investment of £116,000, the resultant shortening of stay in residential care is likely to lead to a saving of £532,000.

[1] Banerjee, S and Wittenberg, R (2009) "The Clinical and Health Economic Case for early diagnosis and intervention services in dementia." *Department of Health.*

Appendix A
Cost Benefit Analysis

		Existing £s	**Proposed £s**	**Additional Impact £s**
One Off Investment				
	Capital			
	Revenue			
Less Savings				
	Capital			
	Revenue			
Net Impact				
Recurrent Cost		*Per annum*	*Per annum*	*Per annum*
	Capital			
	Revenue			
	- Pay	863,132	116,000	
	- Non Pay			
	- Capital Charges			

		863,132	116,000	
Less Savings				
	6%			648,000
	10%			1,080,000
	20%			2,160,000
Net Impact				331,132 (6%)

Appendix B

Extract from July 2008 Approved SCHEDULE OF MATTERS DELEGATED TO OFFICERS (V3)

Delegated matters in respect of decisions, which may have a far-reaching effect, must be reported to the Chief Executive. **The delegation shown below is the lowest level to which authority is delegated. Authority can be delegated upwards with no further action being required.** However, delegation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising such delegation, consult with other Senior Officers as appropriate. All items concerning Finance must be carried out in accordance with Standing Financial Instructions and Standing Orders. All financial limits in this schedule of matters delegated to officers are subject to sufficient budget being available.

DELEGATED MATTERS	AUTHORITY DELEGATED TO
Business Cases	
a) Up to £49,999	a) Deputy Director of Finance / Executive Director
b) £50,000 to £249,999	b) Director of Finance / Executive Director/ Chief Executive
c) £250,000 to £499,999	c) **Non clinical –** Chief Executive **and** Director of Finance **and** Director not associated with business case **Clinical** – as above **plus** Medical Director
d) £500,000 to £999,999	d) Director of Finance **and** Chief Executive
e) Over £1,000,000	e) Full business case for Board approval

NB: This schedule aligns to the Oxfordshire PCT Scheme of Delegation (V3)

This page is intentionally left blank

Consultation Report:

Early Diagnosis in Dementia

Author(s)	**Sara Price, Communications & Engagement Coordinator**
Status	**Final**
Date	**7th June 2010**

Contents

1. About NHS Oxfordshire

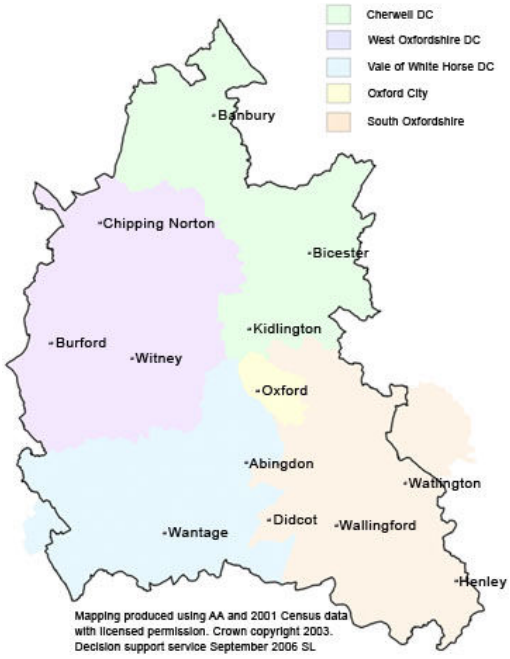
NHS Oxfordshire is a Primary Care Trust (PCT) and serves a population of around 600,000.

We are ambitious about improving the health and wellbeing of local people. NHS Oxfordshire intends that, by 2013, the people of Oxfordshire will:

- be healthier, particularly if they are vulnerable or live in our most deprived communities
- be working with NHS Oxfordshire to promote physical and mental wellbeing and prevent ill health
- be actively supported to manage their health and care needs at home when this is appropriate
- have access to high quality, personalised, safe and appropriate health services
- get excellent value from their local health services
- have a PCT which is a high performing organisation.

Oxfordshire is the most rural county in south east England and has a large geographical area to cover as well as a diverse population to serve. The population of Oxfordshire ranges from a predominantly older, white population in the rural areas to very ethnically diverse populations in Banbury and Oxford city where one third of the population are students.

NHS Oxfordshire works with our communities and our partners to improve health in the area and to make sure that local people's needs are being met. We also work with organisations from the voluntary, private and community sectors so that we can make sure that the organisations providing health and social care services are working effectively.



Area covered by NHS Oxfordshire
Oxfordshire PCT serves a population of approximately 630,000 and covers the areas of Cherwell Vale District Council, Oxford City, South Oxfordshire, Vale of White Horse District Council and West Oxfordshire District Council.

2. Executive summary

2.1 Purpose of the public engagement

The Communications and Engagement directorate at NHS Oxfordshire, in partnership with Oxfordshire County Council embarked on a period of engagement from May-June 2010, to engage and involve all those patients, carers and families with experience of dementia[1], and those organisations interested in helping to ensure more people receive a good early diagnosis of dementia. The feedback gathered and results from this report will then be used to inform and determine the shape of the care pathway for early diagnosis in dementia in Oxfordshire.

2.2 Process & Methodology

A number of consultation and engagement methods were used simultaneously to enable maximum feedback from a wide variety of stakeholders in the time available. This included a public consultation workshop at County Hall, Oxford; gathering feedback at the Dementia Awareness Day and online engagement methods on the '*Talking Health'* website, a questionnaire and feedback via email or by phone.

2.3 Key Findings

Analysis of the consultation findings from the public consultation workshop, written responses, email and online responses interestingly resulted in very similar response themes. These included:

- The need for clearer access points at which patients, their families and carers can get the information and help that they need
- The need for better quality information and support for dementia
- The need for more specialist knowledge about dementia in GP surgeries and therefore more training on dementia to be provided.
- Follow up appointments to be carried out by a dementia specialist – this could be a GPSI, a specialist nurse or a specialist at a memory clinic. The important thing is that they are a specialist in dementia.
- A more person-centred approach to services and care – including the need for home visits and (younger) age related services where appropriate
- A more integrated and coordinated approach to dementia diagnosis, care and support, with systems and processes to support this.

[1] An explanation of dementia is included in Appendix 3.

- More awareness raising to help understanding of dementia and prevent negative attitudes/stigma.

2.4 Conclusion

The report recommends that the participants' concerns from this consultation are fully considered and as many of their comments and suggestions regarding dementia diagnosis, support and care are incorporated wherever possible into the design of the new care pathway for early diagnosis in dementia in Oxfordshire.

3. Background

3.1 Why do we need a care pathway for early diagnosis in dementia?

A strategic, cross-cutting approach is vital if we are to deal with the challenges and consequences of dementia as a society. The National Dementia Strategy for England, 2009 outlines 17 key objectives to transform services for people with dementia and their carers, making dementia a key national priority. The national strategy is outcome-focused and the objectives have been grouped into three broad themes:

1. Raising awareness
2. Early diagnosis
3. Living well with dementia

The project will deliver objective two of the National Dementia Strategy 2009 - Good-quality early diagnosis and intervention for all.

3.2 The local context

NHS Oxfordshire and Oxfordshire County Council ("the Commissioners") have a joint strategy for the development of dementia services across the county. Oxfordshire already has in place a number of well established memory clinics, however there are at present two providers with different service models and lack of equity to capacity of population needs. This consultation on early diagnosis in dementia is part of a project is to build and develop the current services to meet the project aims and objectives.

3.3 The Vision for Dementia Services

To develop the current Memory Clinic provision within Oxfordshire with an agreed pathway of care for early diagnosis and intervention in dementia across all healthcare sectors, which has the capacity to assess all new cases occurring in Oxfordshire. This service will offer assessment, treatment initiation and support following diagnosis and will significantly increase the number of people receiving a diagnosis of dementia, also providing a diagnosis earlier in the course of the illness.

3.4 What was the purpose of this consultation?

NHS Oxfordshire and Oxfordshire County Council were seeking views and feedback from the public to enable the development of an agreed pathway of care for early diagnosis and intervention in dementia for patients in Oxfordshire. The purpose of the consultation was to:

- Provide an opportunity for the public to tell us about their experiences of dementia diagnosis – what works and what doesn't
- Examine the proposed care pathway for diagnosis of dementia and allow the public to give their views on what changes need to be made
- Give the public a chance to tell us what their vision of a care pathway for early diagnosis in dementia looks like

3.5 How will the feedback be used?

The opinions gathered from all of the consultation methods - including the workshop, the online consultation, and the questionnaire responses - are being used to help shape the design of the care pathway for services and care to support early diagnosis in dementia and to feed into the strategic and operational plans for the development of dementia services in Oxfordshire.

4. Stakeholders

The stakeholders for the early diagnosis in dementia consultation are patients, their families and carers of people that have dementia as well as organisations or groups with an interest in supporting people with dementia.

4.1 Stakeholders

The key stakeholders identified for this consultation were:

Patients with dementia, their families and carers
This is the primary target group and provides an opportunity for those who have experience of diagnosis as carers, dementia patients or supporting organisations to identify the key issues which may be preventing or mitigating against early diagnosis

Current Service Providers (including the voluntary sector where appropriate)
Engaging with these groups when and where appropriate and encouraging dissemination of information of the consultation to further interested individuals, groups and organisations.
E.g. Memory clinic staff, GPs

Other Organisations and groups with an interest in dementia
It was important to ensure that other voluntary organisations with an interest in this work are kept informed and provided with appropriate opportunities to engage, including attending and participating in the consultation workshop.

NHS Oxfordshire staff
NHS Oxfordshire staff may have experience of working with those patients with dementia, their families or carers or may have personal experiences that they would like to share. It was important to therefore include and engage with staff in this consultation.

Those generally interested in dementia, older people and general mental health issues
There may also be people in Oxfordshire who, whilst not having any personal experience, may have a particular interest in dementia or related issues. It was important that the consultation was therefore communicated in a way that enabled as many people as possible to participate.

Media
Throughout the project media activity was developed when and where appropriate published to ensure communication is open and helpful and that were providing and supporting positive messages to enable maximum stakeholder involvement.

Other

When communicating this consultation with the key stakeholders listed above, encouragement was also given to share this information with any individual or organisation that may be interested in issues regarding dementia in Oxfordshire.

5. Engagement process

Due to the limits placed on the consultation duration due to election activities, efforts were made to engage with and facilitate feedback from the public, families, carers of dementia and staff of dementia related services using as many different methods as possible.

The consultation was communicated to over 200 organisations and individuals with an interest in dementia. In total 62 people actively engaged with NHS Oxfordshire regarding the dementia consultation:

- 26 attended the workshop
- 19 commented during the dementia awareness day
- 17 engaged with the consultation online

5.1 'Early Diagnosis in Dementia' – Online engagement

NHS Oxfordshire Talking Health website

The care pathway diagram

The early diagnosis in dementia care pathway diagram was set up on the *Talking Health* website to enable stakeholders to have a visual picture of the care pathway and to enter their own comments, views and feedback. The care pathway diagram can be seen in Appendix 1.

Early Diagnosis in Dementia Questionnaire

A questionnaire on early diagnosis in dementia was set up on *Talking Health* to ask key questions about the proposed care pathway and to gather further feedback and ideas. This questionnaire was also shared in hard copy format among key organisations and the attendees of the consultation workshop. A copy of the questionnaire can be seen in Appendix 2.

NHS Oxfordshire Intranet

NHS Oxfordshire's intranet was used to communicate the consultation and available response methods to all staff, encouraging further dissemination of information to organisations and interested individuals.

All Staff email

The consultation was communicated widely to all NHS Oxfordshire staff in the weekly staff bulletin via the everyone@... email facility.

Twitter and Facebook

A number of announcements and 'tweets' were made on the Twitter and Facebook websites for NHS Oxfordshire about this consultation and the associated public consultation workshop.

Email

An email campaign promoting the 'Early Diagnosis in Dementia' consultation workshop and other response methods was communicated to a large target audience of over 200 individuals, community and voluntary groups across the county.

5.2 'Early Diagnosis in Dementia' consultation workshop

The consultation workshop for early diagnosis in dementia was held at County Hall, Oxford on the 18th May 2010.

It included an introductory talk by Meg Barbour, giving a brief insight into her own personal experience as the wife and carer of someone with dementia, and the importance for her and her family of receiving an early diagnosis.

Duncan Saunders then gave a further explanation of why NHS Oxfordshire is doing this consultation and how the views and feedback that people give will be used to shape the care pathway.

The attendees then split into three groups of approximately 8 people for the workshops. Three key questions were discussed:

1. In your experience, what currently works well with dementia diagnosis?
2. In your experience, what currently does not work well with dementia diagnosis?
3. (Blue sky thinking) – What things would need to be included for a really good dementia diagnosis?

The questions were answered in a progressive manner which meant that each group started with a different topic. In the next group, they then built on what the previous group has already said, and then finally the attendees were asked to discuss and prioritise the final topic.

At the end of the workshop, discussion comments were shared with all attendees at the event both by verbally summarising key themes discussed in each group and by putting flipchart posters of notes up around the room for all to view.

Time was also allowed at the end of workshop to raise any specific questions that stakeholders had about 'Early Diagnosis in Dementia' and for attendees to add any personal comments or ideas to the flipcharts using post-its.

5.4 Other methods of engagement

Dementia Awareness Day

A Dementia Awareness Day, hosted by Oxfordshire County Council and other partner organisations, was held on the 23rd May at the Ashmolean museum, Oxford to raise awareness of the condition and also to gather views on the proposed care pathway for early diagnosis. The event was promoted throughout NHS Oxfordshire, Oxfordshire County Council, key partners and interested organisations.

A tabletop display, manned by NHS Oxfordshire, was set up at this event to invite people to give their views on diagnosis of dementia and to comment on the care pathway.

Parish Magazines
The early diagnosis in dementia consultation was circulated by email to all parishes in Oxfordshire and then published in a number of parish magazines on online newsletters such as the Benson Bulletin, Hook Norton Newsletter and Kennington Chronicle.

6. Engagement Findings – Consultation workshop

6.1 Number of responses

In total 26 people attended the consultation workshop at County Hall, Oxford. These consisted mostly of an even split between carers/family members of people with dementia and individuals from interested organisations.

6.2 Discussion questions

The comments from each of the three discussion questions at the consultation workshop were gathered into response themes so that trends could be identified.

The results for the discussion questions are shown below:

Discussion question 1: In your experience, what currently works well with dementia diagnosis?

The key themes for this discussion question are shown below.

Resources and support were the main themes for this discussion question and respondents highlighted some of the existing sources of good information, support and advice for dementia patients, their families and carers.

Key Theme	**Resources**
Comments	• Wonderful staff in the system • Learning very helpful – books recommendations • Age Concern – useful advice • Oxford carers centre – run courses with experts – offer other support i.e. transport • Information and advice from the consultant – (breathing clinic)
Key Theme	**Support Groups**
Comments	• Carers groups and being part of group – knowledge – was a constant when other care is very fragmented. Offer practical advice • Care Management (SS) support is very good, reduces pressure on family (process took about 1 year) • Family support groups

Another key theme of what works well was the current activities taking place – particularly in the media - related to raising awareness of dementia and some people's positive attitudes towards dementia.

Key Theme	Attitudes
Comments	• Always looking for positives – concentrating on what people can do • Becoming less scared to seek help – less stigma
Key Theme	**Raising Awareness**
Comments	• Terry Pratchett! Talking about it – other celebrities publicising. Public awareness through drama – 'The Archers' • General public – raising awareness • Increased awareness of the disease – more media coverage (although people still afraid)

Other themes of things that are currently working well with dementia diagnosis were related to some of the good training and research that is currently taking place.

Key Theme	Training
Comments	• Best GP referrals come from GPs who have had specialist training • Carers training in dementia/workshops. E.g. "Dignity champions", "Caring with confidence"
Key Theme	**Research into Dementia**
	• Donating Brains for research. Positively/actively taking part in research • If can get early diagnosis – can get accurate understanding – could be another memory problem that can be cured
Key Theme	**Others**
Comments	• Works well when services follow similar route to cancer – "hidden disease"

Discussion question 2: In your experience, what currently does <u>not</u> work well with dementia diagnosis?

There were quite a number of comments made about what currently does not work well in dementia diagnosis.

The three main themes that were highlighted that needed attention were: the need for GPs to have more time, specialist knowledge, and understanding of dementia; problems with communication/delays within the system; and the need for both better and more information and support for patients, families and carers of those with dementia.

Key Theme	GPs
Comments	• GP's feel disempowered/lack of confidence and therefore gate keep using 'confidentiality' • GPs need to allow time with carer on his/her own to understand the problem

	• Had to fight to get a referral • There is a reluctance to refer to diagnosis by GPs • Some GPs not trained or don't use what they have learned. SO don't identify or know where to send for support
Key Theme	**Information/Support**
Comments	• Need to increase knowledge in all areas i.e. benefits • Information in Surgeries – little available • Don't know who to talk to • More support at end stages i.e. Vale House • Info not passed around the family
Key Theme	**Communication/delays**
Comments	• Systems e.g. at memory clinic do not allow advance booking so carer has to be responsible for remembering repeat booking • Delays in getting diagnosis – (even this pathway doesn't look like a one-stop-shop.) • Time delay if referral to community team and then a memory clinic • Referral for C.T. Scans can delay the diagnosis because of medical focus on another illness can mean dementia is not properly addressed • Once in system sometimes takes a while to get into service. "Missed opportunities"

Other comments about what was not working well in dementia diagnosis related to transport problems when patients/families wanted to access support services and also the negative attitudes surrounding dementia. These negative attitudes appeared to be apparent across all areas – in the general public, relatives, in local communities and even in some health care staff.

Key Theme	**Access/Transport**
Comments	• Access issues often run during the day • Really difficult if family carer is living at a distance even harder to get the system to support
Key Theme	**Attitudes**
Comments	• Fear of dementia in public causes issues • Like a 'cloudy' room for the relatives – can be in denial • Ageist attitudes – ignored in A&E because with an elderly patient. • Attitudes in community – fear, ageism, breaking bad news

Discussion question 3: (Blue sky thinking) – What things would need to be included for a really good dementia diagnosis?

The participants of the consultation workshop came up with a lot of suggestions on what a really good dementia diagnosis would need to include.

Key Theme	**Patient/carer focused**
Comments	• Take into account different people's needs. Carers versus patients' needs • Carer involvement in diagnosis • Carer Involvement facilitated in TVE way
Key Theme	**Good support for patients and carers**
Comments	• Support in the clinic when diagnosis made – someone to give information and answer questions • Effective social service to support person with dementia in community • Carer support and information sign posting • Practical support to get people to GP initially • Support to adjustment - emotional and practical
Key Theme	**Consistency**
Comments	• Consistent point of contact to go back to if information needed later • Continuity of care needed
Key Theme	**Good communication of information**
Comments	• Copy of report sent to referrer, (consultant – GP) and carer. • Effective systems integrated and joined up • Transparency with diagnostic process – Patient information to help them understand and be reassured that symptoms taken seriously • Central repository of information – help translating this into framework
Key Theme	**Attitudes**
Comments	• Knowledge, awareness raising to drop stigma with both professionals and public. • Confusion about labels 'Dementia' and 'Alzheimers'. • Demystifying needed.
Key Theme	**Holistic and proactive approach**
Comments	• Holistic/Relationship based model of care where all area addressed • Good co-ordination between providers and families – care navigation and proactive management. • System needs to have a more pro-active approach to supporting, assisting and informing the carer.
Key Theme	**Location of care**
Comments	• Memory clinics in the community. • First point of contact – GP – does this need to be the GP? More important to have the appropriate understanding, knowledge and communication

Key Theme	Others
Comments	• Quicker diagnosis • General strategies are needed to support even if no diagnosis is made

Good Ideas
Attendees were also asked to add any comments or good ideas towards the end of the workshop.

Some of the key themes included the need for a clear, central place for patients, families and carers to go to whenever they need more information on dementia – whether this is at before, at, or after diagnosis.

"Need a one stop shop with easy access to information and support for patient and family."

"It needs Primary Care services to see themselves as THE hub for dementia services – proactive and relationship building."

The majority of suggestions were made around the whole approach to dementia diagnosis and the need for care to be more integrated and joined up.

"We need systems which are fully integrated and supportive of carers/family members and recognise the holistic nature of the condition."

"We need proper care – co-ordination and care. Navigation from the earliest possible identification. Current state is a rag-bag, no-one "holding" the issue."

"The solution is not with health care alone, a comprehensive health and social care system needs to be established, which removes the block of the means test."
A number of comments and suggestions were also made around the patient – with a focus on both diagnosis and care being person-centred and tailored to the individual.

"Thorough medical assessment of an individual's physical and mental health is needed to reach accurate diagnosis."

"Person Centred Care training should be offered to all who work with people with dementia, including in generic services."

Other ideas included:

"Memory clinic administration needs/must be supported by bespoke software (database) as currently relies on completely inadequate systems"

"GPs should have useful strategies to help carer get the 'patient' to go to the GP to start the assessment process. It can be very difficult to get patient to go to GP for that first appointment."

6.3 Prioritising responses

After working through the discussion questions, the final activity for the consultation workshop participants was to prioritise the suggestions and comments that had been made, identifying three key areas for each.

Discussion question 1: In your experience, what currently works well with dementia diagnosis?

The priorities that the workshop participants identified for this discussion question were:

- Resources – wonderful staff in system
- Awareness raising and the use of key public figures
- Some good sources of support out there (if you know where to look)

Discussion question 2: In your experience, what currently does not work well with dementia diagnosis?

The priorities that the workshop participants identified for this discussion question were:

- Some GPs not trained or don't use what they have learned. So don't identify or know where to send for support
- Attitudes in community – fear, ageism, breaking bad news
- Delays in getting diagnosis – even the pathway doesn't look like a one-stop-shop

Discussion question 3: (Blue sky thinking) – What things would need to be included for a really good dementia diagnosis?

The priorities that the workshop participants identified for this discussion question were:

- A quality of first point of content – knowledgeable, compassionate, understanding
- Information for the carer and sufferer needs to be in formats appropriate to needs, at key stages
- Awareness raising needs to take place for the public and professionals – memory clinics widely available.

7. Engagement Findings – Other methods

7.1 Comments on the care pathway

The following are key themes and examples of comments on the care pathway diagram for early diagnosis in dementia (as shown in appendix A) that were taken both from the 'Talking Health' website and from the Dementia Awareness Day on the 23rd May at the Ashmolean museum, Oxford.

Two main themes came out of the comments made. These were around support for patients and carers and also comments regarding the point at which a diagnosis is made.

It was clear from comments made that respondents felt that the support - not just for patients - but also for families and carers, needed to be improved:

"Support and follow up; ideal to have groups in the same location as medical appointments."

"Need to consider support for carers."

"Very little support and no counselling was given to my father."

There were also many comments related to importance of a good, early diagnosis and the need for the knowledge, skills and training to be there to enable GPs to give and accurate, early diagnosis.

"Need an earlier diagnosis to help them to plan: sometimes there is a reluctance to diagnose, or to refer among GPs. Also a reluctance from the person to allow diagnosis."

"DLB hard to diagnose; clinic struggled, diagnosis came late."

"When GP refers quickly, system works well."

Other comments related to things such as the need to improve attitudes to dementia, transport and for good sources of supporting information:

"Attitudes vary among GPs; there is need to ensure GP buy in, and make sure they are on board with the pathway."

"Ensure other information services are tied in; examples of good practice from other agencies, statutory and voluntary"

"Consider where people obtain information before they see GP."

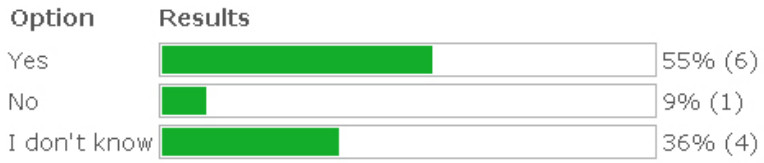
"Car parking needs to be good."

7.1 Questionnaire responses

The online and hard copy questionnaire asked key questions about the proposed care pathway and gathered further feedback and ideas. The responses are detailed below:

Question 1 – About You
There were just 11 responses to this questionnaire. 4 of which were from carers, 3 from organisations with an interest in dementia and 4 from people who had some experience of working with those with dementia e.g. nurse

Question 2 - Should the entry point into memory services be via a referral from the patient's GP?



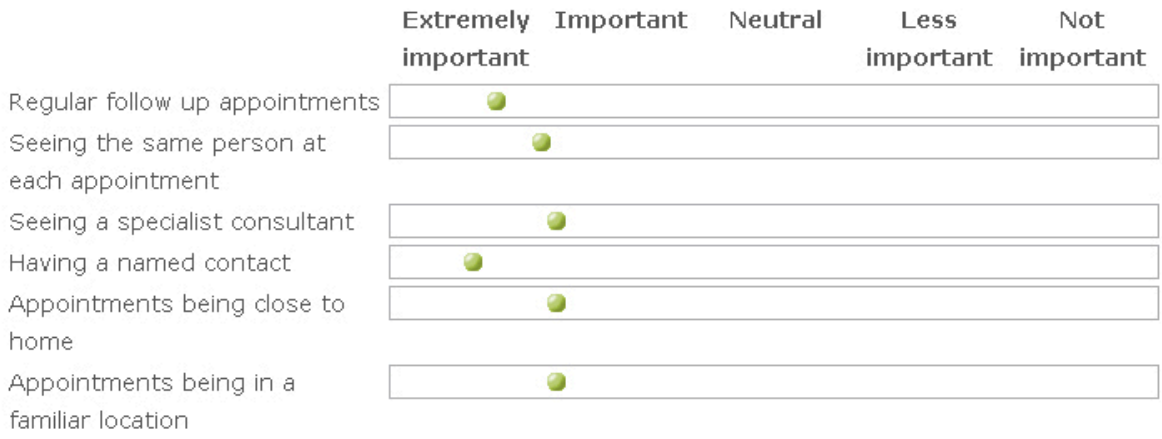
The majority of responses felt that the referral should come from the GP, however when asked to comment on their response a number of concerns were also expressed about GP's needing the time, training, specialist knowledge and awareness of dementia.

"Gps often too busy to spend enough time to develop awareness"

Suggestions were also made in the comments section that the referral could come from another specialist at a GP surgery:

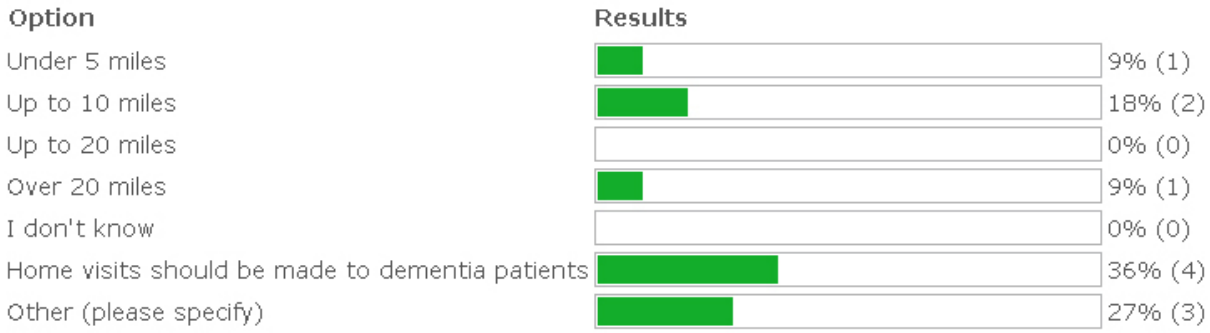
"Use trained persons in surgeries who can be more caring about dementia and the fear for families"

Question 3 – Please rank the following in order of importance for the patient:



All of the above factors were felt to be of fairly high importance for a person with dementia and the most important factor, which was ranked 'extremely important' by 90% of respondents, was the need to have a named contact. This was closely followed by the need to have regular follow up appointments.

Question 4 - How far do you think it is acceptable to travel for a Memory Clinic appointment for a patient with dementia?



When asked about how far people thought it would be acceptable to travel to a Memory Clinic appointment, the response was mixed. However the majority of responses (36%) indicated that it was important that home visits should be made to dementia patients.

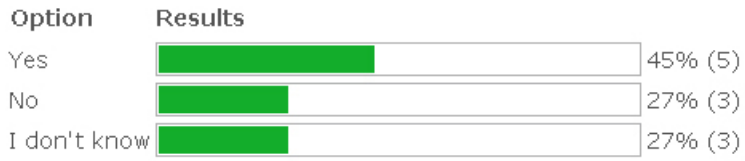
Only one person felt it was acceptable to travel over 20 miles to a memory clinic appointment.

When asked to comment on their responses to this question it became clear that the acceptable distance to travel depended very much on the needs of the individual patient:

"I think the distance depends on the individual. Someone with an existing disability or long term condition who then goes on to develop dementia will tolerate travelling less well."

"I think it depends on what people are used to e.g. in a rural area, longer distances are the norm."

Question 5 - Should younger people with dementia follow the same care pathway as older people with dementia?

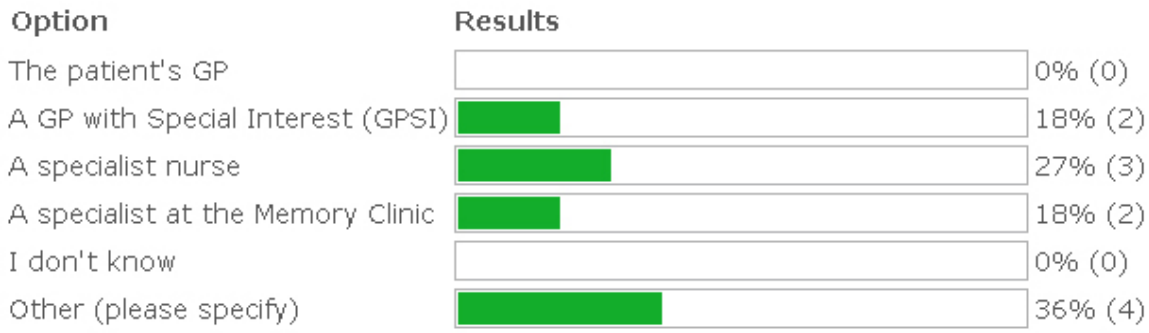


The majority of respondents (45%) indicated that younger people with dementia should follow the same care pathway as older people with dementia. However, when asked to comment on their responses it was clear that people felt that although the care should be more or less the same, the services that people visit should be more tailored to younger people:

"They should follow the same generic process/pathway, but be in clinics not full of very old/frail demented patients (at late stage!)"

"Make care applicable to younger people somehow."

Question 6 - Who should conduct the patient's ongoing follow-up appointments once a dementia assessment and diagnosis have been given?



The response to who should conduct the follow-up appointments was fairly evenly spread across the GP with Special Interest (GPSI), a specialist nurse, and a specialist at the Memory Clinic.

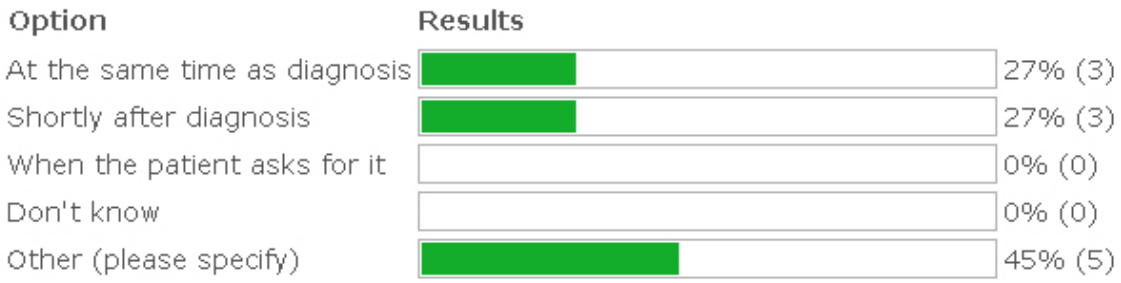
The majority of responses however came back as 'Other' (36%). When asked to indicate what people meant by 'Other' respondents again indicated that it should

be any of the GPSI, specialist nurse or a specialist at the Memory Clinic and that specialist training and knowledge were the most important factors.

"The GPSI, specialist nurse or specialist at the memory clinic are all acceptable."

"Any of above - training & knowledge of dementia are more important than professional qualifications."

Question 7 - When should supporting information on dementia be given to the patient?



Responses to when supporting information should be given to the patient/their family, were equally split between 'at the same time as diagnosis' and 'shortly after diagnosis'.

The majority of responses made were 'other' (45%). When asked to indicate what they meant by 'Other' respondents indicated that supporting information should be given whenever a patient, their family or their carer needs or asks for it:

"Both at the same time as diagnosis and then whenever the patient/family asks for it."

"Information needs to be continuously available so that people can keep coming back to it as they need to."

The survey also gave respondents the opportunity to feedback on the same discussion questions that were asked in the consultation workshop:

Question 8 - Are there any areas of the current dementia care pathway that <u>are</u> working well?

There were only a few responses related to things that are currently working well with the dementia care pathway, indicating that the current care pathway for early diagnosis in Oxfordshire is not consistent in the existing care, support and services that are being provided.

"Medication"

"The GPs who have a good understanding and work in a holistic way who know where to find support."

"Not too many."

"Yes. Some people receive some very timely and effective intervention and good support for their carers."

Question 9 - Are there any areas of the current dementia care pathway that are <u>not</u> working well?

There was quite a large response to this question. Comments were varied, but as in the rest of the questionnaire and consultation workshop, common themes became apparent.

Inconsistencies in existing dementia services were one of the main themes:

"Fragmented, inconsistent services"

"The care pathway is not consistent and people's experience is mixed."

"It's fragmented and not always accessible. Services have little to offer after diagnosis - resources are poor."

Support for dementia patients and their carers was also another strong theme for things that are not currently working so well:

"The lack of an effective social care system to enable someone to be properly cared for in their own home

"Information and advice to family/relatives/carers - and GP practices not having funds/interest or specialism."

"From a carers perspective, it is continuously like "pulling teeth" getting any real input, support or access to appropriate services (health or social care) for my mother."

Other comments related to attitudes and the need for a more coordinated, person-centred approach:

"Attitude of GP services is not helpful"

"People of her age with dementia have multiple complex needs…requiring a combined and coordinated approach."

Question 10 - any other comments or feedback that you would like to add regarding early diagnosis in dementia

When asked to make any further comments, respondent to the questionnaire made a number of suggestions on how they would like to see services and the care pathway for early diagnosis in dementia to be developed. This included the need for services to be more integrated, with systems to support an integrated approach to working; having information available for patients in an Easy Read format; the need for quicker diagnosis and to increase the level of knowledge of the condition so that there are more specialists available for patients.

"Services need to be developed in a fully integrated relationship-based way, with systems that are supportive, inclusive and pro-active."

"Diagnosis should be the sooner the better - to enable medium and longer term planning and support for and to families."

"Those that make the diagnosis MUST really know about the disease and real markers of disease progression, and know how to access help and support."

8. Limitations

8.1 The Election

The election posed a number of restrictions on the dementia consultation due to a period known as 'purdah'. This lasts from the moment a forthcoming election is announced, until the moment the new government is announced. The purdah period means that all public sector organisations are restricted in making any pro-active communications.

NHS Oxfordshire was therefore unable to promote the early diagnosis in dementia consultation as much as it could have done in normal circumstances. We did however ensure that as much awareness was raised as possible within the purdah guidelines. Interested organisations were informed of the forthcoming consultation workshop date and a 'future consultation' announcement was made on the *Talking Health* website. The start date of the consultation was delayed by a few days due to purdah whilst the coalition government arrangements were agreed. However as soon as the restrictions were lifted, full promotion and communication of the consultation could begin.

8.1 Other Limitations

Due to the nature of the symptoms of dementia, such as memory loss and the ability to reason, the early diagnosis in dementia consultation did not receive many known responses from those patients with the illness. The majority of responses were therefore from carers/family members of those that have/have suffered from dementia and those that work with patients with dementia or for organisations with an interest in this area.

9. Key recommendations

The findings from the consultation on 'Early Diagnosis in Dementia' has highlighted the need for:

Clearer pojnts at which patients, their families and carers can access supporting information

- Throughout the consultation, respondents regularly raised the need for better supporting information and the need for a central 'hub' or clear point at which they should go to get this information.

The need for more specialist knowledge about dementia in GP surgeries

- Whilst it was felt that the GP surgery is the main place from which referrals to Memory Clinics should be made. General concerns were raised around the in-depth knowledge of the condition and that more specialist knowledge and/or training in dementia is needed.

Follow up appointments to be carried out by a dementia specialist

- Respondents were less concerned with the job title/role of the person conducting the follow up appointments, and felt it was much more important that the person had specialist knowledge of dementia.

A more person-centred approach to services and care

- In many responses to survey questions and in the workshop, it was highlighted that the services and care needs to be more person-centred. A more holistic consideration needs to be given to an individuals health needs, transport needs and communication needs.

A more integrated and coordinated approach to dementia diagnosis, care and support

- Inconsistencies was a common theme in current services for dementia and so to enable both more and earlier diagnosis of dementia to be made, there clearly needs to be a more integrated and coordinated approach.

More awareness raising to help understanding of dementia and prevent negative attitudes/stigma

- It was highlighted that one of the main positive things currently happening relating to dementia diagnosis was the recent awareness raising activities and adverts in the media. In addition it was highlighted that negative attitudes are one of the main problems related to dementia and so it is recommended that more activities and communication takes place to help reduce the stigma associated with dementia.

10. Next steps

A copy of this consultation report will be made available to all those that participated in the early diagnosis in dementia consultation workshop and questionnaire and will also be available for download on NHS Oxfordshire's website: www.oxfordshirepct.nhs.uk

The report will used by NHS Oxfordshire and Oxfordshire County Council (the commissioners) to develop a care pathway for early diagnosis in dementia that appropriately meets the needs, concerns and expectations of dementia patients, their families and carers.

11. Thanks

Thanks to all those who responded to this consultation and particularly to both patients, their families and carers of dementia who shared their personal experiences of receiving a dementia diagnosis.

13. Supporting information

Definitions

Stakeholders

- A person or group with a direct interest, involvement, or investment in something.
- Stakeholders are individuals or organisations that have a direct interest in a service being provided.

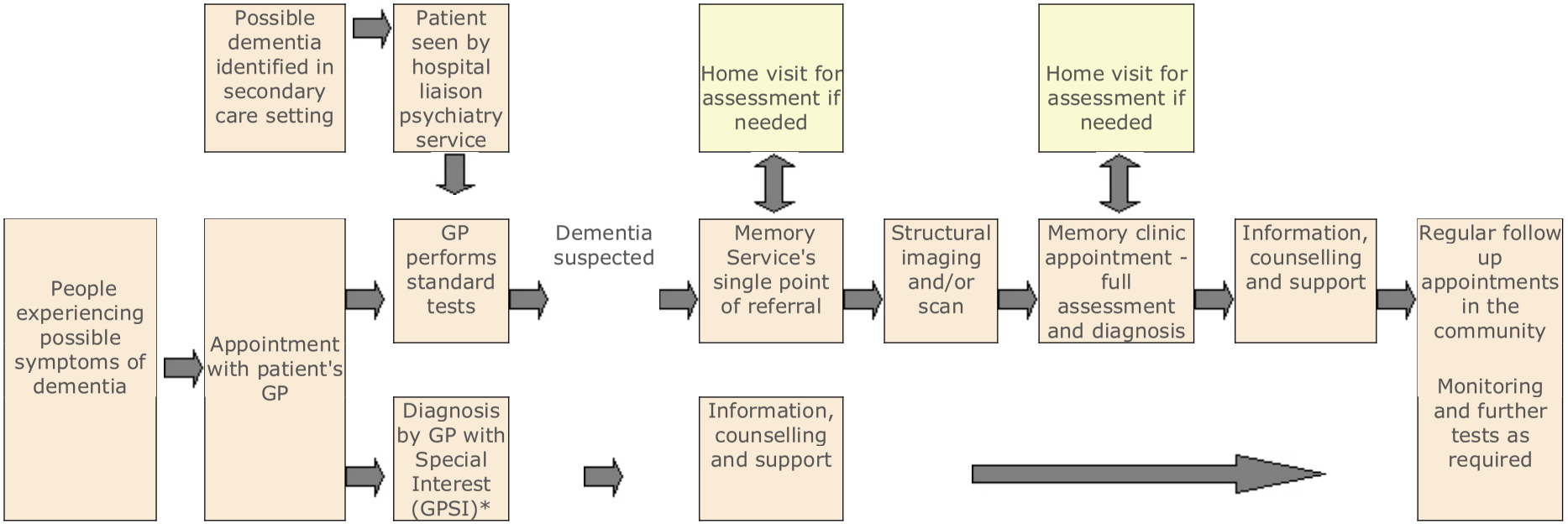
Glossary

NHS	National Health Service
PCT	Primary Care Trust
Facebook	Social networking website
Twitter	Twitter is a social networking tool aimed at enabling its users to exchange up-to-the-minute news and opinions on specific topics.
Intranet	A private computer network open to users working within an organisation to share information, news and documents
Talking Health	NHS Oxfordshire's consultation and engagement area on our public website

14. Appendices

Appendix 1: Early Diagnosis in Dementia Questionnaire

The diagram below illustrates the proposed care pathway for early diagnosis in dementia:



*There are currently no GPSI's in Oxfordshire to support dementia at the moment.

The Early Diagnosis in Dementia care pathway - explained

The table below further explains certain sections of the dementia care pathway diagram:

Section of dementia care pathway	Further details
GP performs standard tests	These tests may include a memory assessment and blood tests. If dementia is then suspected a referral is sent on to the Memory Service.
Diagnosis by GP with Special Interest (GPSI)	A patient's GP could refer the patient to a GP with Special Interest (GPSI). GPSIs could provide a diagnosis to a patient with dementia in the future (there are currently none in Oxfordshire at present).
Memory Service single point of referral	Referrals are assessed and assigned at the Memory Service according to clear criteria.
Memory Clinic appointment - full assessment and diagnosis	Memory Clinics operate throughout Oxfordshire at main community locations and offer assessment, support, information and advice to those with memory problems and their carers. A full assessment and diagnosis is given at the Memory Clinic in line with National Institute of Clinical Excellence (NICE) guidance. The decision to start medication for dementia is also made.
Home visit for assessment if needed	If the patient with dementia has mobility or travelling difficulties then an assessment at home can be arranged.
Information, counselling and support	After a dementia diagnosis is given, information is provided for the person with dementia and their family/carer as necessary. Post diagnosis services are offered (such as counselling) and a letter is sent to the patient's GP confirming the diagnosis. It is important that equal access to information and support is provided regardless of whether a diagnosis is given through a GPSI or a Memory Clinic.
Regular follow up appointments in the community Monitoring and further tests as required	Follow up appointments could take place in the community by a specialist nurse or GP. This may include monitoring of medication and tests for the progression of dementia, including other related problems such as depression.

Appendix 2: Early Diagnosis in Dementia Questionnaire

Early Diagnosis in Dementia – Questionnaire

We would like to hear about your views on dementia diagnosis in Oxfordshire. This survey will take no more than 5 minutes to complete.

1 - About You
Are you...

- ☐ A patient with dementia
- ☐ A carer of someone with dementia
- ☐ A family member of someone with dementia
- ☐ Representing an organisation with an interest in dementia
- ☐ Other (please specify)

---

2 - About the early diagnosis in dementia care pathway
Should the entry point into memory services be via a referral from the patient's GP?

- ☐ Yes
- ☐ No
- ☐ I don't know

Please give any reasons below:

3 - Please rank the following in order of importance for the patient:

	Extremely important	Important	Neutral	Less important	Not important
Regular follow up appointments	☐	☐	☐	☐	☐
Seeing the same person at each appointment	☐	☐	☐	☐	☐
Seeing a specialist consultant	☐	☐	☐	☐	☐
Having a named contact	☐	☐	☐	☐	☐
Appointments being close to home	☐	☐	☐	☐	☐
Appointments being in a familiar location	☐	☐	☐	☐	☐

4 - How far do you think it is acceptable to travel for a Memory Clinic appointment for a patient with dementia?

- ☐ Under 5 miles
- ☐ Up to 10 miles
- ☐ Up to 20 miles
- ☐ Over 20 miles
- ☐ I don't know
- ☐ Home visits should be made to dementia patients
- ☐ Other (please specify)

---

5 - Should younger people with dementia follow the same care pathway as older people with dementia?

- ☐ Yes
- ☐ No
- ☐ I don't know

Please give any reasons below:

6 - Who should conduct the patient's ongoing follow-up appointments once a dementia assessment and diagnosis have been given?

- ☐ The patient's GP
- ☐ A GP with Special Interest (GPSI)
- ☐ A specialist nurse
- ☐ A specialist at the Memory Clinic
- ☐ I don't know
- ☐ Other (please specify)

---

7 - When should supporting information on dementia be given to the patient?

- ☐ At the same time as diagnosis
- ☐ Shortly after diagnosis
- ☐ When the patient asks for it
- ☐ Don't know
- ☐ Other (please specify)

Your Experiences

8 - Are there any areas of the current dementia care pathway that are working well?

9 - Are there any areas of the current dementia care pathway that are not working well?

10 If you have any other comments or feedback that you would like to add regarding early diagnosis in dementia, please give them below:

11 Please add your contact details below if you would like to receive a copy of the consultation report:

Name: Address:	Email: Phone:

Thank you for taking the time to answer this questionnaire

Appendix 3: What is dementia?

What is dementia?

Dementia is the term used to describe a range of symptoms that occur when the brain is affected by certain diseases or conditions. Dementia can affect anyone in society – irrespective of gender, ethnicity or class. Symptoms of dementia may include memory problems mood changes and communication difficulties.

Dementia is actually quite common. Around 750,000 people in the UK have dementia, which becomes more common with increasing age. Younger people can also be affected by dementia; about 18,000 people under the age of 65 in the UK have dementia.

Other sources of information

For more information see the Alzheimer's Society factsheet: What is Dementia?
http://www.alzheimers.org.uk

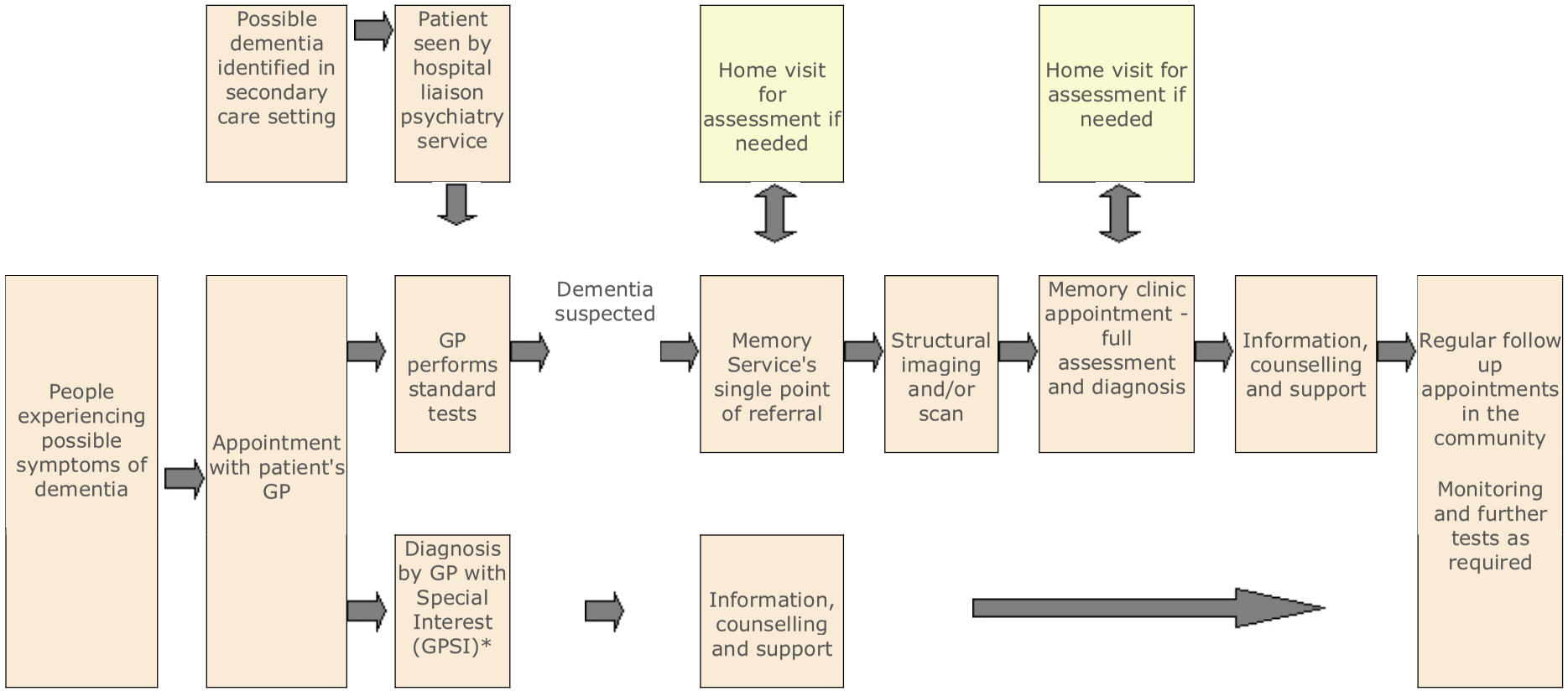
DementiaWeb - Dementia information sources for Oxfordshire
http://www.dementiaweb.org.uk

Alzheimers society helpline – Tel: 0845 300 0336

This page is intentionally left blank

For consultation –
The proposed care pathway for early diagnosis in dementia

The diagram below illustrates the proposed care pathway for early diagnosis in dementia:



*There are currently no GPSI's in Oxfordshire to support dementia at the moment.

The Early Diagnosis in Dementia care pathway - explained

The table below further explains certain sections of the dementia care pathway diagram:

Section of dementia care pathway	Further details
GP performs standard tests	These tests may include a memory assessment and blood tests. If dementia is then suspected a referral is sent on to the Memory Service.
Diagnosis by GP with Special Interest (GPSI)	A patient's GP could refer the patient to a GP with Special Interest (GPSI). GPSIs could provide a diagnosis to a patient with dementia in the future (there are currently none in Oxfordshire at present).
Memory Service single point of referral	Referrals are assessed and assigned at the Memory Service according to clear criteria.
Memory Clinic appointment - full assessment and diagnosis	Memory Clinics operate throughout Oxfordshire at main community locations and offer assessment, support, information and advice to those with memory problems and their carers. A full assessment and diagnosis is given at the Memory Clinic in line with National Institute of Clinical Excellence (NICE) guidance. The decision to start medication for dementia is also made.
Home visit for assessment if needed	If the patient with dementia has mobility or travelling difficulties then an assessment at home can be arranged.
Information, counselling and support	After a dementia diagnosis is given, information is provided for the person with dementia and their family/carer as necessary. Post diagnosis services are offered (such as counselling) and a letter is sent to the patient's GP confirming the diagnosis. It is important that equal access to information and support is provided regardless of whether a diagnosis is given through a GPSI or a Memory Clinic.
Regular follow up appointments in the community Monitoring and further tests as required	Follow up appointments could take place in the community by a specialist nurse or GP. This may include monitoring of medication and tests for the progression of dementia, including other related problems such as depression.