Public Document Pack

NHS Oxfordshire Clinical Commissioning Group

OXFORDSHIRE COUNTY COUNCIL

healthwatch Oxfordshire

To: Members of the Oxfordshire Health & Wellbeing Board

Notice of a Meeting of the Oxfordshire Health & Wellbeing Board

Thursday, 13 March 2014 at 2.00 pm

County Hall, New Road, Oxford

Peter G. Clark
County Solicitor

March 2014

Contact Officer: ***Julie Dean, Tel: (01865) 815322***
julie.dean@oxfordshire.gov.uk

Membership
Chairman – Councillor Ian Hudspeth
Vice Chairman - Dr Joe McManners

Board Members:

Councillor Mark Booty *(West Oxfordshire District Council)*	Chairman of the Health Improvement Partnership Board
Councillor Mrs Judith Heathcoat *(Oxfordshire County Council)*	Chairman of the Adult Health & Social Care Partnership Board
Councillor Hilary Hibbert-Biles	Member of Health Improvement Partnership Board
John Jackson	Director for Social & Community Services
Dr Mary Keenan	Chairman of the Children & Young People's Partnership Board
Jim Leivers	Director for Children, Education & Families
Vacancy	Vice Chairman of the Adult Health & Social Care Partnership Board
Dr Jonathan McWilliam	Director of Public Health
Matthew Tait	Area Director, Thames Valley NHS Commissioning Board
Councillor Melinda Tilley *(Oxfordshire County Council)*	Vice Chairman of the Children & Young People's Partnership Board
Councillor Ed Turner *(Oxford City Council)*	Vice Chairman of the Health Improvement Partnership Board
Larry Sanders	Chairman of Healthwatch Oxfordshire

In Attendance: Joanna Simons, Chief Executive
Ian Wilson, Interim Chief Executive, OCCG

Notes:•Date of next meeting: 17 July 2014

Declarations of Interest

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

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

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

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

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

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

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

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

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

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

For a full list of Disclosable Pecuniary Interests and further Guidance on this matter please see the Guide to the New Code of Conduct and Register of Interests at Members' conduct guidelines. http://intranet.oxfordshire.gov.uk/wps/wcm/connect/occ/Insite/Elected+members/ or contact Rachel Dunn on (01865) 815279 or rachel.dunn@oxfordshire.gov.uk for a hard copy of the document.

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, but please give as much notice as possible before the meeting.

AGENDA

1. Welcome by Chairman, Councillor Ian Hudspeth

2. Apologies for Absence and Temporary Appointments

3. Declarations of Interest - see guidance note opposite

4. Petitions and Public Address

5. Note of Decisions of Last Meeting (Pages 1 - 10)

To approve the Note of Decisions of the meeting held on 21 November 2013 (**HBW5**) and to receive information arising from them.

6. Terms of Reference

2:05

Board Member(s) responsible: All Members of the Health & Wellbeing Board
Person giving report: Peter Clark, Head of Law & Culture, OCC

There is a requirement to amend the OCC Constitution (Health & Wellbeing Membership) to reflect changes within the Oxfordshire Clinical Commissioning Group. These changes are such that the former Chief Executive role will be split into two separate roles ie. the Chief Executive and the Clinical Chair, to reflect the challenges facing health services in Oxfordshire.

Following an election for Clinical Chair, Dr Joe McManners has been appointed as the OCCG's new Clinical Chair. Dr McManners is currently a member of the Oxfordshire Health & Wellbeing Board by virtue of his office as Vice Chairman of the Adult Health & Social Care Partnership Board.

Dr Stephen Richards has formally resigned from his role as Accountable Officer (Chief Executive Officer) of the OCCG and the Board are advised that Ian Wilson, as Interim Chief Executive, will be taking on the role of Accountable Officer to the OCCG temporarily, whilst a permanent officer is recruited.

The OCCG Governing Body have notified us that Dr McManners will take on the Vice-Chairmanship of the Health & Wellbeing Board and the Interim Chief Executive will join Joanna Simons in the role of 'In Attendance' to the Board.

Action Required: in order to reflect the above changes the Board are RECOMMENDED:

(a) to agree that the current wording of the Terms of Reference for the

Board to be amended from (amendments underlined):

'Meetings of the Board will be chaired by the Leader of the Council and the Vice-Chairman will be the Chief Executive of the Clinical Commissioning Group' to:

'Meetings of the Board will be chaired by the Leader of the Council and the Vice-Chairman will be 'either the Chief Executive of the Oxfordshire Clinical Commissioning Group or its Clinical Chair as notified to the Monitoring Officer of Oxfordshire County Council'

(b) that a nomination be sought from the OCCG for a GP representative to join the Adult Health & Social Care Partnership Board; and

(c) to thank Dr Stephen Richards for the considerable part he has played in developing the partnership aspect to clinical commissioning within the County via the Shadow and the statutory Health & Wellbeing Board and for all his valuable hard work and dedication to this.

7. Joint Strategic Needs Assessment (Pages 11 - 48)

2:05

Person(s) responsible: Members of the Health & Wellbeing Board
Person giving report: Director of Public Health

To consider a report (**HWB7**) on trends in local data which impact on health and wellbeing. It includes recommendations for updating the Joint Health & Wellbeing Strategy.

The Board is RECOMMENDED that:

(a) the findings highlighted in this report are used in the process of updating and revising the Joint Health & Wellbeing Strategy (JHWBS);

(b) the outcomes achieved in 2013-14 and set out in the performance report (agenda item 9) are also taken into consideration in affirming and setting a concise set of outcome measures for 2014-15; and

(c) a revised draft Joint Health & Wellbeing Strategy for 2014-15 is brought to the next meeting of the Health & Wellbeing Board on 17 July 2014 for discussion and adoption.

8. Pharmaceutical Needs Assessment for Oxfordshire (Pages 49 - 52)

Board Member(s) responsible: All Members of the Board
Person giving report: Director of Public Health

A report is attached (**HWB8**) advising the Board on work in progress in relation to the production of a Pharmaceutical Needs Assessment for Oxfordshire on behalf of the Health & Wellbeing Board.

The Board is RECOMMENDED to:

(a) agree to the process set out in this paper and delegate authority to the Director of Public Health, in consultation with the Chairman and Vice Chairman of the Health and Wellbeing Board, subject to financial and legal approvals, to procure and manage the service of a contractor to produce a Pharmaceutical Needs Assessment for Oxfordshire on behalf of the Health and Wellbeing Board; and

(b) consider a progress report on this work at the July 2014 meeting.

9. Performance Report (Pages 53 - 78)

2:20

Board Members responsible: Members of the Health & Wellbeing Board
Person giving reports: Director of Public Health

There will be a review of current performance (**HWB9**) against all the outcomes for 2012 – 13 set out in the Health & Wellbeing Strategy.

Performance for each Partnership Board will be presented in turn:

- Children & Young People Partnership Board (Jim Leivers and Dr Mary Keenan)
- Adult Health & Social Care Partnership Board (John Jackson and Cllr Mrs Judith Heathcoat);
- Health Improvement Partnership Board (Dr Jonathan McWilliam and Cllr Mark Booty).

10. Oxfordshire Clinical Commissioning Group 5 Year Plan (Pages 79 - 154)

2:40

Board Member responsible: Clinical Chair, OCCG
Persons giving report: Interim Chief Executive Officer, OCCG and Clinical Chair, OCCG

To agree the Oxfordshire Clinical Commissioning Group 5 Year Plan prior to its submission to NHS England by 4 April 2014. A presentation will be given on the draft Strategic Plan **(HWB10**) and the Board will receive information on outcome based commissioning.

The Board is RECOMMENDED to agree the Oxfordshire Clinical Commissioning Group Strategic Plan.

11. Better Care Fund Plan (Pages 155 - 184)

3:05

Board Members responsible:	Director for Social & Community Services, OCC and Clinical Chair, OCCG
Persons giving report:	Director for Social & Community Services and Clinical Chair, OCCG

To seek agreement from the Health & Wellbeing Board on the proposed use of the Better Care Fund in Oxfordshire (**HWB11)**, prior to submission to NHS England (as an integral part of the Oxfordshire Clinical Commissioning Group's Strategic and Operational Plans) by 4 April 2014.

The Board is RECOMMENDED to:

(a) agree the Better Care Fund Plan for Oxfordshire for submission to NHS England by 4th April 2014, subject to subject to the inclusion of any necessary changes which may be required following consideration by County Council Cabinet and Clinical Commissioning Group Governing Body as agreed by Chairman and Vice Chairman of the Health and Wellbeing Board;

(b) in so doing, to agree the use of the Health Transfer to Social Care Funding in 2014/15 as set out in the financial template, and for this to form the basis of a section 256 agreement following legal review by the County Council and NHS England and as agreed by the Director for Social & Community Services following consultation with the Cabinet Member for Adult Services; and

(c) to receive an updated plan in March 2015 prior to implementation, reflecting performance in 2014/15 and any emerging pressures and priorities.

12. Local Information Steering Group (Pages 185 - 186)

3:30

Board Member responsible: Clinical Chair, OCCG
Person giving report: Dr Paul Park, OCCG

To consider a proposal to set up a multi-agency group to enable collaboration on Information Management and Technology (**HWB12**).

The Board is RECOMMENDED to endorse the proposal.

13. Local Healthwatch (Pages 187 - 192)

3:40

Board Member responsible: Larry Sanders, Chair of Healthwatch, Oxfordshire,
Board Member giving report: Larry Sanders, Chair of Healthwatch, Oxfordshire

Larry Sanders will give an update (**HWB13)** on recent developments. Issues raised will include:

- The mortality gaps for people with mental health problems and/or learning disabilities
- Monitoring the combined effects of Social Care cuts, NHS efficiency savings and benefits changes
- Care data.

14. Reports from Partnership Boards

3:50

Oral reports on activities since the last meeting in November will be presented by:

- The Chair of the Children & Young People Partnership Board, Dr Mary Keenan
- The Chairman of the Adult Health & Social Care Partnership Board, Cllr Mrs Judith Heathcoat
- The Chairman of the Health Improvement Partnership Board, Cllr Mark Booty

Action Required: To receive updates from each Partnership Board.

15. PAPERS FOR INFORMATION ONLY

- Summary of communications received by the Chairman of the Board from November 2013 to February 2014 by the Chairman of the Board and how it was responded to (attached).

OXFORDSHIRE HEALTH & WELLBEING BOARD

OUTCOMES of the meeting held on Thursday, 21 November 2013 commencing at 2.00 pm and finishing at 4.10 pm

Present:

Board Members:	Councillor Ian Hudspeth – in the Chair Dr Stephen Richards (Vice-Chairman) District Councillor Mark Booty Councillor Mrs Judith Heathcoat John Jackson Jim Leivers Dr Joe McManners Dr Jonathan McWilliam Matthew Tait Councillor Melinda Tilley City Councillor Ed Turner Larry Sanders Dr Matthew Gaw (In place of Dr Mary Keenan)
Other Persons in Attendance:	Joanna Simons (Chief Executive, Oxfordshire County Council); James Drury (Director of Finance, Thames Valley NHS Commissioning Board0
Officers:	
Whole of meeting	Peter Clark and Julie Dean (Oxfordshire County Council)

These notes indicate the outcomes of this meeting and those responsible for taking the agreed action. For background documentation please refer to the agenda and supporting papers available on the Council's web site (www.oxfordshire.gov.uk.)

If you have a query please contact Julie Dean, Tel: (01865) 815322 (julie.dean@oxfordshire.gov.uk)

	ACTION
1/13 Welcome by Chairman, Councillor Ian Hudspeth (Agenda No. 1)	

2/13 Apologies for Absence and Temporary Appointments (Agenda No. 2)	
Cllr Hilary Hibbert-Biles Dr Matthew Gaw attended for Dr Mary Keenan	Julie Dean
3/13 Declarations of Interest - see guidance note opposite (Agenda No. 3)	
There were no declarations submitted.	
4/13 Petitions and Public Address (Agenda No. 4)	
No requests to address or to petition members of the Board had been received.	
5/13 Note of Decisions of Last Meeting (Agenda No. 5)	
The Note of Decisions of the meeting held on 25 July 2013 (HWB5) was approved subject to an amendment to the phrase 'would be free to ' in page 4, paragraph 4, line 4 with the word 'should' to read as follows: 'The individual partnership boards ***should*** 'drill down' into inequalities issues at sub county level (whether geographical or affecting specific vulnerable groups.'	)))) Julie Dean)))
6/13 Performance Report (Agenda No. 6)	
The Board had before them a Performance Report reviewing current performance against all the outcomes set out in the Health & Wellbeing Strategy (HWB 6). This was the first report against the new measures agreed at the last meeting as part of the refreshed strategy. A table showing the	

agreed measures under each priority in the Joint Health & Wellbeing Strategy, expected performance and current performance was attached at Appendix A. With regard to target 6.2, Members of the Board discussed the various measures being taken by the NHS organisations and the County Council to tackle the number of delayed transfers of care within the County. The Oxfordshire Joint Health Overview & Scrutiny Committee were due to scrutinise this issue at their 5 December meeting at which all organisations were to be represented. It was requested that section 256 arrangements feed into the Performance Report. It was **AGREED** to note the report.	Ben Threadgold
7/13 Quality in Health and Social Care Services (Agenda No. 7)	
Following public consultation and discussion at the Health & Wellbeing Board it had been agreed that the revised Joint Health & Wellbeing Strategy should include some specific work on assurance of quality in service. Dr. McWilliam introduced the joint report HWB7 which gave an overview of current quality assurance systems operated by partners in the Health & Wellbeing network on a local, regional and national basis in Oxfordshire. Current working arrangements and systems of reporting should continue as they were. The report set out for discussion and ratification a number of proposals for how the Board could develop its responsibility to provide a strategic focus on quality. The Board **AGREED**: (a) quality leads from partner organisations to produce annual summary reports from the local and regional quality assurance groups listed in the report: to include an overview of common issues and concerns raised in the groups and a summary of issues reported by regulators; (b) to continue to receive reports on national issues of concern as they arise, with information on the situation in Oxfordshire as reported by the Quality leads from partner	All All

organisations; and (c) that the role of Oxfordshire Healthwatch will develop alongside the operational quality assurance systems providing a strong and independent network to raise issues of concern across health and social care both directly to this Board and in other forums.	Larry Sanders
8/13 Financial Challenge (Agenda No. 8)	
Dr Stephen Richards introduced, and the Board discussed the report HWB8 which provided a briefing on the financial performance of the OCCG for the 2013 – 14 financial year to September 2013 and the ongoing financial challenge now faced. A deficit situation had been declared at present with a forecast of an outturn around 6m in deficit. This was being addressed internally via the OCCG's Financial Challenge Programme Board and external support had also been commissioned. These initiatives aimed to ensure sufficient capacity and capability to address the challenges of the current financial position for the current year and in planning for future years. Dr Richards stated that OCCG were doing everything they could to diminish the deficit. Patient and public views were being sought as part of this effort. Matthew Tait reported that the Area Team were working closely with the CCG and had accepted that a deficit was the most likely outcome for Oxfordshire. The Board **AGREED** to note the report.	
9/13 Integration Transformation Fund (Agenda No. 9)	
The Board considered a joint report of the OCCG and OCC (HWB9) seeking to establish the process by which the Health & Wellbeing Board could agree a plan to use the resources allocated to Oxfordshire via the Integration Transformation Fund by April 2014. The Board **AGREED** (a) to approve the proposed process as set out in	))

paragraphs 18-23 of the report, subject to the planning template being emailed around all members of the Board for comment in advance of its approval by the Chairman and Vice-Chairman; and (b) to consider the final Integration Transformation Fund plan at the 13 March 2014 meeting of this Board, alongside proposals for the Health to Social Care funding transfer for 2014/15.	)))) John Jackson))))
10/13 Clinical Commissioning Group Strategy and Operating Plan (Agenda No. 10)	
Dr Richards introduced, for discussion and questions, the OCCG's draft strategic overview document entitled 'Improving the Health of Oxfordshire' which was currently out for consultation (HWB10). This was aligned to views which were currently being sought on the NHS England 'Call for Action'. The Board also had before them at HWB10 a report which provided an outline of this forthcoming national consultation on priorities in the light of restricted funding. It was accompanied by a number of background documents which were for information only. Comments on the overview document from individual members of the Board included: • A suggestion by a district council representative that the OCCG may wish to work with the district councils on one of their priorities to reduce health inequalities by providing a strong locality focus to address local variation in health outcomes (page 58); • A suggestion that as the majority of Oxfordshire residents were in good health, this should be reflected more in the document with more of a focus on the prevention agenda; • More people would attend and engage with the consultation if further evening consultation meetings were to be planned into the process. The Chairman asked Board members to feed through to the OCCG any further comments they may have.	All members to note

11/13 Annual Reports from the Children's and Adults Safeguarding Boards (Agenda No. 11)	
Peter Clark, Vice-Chair of the Oxfordshire Safeguarding Children's Board presented their Annual Report in the interim Chair, Paul Burnett's absence and made himself available for questions. John Jackson presented the Annual report for the Oxfordshire Safeguarding Adults Board in Chair, Donald McPhail's, absence and made himself available for questions. Dr Richards made the Safeguarding Board aware that there were slide sets available from the Government to help explain their response on the Francis Inquiry. The Board **AGREED** to receive the reports.	Peter Clark
12/13 Oxfordshire Children & Young People's Plan 2013/14 (Agenda No. 12)	
The Oxfordshire Children & Young People's Plan 2013/14 had been considered by the Children & Young People's Partnership Board on 24 October 2013. It was now before the Board for consideration and approval (HWB12). The Director of Children's Services explained that although there was no longer a statutory obligation to produce this three year plan, it was considered that an overarching strategic document should be put in place to give guidance and direction. If approved by the Board it would act as a sister document to the Health & Wellbeing Strategy and other associated documents in order to keep work as streamlined as possible. It was **AGREED** to approve the Children & Young People's Plan 2013/14.	Jim Leivers
13/13 Local Healthwatch (Agenda No. 13)	
The Chairman of Healthwatch Oxfordshire, Larry Sanders, gave an oral report on activities and short-term priorities. These included: • An interim Director, David Roulston, had been recruited and had been able to start immediately;	

• The full Board had now been recruited; • 15 applications had been received for small projects including an application received from a group of carers of people with a learning disability to inform a possible project on how mental health difficulties are experienced by people with a learning disability. A questionnaire on health and social care amongst students had recently gone live. Also an application had been received from an Asian women's group; • Some priorities for review had been set. These included access to GP appointments; work with Oxfordshire relatives and residents associations on older people's experience in care homes; domiciliary care; and whistle blowing; • Oxfordshire Healthwatch also had an interest in fuel poverty and issues around the insulation of homes; working with the Oxford & District Child Poverty Group; the Government's response to the Francis Report; and what are the issues for people who do not receive access to advocacy. Larry Sanders was thanked for his report. The Director of Social & Community Services reported that officers were currently in the process of looking for expressions of interest to run Oxfordshire Healthwatch from 1 April 2014.	
14/13 Reports from Partnership Boards (Agenda No. 14)	
Councillor Melinda Tilley, Councillor Judith Heathcoat and Dr Joe McManners each gave oral progress reports on recent activity of each of the three Partnership Boards. <u>Children & Young People's Partnership Board</u> Councillor Tilley reported on a meeting to be held with members of the Partnership Board and the Chair and Vice-Chair of the Oxfordshire Safeguarding Children's Board to clarify roles. Further work was also underway to ensure the functions previously held by the Children's Trust were covered appropriately. Changes to the membership had also occurred to include new PIN and Young Persons representatives and a representative from the voluntary sector. The Board had considered the following: • A paper on outcomes based commissioning for maternity services in Oxfordshire which was now being taken forward; • The Children & Young People's Plan for Oxfordshire	

2013/14;
- The Oxfordshire Safeguarding Children's Board Annual Report 2012/13
- Integrated Pathway and Multi Agency Safeguarding Hub (MASH).

It had been proposed to hold an extended meeting of the Partnership Board shortly to drive forward the development of the new Children & Young People's Plan 2014-18. This would engage a wider range of partners.

<u>Adult Health & Social Care Partnership Board</u>
Councillor Mrs Heathcoat and Dr McManners reported on membership changes to include two new Public Involvement Network representatives.

The Partnership Board had considered the following:
- Work that Oxford City Council and Oxfordshire County Council were doing on welfare reform. It had been agreed that the Partnership Board had agreed to monitor the impact of welfare reform for vulnerable groups and a report would be brought back to a future meeting;
- The Older people's Housing Strategy – Needs Analysis, one of the indicators in the priorities for the Health & Wellbeing Board – the Partnership Board were keen to ensure that the work was being taken account of in other strategies, in particular the district council housing strategies and the work of the OCCG;
- The Joint Health & Wellbeing Strategy – Report on Performance Targets – highlighting the challenges raised by the increase in demand and the changes to services as a result. The Partnership Board had supported the multi-agency approaches and the work being carried out to address the indicators that were not meeting targets;
- The Oxfordshire Joint Older People's Commissioning Strategy – Programme Board update.

A Mental Health workshop had been jointly organised in October by the Partnership Board and the Better Health in Oxfordshire Programme Board and had been attended by over 60 professionals, service users and carers. It had focused on the links between mental health and physical and other conditions. A number of key actions had emerged from the event. These were:
- a need for better co-ordination of services, communication between professionals and integration of mental health and drug and alcohol services;
- Improving of information and setting up information management systems;
- Reviews about a person's mental health to be

informed by physical health;
- A mental health lead to be in all GP practices;
- Consider pooling budgets for mental health and drugs and alcohol; and
- Closer working arrangements with organisations outside of health and social care, such as housing.

The workshop report would be taken to the OCCG GP Locality Groups and the Drug and Alcohol Action Team (DAAT).

A joint workshop for members of the Partnership Board and the Learning Disability Partnership Board was planned in December to begin the process to update the Big Plan for People with Learning Disabilities. The aim would be to identify the services and processes that were working well and the areas for development. People with learning disabilities, carers, providers and commissioners were to be invited.

Health Improvement Partnership Board

Councillor Mark Booty reported on membership changes to include representation of all the district councils and two PIN representatives.

He reported that the Partnership Board was looking closely on all the outcomes in the performance framework and ensuring that further work is focused on those areas with poorer outcomes.

Work had developed since the last report to the Health & Wellbeing Board on:

- producing a Healthy Weight Strategy;
- a joint Public Health Strategy between the Oxford University Hospitals NHS Trust and a draft strategy was expected in January 2014;
- sharing information on Health Improvement Campaigns – for example, working together on Flu Immunisation campaign and preparing messages on safe consumption of alcohol leading up to Christmas.

One of the Partnership Board's Working Groups, the Public Health Protection Forum was to meet in December to ensure that immunisations, screening and health protection issues in the county were proceeding well. Also the prevention of early death and promotion of healthy lifestyles would be a topic for discussion at a meeting of the Partnership Board in the new year.

The Partnership Boards were thanked for their reports.

..... in the Chair

Date of signing .....

Division(s): All

HEALTH & WELLBEING BOARD – 13 MARCH 2014

JOINT STRATEGIC NEEDS ASSESSMENT AND THE PROCESS OF UPDATING THE JOINT HEALTH & WELLBEING STRATEGY

Report by Director of Public Health

Overview

1. Joint Strategic Needs Assessments (JSNAs) are the means by which local leaders work together to understand and agree the needs of all local people. The Joint Health & Wellbeing Strategy sets out the agreed priorities for collective action.

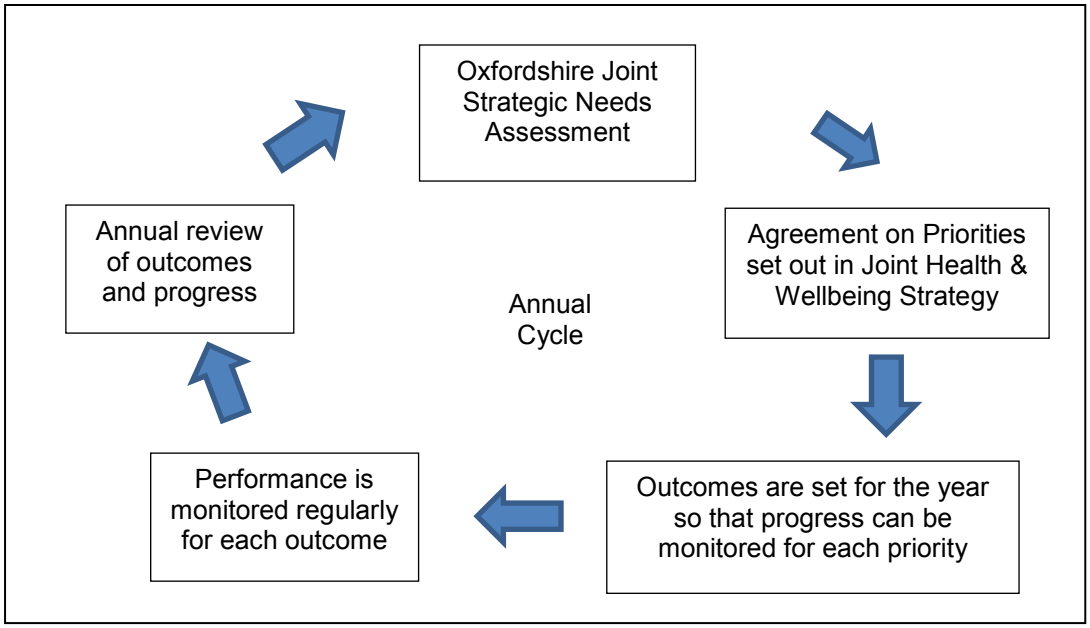
2. The JSNA and Joint Health & Wellbeing Strategy enable Health & Wellbeing Boards to address the wider determinants that influence improved health and wellbeing, such as housing and education. They also enable commissioners to plan and commission integrated services that meet the needs of their whole local community, in particular for the most vulnerable individuals and the groups with the worst health outcomes.

3. From April 2013, local authorities and Clinical Commissioning Groups (CCG) have had equal and explicit obligations to prepare a JSNA, and this duty has to be discharged by the Health & Wellbeing Board

4. Oxfordshire's JSNA is now in its seventh year and a wealth of material is in existence. The data collection itself and extensive analysis is available on a public website (http://insight.oxfordshire.gov.uk/cms/joint-strategic-needs-assessment).

5. An annual review of that data is put together by a multi-agency steering group and makes up the second part of this paper. This gives an understanding of trends which may be a cause of concern and changes in the health of the population that could be addressed.

6. The diagram below shows the process of using data and analysis to set priorities:



7. Following the presentation of this annual JSNA report to the H&WB it is expected that discussion will focus on priorities for the work of the Board for the year ahead. This may result in affirming or changing the priorities currently set out in the Joint Health & Wellbeing Strategy in the light of the JSNA report and also assessing the performance reported to the Board on the outcomes set for 2013-14.

RECOMMENDATION

8. It is RECOMMENDED that:

(a) the findings highlighted in this report are used in the process of updating and revising the Joint Health & Wellbeing Strategy (JHWBS)

(b) the outcomes achieved in 2013-14 and set out in the performance report (agenda item 8) are also taken into consideration in affirming and setting a concise set of outcome measures for 2014-15; and

(c) a revised draft Joint Health & Wellbeing Strategy for 2014-15 is brought to the next meeting of the Health & Wellbeing Board in July 2014 for discussion and adoption.

DR JONATHAN MCWILLIAM
Director of Public Health

Background Information: Nil
Contact Officer: John Courouble, Research & Intelligence Manager, Tel: (01865) 89616 February 2014

Joint Strategic Needs Assessment Annual Report 2014

The Joint Strategic Needs Assessment (JSNA) monitors trends in the health and wellbeing of the Oxfordshire population and assesses changing patterns of need and demand for services across the county. This year's JSNA looks at a wide range of data across the topics of:

- Population
- Groups with protected characteristics
- Wider determinants of health
- Mortality and morbidity
- Healthy Lifestyles and Behaviour
- Service Demand
- Quality of services

New to this update of the Oxfordshire JSNA are locally-produced datasets and analysis including:

- Oxfordshire County Council, Housing Led Population Forecasts
- FACE Needs Profile Database – a database of the social care needs of people on Self-Directed Support;
- Service user feedback from consultation events and complaints teams;
- Operational data from the Central Southern Commissioning Support Unit
- Recent 2011 Census releases.

Finding out more:

For a detailed look at the data which informs this report, go to http://insight.oxfordshire.gov.uk/cms/joint-strategic-needs-assessment. The website includes interactive dashboards showing key datasets, single issue reports and needs analyses (detailed links follow at the end of this document).

Executive Summary

The analysis presents a picture of an increasingly diverse county, which is, in the most part, a relatively healthy and prosperous place to live. However, it is clear that certain areas of the county experience less benign conditions which are associated with poorer health and wellbeing outcomes. These areas tend to be in the more economically deprived parts of South East Oxford and Banbury but include parts of Abingdon, Berinsfield, and Didcot.

The county's population is growing. This is due to increased inward migration, particularly in the urban hubs of Oxford and Banbury, and the increasing life expectancy of the existing population, particularly in the rural areas of the county. The mini baby boom of the past ten years, which has seen numbers of children increasing year on year, is forecast to level off, stabilising demand for early years

provision and schools over the next ten years following a further increase in the immediate future.

The proportion of older people is likely to continue increasing and this will have implications for service demand. Recently, demand for both Children's and Adult Social care has been increasing at a faster rate than even that which would be expected by population growth, suggesting that previously unmet need is coming forward.

Disability free life expectancy is increasing at a faster rate than life expectancy, meaning that not only are people living longer, in the future they might be expected (at the population level) to be living in good health and free of disability for longer towards the end of their lives. This is particularly true for the male population but will need further monitoring to see if it is a sustained trend, and if so what the implications are.

Data on mortality and morbidity suggest that Oxfordshire residents are less likely than those of the wider region to die early from cancers and circulatory diseases but that the identification of cancers is above the regional rate.

Assessment data for older people accessing Self-Directed Support gives a picture of the kinds of needs and disabilities people have at the point when they access care. Analysis has shown that close to one third of older people on Self-Directed Support have dementia, with the proportion being highest among people in the 80-94 age band. For service users over the age of 95 the most common disabling condition was arthritis.

In line with the growing population, as well as shifts in the way people are accessing them, some services are seeing significant challenges in meeting demand. This can be seen in the increasing demand around delayed transfers of care, the proportion of A&E waits which take more than 4 hours, and the increasing demand for adult and children's social care.

Feedback from service users has emphasised the importance of giving clients control over their daily lives including their care choices. Consultation feedback has also highlighted the difficulties people find in accessing up to date information and advice on the care options available.

<u>Limitations of the data and areas for future development</u>

The identified trends in life expectancy and disability free life expectancy are two of a number of factors which should be considered when projecting who will use services in the future. The analysis of rising demand in social care for older people suggests that a large proportion of the people who might be eligible for social care do not currently access services, but that this picture may be changing. Any estimates of population level demand must consider the fact that previously unmet need may come forward creating further pressures on services. Work is already underway with

the London School of Economics to develop a more textured model of future demand for adult social care.

Much of the available data does not allow detailed analysis of health outcomes by particular client characteristics – e.g. age, ethnicity, or local level geographies. This makes it difficult to identify areas where inequalities of outcome exist. In addition, the separate nature of health and social care records limits the ability to analyse patient pathways and understand complex needs in the service user population.

Section 1 – Population

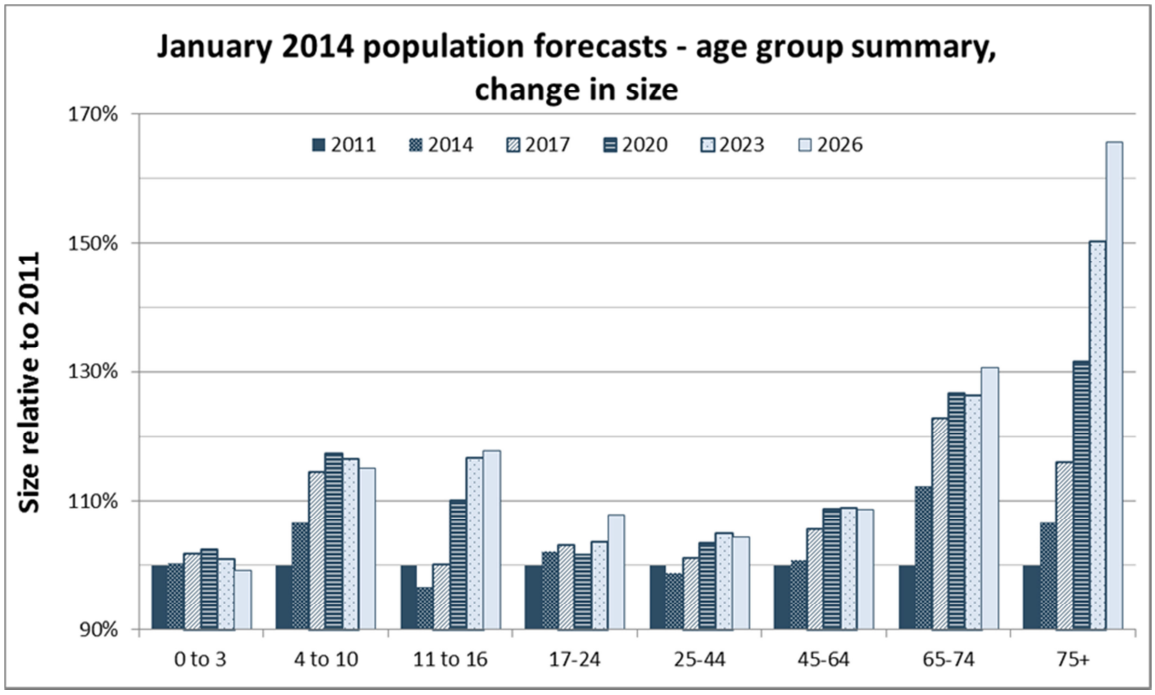
Population change

Unless otherwise stated, this section discusses the outputs of the January 2014 population forecasts produced by Oxfordshire County Council: unlike ONS Population Projections, these forecasts take into account housing supply growth trajectories (some 45,000 extra homes in 2026 vs. 2011) as set out by district planning authorities, giving a more complete picture of future population change.

Oxfordshire's population has aged since the 2001 Census, due to older age groups experiencing greater growth than younger groups. The 65-and-over population grew by 18% from 2001 to 2011, while the number of people aged 85 and over increased by 30%. The number of people in their 30s in the County declined by 12% whilst the number of children aged 4 and under has grown by 13%[1].

Over the next 15 years, Oxfordshire's total population is forecast to grow by 93,000 (14%), from 655,000 residents in 2011, to 748,000 in 2026. This growth will be because the number of births is forecast to exceed the number of deaths by 45,000, and 50,000 more people are forecast to move into Oxfordshire than to move out.

Oxfordshire's population is forecast to continue aging. The proportion of the population that is above the current retirement age (65) is forecast to increase from 16% in 2011 to over 20% by 2026, whilst the proportion that is of working age is forecast to fall.



Source: 2014 Housing led Population Forecasts, Research and Intelligence Team

[1] Figures from ONS, 2001 Census and 2011 Census

Forecast increases are most dramatic in the oldest groups: 66% growth in the 75+ group (from 50,000 in 2011 to 82,000 by 2026) and 69% growth for the 85+ group (up from 15,000 in 2011 to 25,000 in 2026). This is due to a combination of falling death rates, and baby-boomers entering this age range. The rate of growth among these age groups is predicted to be highest in rural areas of the county, with numbers remaining relatively constant in Oxford City.

For the 4-16 age group, the latest forecasts are for growth from a total of 97,000 in 2011 to 127,000 in 2026 (16% growth). Whilst the 4-10 group will peak in 2020, the 11-16 group will peak in 2026. The 0-3 age group will not change significantly over the period.

Fertility rates (the average number of children born to a woman over a whole lifetime) rose across England throughout the 2000s and early 2010s and are expected to reach a forty-year high-point in 2013. International migration into Oxfordshire was shown by the 2011 Census to have been higher than previously expected, which increased the number of women of childbearing age. These two factors have caused a recent "baby-boom" in Oxfordshire which is expected to level off over the next 10 years.

At birth, numbers of people in England recorded as male at birth slightly out-number females, but in the overall population, recorded numbers of females slightly out-number males. This is primarily a result of the fact that mortality rates for men are generally higher than for women.

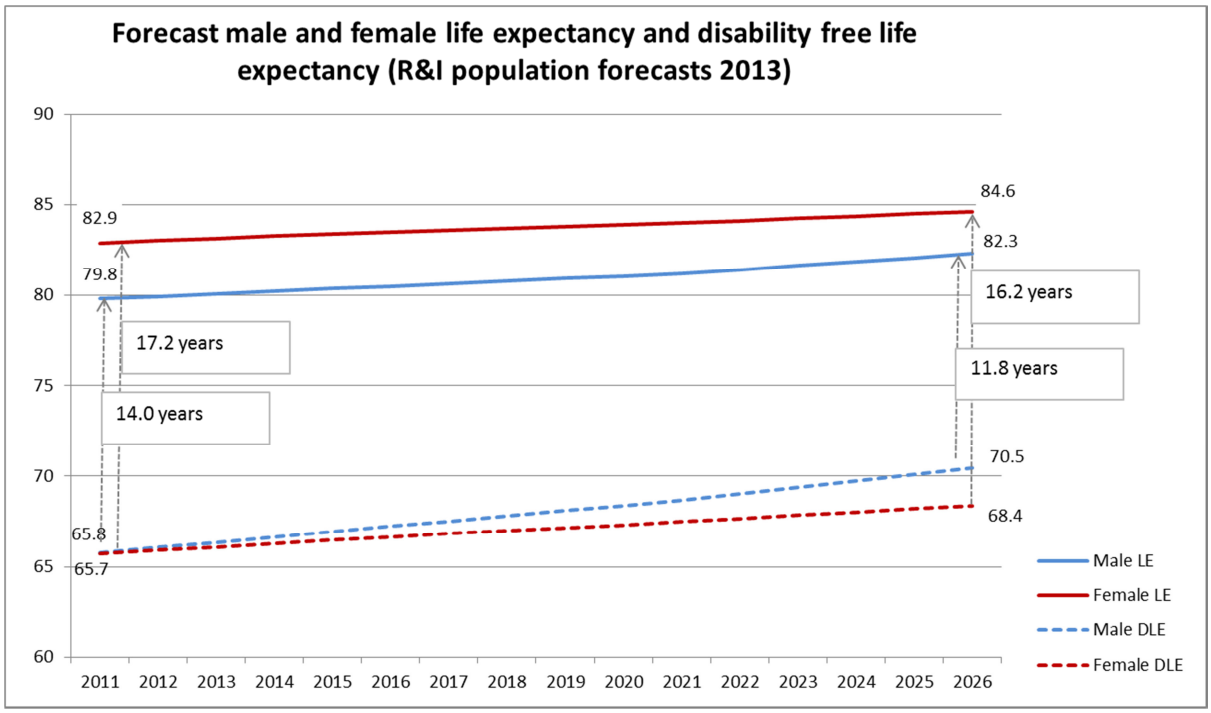
Life expectancy

Life expectancy at birth predicts the average number of years a person born today could expect to live if they were to experience that area's age specific mortality rates. In line with falling mortality rates, life expectancy has been increasing for some time. In Oxfordshire life expectancy for a person born in 2013 was above the national average at 80.3 for males and 84.1 for females[2].

In 2011, female life expectancy in Oxfordshire was higher than male life expectancy by 3.1 years. This gap has reduced in recent years with male life expectancy increasing at a faster rate. If current trends continue the gap in male and female life expectancy will reduce to 2.3 years by the year 2026.

Disability-free life expectancy (DLE) estimates the number of years a person will live before they are affected by a disabling condition. Currently disability free life expectancy is 65.7 for males and 65.8 for females. This is relevant because it predicts the age at which people are likely to need some level of support in their activities of daily living, whether through informal arrangements or formal care through their local authority.

[2] 2013 - Health Profiles, Public Health England http://www.apho.org.uk/default.aspx?RID=49802



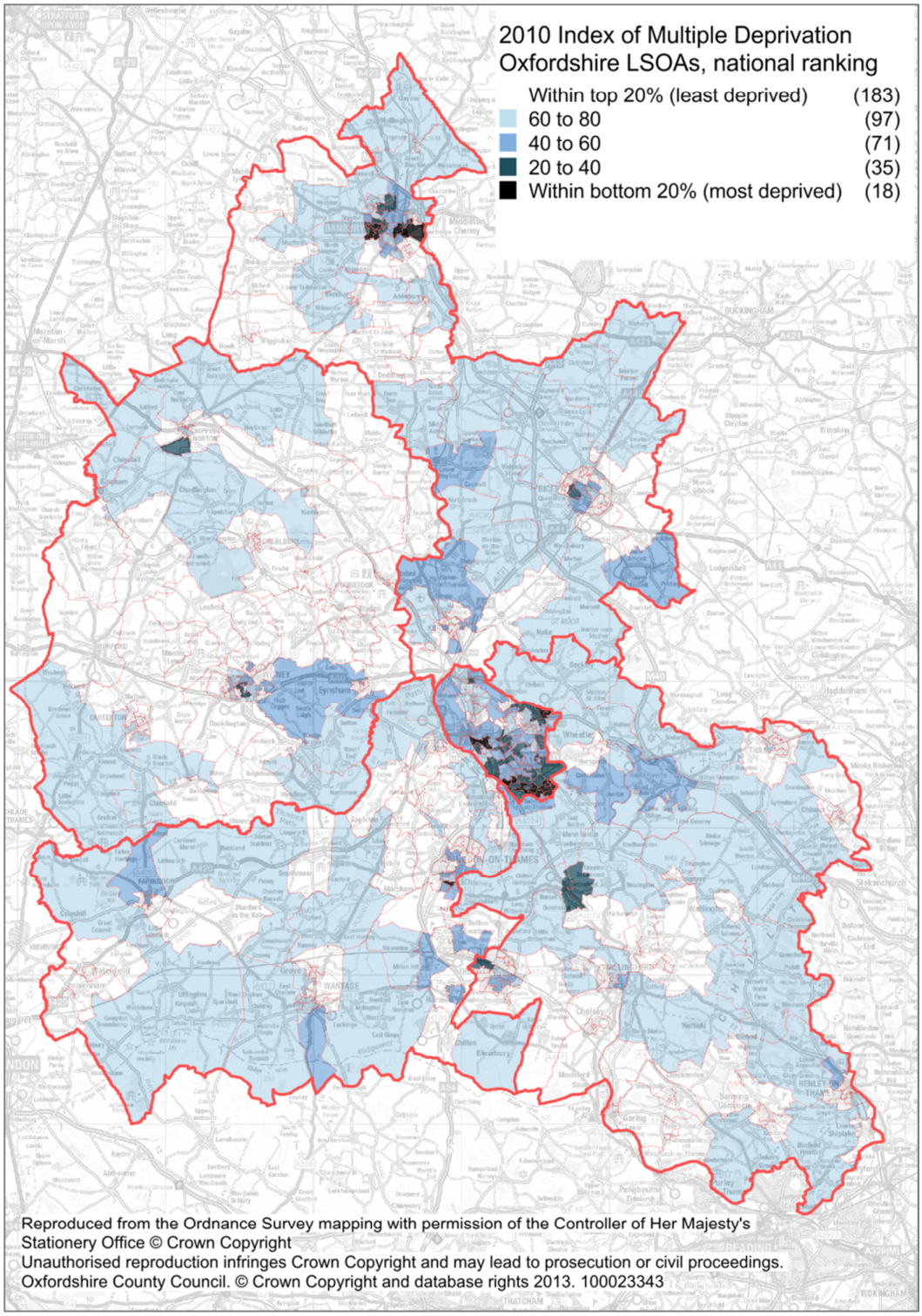
Source: ONS 2011 Mid Year Population Estimates, ONS death data, and ONS mortality assumptions for future years (taken from 2011 SNPPs)

ONS have also produced historic data on the relationship between total life expectancy and disability free life expectancy, which shows that DLE is increasing at a faster rate that LE. Assuming that this historic trend observed 2001 to 2010 continues to apply over the period 2011 to 2026, the gap between life expectancy and disability free life expectancy will reduce for both females (from 17.2 to 16.2 years by 2026) and males (from 14 to 11.8 years by 2026). Assuming the trend continues, by 2026 DLE would be 70.5 years for males and 68.4 years for females.

Deprivation

According to the 2010 Index of Multiple Deprivation, Oxfordshire ranks as the 12th least deprived upper tier local authority in the country. However, 18 Oxfordshire neighbourhoods (Lower Super Output Areas – LSOAs) rank among the 20% most deprived in England. These areas experience significantly poorer outcomes in terms of health, education, income and employment, and include a number of areas of South East Oxford, Abingdon, and Banbury[3]. These areas are shaded in dark blue on the following map:

[3] LSOAs in the following wards - Northfield Brook, Rose Hill and Iffley, Blackbird Leys, Barton and Sandhills, Banbury Ruscote, Banbury Grimsbury and Castle, Littlemore, Holywell, Abingdon Caldecott,



Source: Oxfordshire Insight, data taken from 2010 Index of Multiple Deprivation, DCLG.

It is notable that Oxfordshire contains relatively high levels of deprivation on the geographic barriers index, which assesses the average road distance to key services such as hospitals and schools. 139 of the 404 neighbourhoods in the county are among the 20% most deprived nationwide in this respect. The majority of these areas are in Cherwell, South Oxfordshire, Vale of White Horse, and West Oxfordshire and are predominantly rural.

Further Information

Population dashboard showing population forecasts at district level by single year of age. Download district level forecast data by user defined age bands, and compare population pyramids for different years and districts:

http://insight.oxfordshire.gov.uk/cms/population-forecasts-dashboard

Life expectancy dashboard – Includes data on male and female life expectancy at birth and male and female life expectancy at age 65 by district, county and region:

http://insight.oxfordshire.gov.uk/cms/health

Index of Multiple Deprivation Dashboard - maps and ward profiles for the 2010 Index of Multiple Deprivation:

http://insight.oxfordshire.gov.uk/cms/index-multiple-deprivation-dashboard

Section 2 – Protected Characteristics

All public bodies are required under the equalities act to consider the needs of people with protected characteristics – ethnicity, sexual orientation, and religion (age and gender are described in the population section above). This section gives the latest available data on the numbers of people in these groups, and, where relevant, their geographic distribution.

For the most part it is not currently possible to analyse health outcomes for people in these different groups (available data have been referenced in the Mortality and Morbidity and Lifestyle sections).

Ethnicity

The ethnic composition of Oxfordshire has changed since the 2001 Census. All of the county's black or minority ethnic communities have grown, and now account for 9.2% of the population, just under double the 2001 figure of 4.9% (Census 2011 table: KS201EW).

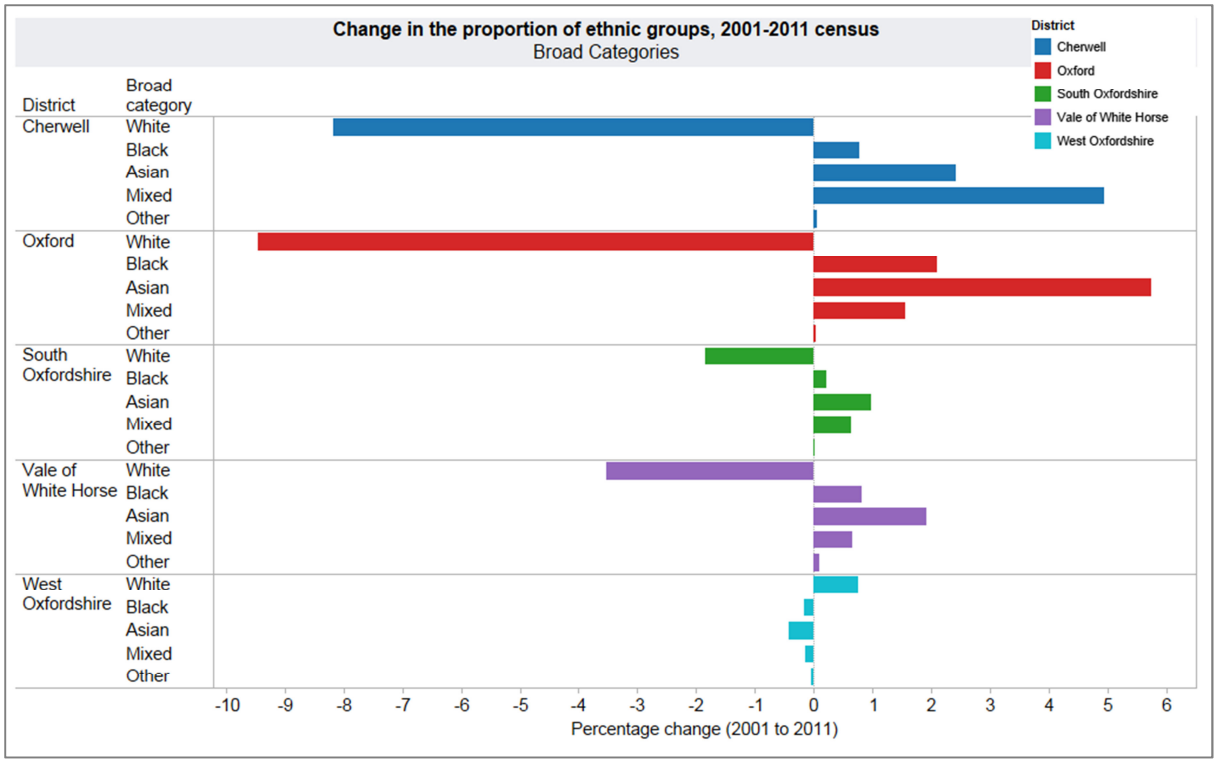
There has been a growth in people from White backgrounds other than British or Irish, who now account for 6.3% of the population (up from 4% in 2001). Much of this increase is explained by a movement of people from the countries which joined the EU in 2004 and 2007. In 2011, 13,000 residents in Oxfordshire were born in these countries, with more than half born in Poland (7,500 people, 2,700 resident in Oxford and 2,300 in Banbury).

People from White Gypsy or Irish Traveller backgrounds make up 0.1% of the county, and this is the same proportion across all the districts aside from West Oxfordshire, where 0.2% of the population classify themselves as such.

4.8% of the population are from Asian backgrounds, twice the 2001 figure of 2.4%. People from Asian communities form the largest minority ethnic group in the county, and most come from Indian or Pakistani backgrounds (2.45%).

The proportion from all Black backgrounds has more than doubled, from 0.8% to 1.75% of the county's population. People from mixed ethnic backgrounds account for 2% of the population (up from 1.2% in 2001).

The change in ethnicity across each district is shown in the chart below. Oxford City and Cherwell have seen the largest increases since the last census, as shown below.



Source: Oxfordshire Insight, taken from Census table KS201EW

Oxford City has seen a 5.8% increase in people of Asian ethnicity, the largest increase of any broad category. There has been a 4.9% increase in the proportion of people of mixed ethnicity in Cherwell. West Oxfordshire is the only district where there has been a reduction in the proportion of people from BME communities since the 2001 census.

Religion

60% of the county's population are Christian, whilst 28% do not have any religion. The county's Muslims make up 2.4% of the populace. The proportion of Hindus in Oxfordshire in 2011 was 0.6%. The size of the county's Jewish population is 0.3%. The growth and size of county's Buddhist population (0.5%) is in line with the regional and national figures.

Sexual Orientation

Reliable figures on the number of lesbian, gay, or bisexual people in the county are still difficult to obtain. The Census did not include a question on sexual identity or sexual orientation, and using the number of people in a civil partnership will not capture those who are either in a relationship but are not registered or those who are single.

Experimental statistics from the ONS's 2012 'Integrated Household Survey' suggested that the proportion of people identifying as gay, lesbian, bisexual, or other was 1.6% in the South East, against a figure for England of 1.9%.

Disability

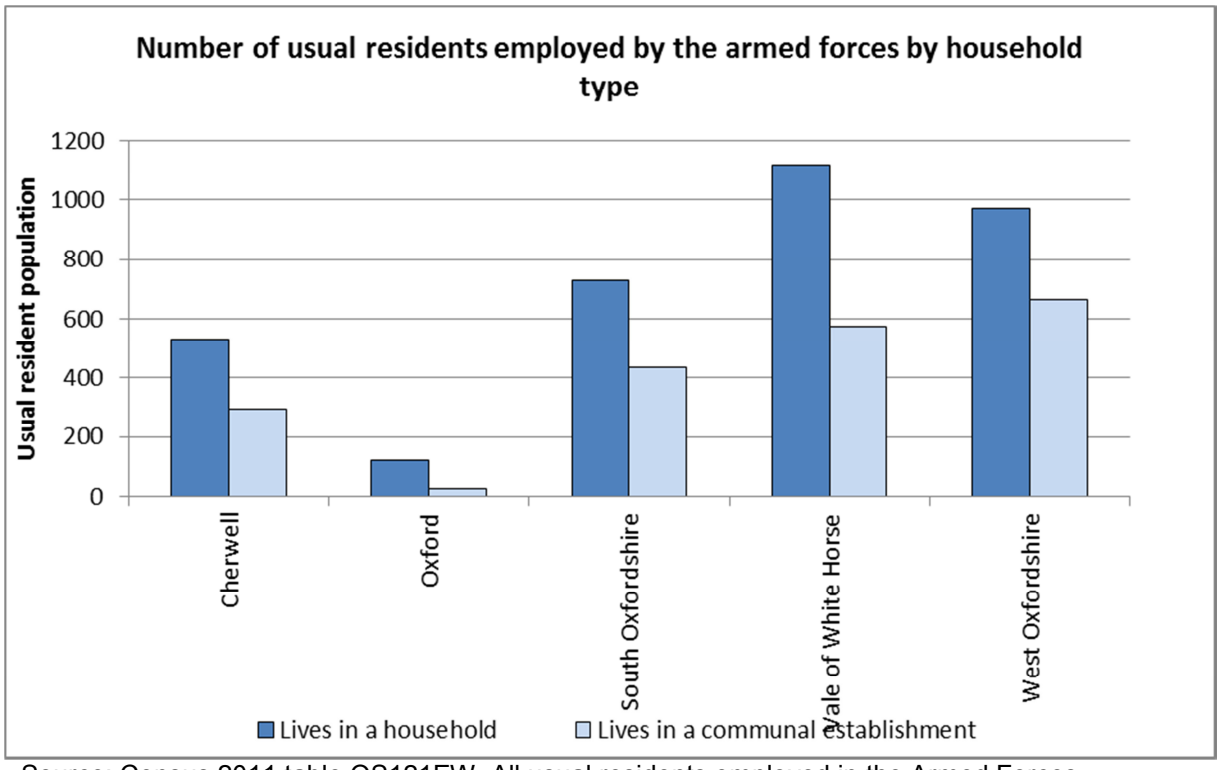
90,000 people countywide are limited in their daily activities by a long term health problem or disability. This equates to 14% of the population. A smaller proportion (8%) reported that their activities were 'limited a lot' by their condition. These proportions are broadly similar across the districts. However, there is some variation in the rates for specific age groups across districts, with Oxford (24.7%) and Cherwell (23.2%) containing higher rates among people over 65 than the county average (21.6%).

12,400 people aged 85 and over in households are living with day-to-day activities significantly limited by a health problem or disability. This is equivalent to 49% of the total resident population aged 85 in households. Cherwell, Oxford and Vale of White Horse Districts are above the regional average on this measure.

Other population groups

Armed forces personnel

At the time of the 2011 census Oxfordshire was home to 5470 armed forces personnel, of whom 33% lived in communal establishments. The remaining 67% live in households.



Source: Census 2011 table QS121EW. All usual residents employed in the Armed Forces

31% of armed forces personnel in the county live in Vale of White Horse, with a further 30% in West Oxfordshire.

Carers

The 2011 Census suggests that 9.4% of the Oxfordshire population provide some level of informal care to a relative or friend. This equates to approximately 60,000 people, of whom 72% provided between 1 and 19 hours of care per week, 10% provided between 20 and 49 hours, and 18% provided more than 50 hours.

2% of people under 25 and 9% of people aged 25 to 49 provide some unpaid care, compared to 14% for people aged 65 and over. The group most likely to provide unpaid care was people aged 50-64, with 20% providing some level of care.

Feedback from county council surveys has suggested that being an informal carer is very demanding, with many carers caring for long hours. 61% responding to the Carers Survey said they were satisfied with services. This was lower than satisfaction levels among users of adult social care services which follows the national trend (see section 7 - Quality of Service). Most carers wanted more time to do what they wanted, more control, support and social contact; and to be fully involved in decisions about those they care for.

Carers also stated that they find it hard to access the information they want, though when they find it they are usually satisfied.

Further Information

Compare changes in ethnicity in Oxfordshire's population between 2001 and 2011:

http://insight.oxfordshire.gov.uk/cms/ethnicity-dashboard

View charts and tables on Disability, Caring, and Health by age from the 2011 Census:

http://insight.oxfordshire.gov.uk/cms/health

Section 3 - Wider determinants of health

The Marmot review 'Fair Society, Healthy Lives'[4] highlighted the fact that health inequalities arise from a complex interaction of a range of social and environmental factors - housing, income, education, social isolation, and exposure, or perceived exposure, to crime - all of which are strongly affected by one's economic and social status. This section looks at recent trends across these domains, identifying geographic areas in Oxfordshire where outcomes tend to be below the regional and national averages.

Housing and homelessness

The pattern of housing tenure differs in Oxford City compared to other districts, with a much higher proportion of people in local authority social housing (13.4%) and private rented housing (26.1%) than the county average (4.6% and 15.2% respectively).

Close to 280,000 people in Oxfordshire live in households with more than 1 person per bedroom. This includes 76,000 people who live in households with more than 1.5 people per bedroom, equating to 12% of the population.

There are 22 neighbourhoods (Lower Super Output Areas) in the county where the proportion of people in households with more than 1 person per bedroom is greater than 50%. 12 of these areas are in South East Oxford, 4 are in Banbury, with the remainder in Berinsfield, Didcot All Saints, Abingdon Caldecott, Benson, and Marcham and Shippon (Source: Census table QS414EW).

Education

The percentage of people over 16 in Oxfordshire with at least a bachelor's degree (census category - level 4 and above) has risen to 35.7 per cent (up from 27.7% in 2001). This is similar to the national increase. All Oxfordshire districts contain above the national average, with Oxford City containing the highest proportion of people with level 4 and above qualifications.

16.7% of Oxfordshire's population lack any qualification, down from 18.6% per cent in 2001 and below the average for England (22.5%). Except for Cherwell, the proportion of Oxfordshire's population without a qualification is higher than the national and South East averages. Oxford City contains the lowest proportion of people with no qualifications at 13.6% of the population.

[4] http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

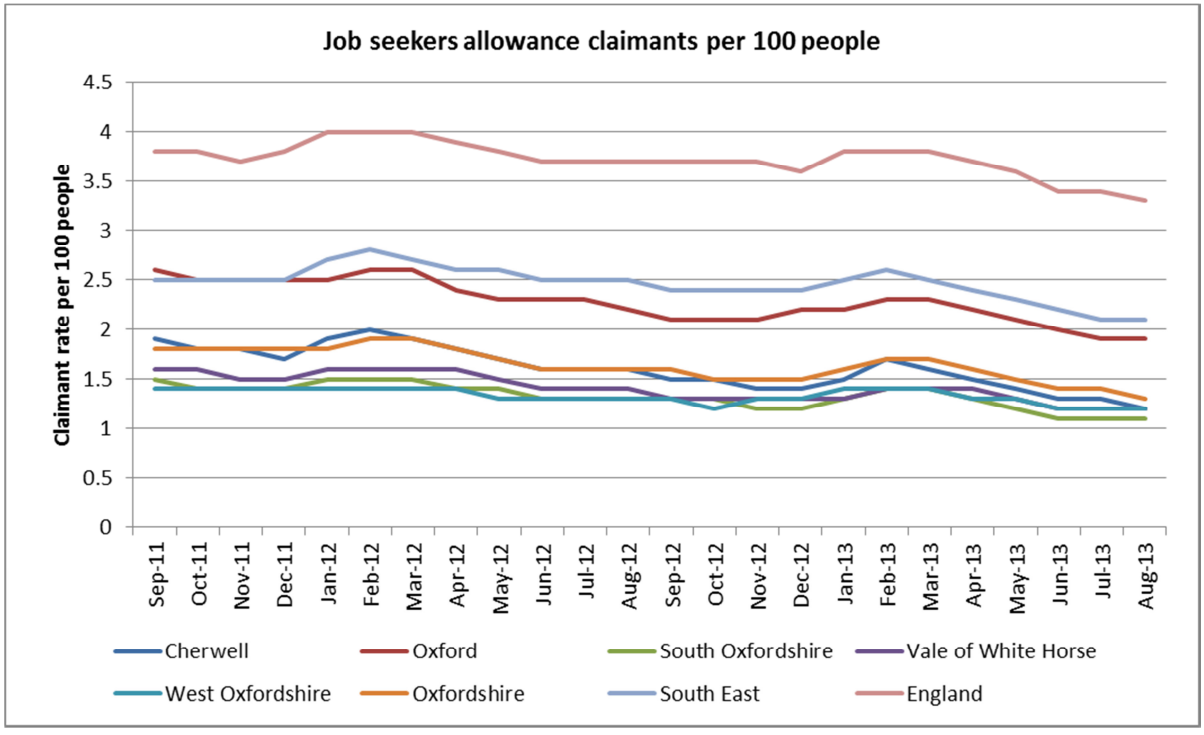
The wards with the highest proportion of people with level 1[5] or no academic or professional qualifications are Blackbird Leys (54.9%), Northfield Brook (46.3%), Banbury Ruscote (55.2%), Barton and Sandhills (37.4%), and Littlemore (37.8%).

Employment

In June 2013, there were 427,800 people aged between 16-64 (this is classed as the working aged population) in Oxfordshire. There are a total of 342,600 working aged people in employment, which equates to 77.1%. This compares with 74.7% for the South East and 71.1% for Great Britain.

In June 2013 the unemployment rate was 6.3% which equates to 23,000 people, compared with 6.2% for the South East and 7.8% for Great Britain.

In August 2013 1.3% of working aged people in Oxfordshire people claimed Job Seekers Allowance (JSA), compared with 2.1% for the South East and 3.3% for Great Britain. Oxford City had a higher rate than the county at 1.9% of the population but remained below the regional average.



Source: Nomis, Official Labour Market Statistics

11 wards had a higher JSA claimant rate than that of the South East region, namely Blackbird Leys, Northfield Brook, Rose Hill and Iffley, Banbury Ruscote, Barton and Sandhills, Cowley, Iffley Fields, Banbury Grimsbury and Castle, Abingdon Abbey and Barton, Witney Central, Littlemore, and Didcot Northbourne.

[5] Level 1 qualifications: 1-4 O Levels/CSE/GCSEs (any grades), Entry Level, Foundation Diploma, NVQ level 1, Foundation GNVQ, Basic/Essential Skills

In May 2013, 32,530 people in Oxfordshire were claiming Key Out of Work Benefits (Job Seekers, ESA and Incapacity Benefits, Lone Parents and Others on Income Related Benefits). This is higher than the number of unemployed as it includes a number of people who are in work, but claim income related benefits. The Oxfordshire Rate of 7.6% was lower than the South East (10.1%) and almost half that of Great Britain (13.9%).

Crime

In the 12 month period ending December 2013, there were 10,397 Anti-social behaviour incidents across the county. This represents a fall of 11.2% compared to the previous 12 month period. The areas with the highest rates of antisocial behaviour were Oxford East, Wheatley/Chalgrove, and Banbury Rural (Thames Valley police area classifications).

After a reduction up to April 2012, Violent Crime has remained at the same rate for the last 12 months. Violent Crime is lower in Oxfordshire compared with the regional and national rates. The summer months have higher proportions of crime compared with the monthly average. Violence with injury has reduced by 15.2% (298 crimes) over the last 12 months, whereas violence without injury has increased by 6.7% (293). The Oxford district rates are higher than the Country and Thames Valley Police rates, whilst Cherwell district rates are higher that the County rates.

Hate Crime has fallen by 13.0% between April 2013 - December 2013 and the corresponding period in 2012. The most common type of hate crime incidents were racist, accounting for 75% of the 662 incidents between September 2010 and August 2013. These were predominantly classified as public order offences (55%). A further 31% of racist incidents were classified as violent.

The number of domestic abuse incidents (non-recordable crime) increased from April to December 2013. This does not indicate that domestic abuse is more prevalent but demonstrates that victims are reporting abuse earlier and that reporting is increasing. This suggests that the preventative approach in Oxfordshire is working. In 2012/13, 2,829 victims of DA accessed dedicated support services. For the period April-September 2013 1,601 victims of DA accessed dedicated support services.

The prevalence of Child Sexual Exploitation has been an emerging national issue of concern over recent years. Operation Bullfinch was a joint surveillance operation by Police and Social Workers within Oxfordshire which commenced in 2010 due to growing concerns about possible street grooming of vulnerable girls by a gang of men acting together. This resulted in the successful prosecution and conviction of 7 men for a range of serious sexual offences against these girls and young women.

The Oxfordshire Safeguarding Children Board has instigated a Serious Case Review into this matter and commissioned a special task group to identify and action improvements into how agencies can better work together in combatting this horrific form of abuse. A formal strategy to address this abuse has been agreed by all statutory agencies, procedures reviewed and training undertaken for key professionals involved in this area.

The Kingfisher team has been established as a multi-agency professional group charged with the responsibility of investigating all referrals where Child Sexual Exploitation is suspected. The Team has handled over 90 referrals in the last 12 months, as a result of work by all agencies to pro-actively identify children who present risk factors for CSE using the CSE screening tool. Following referral these children receive preventative support, protection and further investigation as appropriate to their individual circumstances. All these children have multi-agency plans in place to ensure all risks are assessed and addressed.

In the last 12 months 13 women have been identified by GPs, Community Midwives and the Hospital Consultant Obstetrician as having been subjected to FGM; all are believed to have undergone FGM abroad prior to coming to this country. There is currently no reliable data on the extent of Female Genital Mutilation (FGM) in Oxfordshire or even the United Kingdom. It is estimated that in 2001 nearly 66,000 women with FGM were living in England and Wales with an additional 5,000-8,000 girls who may possibly be affected in the future. The Oxfordshire Safeguarding Children Board (OSCB) has for some years had a clear procedure in place but is taking a more pro-active approach on this to ensure that there is better awareness of this form of physical abuse and strengthen the co-ordinated approach with partners.

Isolation

Feedback from service users and communities has suggested that isolation, loneliness and social contact are crucial ingredients for health and wellbeing for carers, users, and people in rural areas. Engagement events have highlighted the role that local groups, volunteers, and the faith and community sectors play in providing local supports.

At the time of the last census 28.7% of Oxfordshire residents aged over 65 lived alone. Though this does not directly equate to loneliness, these people are significantly more likely to be socially isolated which may lead to experiences of loneliness.

Further Information

Education and Skills Dashboard – charts on highest levels of qualification by areas

http://insight.oxfordshire.gov.uk/cms/education-and-skills-dashboard

Community safety dashboard – time series charts on the number of recorded crimes by type and by geographic area:

http://insight.oxfordshire.gov.uk/cms/community-safety-dashboard

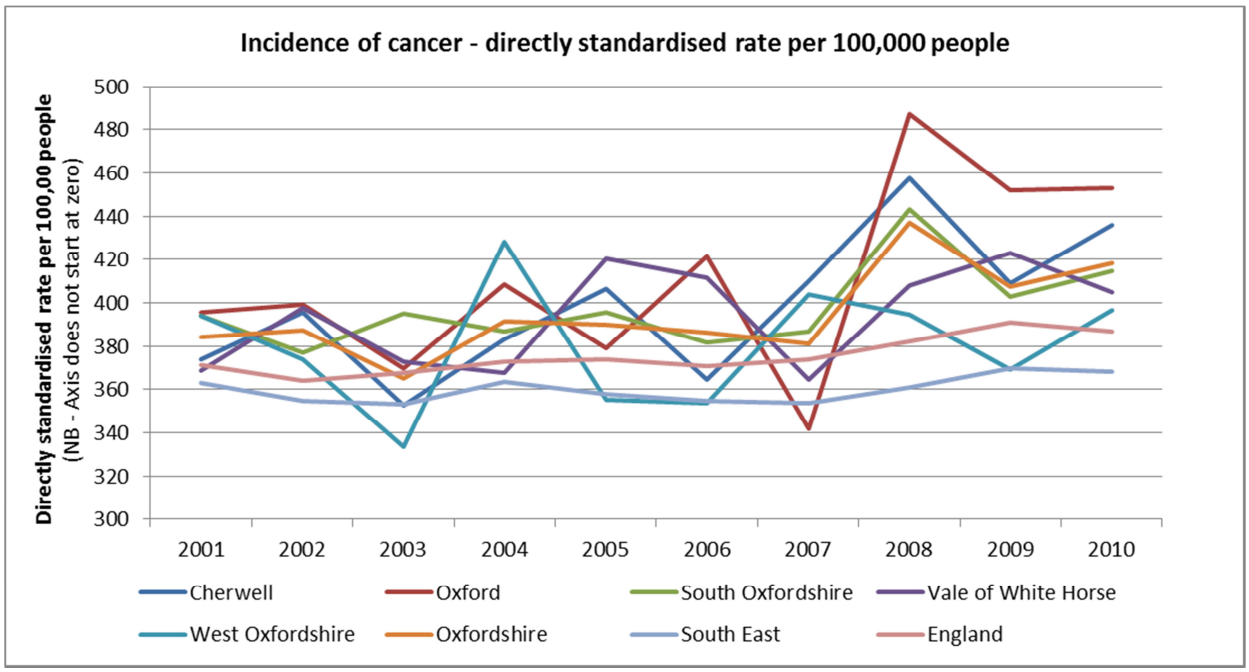
Section 4 - Morbidity

Diabetes

There are over 26,000 people aged 17 years and over diagnosed with Diabetes registered in Oxfordshire GP practices, representing almost 5% of that age group. This gives some indication of the prevalence of the disease and the majority are likely to have Type 2 Diabetes. Overall Oxfordshire percentages are lower than England and this may be due to lower prevalence.

Cancer

The incidence of cancers has been steadily increasing across all areas in men and women under the age of 75. The latest data (2008-10) shows Oxfordshire has a significantly higher rate of incidence than England in both men and women. The higher rate may in part be explained by better ascertainment i.e. local health services may be better than other areas at diagnosing cancer or the local population may be more aware of the signs and symptoms of cancer and seek medical advice early resulting in a prompt diagnosis.



Source: Health and Social Care Information Centre, Indicator Portal

Circulatory diseases

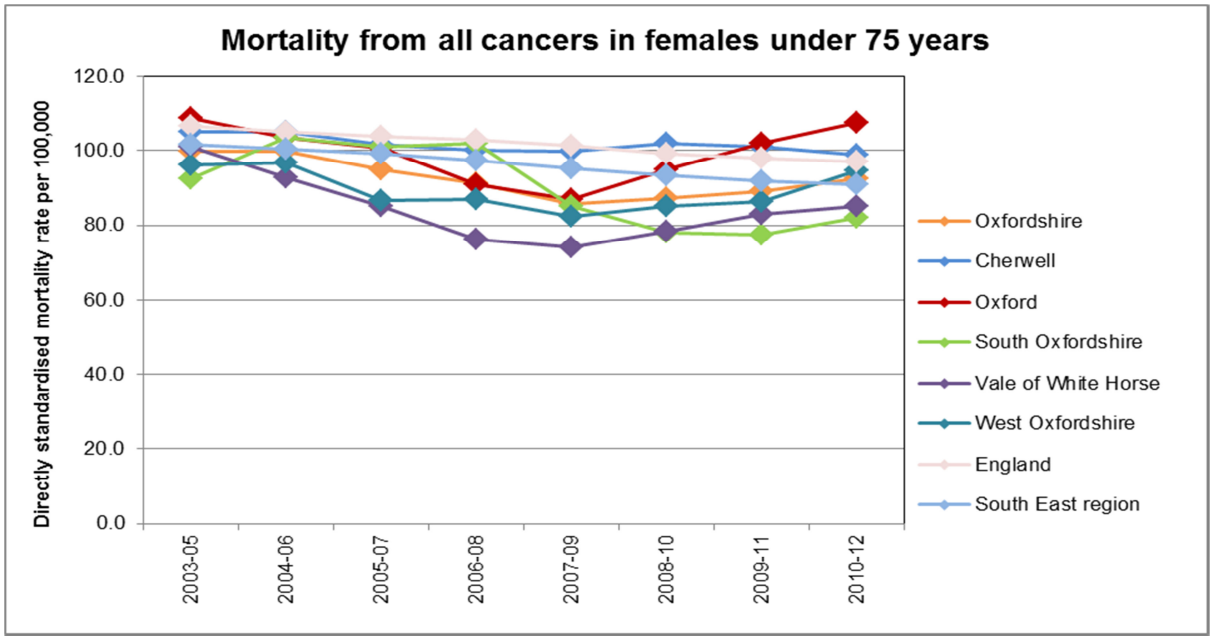
The estimated prevalence of stroke and coronary heart disease can be taken from GP-recorded information. These data do not reflect true levels as they are based on general practice recording. Nevertheless general practice in Oxfordshire is of high quality and so it is reasonable to assume that these give us a good estimate. Of Oxfordshire's GP-registered population 1.6% are recorded as having had a stroke or TIA (transient ischaemic attack) and 2.6% has a recorded diagnosis of coronary

heart disease (CHD) in 2012/13. These are both significantly lower than the national average. GP practices within Oxford City have a significantly lower recorded diagnosis of both stroke and CHD (than Oxfordshire) – with a younger population profile than the rest of the county this may account for the lower prevalence.

Mortality

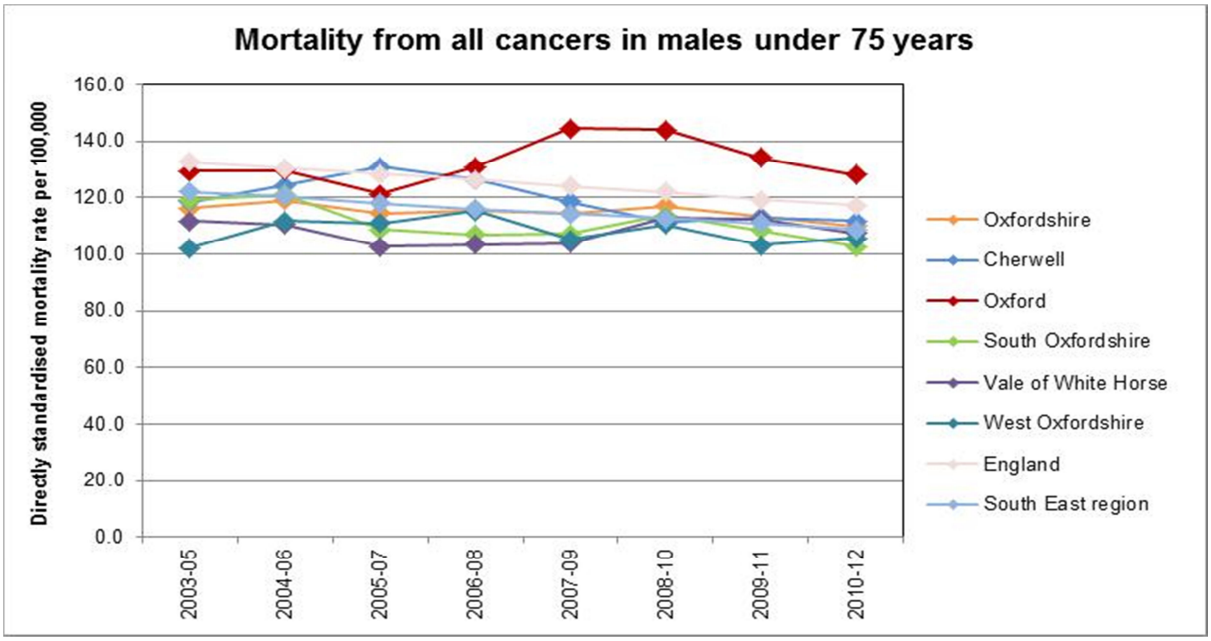
Cancer

Cancer is the biggest cause of mortality in males and females under the age of 75 in England and Oxfordshire. Cancer mortality accounts for approximately 700 deaths per year in Oxfordshire. Both nationally and locally the mortality rate from all cancers is significantly lower in women than men, although the gap is closing as the rate in men has been decreasing at a more rapid rate.



Source: Health & Social Care Information Centre Indicator Portal

Male cancer mortality in Oxfordshire remains significantly lower than the England average however this is no longer the case for females in 2010-12.



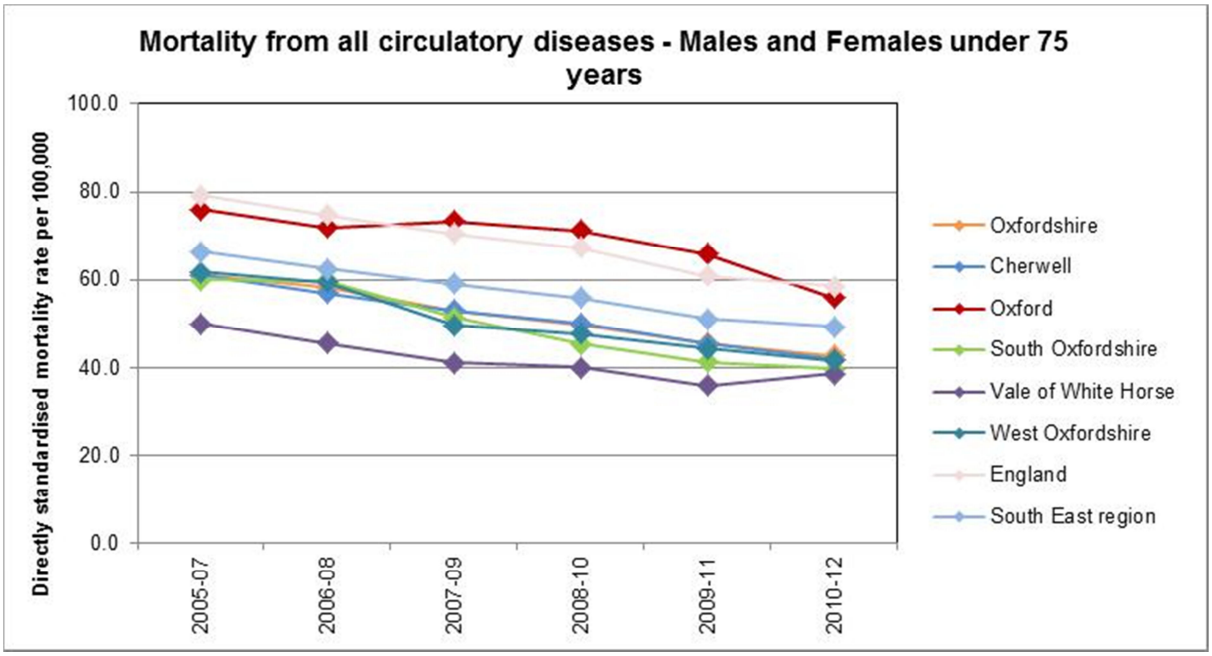
Source: Health & Social Care Information Centre Indicator Portal

There are many causes of cancer; smoking remains the biggest single cause. Lung cancer is the most common cause of death from cancer for men, responsible for nearly a quarter (22%) of cancer deaths in males in Oxfordshire. Colorectal cancer accounts for a further 11% and prostate cancer 8%. In women 17% of cancer deaths are from lung cancer whilst breast cancer accounts for 19% and colorectal cancer 9% (figures are based on numbers for 2010-12 three years combined).

Screening programmes were introduced for early detection of bowel, breast and cervical cancer and late detection is almost certainly a major contributor to poor survival.

Circulatory diseases

Circulatory diseases such as heart disease and stroke also contribute to the main causes of mortality. Trends indicate a decline in mortality rates in people under 75 years. There is some fluctuation at a district level but this will be due in part to the low numbers involved. Although still a leading cause of death, Oxfordshire has a significantly lower level of mortality from circulatory diseases than the national and regional averages for both males and females.



Source: Health & Social Care Information Centre Indicator Portal

Nationally heart diseases are a leading cause of death for men aged 50 and over, and for women aged 65 to 79 years. These diseases are usually caused by the build-up of fatty deposits on the walls of the arteries around the heart. Lifestyle choices (such as smoking and diet), and other conditions such as high cholesterol, high blood pressure and diabetes, can also lead to heart disease.

Further Information

Mortality dashboard – charts and tables on the causes of death and standardised mortality ratios at district level. Burden of ill-health dashboard – Charts on incidence of cancer:

http://insight.oxfordshire.gov.uk/cms/health

Public Health Outcomes Framework data tool:

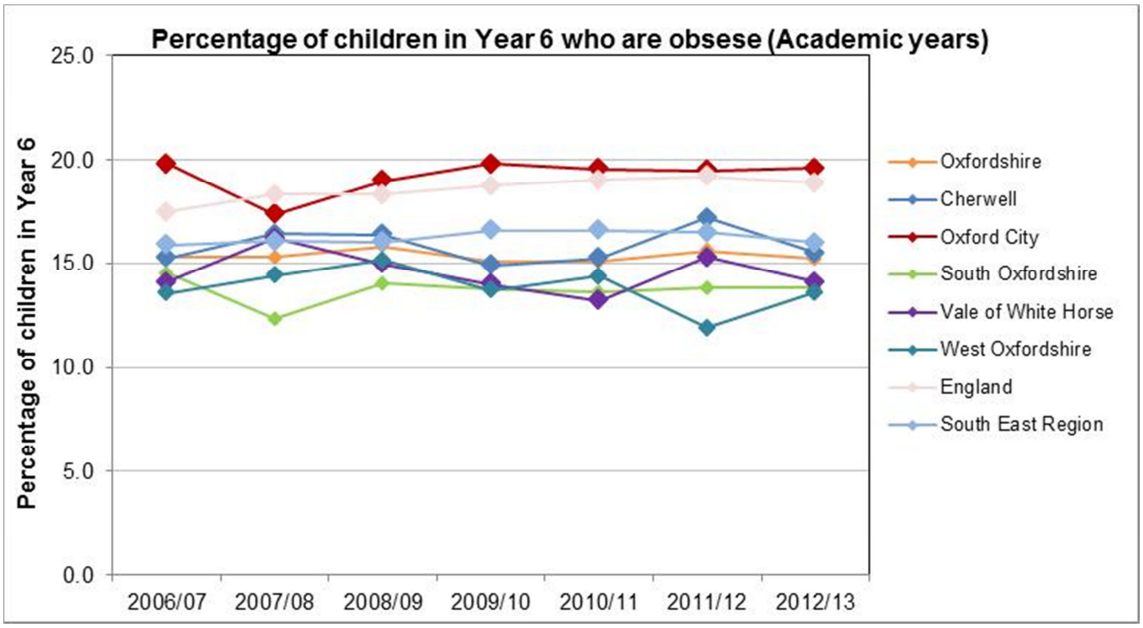
http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000049/pat/6/ati/102/page/0/par/E12000008/are/E10000025

Section 5 – Lifestyles

Obesity

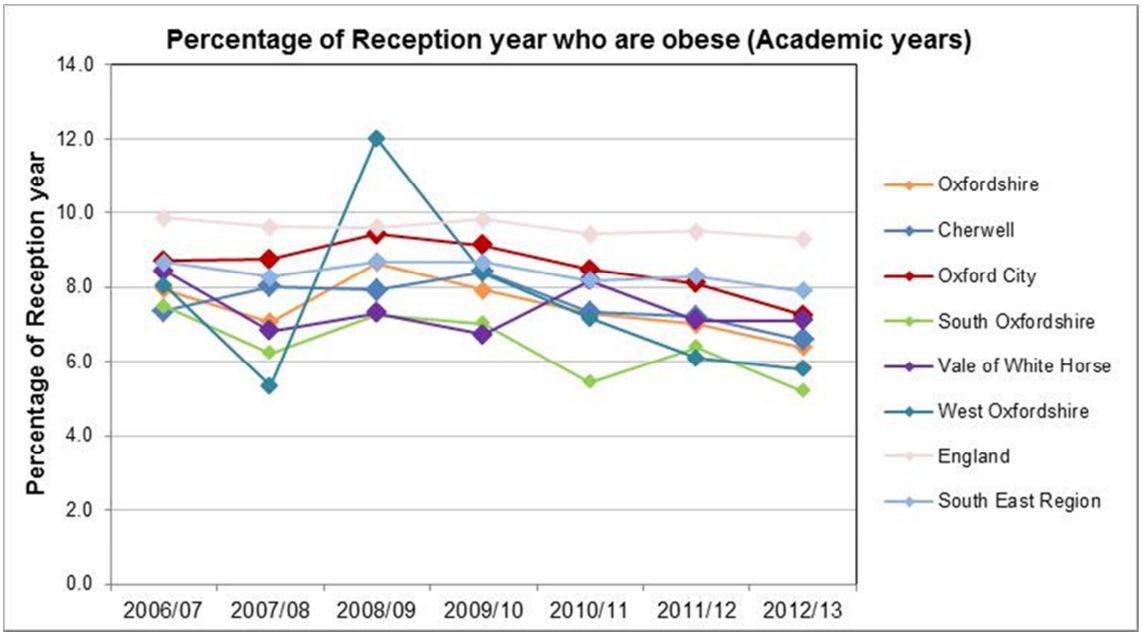
The rise in obesity both nationally and locally has caused concern. There is little robust data at a local level - latest data from Health Survey for England indicates that obesity could be as high as 29% in people aged 16 years and over in Oxfordshire. However GP-recorded cases of obesity show a much lower proportion (10%) which is likely to underestimate as not all people will have had their BMI recorded.

For children there is a more robust source of obesity data as Reception year and Year 6 have been measured in schools since 2006/7 which gives us some good trend data. Oxfordshire remains significantly lower than the national average.



Source: Health & Social Care Information Centre Indicator Portal

Children in year 6 have a higher prevalence of obesity than those in Reception year. Once established, obesity is difficult to treat so prevention and early intervention are important. Being obese or overweight can increase the risk of developing a range of serious diseases in later life. There is a strong relationship between deprivation and childhood obesity. Analysis of data from the National Child Measurement Programme (NCMP) for 2012/13 shows that obesity prevalence among children in both Reception and Year 6 increases with increased socioeconomic deprivation (measured by 2010 Index of Multiple Deprivation (IMD) score). The NCMP also reveals substantial variation in childhood obesity prevalence between ethnic groups at a national level.



Source: Health & Social Care Information Centre Indicator Portal

A consultation in August 2013 involving nearly 200 parents, children and young people about Childhood Obesity highlighted a number of challenges for families:

- Benefits of breastfeeding are well known, but parents had mixed experiences of support
- Affordability and availability of healthy food in some areas
- Time it takes to buy and prepare fresh food compared to fast convenience food, for working mothers with families
- Lack of basic cooking skills and knowledge in nutrition
- Healthy eating messages need to be 'cool'
- Affordability of exercise classes/activities, especially in winter
- Schools and Children's Centres seen as core and influential hubs for information in communities

Physical activity

Of the adult population (16+ years) in Oxfordshire, 61.2% partake in moderate equivalent physical activity for at least 150 minutes per week. These data are based on survey results conducted by Sport England and weighted to represent the demographic population of each geographic area. Oxfordshire has a significantly higher proportion than the national average. This indicator has changed so there are no trend data available.

Smoking

The most up to date data available for smoking prevalence is for 2011/12. These figures are taken from a national survey but are the only data available for smoking prevalence. They indicate that approximately 17% of the adult population (18+ years) in Oxfordshire are smokers. This is significantly lower than the national average.

Further Information

Children's bodyweight dashboards Smoking, drinking, and drugs dashboard – charts on prevalence rates for overweight children in year 6 and reception years:

http://insight.oxfordshire.gov.uk/cms/health

Public Health Outcomes Framework data tool:

http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000049/pat/6/ati/102/page/0/par/E12000008/are/E10000025

Section 6 – Service Demand

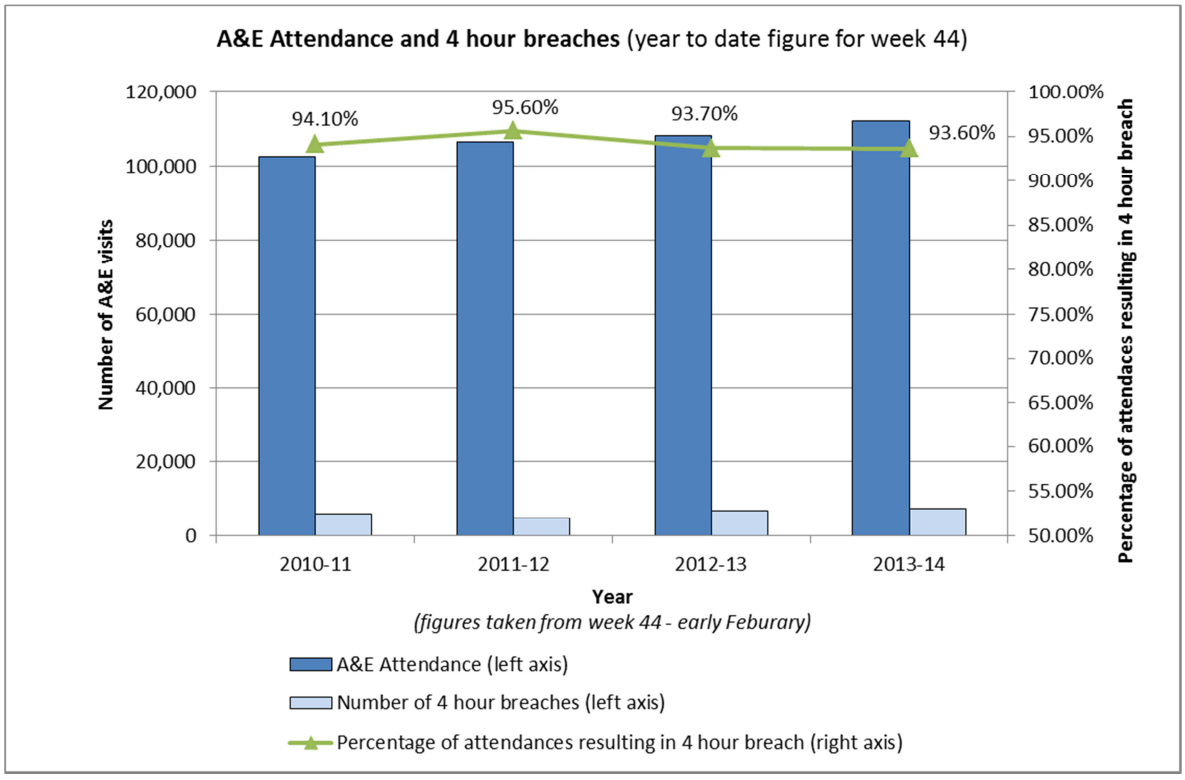
GP Practice population

There were 698604 people registered with Oxfordshire GPs in 2013. This has increased by 4% since 2010. The number of people registered with GPs has increased by 15% in the South East Locality over the same period.

The number of people registered with a GP does not necessarily reflect the actual number of people using GP services, and is likely to include the records of people who remain registered despite leaving the area, as well as people who live in neighbouring counties but are registered with GPs in Oxfordshire. This explains the fact that the GP registered population is higher than the county population.

A&E attendance and breaches

The number of people attending accident and emergency has increased steadily over the past four years.



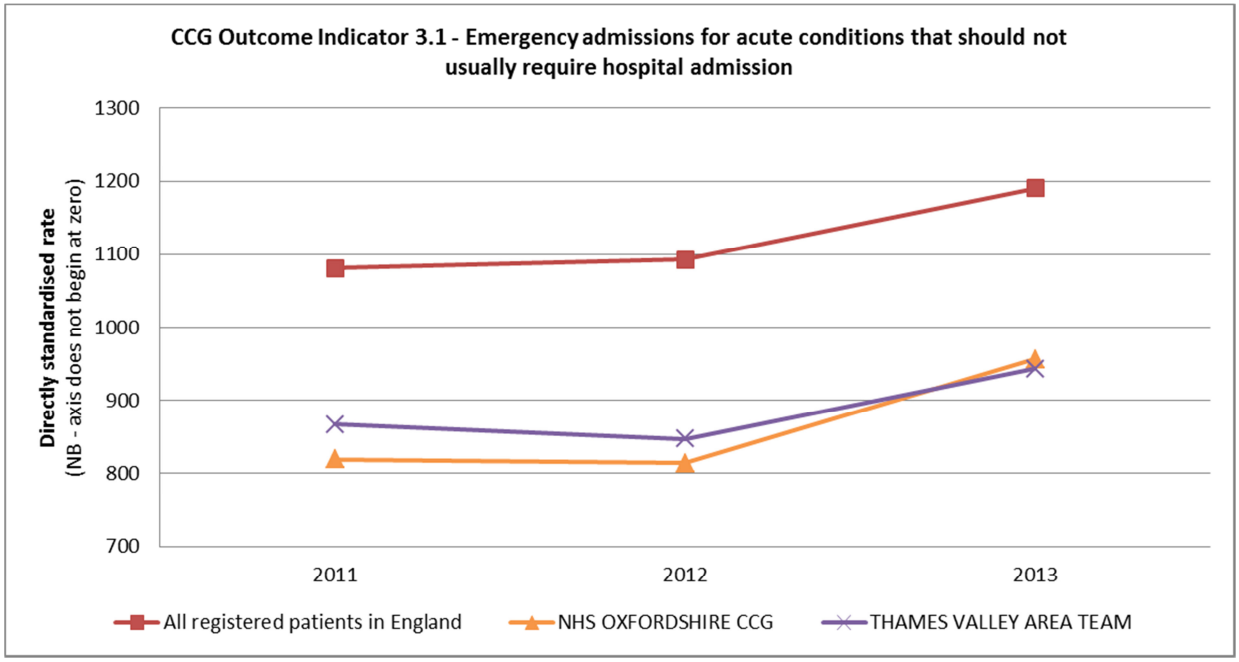
Source: Central Southern Commissioning Support Unit

Over the same period the proportion of people attending who were seen within 4 hours has reduced (episodes exceeding this are known as A&E Breaches) to 93.6%, as shown in line on the above chart[6].

[6] 4 hour breach figures for 2011/12 are estimated. Data was not collected during the final 4 months of the year.

Emergency Admissions for Acute conditions that should not usually require Hospital Admission

The past year has seen an increase in the number of emergency admissions for acute conditions that should not usually require hospital admission. The directly standardised rate has risen from 814.1 to 956.2, taking it above the Thames Valley figure of 943.3 (CCG Outcomes Framework 3.1).



Source: CCG Outcomes Framework, Health and Social Care Information System

Data from the Southern Central Commissioning Support Unit suggests that this increase is mostly attributable to increases in admissions for Skin Infections and Dental & Other Mouth Problems. Convulsions (many of which will be related to Epilepsy) and Gastrointestinal Infections have also shown increases. There has been a reduction in the number of emergency admissions for genitourinary system infections over the same period.

Delayed Transfers of Care (DTOC)

Although delayed transfers of care have fallen in recent months from a high of 166 in September 2013 to 133 in December, Oxfordshire continues to have the highest number of delays nationwide.

Aggregation of the reasons for delays as at week ending 23rd February 2014 suggests that the most common category of delays were people awaiting community hospital beds which accounted for 27% of delays. Further common categories/subdivisions were people waiting for a care home placement (21%); people awaiting a re-ablement care package (15%) and patient and family choice (18%).

Social Care – Older People

The number of users of adult social care is growing at a faster rate than that which could be attributed to population growth alone. In 2012/13 the number of older people receiving long term support from the County Council rose by 4.8% and by a further 7.9% to a figure of 4,037 by September 2013. By contrast the population of older people is estimated to have grown by around 3% each year since the 2011 Census.

The average number of hours of care provided per week rose by 9.2% and 1.7% over the same period, suggesting that the levels of need among people entering the system may also be increasing.

This suggests that demand is rising due to pre-existing unmet need in the population which is now presenting to social care. The table below uses service data and figures from the 2011 census to estimate the potential scale of 'unmet need' in Oxfordshire:

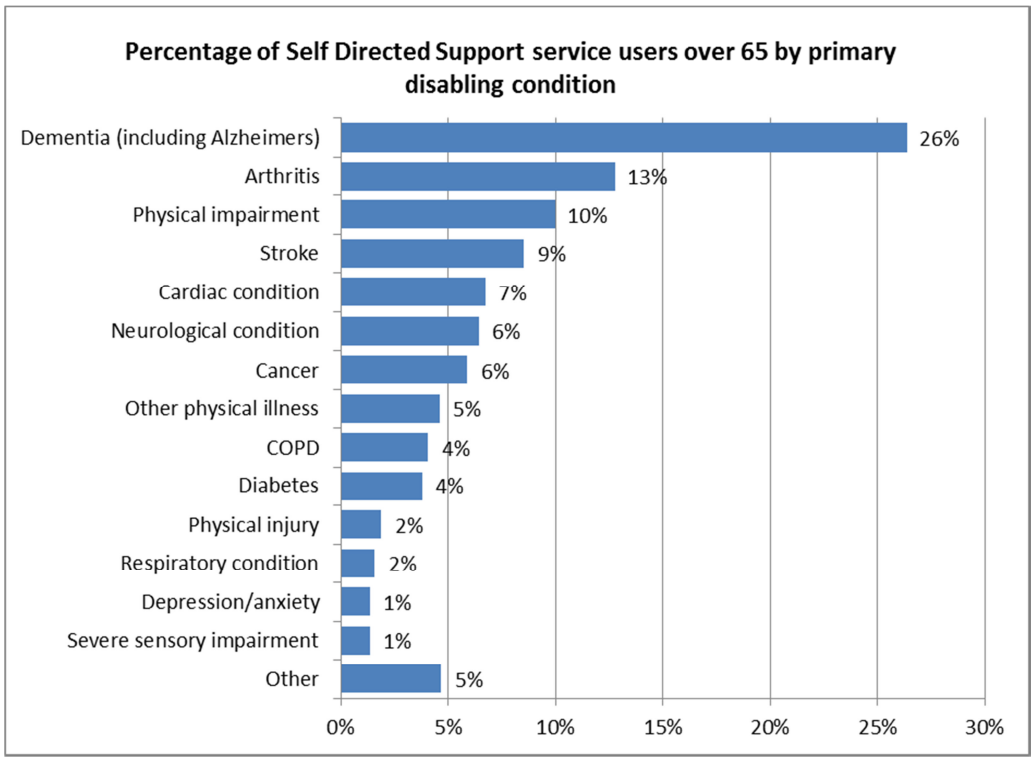
Estimate of needs and services in Oxfordshire

Category of Need	**Number**
Older People whose activity of daily living are limited a lot	24,000
People receiving long term support managed by the local authority	4,000
Estimate of older people receiving intensive (50 hours plus) informal care from a family or friend	5,700
Older People self-funding care home placements	2,100
Older People self-funding care at home	3,400
Needs currently met (local authority; informal; private)	15,200 (63%)
Potential unmet need which could come forward	**37% (8,800)**

In the current population, there are at least 8,800 older people who have serious difficulties in their activities of daily living but do not currently meet these needs through private care, social care, or informal care. The care bill is likely to create additional incentives for people to access formal care, ultimately increasing the

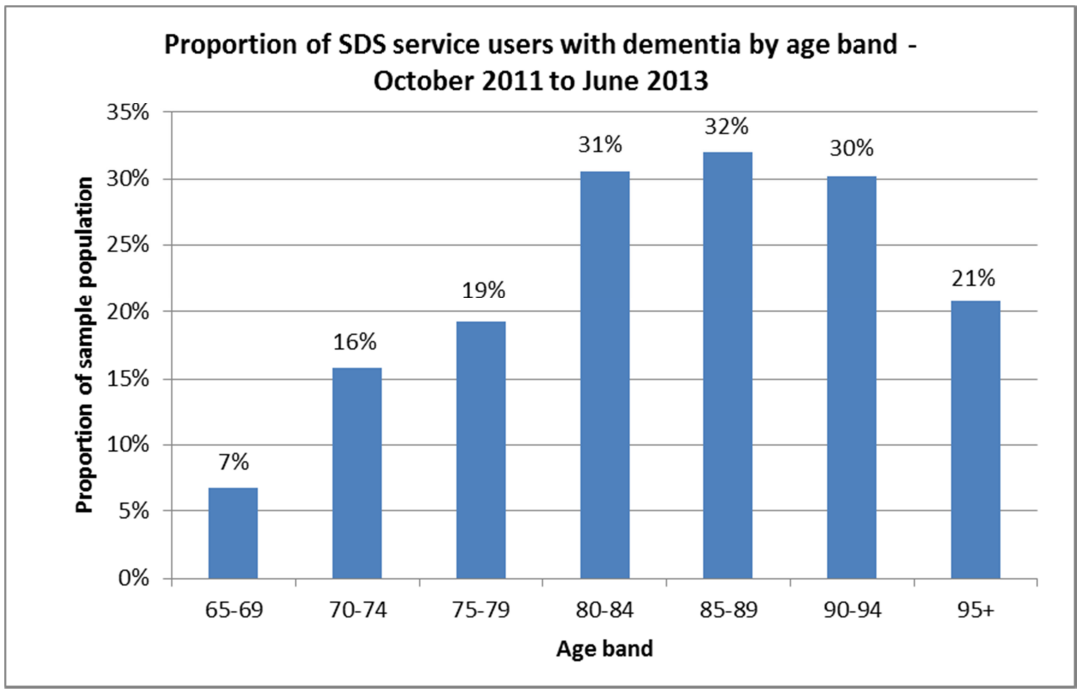
proportion of needs met through Local Authority managed care. Whilst this is on the surface a positive development for the service user, it will present serious challenges for the capacity of the social care system as currently constituted.

Analysis of assessment data offers further texture to the types of needs people have when entering the social care system. A sample of assessment forms for 1500 Self Directed Support service users over the period of October 2011 to July 2013 suggests that the condition most affecting the activities of daily living for older people presenting to social services is dementia, which affected 26% of the sample (a further 6% recorded dementia as their secondary condition). Other common conditions included Arthritis (12%), Physical impairment (10%), Stroke (9%), Cardiac conditions (7%), Neurological conditions (6%), and Cancers (6%).



Source: FACE Needs Profile Database, Oxfordshire County Council

The same data suggest that the likelihood of a client presenting with dementia increases with age, with 7% of people aged 65 to 69 presenting with dementia as a primary disabling condition, compared to 32% for people aged 85 to 89, as shown in the following chart.



Source: FACE Needs Profile Database, Oxfordshire County Council.

For those over the age of 95, the most common condition affecting activities of daily living was arthritis, which affected 26% of this age group.

Feedback from older people in Oxfordshire cited three key things as contributors to quality of life: health, control over daily living, and social contact.

Service users have highlighted the fact that good, up-to-date, accessible information and advice underpins people's ability to be more independent, have more control and make better choices. It needs to be jargon free, accessible in a variety of formats and channels, up-to-date and simple.

Learning Disabilities

National prevalence rates[7] suggest that there are likely to be around 9,000 adults with some level of learning disability in the county. In September 2013, 1923 people with learning disabilities were known to social services. This equates to 21% of the estimated total which matches the national rate.

National estimates predict that demand for services will increase at a rate between 0.6% and 4% per year between 2009 and 2026[8]. Although there has been a steady increase in the number of people open to learning disability teams in recent years (from 1792 in March 2012 to 1923 in September 2013), the number of people in

[7] http://www.improvinghealthandlives.org.uk/uploads/doc/vid_9244_IHAL2011-02PWLD2010.pdf
[8] http://eprints.lancs.ac.uk/21049/1/CeDR_2008-6_Estimating_Future_Needs_for_Adult_Social_Care_Services_for_People_with_Learning_Disabilities_in_England.pdf

supported living and care homes increased between 2011/12 and 2012/13 but fell in the first 6 months of 2013/14.

Physical Disabilities

In Sept 2013, Oxfordshire County Council supported 591 adults (aged 18-64) with a Physical Disability. A large majority of this group (86%) receive either home care or direct payments with the rest supported in care homes. The latter group has remained largely unchanged since March 2012 whilst the former grew by 29% from March 2012 to September 2013.

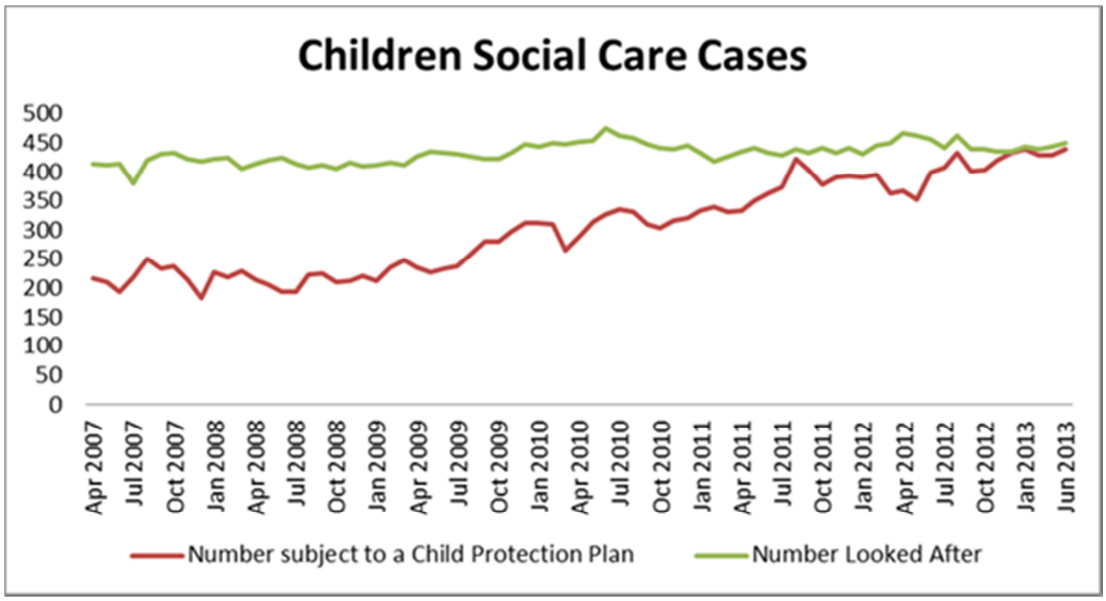
Consultation on the PD strategy in April 2012, involving 274 people suggested the strategy should find ways to measure social integration, quality of life and overall well-being among people with a physical disability, rather than relying too heavily on indicators such as employment and the receipt of direct payments which were viewed as somewhat crude proxies for independence.

Children's Social Care

Activity levels in Children's Social Care are higher than would be expected based on relative measures of need in the population, and are increasing at a faster rate than the national trend.

Whilst there is no single predictive measure of need for children's services, the level of income deprivation affecting children (IDACI index) is a nationally used proxy for understanding the proportion of a population who might be referred to social care.

At the end of 2012/13, Oxfordshire had a rate of 30.9 children on a child protection plan for every 10,000 children and young people countywide. Whilst this is lower than the national rate of 37.9, when it is weighted for the number of income deprived children/young people, Oxfordshire has a higher rate than would be expected. Nationally, for every 60 deprived children/young people, there is one on a child protection plan. In Oxfordshire the ratio is one child on a plan for every 40 deprived children/young people.



Source: Joint Commissioning, Oxfordshire County Council

The chart shows that the number of children on child protection plans has more than doubled over the past five years, whilst the number of looked after children has remained relatively stable. The most recent national statistical returns showed that between 2011/12 and 2012/13 the number of children on a plan in Oxfordshire increased by 17% compared to 0.3% nationally.

There is reason to believe that the upward trend is attributable to more effective screening and referral processes, resulting in greater numbers of children being put on plans, and remaining on plans, than was previously the case. Although this represents positive performance relative to the national picture, it does present challenges for the capacity of the service.

Alternative hypotheses might be that the overall level of need has increased at the population level, or that the application of eligibility criteria is being applied more stringently than it had been in the past. However, it is unlikely that population level needs have increased given the scale of the change – a twofold increase in the number of children on plans over a five year period. Furthermore, the pattern is visible in Oxfordshire but not at the national level, which would be expected if the increase were a consequence of the economic recession. Audits of case files by senior social work managers have found that threshold criteria at key points have been consistently applied over the period.

In a Survey of Looked After Children in Dec 2013, 85% stated that they were happy with their social workers. Further feedback from children and young people has suggested that transition planning and management at key transition points is not always smooth, particularly between children and adults social care and health services, at admission/discharge from hospital, and from primary to secondary school. It was emphasised that communication between professionals and across organisations at transition points is key.

Further Information

Adult Social Care Outcomes Framework Dashboard – view Oxfordshire's relative scores on ASCOF outcomes framework indicators for past three years:

http://insight.oxfordshire.gov.uk/cms/adult-social-care-outcomes-framework

National Adult Social Care Information System (NASCIS):

https://nascis.hscic.gov.uk/Portal/Tools.aspx (requires registration)

Section 7 – Quality of Services

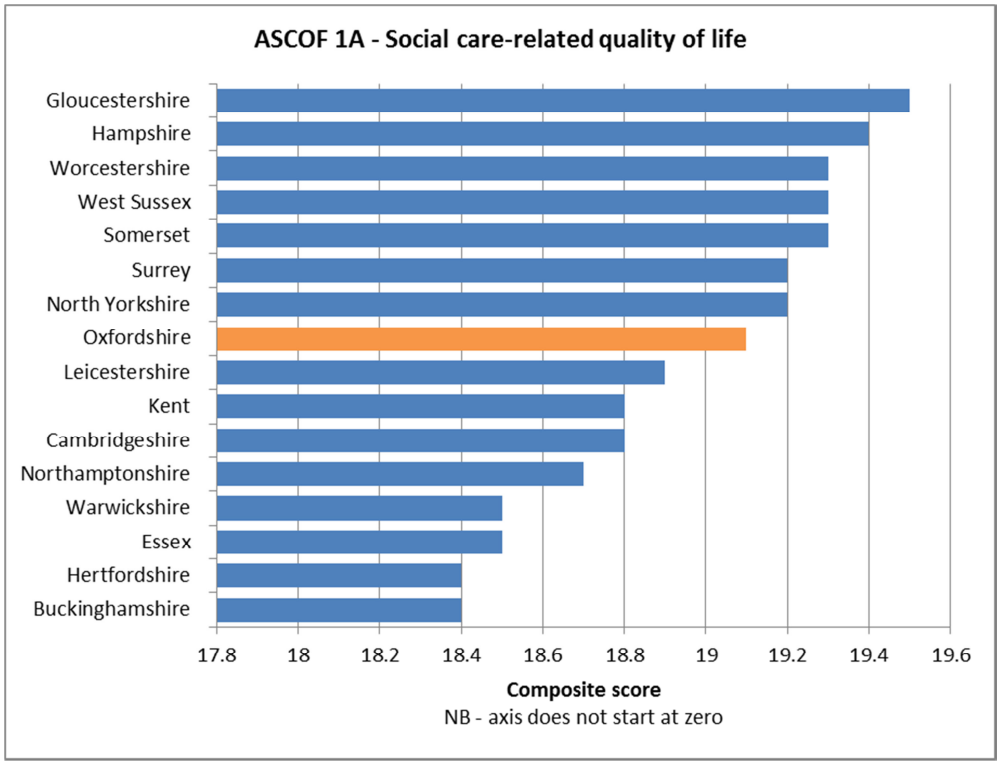
GP Survey

For the most part, Oxfordshire service users have above average satisfaction levels for most measures in the GP survey. The last set of data from the CCG outcomes framework suggests a fall in patient satisfaction of out-of-hours health services, down from 76.3% to 72.7% for the period July 2012 to March 2013. This puts the Oxfordshire figure below that of the Thames Valley area team (73%). It is too early to say whether this is the start of a sustained trend or a statistical anomaly.

Adult Social Care User survey

The Personal Social Services Adult Social Care Survey (ASCS) for England is an annual survey and took place for the third time in 2012-13. The survey is designed to cover all service users aged 18 and over receiving services funded wholly or in part by Social Services during 2012-13, and aims to learn more about whether or not the services are helping them to live safely and independently in their own home and the impact on their quality of life.

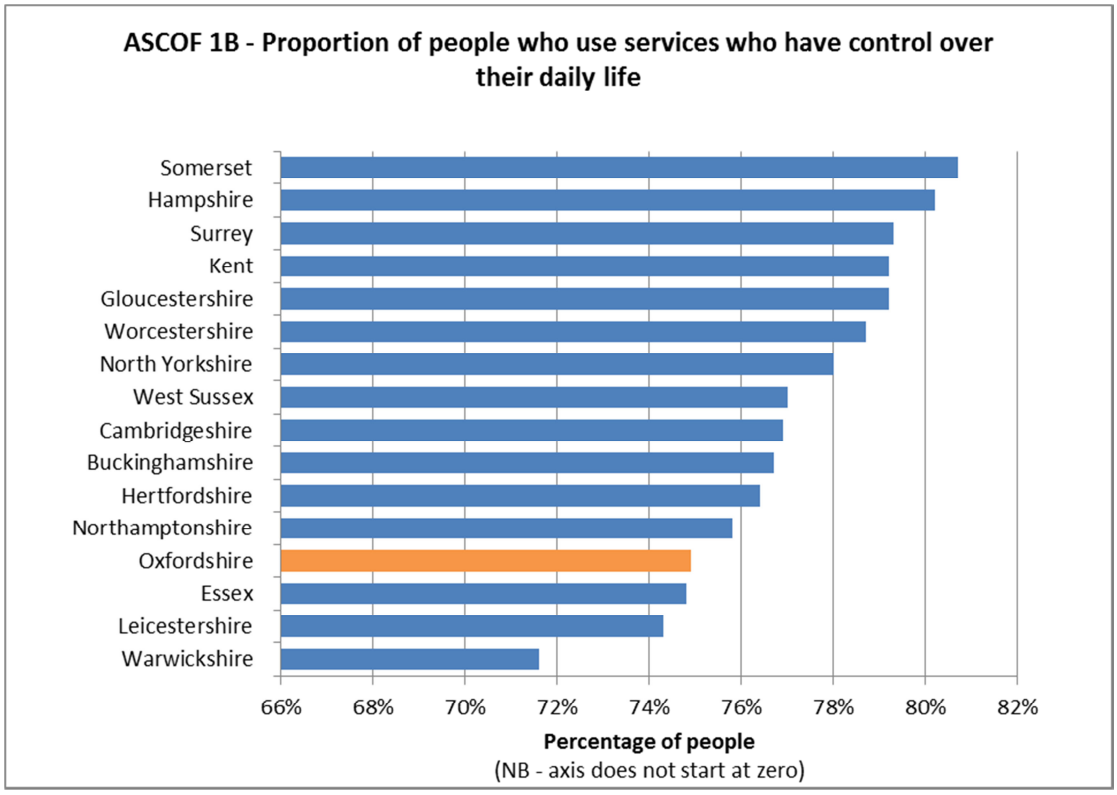
The headline measure in the Adult Social Care Outcome Framework is social care related quality of life. This is a composite of 8 different outcome domains. Oxfordshire ranked 8 out of a cohort of 15 local authorities of a similar socio-economic profile with a score of above 19.1 which puts it above the national average of 18.8.



Source: Oxfordshire Insight, data from NASCIS Online Analytical Processor

93% people reported positive experience of care which is above the national average of 90%. 93% of respondents said that social care services improved their quality of life and over two thirds of adult social care users felt as safe as they want to. Where they do not feel as safe as they want to, the major concern is falls, particularly in the home.

Feedback from service users has emphasised the importance of giving them control over their care and, although Oxfordshire has a high proportion of clients on personal budgets, the level of control service users said they have over their lives ranked 12 out of 15 comparator authorities in 2012/13.



Source: Oxfordshire Insight, data from NASCIS Online Analytical Processor

In the previous two years Oxfordshire ranked 4 out of 15 on the same measure so further investigation may be needed to understand whether this is a sustained trend or a statistical anomaly.

Friends and Family Survey

The recently introduced friends and family feedback survey gives an indication of user satisfaction with secondary care services. Patients are asked a single question: "How likely are you to recommend our ward/A&E department/maternity service to friends and family if they needed similar care or treatment?" Responses are given on a six point scale and a single score is calculated for the organisation.

Currently the friends and family test applies to all accident and emergency attendances, in patients and more recently addition of maternity services.

The first sight of the data for A&E services at the Oxford University Hospitals Trust suggests levels of satisfaction above the Thames Valley average of 45but below the England average of 56. The most recent results show a score of 49 for December 2013., Inpatient satisfaction levels are higher than those for A&E at 70 in December 2013. This was comparable with the England score of 71 and Thames Valley score of 69.

Further Information

Adult Social Care Outcomes Framework Dashboard:

http://insight.oxfordshire.gov.uk/cms/adult-social-care-outcomes-framework

National Adult Social Care Information System (NASCIS):

https://nascis.hscic.gov.uk/Portal/Tools.aspx (requires registration)

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Division: N/A

OXFORDSHIRE HEALTH & WELLBEING BOARD – 13 MARCH 2014

PHARMACEUTICAL NEEDS ASSESSMENT (PNA)

Report by the Director of Public Health

Background

1. The Health and Social Care Act 2012 gave Health and Wellbeing Boards the statutory duty to develop and publish Pharmaceutical Needs Assessments (PNA) for their areas by April 1st 2015. Requirements for PNAs are set out in the National Health Service (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013. These cover the minimum information to be included, the matters which must be considered, and the process to be followed. This process includes formal consultation with specific stakeholders for a minimum of 60 days.

2. The PNA is a key commissioning tool to ensure that local areas have high quality pharmaceutical services that meet needs. The PNA sets out the community pharmaceutical services that are currently provided and gives recommendations to address any identified gaps, taking into account future needs. It supports the commissioning intentions for pharmaceutical services and other services that could be delivered by community pharmacies and other providers. The PNA will inform commissioning decisions by local authorities, NHS England and clinical commissioning groups. [1]

3. Oxfordshire needs a thorough and robust PNA that complies with the regulations and follows due process. This will ensure that community pharmacy services are provided in the right place and that commissioned services meet the needs of local communities. This PNA needs to be presented to the H&WB in March 2015.

The process

4. Establish a steering group with representatives of relevant H&WB partners:

   Oxfordshire Clinical Commissioning Group
   NHS England Thames Valley Area Team
   Local Pharmaceutical Committee
   Local Medical Committee
   Public Health England Thames Valley Centre
   Oxfordshire County Council –Research and Intelligence team
   Oxfordshire County Council – Public Health
   Healthwatch Oxfordshire

[1] Pharmaceutical needs assessments. Information pack for local authority Health & Wellbeing Boards. https://www.gov.uk/government/publications/pharmaceutical-needs-assessments-information-pack

5. Because of the specialised nature of this work it has been agreed to secure a contract with an organisation who will deliver a PNA for Oxfordshire by March 2015. It is proposed that this is jointly contracted on behalf of Buckinghamshire County Council too, so that efficiencies will mean a lower price for each county.

6. Specify the work to be completed and go out to tender in March 2014. The contractor must deliver:

- A project plan and risk log
- A community pharmacy questionnaire (using a national template)
- A stakeholder engagement plan
- Two draft PNA documents for consultation, one for each county
- A consultation framework to ensure engagement with key local stakeholders for the required 60 day consultation
- Co-ordination of the consultation and collation of the consultation responses into a report(s)
- The final PNA for each county, including the consultation report
- Recommendations for maintaining the PNAs in the future
- Supplementary deliverable – outline of circumstances when the PNAs might need to be updated in the future
- Map of premises at which pharmaceutical services are provided in each county, as well as further maps covering current commissioned services in pharmacies, access and relevant demography
- A template for supplementary statements after publication

7. Award the contract in April 2014 and steer the work of the contractor with a Management Group for every day issues and the expertise of the Steering Group being called on as needed.

8. Present the final PNA to the H&WB in March 2015 and set up arrangements for updates.

RECOMMENDATIONS

9. The Board is RECOMMENDED to:

(a) agree to the process set out in this paper and delegate authority to the Director of Public Health, in consultation with the Chairman and Vice Chairman of the Health and Wellbeing Board, subject to financial and legal approvals, to procure and manage the service of a contractor to produce a Pharmaceutical Needs Assessment for Oxfordshire on behalf of the Health and Wellbeing Board; and

(b) consider a progress report on this work at the July 2014 meeting.

DR JONATHAN MCWILLIAM
Director of Public Health

Contact Officer: Jackie Wilderspin, Public Health Specialist, Tel: (01865) 328661

February 2014

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Health and Wellbeing Board
13 March 2014

Performance Reporting

Current Performance

1. A table showing the agreed measures under each priority in the Joint Health and Wellbeing Strategy, expected performance and current performance is attached as appendix A.

2. This report includes performance up to and including quarter 3 (October – December 2013) where possible. Performance can be summarised as follows:

   23 indicators are Green
   14 indicators are Amber (defined as within 5% of target)
   7 indicators are Red
   32 indicators are not expected to report in this quarter, or do not have information available – explanation is included in the notes column in the appendix.

3. Current performance is generally good, with many targets being met and exceeded. Appropriate action is being taken where performance is not meeting expected levels to improve this. This has been summarised in the notes column of the appendix.

4. It is worth noting that:

   a. There has been a notable increase in the take up of free early education for eligible 2 year olds, including amongst looked after children (indicators 2.1 and 2.2).

   b. The numbers of children going missing remains similar to last year (514 from April to December) but an increasing number have gone missing more than once - 65 compared with 56 this time last year (indicator 3.4).

   c. NEET performance is below target and is the lowest rate it is been for a number of years. The numbers of young people whose status is unknown also continues to decrease due to a range of measures introduced. There continue to be variations across the county, with numbers highest in Oxford City (indicator 4.9).

   d. There has been a 6.5% increase in the number of people supported at home this year, but the increase in people supported in care homes, means that a lower proportion of people are supported in their own homes than was planned. (indicators 6.5 and 6.7)

e. Although the number of people receiving a reablement service remains below target, the general trend is of increasing activity (indicator 6.10)

f. the number of front line health and social care workers that received autism awareness training increased significantly in the period (indicator 5.8)

5. It is also worth noting that there have been significant changes to the way that a number of indicators are reported and calculated, meaning it has not been possible to report as anticipated and some targets have changed. This has been particularly true of indicators reported by the NHS. This will need to be considered in setting measures and targets for next year, as the significant number of targets that are reported on an annual basis or significantly later than the performance period they relate to mean it is difficult for the Boards to effectively manage performance or take appropriate action in a timely way.

6. The Board may wish to consider this in the context of the Joint Strategic Needs Assessment and process for updating the Joint Health and Wellbeing Strategy, as reported elsewhere on the agenda for this meeting.

Ben Threadgold
Strategy and Performance Manager, Joint Commissioning
February 2014

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes

Oxfordshire Health and Wellbeing Board
Performance Report

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
Priority 1: All children have a healthy start in life and stay healthy into adulthood										
1.1	Increase percentage of women who have seen a midwife or maternity health care professional by 13 weeks of pregnancy from 90% to 92% by end March 2014.	**Expected** 90.5% **Actual** 90.6%	G	**Expected** 91% **Actual** Due March 2014		**Expected** 91.5% **Actual** Due March 2014		**Expected** 92% **Actual**		The way in which the maternity booking data is reported changed with effect from end December 2013. Nationally validated data will now be publicly available on the NHS England website on a quarterly basis but there will be no information for the rest of this until end of March when an end of year position will be published.
1.2	Ensure that at least 90% of children aged 2-2.5 years old receive a Health Visitor review (currently 90%)	**Expected** 90% **Actual** 94.7%	G	**Expected** 90% **Actual** 94.8%	G	**Expected** 90% **Actual** 95.8%	G	**Expected** 90% **Actual**		During the Q3 period, 2013 children were eligible for review and 1928 children received the review. Data is now available at individual team level so that problems can be identified and good practice shared.
1.3	Reduce the rate of emergency admissions to hospital with infections, for under 18's from 177.5 per 10,000 to 159.8 per 10,000	**Expected** 173.1 **Actual** 129.0%	G	**Expected** 168.7 **Actual** 121.5%	G	**Expected** 164.3 **Actual**		**Expected** 159.8 **Actual**		Q2 data provided this reporting period but Q3 data is not currently available. However local intelligence on activity at Emergency Departments over the Christmas period indicates that this rate is likely to rise significantly over the next two quarters.

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
1.4	By March 2014 we will have developed a joint measure(s) that will demonstrate the impact of services on the mental health and wellbeing of school age children.							Expected New joint measure will be in place **Actual**		Work on options for this indicator is nearing completion and a report will be brought to the next Children and Young People Partnership Board meeting in June.
Priority 2: Narrowing the gap for our most disadvantaged and vulnerable groups										
2.1	Increase the take up of free early education for eligible 2 year olds in 2013/14 to 1080 (from 1050 in 12/13)	**Expected** **360** **Actual** 195	**R**	**Expected** **595** **Actual** 525	**A**	**Expected** **720** **Actual** **715**	**G**	Expected 1080 **Actual**		Targets are set to take into account the starting patterns of children
2.2	Increase the take up of free early education for 2 year-old Looked After children to 80% (currently at 8% - 2/24)	**Expected** 20% **Actual** **nya**		**Expected** 40% **Actual** **nya**		**Expected** 60% **Actual** **84%**	**G**	**Expected** 80% **Actual**		This represents 16 out of 19 children.
2.3	Maintain the improved rate of teenage conceptions (currently at 23.3 women aged 15-17 per 1000 - in quarter 1 of 2012 this was 65 conceptions	**Expected** 65 **Actual** **65**	**G**	**Expected** 130 **Actual** **67** (132 cumulative)	**G**	**Expected** 195 **Actual** **52** (184 cumulative)	**G**	**Expected** 260 Actual		The low number in Q3 follows the same pattern as previous years for the quarter ending Sept 2013.
2.4	Maintain the current low level of persistent absence from school for looked after children ((2012 persistent absence figures were			**Expected** Less than 5%						Data relates to academic year 12/13. Reported cohort refers to children who have been continuously looked after for at least 12 months as of 31 March 2013.

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
	supressed by the Department for Education, however they indicated that the number of children was small, ie less than 4%)).			**Actual** 4.7% (7 pupils) Reported cohort 9.8% (31 pupils) Whole cohort	G					Comparative national figures will be published for this cohort in due course. The whole cohort refers to any looked after child for the period of time that the child was in care only. These figures may be revised further as some data is still outstanding.
2.5	Maintain the number of looked after children permanently excluded from school at zero			**Expected** Zero **Actual** Zero	G					
2.6	Establish a baseline of all children in need who are persistently absent from school			**Expected** Baseline and targets established **Actual**						Due to systems issues in collecting a full set of absence data this will not be available until early 2014.
2.7	Establish a baseline of children and young people on the autistic spectrum who have had an exclusion from school (over a school year) and work to reduce this number in future years			**Expected** Baseline and targets established **Actual** nya						Currently in discussion and baseline and target to be established at next Children and Young People Partnership Board meeting in June

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
2.8	Identify, track and measure the outcomes of all 810 families in Oxfordshire meeting the national Troubled Families criteria (improve attendance and behaviour in school; reduce anti-social behaviour and youth offending; increase adults entering work)	**Expected** 202 **Actual** na		**Expected** 405 **Actual** 500	G	**Expected** 607 **Actual**		**Expected** 810 **Actual**		A claim for 500 identified families was made to the DfE at the end of July. The next claim is currently being submitted and will be reported next quarter.
2.9	Improve the free school meals attainment gap at all key stages and aim to be in line with the national average by 2014 KS2: 23% points; KS4 26% points (currently the free school meal attainment gap in Oxfordshire is in line or above the gap nationally in all key stages)					**Expected** KS2: 23% points; KS4 26% points **Actual** KS2: 22% points; KS4 33% points	R			2012 KS2 figures revised to reflect updated performance measure. Nationally the KS2 gap has remained at 19%points. Oxfordshire is still above this but gap narrowed slightly. Nationally the KS4 gap increased from 26 to 27 %points.
Priority 3: Keeping all children and young people safe										
3.1	Maintain the reduction in risk for victims of domestic abuse considered to be high risk to							**Expected** 85%		85% is based over the last 5 year period. The baseline for 12/13 is 78%

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
	medium or low through Multi-Agency Risk Assessment Conferences (currently 85% for 2012/13 based on a single-agency)							**Actual**		Whilst this trend goes against the direction of travel we understand that it is because we are now dealing with more complex cases of domestic abuse who are less likely to engage with the IDVA service. We also need to bear in mind that this is a single agency measure and therefore a multi-agency measure will be more robust. Partners are working on developing a multi-agency measure for 2014/15 that can be reported on a monthly basis.
3.2	Every child considered likely to be at risk of Child Sexual Exploitation (identified using the CSE screening tool) will have a multi-agency plan in place	**Expected** 100% **Actual** 100%	G	**Expected** 100% **Actual** 100%	G	**Expected** 100% **Actual** 100%	G	**Expected** 100% **Actual**		Every child that is open to the Kingfisher team is subject to a multi-agency assessment and a plan which involves all the agencies as appropriate to their needs.
3.3	Reduce prevalence of Child Sexual Exploitation in Oxfordshire through quarterly reporting on victims and perpetrators to the Child Sexual Exploitation sub group of the Oxfordshire Safeguarding Children's Board	**Expected** Prevalence reported and action taken as appropriate	G	**Expected** Prevalence reported and action taken as appropriate	G	**Expected** Prevalence reported and action taken as appropriate	G	**Expected** Prevalence reported and action taken as appropriate		Prevalence report has been submitted and discussed by the CSE sub-group for the last 3 quarters. All reported incidents of CSE have received an appropriate police and social care response.

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
		Actual Prevalence reported and action taken as appropriate		**Actual** Prevalence reported and action taken as appropriate		**Actual**		**Actual**		CSE is still an emerging phenomenon, so it is not yet possible to determine that it is reducing. However, the prevalence report is established as a key component of the strategy to tackle CSE
3.4	Reduce the proportion of children who go missing from home 3 or more times in a 12 month period	**Expected** 8.0% or less	G	**Expected** 10.0% or less	G	**Expected** 11.0% or less	A	**Expected** 12.0% or less		The numbers of children going missing remains similar to last year (514 from April to December) but an increasing number have gone missing more than once - 65 compared with 56 this time last year. The mitigating actions include: o Staff notified immediately a child goes missing rather than when they return o Implementation of return interviews within 72 hours o Introducing monitoring the reasons why people go missing o Ensuring that multi agency risk assessments are completed on the most vulnerable children o Improved reporting on those most at risk
		Actual **7.9%**		**Actual** **10.5%**		**Actual** 12.6%		**Actual**		

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes

3.5	A regular pattern of quality assurance audits is undertaken and reviewed through the Oxfordshire's Safeguarding Children Board covering the following agencies: children's social care; youth offending service; education services; children and adult health services; early intervention services; services provided by the police. Over 50% of these audits will show a positive overall impact.							**Expected** 50% **Actual**		
Priority 4: Raising achievement for all children and young people										
4.1	Increase the number of funded 2-4 year olds attending good and outstanding early years settings to 83% or 8870 children (currently 80.5% or 8600 children)	**Expected** 81.1% or 8600 children **Actual** n/a		**Expected** 81.7% or 8725 children **Actual** 82.3% or 8800 children	G	**Expected** 82.3% or 8790 children **Actual** 81.5% or 8720 children	A	**Expected** 83% or 8870 children **Actual**		This slightly decreased proportion is a result of a few providers with a larger number of children being judged as requiring improvement in their most recent inspection where previously they were good. All settings that are judged as requiring improvement or inadequate have a comprehensive programme of support from the Foundation Years team to ensure that their judgements improve.
4.2	80% (5700) of children will achieve Level 2b or above in reading at the end of Key Stage 1 of the academic year 2012/13 (currently 78% or 5,382 children for the academic year 2011/12)			**Expected** 80% or 5700 children **Actual** 81% or 5791	G					

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
				children						
4.3	80% (4800) of children at the end of Key Stage 2 will achieve Level 4 or above in reading, writing and maths (currently 78% or 4800 children)			**Expected** 80% or 4800 children **Actual** 77% or 4666 children	A					Updated figure following validated data in December. This was a redefined performance measure this year and although this has not met the aspirational target set, performance remains above national (77% compared to 76%)
4.4	61% (3840 children) of young people achieve 5 GCSEs at A*-C including English and Maths at the end of the academic year 2012/13 (currently 57.9% or 3474 children)			**Expected** 61% or 3840 children **Actual** 60.3% or 3776 children	G					Updated figure following validated data in January. Although performance remains slightly below target, the proportion of children meeting this key measure in Oxfordshire increased from 57.9% in 2012 and is now in line with the national average (60.8%)
4.5	At least 70% (4400 children)) of young people will make the expected 3 levels of progress between key stages 2-4 in English and 72%(4525 children) in Maths (currently 65% or 3800 young people for English and 71% or 4170 young people for Maths)			**Expected** 70% - Eng 72% - Maths **Actual** **71% - Eng** 72% - Maths	G					Updated figure following validated data in January.

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
4.6	Increase the proportion of pupils attending good or outstanding primary schools from 59% (29,160) to 70% (34,590) and the proportion attending good or outstanding secondary schools from 74% (26,920) to 76% (27,640) (currently 67% primary and 74% secondary)	**Expected** Primary: 65% (32,795 pupils) Secondary: 74.5% (26,980 pupils) **Actual**		**Expected** Primary: 70% (35,320 pupils) Secondary: 76% (27,525 pupils) **Actual** Primary: 72% (36,320 pupils) Secondary: 84% (30,420 pupils)	G	**Expected** Primary: 72% (36,325 pupils) Secondary: 80% (28,975 pupils) **Actual** Primary: 74% (37,335 pupils) Secondary: 80% (28,790 pupils)	G	**Expected** Primary: 74% (37,335 pupils) Secondary: 83% (30,060 pupils) **Actual**		Updated targets in education strategy aim for the proportion of children in good/ outstanding schools will be 75% (primary schools) and 86% (secondary schools) by Aug 14. Targets updated to reflect this change.
4.7	Of those pupils at School Action Plus, increase the proportion achieving 5 GCSEs at A* - C including English and Maths to 17% (70 children) (currently 7% or 30 children)					**Expected** 17% or 70 children **Actual** 10% or 40 children	R			Nationally the proportion has increased to 23%.
4.8	To reduce the persistent absence rates in primary schools to 2.6% (1070 children) and secondary schools to 7.2% (2250 children)			**Expected** Primary: 2.6% (1070	A					This is provisional local data – national comparative information is due April 2014.

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
	by the end of 2012/13 academic year. (The current rates are 3.0% or 1233 children for primary schools and 8.0% or 2500 children for secondary schools)			pupils) Secondary: 7.2% (2250 pupils) **Actual** Primary: 2.9% Secondary: 6.4%						
4	Reduce the number of young people not in education, employment or training to 5% (870 children) (currently 5.4% or 937 young people)	**Expected** 4.8% **Actual** 5.8% (1027) June	R	**Expected** 8.0% (NB figures always peak in September) **Actual** 7.4% (919) Sept	A	**Expected** 5.7% **Actual** 4.8% (838) Dec	G	**Expected** 5% or 870 children **Actual**		NEET performance is below target and is the lowest rate it is been for a number of years. The numbers of young people whose status is unknown also continues to decrease due to a range of measures introduced. There continue to be variations across the county, with numbers highest in Oxford City

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
Priority 5:	**Living and working well: Adults with long-term conditions, physical disabilities, learning disabilities or mental health problems living independently and achieving their full potential**									
5.1	75% of working age adults who use adult social care say that they find information very or fairly easy to find (currently 69%, 129 of 186 responses)							**Expected** 75% **Actual**		This target is reported using the results of the annual survey. Provisional results for 2013 will be available in May 2014.
5.2	Maintain the proportion of people with a long-term condition who feel supported to manage their condition at 85%.							**Expected** **Actual**		Target set using the Annual GP Patient Survey.
5.3	100% patients with schizophrenia are supported to undertake a physical health assessment during 2013/14 (this is a new indicator and the baseline will be established this year)							**Expected** 100% **Actual**		Measure being developed by Oxfordshire Clinical Commissioning Group.
5.4	At least 60% of people with learning disabilities will have an annual physical health check by their GP (currently 45.7%)							**Expected** 60% **Actual**		Target reported using information from the Learning Disabilities Observatory. Information for 2013/14 likely to be available in September 2014.
5.5	Maintain the high number of people with a learning disability who say they have seen their GP in the last 12 months at over 90% (currently 93%, 223 of 241 respondents for 2012/13)							**Expected** 90% **Actual**		Target reported using information from the Learning Disabilities Observatory. Information for 2013/14 likely to be available in September 2014.
5.6	Reduce the number of emergency admissions for acute conditions that should not usually require	**Expected** Less than 956 per	**G**	**Expected** Less than 956 per	**A**	**Expected** Less than 956 per 100,000	**A**	**Expected** Less than 956 per		Target based on national indicator from the NHS Information Centre Indicator Portal (NHSICIP).

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
	hospital admission for people of all ages (2012/13 baseline: 956.2 DSR for all ages per 100,000 population)	100,000 **Actual** 948.8		100,000 **Actual** 958.4		**Actual** **964.2**		100,000 **Actual**		Data for this target is now available quarterly. The baseline for this indicator has been adjusted from 1012.6 to 956 per 100,000 due to updated information available in year.
5.7	Reduce unplanned hospitalisation for chronic conditions that can be actively managed (such as congestive heart failure, diabetes, asthma, angina, epilepsy and hypertension) for people of all ages. 2012/13 baseline 603.0 DSR for all ages per 100,000 population	**Expected** 603 per 100,000 **Actual** 588.7	G	**Expected** 603 per 100,000 **Actual** 568.4	G	**Expected** 603 per 100,000 **Actual** **577.5**	G	**Expected** 603 per 100,000 **Actual**		Target based on national indicator from the NHS Information Centre Indicator Portal (NHSICIP). Data for this target is now available quarterly. The baseline for this indicator has been adjusted from 493 to 603 per 100,000 due to updated information available in year.
5.8	Provide autism awareness training for an additional 500 front line health and social care workers in Oxfordshire (1000 have been trained since 2011/12)	**Expected** 125 **Actual** 86	R	**Expected** 250 **Actual** 194	R	**Expected** 375 **Actual** **364**	A	**Expected** 500 **Actual**		More sessions planned for second half of year than first, so anticipated to achieve target
5.9	Develop a measure of how effectively people with mental health needs are supported to find and stay in employment by March 2014, based on the relative severity of people's illness							Expected Measure developed and baseline established **Actual**		Measure being developed by Oxfordshire Clinical Commissioning Group.
	Priority 6: Support older people to live independently with dignity whilst reducing the need for care and support									

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
6.1	Reduce the number of patients delayed for transfer or discharge from hospital so that Oxfordshire's performance is out of the bottom quartile (current ranking is 151/151)	**Expected** 72 delays **Actual** 128	R	**Expected** 72 delays **Actual** 166	R	**Expected** 72 delays **Actual** **133**	R	**Expected** 72 delays **Actual**		Latest comparative figures are for the end of Dec and Oxfordshire rate is still the lowest in the country Work in hand to improve the discharge pathway in Oxfordshire and patient flow through that pathway. This included full 7-day a week working across the pathway; increased investment in the reablement service; new arrangements for domiciliary care agencies to take patients at weekends and a media campaign to explain that people do not have a right to choose their community hospital (a fifth of delays are due to people exercising choice)
6.2	Reduce the average number of days that a patient is delayed for discharge from hospital (baseline 14.8 days in acute hospitals)			**Expected** Less than 14.8 **Actual** **16.8**	R	**Expected** Less than 14.8 **Actual**		**Expected** Less than 14.8 **Actual**		Systems are being set up to report on the length of delay in community hospitals.
6.3	Reduce the number of emergency admissions to hospital for older people aged 60+ (from 25,538 in 2012/13)	**Expected** 7272 (Apr-Jul 2012) **Actual** 5911	G	**Expected** **Actual** 11,809		**Expected** **Actual** 17585		**Expected** **Actual**		Comparative figures for Q2 onwards are being calculated
6.4	Develop a model for matching capacity to demand for health and social care, to support smooth discharge from hospital, by September 2013			**Expected** Model developed **Actual**	G		G			The model has been developed by Oxford Health involving Social Care and Acute Services. This has been implemented across the system in line with the plans for winter.

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
				Model developed						
6.5	No more than 400 older people per year to be permanently admitted to a care home (currently 582)	**Expected** 100 **Actual** 156	R	**Expected** 200 **Actual** 311	R	**Expected** 300 **Actual** **479**	R	**Expected** 400 **Actual**		The number of people permanently placed in care homes has increased this year - 479 at the end of December a 9% increase on last year, when the aim was to reduce this and support more people in the community. Most people who enter a care home do so from hospital. Improved and quicker patient pathways should have a positive knock-on effect to help reduce people being placed in permanent care home places, where these people could have been supported at home.
6.6	By September 2013, review and redesign the range of community services that support people to live independently at home, receive good quality local support of their choice when needed and to help avoid getting into a crisis situation, and implement a way of monitoring waiting times for health and social care services at home that provide support in an emergency.			**Expected** Review completed **Actual** Review completed, actions being implemented	A	**Actual** **Service options being developed**	A			Initial project scoping meetings held with joint commissioning partners. Service options are currently being drafted and will be presented to commissioners for discussion in early December 2014 Focused work has taken place on ensuring much greater consistency & coherence on the whole system discharge pathway Work is underway to reduce the number of contractors involved in delivering the services on the pathway in 2014/15. New services have been commissioned to support people at home
6.7	Increase the proportion of older people with an ongoing care package supported to live at home from 60% to 63% (currently 2122 of 3537 clients)	**Expected** 60.75%	A	**Expected** 61.5%	A	**Expected** 62.25%	A	**Expected** 63%		There has been a 6.5% increase in the number of people supported at home this year, but the increase in people supported in care homes, means that a lower proportion of people are supported

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
		Actual 60.4%		**Actual** 60.9%		**Actual** 61.0%		**Actual**		in their own homes than was planned.
6.8	60% of the expected population (4251 of 7086 people) with dementia will have a recorded diagnosis (currently 49.6% or 3516 people)	**Expected** 52.4% **Actual** 40% (3555 people)	N CI	**Expected** 54.9% **Actual** 42.9% (3815 people)	R	**Expected** 57.4% **Actual** Waiting for info		**Expected** 60% **Actual**		A national tool has been issued for estimating the number of people with dementia and this has increased the numbers in the expected population. The baseline re-worked on the new methodology would be 41 %. A number of initiatives have been put in place to reach what is now a very challenging target set for this year.
6.9	Set up a network of dignity and dementia champions in care homes so that by March 2014 90% of care homes (95 of 105) in the county have a champion (baseline zero as this is a new initiative)	**Expected** 22.5% (24 homes) **Actual**		**Expected** 45% (48 homes) **Actual**		**Expected** 67.5% (71 homes) **Actual** 20% (21 homes)	A	**Expected** 90% (95 homes) **Actual**		Target part of wider campaign to start a network of 300 champions by June 2014.The Oxfordshire Dignity & Dementia Champions Network was set up in October and we have 184 registered champions including 59 from 21 care homes. All care homes have been contacted about the network. There may be cultural barriers to reaching the target as some homes believe that all their staff will champion dignity and do not need to join the network. Further work on sharing good practice in the use of champions with homes is on-going.
6.10	3500 people will receive a reablement service (currently 2197)	**Expected** 819 **Actual** 681	R	**Expected** 1728 **Actual** 1353	R	**Expected** 2652 **Actual** **2037**	R	**Expected** 3500 **Actual**		The general trend (excluding December) is of increasing activity - though this is still below the target. There have been issues with the flow of information from hospitals to the reablement service, which have affected the services ability to pick up cases. To improve this regular meetings take place with staff in

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
			R		R		A			hospitals. At the end of December a significant number (52) of people who had completed their reablement were still in the service as we could not find on-going permanent care. Various initiatives have been put in place and by the end of January this had dropped to 8.
6.11	Increase proportion of people who complete reablement who need no on-going care from 50% to 55% (was 426 of 858 Oct to March, would be 1484 of 2698 based on current numbers)	**Expected** **55%** **Actual** 50%		**Expected** 55% **Actual** 52%		**Expected** 55% **Actual** **54%**		**Expected** 55% **Actual**		This has improved significantly from the last quarter.
6.12	Maintain the current high standard of supporting people at home with dignity as measured by people themselves (currently 89.9%, 246 of 274 respondents).							**Expected** 90% **Actual**		Annual indicator taken from survey.
6.13	Increase the proportion of older people who use social care who reported that they have adequate social contact or as much social contact as they would like to 81.2% (currently 80.4%, 229 of 285 respondents)							**Expected** 81.2% **Actual**		Annual indicator taken from survey.
6.14	Ensure an additional 523 Extra Care Housing places by the end of March 2015, bringing the total number of places to 930	**Expected** 55 **Actual** **55**	G			**Expected** 50 **Actual** **50**	A			Indicator is rated as amber for the whole programme although it is on track for this quarter. Minor slippage from March 2015 to December 2015, with schemes at Chipping Norton (80) and Carterton (92) completing after March due to delays in planning permission and site assembly. 45 extra flats at the proposed Kingston

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
										Bagpuize scheme also now expected by the end of 2015.The programme is still likely to deliver 893 places by the end of 2015
6.15	Produce an analysis of demand for alternative housing options for older people within Oxfordshire to inform future targets and planning by September 2013			**Expected** Analysis completed **Actual**	A		**A**			Delay in completion of the wider Oxfordshire Strategic Housing Market Assessment (SHMA) has impacted on the older persons housing work stream. The SHMA will provide a strategic context for all new housing in the County. Expected for agreement at Health & Wellbeing Board in July 2014.
6.16	Maintain the high number of older people who use adult social care and say that they find information very or fairly easy to find (currently 77.7%, 146 of 188 respondents for adult social care)							**Expected** 77.7% **Actual**		Annual indicator taken from survey.
6.17	Bereaved carers' views on the quality of care the person they cared for received in the last 3 months of life (baseline and target to be confirmed as awaiting national figures – these are due in September 2013)					**Expected** Baseline and target to be confirmed Sept 2013 **Actual**				Annual only. National figures for 2012/13 are not yet published.
6.18	Increase the proportion of adults who use social care that say they receive their care and support in a timely way to 85% (currently 214 of 259 – 83%)							**Expected** 85% **Actual**		Annual indicator taken from survey.

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
Priority 7: Working together to improve quality and value for money in the Health and Social Care System										
7.1	Implement a joint plan for fully integrated health (community and older adult's mental health) and social care services in GP locality areas by March 2014, leading to improved outcomes for individuals							**Expected** Joint plan developed and implemented **Actual**		Plans are in place for integration of community health services, accessed via a single front door by the end of September. Integration of Health and Social Care staff into locality teams to be complete by end of 2014.
7.2	Agree an expanded and genuinely pooled budget for older people by July 2013			**Expected** Pooled budget agreed **Actual** Pooled budget agreed	G					Completed.
7.3	Achieve above the national average of people very satisfied with the care and support they receive from adult social care (currently 62.4% against a national figure of 63.7% for 2012/13)							**Expected** Above the national average **Actual**		Annual indicator taken from survey.

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
7.4	Achieve above the national average of people satisfied with their experience of hospital care (currently 78.7% against national figure of 75.6% for 2012/13)					**Expected** Above the national average **Actual**				Annual indicator taken from survey.
7.5	Achieve above the national average of people 'very satisfied' with their experience of their GP surgery (currently 91% against national figure of 87% for 2012/13)							**Expected** Above the national average **Actual**		Annual indicator taken from survey.
7.6	Increase the number of carers known and supported by adult social care by 10% to 15,265 (currently 13,877 are known so this would represent an additional 1,388)	**Expected** 14,224 carers known **Actual** 14255	G	**Expected** 14,571 carers known **Actual** 14,656	G	**Expected** 14,918 carers known **Actual** 15100	**G**	**Expected** 15,265 carers known **Actual**		Forecasting 15,533 by year end.
7.7	880 carers breaks jointly funded and accessed via GPs (currently 881)	**Expected** 220 **Actual** 409	G	**Expected** 440 **Actual** 633	G	**Expected** 660 **Actual** **737**	**G**	**Expected** 880 **Actual**		Funding only exists for 880 breaks. Once these have been funded new breaks this year will cease.
Priority 8: Preventing early death and improving quality of life in later years										

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
8.1	At least 60% of those sent bowel screening packs will complete and return them (ages 60-74 years)	**Expected** 60% **Actual** 56.6%	**A**	**Expected** 60% **Actual**		**Expected** 60% **Actual**		**Expected** 60% **Actual**		Bowel cancer screening data is released at least 4-5 months in arrears and is not yet available. During Q1 56.6% of individuals (aged 60-69 years) who were sent invitation letters that were adequately FOBt (Faecal Occult Blood test) screened. Across the Thames Valley the average is 56.5% and Oxfordshire ranks 2nd out of the 4 Public Health teams within this area.
8.2	Number of invitations sent out for NHS Health Checks to reach the target of 39,114 people aged 40-74 in 2013-14 (Invitations sent in 2012-13 = 40914 as more people were eligible in 2012-13)	**Expected** 9,778 **Actual** 9,938	**G**	**Expected** 19,557 **Actual** 20,329	**G**	**Expected** 29,335 **Actual**		**Expected** 39,114 Actual		NHS Health Check data is usually available a month after quarter end. 20,329 invitations had been sent out by the end of Q2. This represents 5.3% of the eligible population. This is above the national average of 3.9% and Oxfordshire ranks the highest within the 8 Thames Valley authorities.
8.3	At least 65% of those invited for NHS Health Checks will attend (ages 40-74)	**Expected** 65% **Actual** 41.9% (4165 of 9938)	**R**	**Expected** 65% **Actual** 46% (9351 of 20,329)	**R**	**Expected** 65% **Actual**		**Expected** 65% **Actual**		Report Card was circulated in Nov 2013. Although this indicator remains below the target it represents an improvement in uptake from Q1. Oxfordshire ranks 5th within the group of 8 Thames Valley authorities.
8.4	At least 3800 people will quit smoking for at least 4 weeks (last year target 3676, actual 3703)	**Expected** 851 **Actual** **875**	**G**	**Expected** 1639 **Actual** **1653**	**G**	**Expected** 2523 **Actual**		**Expected** 3800 **Actual**		Smoking quitters data is at least 2-3 months in arrears because people need to quit for 4 weeks to be considered as having quit smoking.

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
Priority 9: Preventing chronic disease through tackling obesity										
9.1	Ensure that the obesity level in Year 6 children is held at no more than 15% (in 2012 this was 15.6%)			**Expected** 14.9% or less **Actual** 15.2%	**A**					Childhood obesity data is an annual data return that follows the school year instead of financial year cycle Although slightly above the target, the proportion of Year 6 pupils that are obese in Oxfordshire is below that nationally (18.9%). Oxfordshire ranks 3rd out of the 9 authorities in the South Central area. The average obesity level within the South Central area is 16.9%.
9.2	Increase to 62.2% the percentage of adults who do at least 150 minutes of physical activity a week . (Baseline for Oxfordshire 61.2% 2011-12)							**Expected** 62.2% **Actual**		This is reported annually from the Active People Survey monitored / managed by the Oxfordshire Sports Partnership. This is a new indicator. The 2012 baseline figure shows that Oxfordshire has the highest proportion out of the 7 authorities in the South East.
9.3	62% of babies are breastfed at 6-8 weeks of age (currently 59.1%)	**Expected** 62% **Actual** **59%**	**R**	**Expected** 62% **Actual** 59.5%	**R**	**Expected** 62% **Actual**		**Expected** 62% **Actual**		Report card was circulated in Nov 2013. A request has been made to Oxford Health to produce a recovery plan detailing work towards improving rates of breastfeeding.
	Priority 10: Tackling the broader determinants of health through better housing and preventing homelessness									

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
10.1	The number of households in temporary accommodation as at 31 March 2014 should be no greater than the level reported in March 2013 (baseline 216 households in Oxfordshire)							**Expected** 216 or less **Actual**		Measure reported annually, expected during Q4.
10.2	At least 75% of people receiving housing related support will depart services to take up independent living	**Expected** 75% **Actual** **85.7%**	G	**Expected** 75% **Actual** **87.2%**	G	**Expected** 75% **Actual**		**Expected** 75% **Actual**		
10.3	At least 80% of households presenting at risk of being homeless and known to District Housing services or District funded advice agencies will be prevented from becoming homeless (baseline 2012- 2013 when there were 2468 households known to services, of which 1992 households were prevented from becoming homeless. 1992/2468 = 80.7%)	**Expected** 80% **Actual** 82.3%	G	**Expected** 80% **Actual** 82%	G	**Expected** 80% **Actual**		**Expected** 80% **Actual**		As might be expected, the highest number of applicant households who were homeless as defined by the Housing Act 1996, were in Oxford City, followed by Cherwell. The lowest number was in West Oxfordshire. The highest percentage of applicants found to be eligible, unintentionally homeless and in priority need was in Vale of White Horse, where 69% applicants were in this category, compared to 51% in Cherwell, 54% in West Oxfordshire, 58% in South Oxfordshire, and 55% in Oxford City.
10.4	Fuel poverty outcome to be determined							**Expected** Outcome measure to be		Work to determine current activity on reducing fuel poverty in Oxfordshire is continuing. It is important for stakeholders to identify where additional work will add value. A new outcome

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
								determined **Actual**		measure is being introduced nationally which may provide an indicator for this work.
Priority 11: **Preventing infectious disease through immunisation**										
11.1	At least 95% children receive dose 1 of MMR (measles, mumps, rubella) vaccination by age 2 (currently 95%)	**Expected** 95% **Actual** 96.2%	G	**Expected** 95% **Actual** 95%	G	**Expected** 95% **Actual**		**Expected** 95% **Actual**		Childhood immunisations data is usually available 1-2 months after the quarter end.
11.2	At least 95% children receive dose 2 of MMR vaccination by age 5 (currently 92.7%)	**Expected** 95% **Actual** 92.4%	A	**Expected** 95% **Actual** 92.4%	A	**Expected** 95% **Actual**		**Expected** 95% **Actual**		Childhood immunisations data is usually available 1-2 months after the quarter end. Oxfordshire County Council has recently run a campaign encouraging parents to ensure their children are immunised before returning to school.
11.3	At least 55% of people aged under 65 in "risk groups" receive flu vaccination (currently 51.6%)							**Expected** 55% **Actual**		Seasonal flu is annual data usually available in Quarter 4.
11.4	At least 90% 12-13 year old girls receive all 3 doses of human papilloma virus vaccination (currently 88.1%).							**Expected** 90% **Actual**		Annual data usually available Quarter 4

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Oxfordshire CCG strategy and plan 2014/15-2018/19

Introduction

This document is the strategy and plan for Oxfordshire CCG for the period 2014/15-2018/19.

It is a plan for the whole health and social care community and is designed to deliver our collective vision of a healthier population, with fewer inequalities, and health services that are high quality, cost effective and sustainable.

The plan is based on a thorough analysis of the strengths and weaknesses of the local health and social care system, and the needs of the changing population.

It sets out a strategy for moving Oxfordshire to a position where it can deliver high quality standards of health and social care in all settings, whilst also delivering financial sustainability.

This plan is ambitious for patients and the public. It focuses on improving outcomes for older people, people with chronic diseases and those suffering from the consequences of health inequality. It focuses particularly on improving the access for these patient groups to urgent and emergency services, in order to help them avoid unnecessary hospital admissions.

The plan also recognises the need to improve the quality of people's experiences of health and social care services.

Our most significant improvement intervention is therefore focussed on integrating services around the patient – wherever possible pulling services closer to the patient's home. This programme will deliver improvements in the integration of health and social care and the integration of people's physical and mental health care. It will deliver closer working between GP practices so that they can drive the integration of primary, community, secondary and social care around the needs of each patient and their family.

The remaining improvement interventions will result in a significant improvement in our performance against the key pledges in the NHS constitution. This will give people much improved quality of experience when they need to use our emergency services or to have a planned procedure and will help to provide better value health and social care services in the County.

Finally, the plan recognises that we need to do much of our core business more effectively. In particular we have described the steps we will take to tackle health inequalities, to place more equal value on our mental and physical health care, to involve the public in our work and to meet quality and safety expectations.

This plan is a draft, and we will not be finalising it until April subsequent to seeking the backing for our proposals from the Oxfordshire Health and Wellbeing Board and then our own Governing Body.

We look forward to receiving the comments and views of our provider and commissioner partners, and of NHS England, before we finalise and adopt this plan.

Dr Joe Mcmanners

Chair, OCCG

Contents

		page
Chapter 1	**5 Year ambition and Vision**	**3**
Chapter 2	**Outcomes**	**29**
Chapter 3	**Values and Principles**	**35**
Chapter 4	**Improving Health and Reducing Inequalities**	**36**
Chapter 5	**Parity of Esteem**	**38**
Chapter 6	**Patient Services**	**41**
Chapter 7	**Wider Primary Care provided at scale**	**43**
Chapter 8	**A modern model of Integrated Care**	**45**
Chapter 9	**Access to the highest quality Urgent and Emergency Care**	**47**
Chapter 10	**A step change in the productivity of Elective Care**	**49**
Chapter 11	**Specialised services concentrated in centres of excellence**	**50**
Chapter 12	**Access**	**52**
Chapter 13	**Meeting NHS Constitution Standards**	**56**
Chapter 14	**Quality**	**61**
Chapter 15	**Delivering Value and Sustainability**	**66**
Chapter 16	**Information Management and Technology**	**69**
Chapter 17	**Organisational Development**	**71**
Chapter 18	**Governance**	**73**
Chapter 19	**Conclusion**	**75**

Chapter 1: 5yr ambition & vision

1.1 Our Vision for the Oxfordshire Health and Social care system in 2018/19

a. The Oxfordshire health and social care system's vision for the system in five years' time is that it will:

   i. Be financially sustainable
   ii. Be delivering fully integrated care, close to home, for the frail elderly and people with complex multimorbidities.
   iii. Have a primary care service that is driving development and delivery of this integrated care, and is itself offering a broader range of services at a different scale.
   iv. Routinely enable people to live well at home and to avoid admission to hospital when this is in their best interests.
   v. Be continuing to provide preventative care and to tackle health inequalities for patients and carers in both its urban and rural communities
   vi. Be providing health and social care that is rated amongst the best in the country for all its citizens in terms of quality, outcomes and local satisfaction with services

b. We will deliver our vision through a programme of 6 Improvement Interventions, which are designed to ensure Oxfordshire further develops the characteristics of a high quality and sustainable system. These are:
   i. Achieving Integration
   ii. Improving emergency and urgent care services
   iii. Improving the efficiency and effectiveness of planned care
   iv. Improving the efficiency and effectiveness of prescribing
   v. Improving the management of Long Term Conditions
   vi. Delivering a new approach to contracting and procurement

1.2 The Oxfordshire context - Population health

a. The May 2013 Director of Public Health Annual Report for Oxfordshire identifies six main challenges to the long term health and wellbeing of the local population[1]. These are:

   i. **An ageing population – the "demographic challenge"** .This strategic plan focusses heavily on joining up health and social care for older people in ways which enable individuals to be in the driving seat of their own care, but which reflect the very different communities and needs across the county. This is the primary focus of our achieving integration programme, which recognises the need for locality based solutions that reflect the differing characteristics of populations across the County.

   ii. **Breaking the cycle of disadvantage.** This plan proposes a much closer partnership programme between OCC, district councils, the third sector, NHS England and Oxfordshire CCG to deliver targeted prevention and health improvement interventions with our most vulnerable rural and urban communities. The programme recognises the substantial changes to the ethnic minority structure of the county (In Oxford nearly half of births (47%) in 2010 were to non UK-born mothers, compared to a national and County average of 26%). It will focus on uptake of prevention and early

[1] http://www.oxfordshire.gov.uk/cms/sites/default/files/folders/documents/publichealth/PH_AR_2013-14.pdf

intervention measures in targeted communities (determined in partnership with the DPH); neighbourhood based partnership work to address the determinants of poor health; measures to tackle loneliness in the older population and ensuring GPs are active partners in the local Thriving Families initiative.

iii. **Mental health and wellbeing: avoiding a Cinderella service.** This plan focusses on ensuring parity of esteem by continuing the good work to develop outcomes based contracts for mental health services, and on the increasing integration of physical and mental health services in primary, community and secondary care settings.

iv. **The rising tide of obesity.** Oxfordshire is doing better than the national average on childhood and adult obesity, but 1 in 4 adults in the County (and rising) are obese. Our public health partners in OCC continue to be heavily focussed on improving access to exercise and weight loss services.

v. **Excessive alcohol consumption .** Whilst alcohol related hospital admissions in Oxfordshire are lower than the national average they are climbing in line with it, with the average age of those admitted being between 55 and 64. The CCG remains an active partner on the Safer Communities Partnership Board and will be developing plans during year 1 of this strategy to provide better access to services for the most vulnerable adults identified in conjunction with the police and voluntary sector agencies, as well as supporting GPs to offer brief intervention advice during the course of NHS Healthchecks.

vi. **Fighting killer infections .** Oxfordshire has well established mechanisms for managing CDIFF and MRSA and these are explored fully in chapter 14. Local increases in TB are small, and are a result of much improved detection rates. The detection and management of TB will remain an area for close scrutiny in the light of known demographic changes, particularly in Oxford City. Our health inequalities and access programme (see chapter 4) will focus on uptake of screening and immunisations in our most vulnerable communities.

1.3 Our local health economy

a. The Oxfordshire health and social care system is under significant financial pressure, with the CCG forecasting a year-end deficit of £6.1m for 13/14 and is proposing a deficit budget for 14/15. Whilst rates of growth have slowed over the last 12 months, key performance pressures continue to be:

   i. Increase in A&E attendances and emergency admissions , with the share of patients with multiple attendances and admissions growing fastest
   ii. Unacceptably high numbers of patients experiencing delayed transfers of care
   iii. The failure to meet referral to treatment time targets and increased outpatient referrals
   iv. The failure of the CCG QIPP programmes to deliver anticipated cost savings.

b. Improving performance in these four areas is an aspect of this plan. Performance will be improved through the delivery of a suite of improvement interventions, underpinned by robust business cases developed with support from our external consultants Deloitte and enshrined in contracts.

c. These are intended to :
    i. Reductions in appropriate use if A&E by offering more effective diversion to primary or community based services
    ii. A primary care service able to drive effective integration of services around the individual patient
    iii. Integrated health and social care community teams that can prevent admission and support early discharge
    iv. A primary care led multi-morbidity model of care for patients with long term conditions, focused on those patients who form the top 2% of health service users
    v. Rapid access to multi-disciplinary assessment services designed to reduce the likelihood of admission by offering same day assessment supported by same day home based treatment and care services to vulnerable older people, patients with complex co-morbidities and those at end of life.
    vi. Contracts that incentivise our principle community and secondary care providers to work together to deliver improved outcomes for patients on the urgent care pathway.
    vii. Community based health and social care support services that enable people to return home from hospital in a timely manner and then to regain their independence
    viii. Improved end of life care through increased registration on palliative care registers, enhanced use of Advanced Care Planning and improved integration of end of life service providers
    ix. A reduction in emergency admissions from care homes.
    x. A reduction in outpatient referrals through GP led peer review and improved access to information on thresholds and guidelines, supported by improved elective care pathways.

d. The current state of readiness of the local system to deliver this change is well placed:
    i. The CCG and Oxfordshire County Council (OCC) already have one of the largest pooled budgets in the country (c£300m), £200m of which relates to older people , who are a key focus of our plans.
    ii. The CCG and OCC are building on these existing arrangements to work closely together to develop and deliver a Better Care Fund Integration plan
    iii. Oxford Health Foundation Trust and Oxford University Hospitals Trust are continuing to work with the CCG and OCC to achieve integrated, outcomes based components in the standard contracts for 14/15.
    iv. The primary care community has embarked on a primary care development programme which will increase its capacity to operate at scale as a provider of integrated services within 12 months.
    v. The CCGs internal capacity and capability building programme has delivered a highly capable interim leadership team, who are now progressing work to secure the formation of a new permanent leadership team for the organisation.
    vi. Work to develop an outcomes based approach to commissioning has engaged a wide community of providers (community, acute, voluntary sector and others) in building a greater understanding of the pressures on the local system and our mutual responsibilities for working together to address those with finite financial resources.

1.4 Key messages from our JSNA

a. Further to analysis of the JSNA, the Oxfordshire Health and Wellbeing strategy 2012-2016 identifies a number of priorities where change is required to improve health:
    i. The need to shift services towards the prevention of ill health.
    ii. The need to reduce inequalities, break the cycle of deprivation and protect the vulnerable.

iii. The need to give children a better start in life.
iv. The need to reduce unnecessary demand for services.
v. To help people and communities help themselves.
vi. The need to make the patient's journey through all services smoother and more efficient.
vii. The need to improve the quality and safety of services.
viii. The need to streamline financial systems, especially those pooled between organisations, and to align all budgets more closely.

1.5 Delivering transformational change

a. The specific material transformation initiatives through which OCCG will deliver the change required are our 6 Improvement Interventions:

i. Achieving Integration
ii. Improving emergency and urgent care services
iii. Improving the efficiency and effectiveness of planned care
iv. Improving the efficiency and effectiveness of prescribing
v. Improving the management of Long Term Conditions
vi. Delivering a new approach to contracting and procurement

b. These have been developed through a robust process of :
i. Patient and public engagement
ii. Locality planning workshops
iii. Data and performance analysis
iv. Outline business case development and review – at which point a number of schemes were rejected
v. Development of full business cases
vi. Review of full business cases by our external support team
vii. Further development of business cases
viii. Programme sign off by the Executive Team of the CCG

c. The projects which make up each Improvement Intervention are summarised below. The aggregated impact we expect that they will have on national outcome measures can be found in chapter 2 and the financial impact expected from this suite of programmes is summarised in chapter 15.

d. In addition to these 6 Improvement Interventions we will maintain focus on tackling health inequalities (see chapter 4), delivering parity of esteem (see chapter 5) and maintaining the highest standards of patient engagement, quality and safety (see chapter 6 and 14).

1.6 The role of our localities in shaping this plan

a. OCCG is a membership organisation, and a fundamental first step in generating this 5 year strategy and 2 year plan was extensive consultation with member practices. Each locality undertook at least 1 planning workshop at which priorities for service transformation were identified.

b. The 6 Locality Clinical Directors then pooled the views of their members, and agreed a set of improvement priorities that were common to all areas of the County.

c. The themes identified as high priority areas for change , and the ways in which these have been addressed in this plan are summarised below:

Identified priority	Action incorporated in plan
Developing primary care to enable it to drive a shift of care from hospital into the community	Primary care development programme scoped and already underway (see chapter 7)
Improving the range and accessibility of community based services to support admission avoidance and to speed discharge Tackling health inequalities by offering targeted support to address lifestyle behaviours and choices	Achieving Integration Improvement Intervention , supported by Better Care Fund Plan , designed to deliver this (see chapter 8) Partnership plan to tackle health inequalities agreed with PH teams in OCC and NHS England (see chapter 4)
Improving the quality of care provided by care homes	Incorporated into Achieving Integration Improvement Intervention. (See Appendix 1 and 1.7.1 d below)
Developing a multimorbidity model to support patients with long term conditions	Improving the effectiveness and efficiency of care for patients with LTCs is one of our 6 major transformational programmes. See appendix 1 and 1.7.5 below
Reducing inappropriate use of A&E by providing greater access to primary skills	Agreement to identify the best way of achieving this is incorporated into the q1 milestones of our urgent and emergency care improvement intervention (see chapter 9)
Improving EOL care	Incorporated into Achieving Integration Improvement Intervention into See Appendix 1 and 1.7.1 f below
Reducing first outpatient activity	Incorporated into our Planned Care Improvement Intervention (see chapter 10)
Improving access too and quality of diagnostic services	Incorporated into our Planned Care Improvement Intervention (see chapter 10)
Improving access to and quality of mental health services, particularly for people with addictions	Incorporated into our ongoing work to tackle health inequalities (see chapter 4) and to deliver parity of esteem (see chapter 5)
Improving the interface between primary and secondary care	Revisions to LCD roles and responsibilities will clarify clinical leadership for key programme areas, and those individuals will lead work on their programme areas with colleagues in secondary care (see chapter 17)
Improving patient education about how to navigate the service	The CCG will work with CSCSU to define and agree a communications programme aimed at improving appropriate use of NHS services

1.7 Improvement Interventions (see Appendix 1 for more detail on each Intervention)

1.7.1 Improvement Intervention 1: Achieving Integration

a. *Agree and deliver Better Care Fund Plan*. TBC but proposals include:

i. Deliver front line integrated health and social care teams underpinned by a single assessment process, integrated care plans and care under single lead professionals
ii. Build reablement into all home care rather than in a separate service
iii. 7 day working in social care

iv. Implement individual service funds for home support
v. Increase investment in carers and the ALERT service
vi. Deliver agreed End Of Life strategy, focussing on working with informal carers
vii. Enhance online information services
viii. Commission one stop health and social care shops for crisis, rapid response and home support
ix. Consider integration of infrastructure with partner commissioners.

b. *Contract for outcomes*

i. Building on the Gateway review of Outcomes Based Commissioning and the inclusion of OBC in the 14/15 Operating Framework, identify an appropriate mechanism to deliver improved outcomes for older people

c. *Primary care development*

i. Appraise options for developing structure of primary care to meet changing expectations re: access and GP led integration of care around the patient
ii. Agree a vision and strategy for primary care development
iii. Develop and deliver an implementation plan for this strategy
iv. Support the development of clinical leaders of primary care so they have the capacity to act as strategic partners in provider discussions
v. Support improvement of the quality of care provided in general practice
vi. Increase the capacity of primary care to innovate and change at the practice level

d. *Quality in care homes*

i. Review and rationalise current care home support services countywide
ii. Enhance primary medical services provisions to residents(SE only)
iii. Increase quality of care to residents, in part through contract review countywide
iv. Increase medicines s management support to staff and provide targeted medicines optimisation work in care homes (SE only)

	Option A South East Pilot		Option B Top 20 Outliers		Option C Oxfordshire-wide	
Finance	2014/15	2015/16	2014/15	2015/16	2014/15	2015/16
Saving	£23,884	£25,712	£53,444	£69,070	£184,203	£248,805
Investment	£199,450	£199,450	£199,450	£199,450	£1,359,500	£1,359,500
Net Saving	-£175,566	-£173,738	-£146,006	-£130,380	-£1,175,297	-£1,110,695

e. *Improve integration of Psychological Services*

i. Pilot anxiety and depression interventions for COPD and cardiac patients
ii. Provide access to community psychological medicine services for people with complex LTC and MUS

iii. Improve identification and management of people presenting with Mental health problems in ED and as inpatients
iv. Develop a service modelled on the Birmingham RAID service to improve rapid access to psychological services in the acute hospital setting

Finance	2014/15	2015/16
Saving	TBC	TBC
Investment	TBC	TBC
Net Saving	TBC	TBC

f. *End Of Life Care (EOL)*

i. Improve EOL care in the community through greater use of community palliative care and hospice services

Finance	2014/15	2015/16
Saving	£81,225	TBC
Investment	£0	TBC
Net Saving	£81,225	TBC

g. *Integrated health hubs*

i. Pilot development of an integrated community health hub model offering health and social care services in Rose Hill – if preferred option of relocating primary care practice onto the estate cannot be achieved.

1.7.2 **Improvement Intervention 2: Improving emergency and urgent care services**

a. Deliver an improved model for urgent and sub acute care through one or a combination of: Service redesign, contractual mechanisms to reward innovation, and integration across the patient pathway between community and acute providers.

b. The service redesign proposal will be the subject of a joint provider/commissioner options appraisal to be completed in q1 of 2014/15, and comprises of:

i. referral of patients presenting at ED whose need is not urgent and could be safely signposted to community based or primary care services
ii. Review of MIU provision
iii. Development of urgent ambulatory care pathways in the acute
iv. Roll out of Emergency Medical Units (EMUs) or equivalent pathways

c. *Retender the PTS contract to:*

i. Deliver current services plus urgent transport to GP and EMUS
ii. Additional discharge journeys
iii. Reduction in aborted journeys
iv. Reduction in 999 initiated ambulance conveyances
v. Procure ambulance transfer of patients to GP practices for acute assessment where that assessment has the potential to prevent admission or allow early EMU assessment with the potential for subsequent community management

Finance	2014/15	2015/16
Saving	£984,106	-£70,568
Investment	£ 23,000	£0
Net Saving	£961,106	-£70,568

d. Retender 111 and OOH to deliver improved and integrated service with enhanced clinical input

Finance	2014/15	2015/16
Saving	£237,355	£237,355
Investment	£0	£0
Net Saving	£237,355	£237,355

1.7.3 **Improvement Intervention 3: Improving the efficiency and effectiveness of planned care**

a. *Enable primary care to reduce first outpatient referrals* by 7,000 over next two years

Finance	2014/15	2015/16
Saving	£972,444	
Investment	£722,500	
Net Saving	£249,944	

b. *Review trauma and orthopaedics pathways* in order to:

i. Improve referral quality and maximise conversion rates
ii. Optimise efficiency of care pathways following referral (including review of MSK hub)
iii. Maximise opportunities to deliver care in alternative settings
iv. Optimise GP use of pathology and radiology and improve quality and cost effectiveness of those services

v. Create a model for improvement of other top cost specialities in subsequent years of the plan

c. Explore potential over 5 years to *expand use of private sector providers* .

d. Continue to work with OUHT to *improve the efficiency of outpatient clinics*

e. Continue GP led audit of *adherence to thresholds and referral guidelines*, supported by rollout of the DXS system

f. Ensure that all *contractual levers* (for example outpatient/daycase agreements) are consistently applied

Finance	2014/15	2015/16
Saving	£1,254,318	£2,234,284
Investment	£0	£0
Net Saving	£1,254,318	£2,234,284

g. Continue existing programme to improve *efficiency and effectiveness of diagnostic services* by:

i. Improving the quality of radiology performance, access and turnaround times to meet national and local standards by March 2016
ii. Optimising GP usage of pathology and radiology imaging services by September 2014
iii. Increasing community provision of radiology

Finance	2014/15	2015/16
Saving	£292,485	TBC
Investment	£0	TBC
Net Saving	£292,485	TBC

h. Improve *dementia diagnosis and treatment* by:

i. Expanding SW dementia pilot to deliver increased dementia diagnosis in primary care countywide
ii. Streamline the memory assessment service pathway across OUHT and OHFT, enabling it to meet projected increase in demand within current spend
iii. Improving carer support and post diagnosis care through enhanced investment in carers grants and additional dementia advisors
iv. Continuing to develop dementia champions across the county to build dementia friendly communities.

Finance	2014/15	2015/16
Saving	-£10,913	£234,633
Investment	£209,032	£32,505
Net Saving	-£219,945	£202,139

1.7.4 **Improvement Intervention 4: Improving the efficiency and effectiveness of prescribing**

a. *Improve primary care prescribing* by:

i. Focussing on medicines optimisation for: antimicrobials, vitamin D, diabetes and COPD.

ii. Working closely with primary care to improve medicines optimisation in care homes and medicines optimisation in HF patients

Finance	2014/15	2015/16
Saving	£2,400,000	TBC
Investment	£0	TBC
Net Saving	£2,400,000	TBC

iii. Reducing waste by:

- reviewing "when necessary" and "not dispensed" items
- Pilot "costs on bags" project
- Pilot "not dispensed" project
- Review of repeat prescribing and dispensing
- Synchronisation of meds

Finance	2014/15	2015/16
Saving	£42,453	£65,768
Investment	£2,781	£4,250
Net Saving	£39,672	£61,518

b. Ensuring most *cost effective prescribing in secondary care* for diabetic macular oedema; retinal vein occlusion and age related macular degeneration.

Finance	2014/15	2015/16
Saving	£664,336	TBC
Investment	£0	TBC
Net Saving	£664,336	TBC

c. *Retendering* supply of wound care dressings to rationalise wound care costs.

Finance	2014/15	2015/16
Saving	£25,000	£0
Investment	£0	£0
Net Saving	£25,000	£0

1.7.5 **Improvement Intervention 5: Improving the management of Long Term Conditions**

a. Develop a *reconfigured LTC service model* to improve the quality of care for people with LTC, reducing unnecessary emergency hospital admissions. This will be achieved through:

i. Preventing people with LTC presenting at hospital by better managing people with LTC in the community through integrated local multidisciplinary teams
ii. Development of a pro-active, primary care led, multi morbidity service focussed on those patients who are the top 2% of service users.

b. Heart Failure:

i. Review diagnostic referral pathway
ii. Prescribing review and meds optimisation (ensuring close joint working with prescribing intervention)
iii. Develop integrated care team (MH/PH/rehab)
iv. Deliver education on self care

c. *Diabetes*:

i. Develop new integrated pathway based on OBC model to be delivered from April 15
ii. Implement new pre-diabetes prevention approach from April 2014 (and then integrate into new pathway)
iii. Develop secondary care CQUIN to improve responsiveness to inpatients with diabetes
iv. Evaluate value of multimorbidity integrated pathway

Finance	2014/15	2015/16
Saving	£738,707	£1,470,000
Investment	£0	£tbc
Net Saving	£738,707	£1,470,000

1.7.6 **Improvement Intervention 6: Delivering a new approach to contracting and procurement**

i. Improve the use of formal contract affordability envelopes and clear negotiation strategies
ii. Contract for delivery of improvement interventions, using all the levers available in the national standard contract and national business rules
iii. Integrate the learning from our investment in Outcomes Based Commissioning into all our contracting practice, with particular emphasis on using contracts to pursue integration to benefit our whole health system and contribute to its sustainability .
iv. Explore potential over 5 years to expand the use of alternative providers (including new primary care organisations where these emerge),in the context of a clear commercial strategy.
v. Establish improved business disciplines within the CCG including Programme Management Office, Business Intelligence and contracting and procurement expertise .

1.8 The role of our localities in delivering this plan

a. OCCGs member practices will play a key role in ensuring the successful delivery of this plan. In particular practices will need to:

i. Engage in the primary care development programme
ii. Deliver prescribing savings
iii. Continue to reduce first outpatient referrals
iv. Deliver a shared care model for dementia, and build on the SW 12/13 pilot to increase capacity for dementia diagnosis and management in primary care
v. Increase rates of IAPT referral
vi. Refer patients with COPD and HF to CBT services
vii. Use the newly available community psychological medicine liaison service
viii. Help shape the development of integrated community teams and sub acute community based urgent care services, and then make active use of those new services
ix. Increase the identification of patients who are palliative and improve use of Advanced care Plans
x. Participate in a pilot programme to develop better ways of providing medical support to care homes (not all practices) and to improve the quality of care homes provide
xi. Deliver the new GMS provisions for risk stratification and case management, and build on these to deliver a multi-morbidity model of care for patients with long term conditions
xii. Support delivery of the partnership work with public health partners to tackle health inequalities (not all practices)
xiii. Continue to develop PPGs so that the patient voice is informed, representative and empowered in the commissioning process and encourage them to enhance their relationships with practices by focusing on preparation for CQC inspection as well as addressing other practice specific concerns.
xiv. Provide effective signposting to interventions and opportunities to support self-care, develop healthy lifestyles and make informed choices around healthcare options.

1.9 The 6 characteristics of a high quality and sustainable system

This performance improvement programme will help move Oxfordshire towards being a system that has the six characteristics of a high quality and sustainable system and transformational service models highlighted in the guidance.

1.9.1 Characteristic 1: Ensuring that citizens will be fully included in all aspects of service design and change, and that patients will be fully empowered in their own care

a. Our 6 objectives have been developed in response to a widespread public engagement exercise.

b. Delivery of all our improvement interventions will be underpinned by:

   i. The structured inclusion of patients, carers and voluntary organisations in our service redesign work.

   ii. The ongoing development of pro-active and inclusive Patient Participation Groups (PPGs) in all of our practices, led by the lay chairs of our 6 locality patient forums who in turn have a direct relationship with our Non Executive lead for public involvement. Support for PPG development will be focussed on practices with populations experiencing health inequalities.

   iii. Ensuring that our service redesign proposals empower people to look after themselves. For example Our Better Care Fund plan will ensure that home care is re-contracted so that successful re-ablement is specified as an outcome of home care, rather than being commissioned as a separate stand alone service, and our Long Term Conditions Improvement Intervention will incorporate structured support to patients to self care.

   iv. Delivery of an ongoing programme of public consultation and engagement through Talking Health, public meetings, meetings in public, media campaigns and joint work with our local authority partners.

1.9.2 *Characteristics 2 and 3 : Wider primary care, provided at scale and a modern model of integrated care*

a. The most significant improvement intervention in our plan is our programme to achieve integration of services led by primary care. In year one of this programme we will therefore undertake an options appraisal for the future development of primary care, agree a vision and strategy for primary care in Oxfordshire and develop an implementation plan for delivering that change.

b. In order to ensure we have full engagement in, and support for, the outcomes of this work, we do not anticipate implementation getting underway until early in year 2. Our Locality Clinical Directors, and through them our wider primary care membership, have however already agreed that the objectives of this programme are:

   i. To produce an agreed vision and five year strategy for the development of primary care in Oxfordshire which addresses the role of practices in:

   ii. Providing more proactive coordination of care, particularly for people with long term conditions including dementia

   iii. Providing more holistic, integrated care in the community

iv. Ensuring fast, responsive access to urgent care needs

v. Preventing ill health, including more timely diagnosis and early identification of people at greatest risk of becoming unwell

vi. Involving patients and carers more fully in their self care

vii. Ensuring high quality care, in particular the patient experience

c. To produce and support the delivery of a plan for federated working in Oxfordshire which articulates the preferred function and form of federated working in the county so that primary care is in a position to:

i. Meet changing expectations re: access and GP led integration of care around the patient

ii. Enter the market as a provider of services operating at scale across the county

iii. Develop more innovative and integrated primary and community services which deliver improved access and increased continuity of care

iv. Support effective urgent and emergency care pathways

v. Address health inequalities more effectively in areas of both urban and rural deprivation

d. To develop the leadership capacity of primary care so that leaders are identified and supported to act as strategic partners in provider discussions around changes in service delivery.

e. To support improvement of the quality of general practice, working closely with the Local Area Team, to ensure that core GMS/PMS services as well as enhanced services improve and to address adverse performance variation.

f. To develop change management capacity within general practice, through a programme of organisational development and incentives to ensure that changes are made at the practice level which will transform out-of-hospital care and improve access to services.

g. Our Integration Improvement Intervention also incorporates programmes that will deliver a modern model of integrated care. These are:

i. Our Better Care Fund Plan which will result in creation of single, locality based teams delivering front line social work, occupational therapy and community health services (including District Nursing). Patient care will be informed by a single assessment process and delivered via a joint care plan, owned by an accountable lead professional. Delivery will be underpinned by integrated IT systems and jointly owned performance metrics. These teams will need to incorporate (or at least access) primary, community , secondary care and social care expertise, and :

- To deliver joined up health and social care to the frail elderly, patients with multimorbidities (particularly the top 2% of cost risk), patients with physical and mental health needs (including those with dementia), and patients on the palliative care register

- Have named social and community healthcare link workers assigned to each general practice
- Have clearly defined roles and responsibilities within urgent and emergency care pathways

ii. Our plan to integrate psychological services in primary and secondary care. This will ensure that patients who have both a long term condition (or multiple conditions) and anxiety or depression are treated holistically in the community, at ED and as inpatients.

iii. Our Quality in Care homes programme which will ensure that the residents of our nursing and residential care homes benefit as much from the development of modern integrated services as people still living in their own home.

h. Our integration intervention is heavily dependent on our contracting improvement intervention. It is our intent to negotiate an element of the OHFT contract jointly with the OUHT contract, in order to start implementation of Outcomes Based Commissioning for Older People. Discussions are underway with Oxfordshire County Council to see if any of their commissioned services could be included. Such a contracting intervention would seek delivery of services though a visibly integrated pathway which links the pathway though primary, community and acute services. This would be though a holistic approach meeting the person's physical health, mental health and social care needs**.**

1.9.3 Characteristic 4: Access to the highest quality urgent and emergency care

a. There has recently been increased commitment to multi-agency engagement, to identify and deliver improvements in the urgent care flow. This will continue as part of the Urgent care Working Group, ensuring short, medium and long term interventions are focused on improving bottlenecks in the pathway.

b. An improved model for urgent and sub acute care may be delivered as a combination of the contract improvement intervention, using contractual mechanisms to reward innovation, and service redesign. The service redesign proposal will be commence with a joint provider/commissioner options appraisal to be completed in q1 of 2014/15 and will cover:

i. referral of patients presenting at ED whose need is not urgent and could be safely signposted to community based or primary care services ()

ii. Review of MIU provision
iii. Development of urgent ambulatory care pathways in the acute provider
iv. Roll out of Emergency Medical Units, or equivalent pathways that can provide same day geriatrician led, multidisciplinary health and social care assessment and treatment services that enable patients to avoid admission.(this will also contribute to our integration ambitions).

c. Greater integration between our OOH provider and the 111 service – ensuring right place first time is achieved more consistently.

d. Greater integration between our PTS and ambulance services – ensuring it is easier for people to aces the right emergency care, in the right place first time, and supporting more effective discharge to improve flow.

e. Procure ambulance transfer of patients to GP practices for acute assessment where that assessment has the potential to prevent admission or allow early EMU assessment with the potential for subsequent community management.

f. Whole system ownership of the Urgent Care Improvement Plan, covering service improvements across the entire patient flow, overseen by the Urgent Care Working Group

g. Identification and assertive case management of the small number of children who make up the majority of non-elective admissions, ensuring children are managed closer to home and inappropriate admission is avoided.

1.9.4 Characteristic 5: A step change in the productivity of elective care

a. Our Planned Care Improvement Intervention will take approx. 4million out of the planned care activity budget from 2014 to 2016. This will be achieved through:

i. Reducing variation in outpatient first appointments in General Practice through delivery of the following 9 projects:

- Demand management by peer review of 1st out-patients referrals within practices – Identification of out-patient referrals where there is no benefit from a secondary care referral, lessons learned fed back at Locality meeting alternatives sought and education sessions developed
- Demand management through reduction of those consultant to consultant referrals
- Expansion of e-mail advice
- Practice Level specialist enhanced review – where specialist knowledge exists within a practice
- Locality based specialist review
- Supportive referral review within secondary care for urology and Gastro
- Dermatology project
- Ophthalmology extension of IOP scheme to reduce referrals based upon false positives; setting up community triage and treatment pathways.
- Review of the MSK triage – to assess value for money / quality

ii. A focus initially on the Trauma and Orthopaedics pathway, to deliver a combination of:

- Improvements in efficiency of outpatient clinics *
- Robust application of treatment thresholds
- Movement of day case to outpatient procedures
- Improved patient pathways and shared decision making

*OUH plan to save 2.7 million over three years over several specialities **

iii. Better value diagnostic services

iv. Improved dementia diagnosis and care

b. The CCG is also planning to expand its use of the wider healthcare market in the next five years. Given pressures on the main acute provider in terms of capacity and demand, making better use of the private provider facilities in the county makes sound sense.

c. There is recognition that prices may not be lower in the independent sector but that there is more will to discuss and agree total price patient pathways across specialties. This would make it easier to project spend across the financial year.

1.9.5 Characteristic 6: Specialised services concentrated in centres of excellence (as relevant to the locality)

We are still working with colleagues in Wessex to agree the detail of how this characteristic will be met.

1.10 Sustainability, outcomes and inequalities

1.10.1 Delivering a sustainable NHS for future generations in Oxfordshire

a. The Oxfordshire health and social care system is challenged financially, and this plan sets out to achieve run rate balance by 2015/16, and then a sustained financial balance thereafter.

b. Our improvement interventions have been designed to deliver the transformational change required to reach a sustainable position – and we are very clear that delivery of the Better Care Fund, primary care, planned care and urgent care interventions are particularly critical to the long term sustainability of the system, but that they will take time to bear fruit in terms of delivering shifts in activity.

c. Taking this more transparent and realistic approach to our planning gives us confidence that we can deliver sustainability, particularly as our planned interventions are underpinned by two other significant changes:
    i. Committing to an improvement intervention solely focused on contracting and procurement, through which we will:
        - Appraise the options for achieving our goals through contracting or procurement (in addition to system leadership) improving the disciplines of formal contract affordability envelopes and clear strategies
        - Contract for delivery of improvement interventions, using all the levers available in the national standard contract and national business rules
    ii. Ensure that we integrate the learning from our recent investment in Outcomes Based Commissioning into all our contracting practice, in line with Everyone Counts , with particular emphasis on using contracts to pursue integration in way which benefits our whole health system and contributes to its sustainability

d. Improving our business disciplines to ensure that we deliver our Plan and our improvement interventions by establishing a PMO in the CCG, embedding contracting and procurement capability into our appraisal of options to achieve improvement interventions and ensuring we have robust , industry standard , approaches in place to manage and monitor delivery of the 6 improvement interventions we have identified and applying those disciplines to business as usual.

1.10.2 How our plan will improve health outcomes in alignment with the seven NHS outcome ambitions

a. Ambition 1: Securing additional years of life for the people of England with treatable mental and physical health conditions
    i. Our Integration intervention includes a specific initiative to deliver improved psychiatric liaison in primary, community, emergency and secondary care inpatient settings – with priority given to improving care for patients with COPD, HF, multimorbidity and/or medically unexplained symptoms.
    ii. Our Long Term Conditions Intervention will deliver an enhanced, multimorbidity based, care model for patients with LTCs that comprises risk stratification, integrated care planning, care under a single named lead professional and support to self care.
    iii. We will build on the excellent work done to develop outcomes based commissioning for people with mental health problems in our contract negotiation with OHFT. Our aspiration is to contract with the main provider and our principle

voluntary sector partners to deliver care that results in improved quality of life (as defined by service users) in order to aid sustained recovery.

iv. Learning from the good practice in iii) above we will explore using the outcome based approach for Child and Adolescent Mental Health Services.

Potential Years of Life Lost from conditions considered amenable to healthcare – 5 year ambition

E.A.1	PYLL (Rate per 100,000 population)
Baseline	1779.7
2014/15	1807.0
2015/16	1804.0
2016/17	1789.0
2017/18	1763.0
2018/19	1722.7

b. Ambition 2: Improving the health related quality of life of the 15 million + people with one or more long term condition, including mental health conditions

i. Our integration and LTC interventions will result in the care of patients with LTCs being co-ordinated by GPs but delivered by our new integrated health and social care community teams. The Locality Commissioning teams will continue to support case finding by these new multidisciplinary teams using the ACG tool. GP led integrated teams will then deliver single assessments, and develop integrated care plans under the leadership of single named professionals. The new MDT teams will break down silos between specialist LTC teams and between health and social care, and will ensure treatment of the whole person and not the conditions that the person may have. A full suite of self-care interventions designed to motivate and empower patients will be available, and the planned integration of psychiatric liaison support in primary, community and secondary care – with a clear focus on patients with LTCs - will ensure parity of esteem.

Health related Quality of life for people with long term conditions – 5 year ambition (Percentage of people responding yes definitely or yes to some extent to q32 of GP patient survey)

E.A.2	Average EQ-5D score for people reporting having one or more long-term condition
Baseline	76.90
2014/15	76.90
2015/16	77.00
2016/17	77.00
2017/18	77.10
2018/19	77.20

c. *Ambition 3: Reducing the amount of time spent avoidable in hospital through better and more integrated care in the community, outside of hospital*
A number of our planned improvement interventions will contribute to delivery of this ambition.

i. Our integration and LTC Improvement Interventions will deliver integrated health and social care close to home for the elderly and those with LTCs and integrated physical and mental health care in year 1 of the plan.

ii. Our primary care development programme will ensure we can deliver the evolution required in primary care to ensure general practice is contributing fully to this priority from the beginning of year 2.

iii. Our urgent and emergency care improvement intervention will remodel our emergency and sub-acute pathway so that it delivers :
- referral of patients presenting at ED whose need is not urgent and could be safely signposted to community based or primary care services
- A dedicated Clinical Decision Unit for Paediatrics, co-located with the Emergency Department at the JR
- Enhanced MIU provision
- Access to urgent ambulatory care pathways in the acute
- Roll out of Emergency multidisciplinary units to provide 1 stop shop alternatives to A&E for those needing a speedy assessment and same day package of community health and social care in order to remain at home.

iv. As part of the Urgent Care Working Group, OCCG will continue to deliver activities from the Urgent Care Improvement Plan, and lead the engagement across the system, to identify short and medium term interventions to improve flow. These include a range of service improvements taken by providers, of which there is on-going focus to embed at operational level.

Combined 5 year ambition for measures assessing unplanned hospitalisation for : chronic ACS conditions; asthma, diabetes and epilepsy in u19s,; acute conditions not normally requiring hospitalisation and emergency admission for children with respiratory tract infections (Admissions per 100,000 of the population)

E.A.4	Emergency admissions composite indicator
Baseline	1471.7
2014/15	1414.1
2015/16	1329.1
2016/17	1240.7
2017/18	1148.7
2018/19	1056.4

d. *Ambition 4: Increasing the proportion of older people living independently at home following discharge from hospital*

i. Our Achieving Integration improvement intervention will deliver a developed primary care market that is leading delivery of community based integrated care for older people , with access to:

- front line integrated health and social care teams who can provide multidisciplinary physical health, mental health and social care to older people, managed by a single lead professional and designed to keep people at home
- home care support services with built in re-ablement
- enhanced ALERT services

ii. This will be underpinned by:

- an outcomes based component of our core contract for services for older people with OUHT and OHFT that requires them to deliver the Better Care Fund outcomes
- enhanced investment in carers
- development of lay and/or clinical dementia champions across the County who will lead development of dementia friendly communities.

iii. Our Urgent and Emergency Care Improvement Intervention will deliver improved emergency and sub acute care for older people which minimises admissions and lengths of stay, so enhancing the likelihood of people remaining independent at home.

Metrics		Current Baseline (as at….)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	71.70%	N/A	80%
	Numerator	345		400
	Denominator	480		500
		(April 2012 - March 2013)		(April 2014 - March 2015)

e. *Ambition 5: Increasing the number of people having a positive experience of hospital care*

i. Our Planned and Urgent and Emergency Care Improvement Interventions will deliver improvements to:

- the management of OP and OPFU
- diagnostic waits
- choice available to patients
- urgent care pathways
- urgent care for people with ACS conditions
- friends and family test scores

ii. Our Achieving Integration Intervention will deliver improved care for older people and people with complex co-morbidities across the pathway (including inpatient care). This will particularly impact those patients identified through risk stratification as being in the top 2% of service users.

iii. Our work on maternity commissioning will deliver improved experience for women using the CQC survey (2010, 2013) as baselines. The aim is to improve continuity of care and to reduce the number of women who deliver in an obstetric led unit by maximising capacity at the Freestanding Midwifery Led Units.

5 year ambition for keeping the numbers of people reporting poor inpatient care low (Total number of poor responses divided by total no of respondents, expressed as average no of negative responses to multiple questions per 100 patients.)

E.A.5	The proportion of people reporting poor patient experience of inpatient care
Baseline	149.7
2014/15	149.6
2015/16	149.5
2016/17	149.4
2017/18	149.3
2018/19	149.2

f. *Ambition 6: Increasing the number of people with mental and physical health conditions having a positive experience of care, outside hospital, in general practice and in the community*

i. Our Achieving Integration Improvement Intervention will deliver:

- a development of psychiatric liaison services in primary, community, emergency and inpatient settings
- increased access to psychological therapies for patients with ACS conditions –particularly cardiac and COPD
- multidisciplinary community teams that incorporate older adult mental health workers.

5 year ambition for keeping the numbers of people reporting poor GP and OOH care low (Average no of negative responses per 100 patients)

E.A.7	The proportion of people reporting poor experience of General Practice and Out-of-Ours Services
Baseline	4.80
2014/15	4.81
2015/16	4.82
2016/17	4.83
2017/18	4.84
2018/19	4.85

g. *Ambition 7: Making significant progress towards eliminating avoidable deaths in hospital caused by problems in care*

i. Oxfordshire does not have a significant problem with avoidable deaths. It is already business as usual for the CCG and its provider partners to review Dr Foster data and to take early preventative action where this flags any early warning signs. For example in the course of the last year we have worked with OUHT to improve management of diabetes and pneumonia.

1.10.3 **How our plan will reduce health inequalities**

a. OCCG has developed and agreed a partnership approach to reducing health inequalities with the Public Health teams at OCC and NHS England.

b. Data will be pooled (within Information Governance and data protection regulations) by the 3 partners to identify those primary care practices where:

i. we have populations that have been agreed as priorities for this work in the Health and Wellbeing Strategy, based on data in the JSNA. Ie: Children in poverty; Ethnic minorities; Carers; Lonely old people; High number of mental health service users; People with physical and learning disabilities

ii. and there is :

- Low uptake of core PH interventions (smoking cessation, breastfeeding, weight loss, screening, immunisations , healthchecks)
- Populations with potential to benefit from improved blood pressure, cholesterol, anti-coagulation and blood sugar control.
- Low carer registration

c. OCCG locality support pharmacists will then provide hands on support to those identified target practices to identify individuals, groups or communities that might benefit from targeted outreach work by Locality Equality and access teams.

d. OCCG will work with clinicians to ensure priority is given to delivery of interventions to improve blood pressure, cholesterol, anti-coagulation and blood sugar control.

e. OCC and NHS England will ensure that service providers target their resources to provide services to these priority practices.

f. OCC and OCCG will work together to ensure that families identified via the national Troubled Families initiative can be identified in primary care and that their case workers are fully aware.

g. In addition OCCG Equality and Access teams will continue to support neighbourhood based strategic partnership work in areas of deprivation; will work closely with Age UK and will continue to support military and veteran communities.

h. OCC and OCCG will deliver joined up services to prevent, detect and intervene early where children are being exploited or at risk of being exploited.

i. OCC and OCCG will make a ‘core offer’ for all children who are Looked After or Leaving Care so that there is consistent assessment of their health needs, early intervention where necessary and speedy access to more specialist services (such as CAMHS) when required.

1.11 Partner sign up to this plan

a. This plan has been developed in response to established local Health and Wellbeing Board priorities and the Call to Action Consultation.

b. The core content has been developed with input from the 6 locality Clinical Directors, who have approved the content as set out in this draft for sharing with NHS England.

c. A draft Plan on a Page summary has been shared with our key stakeholders in the NHS, local government, the academic community and the voluntary sector, and we are awaiting feedback.

d. Draft content has been shared at the Health and Wellbeing Board Steering Group, and the full suite of plan documents will be taken for formal approval by that body in March.

1.12 Alignment between our Better Care Fund plan and 5 year strategic vision

a. Our Better Care Fund plan is designed to further the aims and objectives of Oxfordshire's Joint Health and Wellbeing strategy (2012-2016) and the OCC/OCCG Joint Older People's Commissioning Strategy (2013-2016) – both of which were fully informed by the JSNA and user engagement.

b. The Better Care Fund will be used to deliver our joint ambition for integration, in that it will be used to:

i. Deliver joined up health and social care to the frail elderly, patients with multi-morbidities (particularly the top 2% of cost risk), patients with physical and mental health needs (including those with dementia), and patients on the palliative care register through the creation of integrated, locality based, health and social care teams.
ii. Deliver anticipatory care plans and care co-ordination when unstable for those patients.
iii. Develop locality based 'hubs' that are community facing and offer rapid access, multi-disciplinary health and social care team assessment for diagnosis and care planning.
iv. Move to acute hospital stays that are as brief as needed, so the patient moves to the most appropriate place as soon as possible without delay
v. Help primary care develop to work better together and improve joint working with community, social care and secondary care.
vi. Develop the primary care provider community so that GP services can contribute and potentially lead integrated care services
vii. Have named social and community healthcare link workers assigned to each general practice and embedded within locality based integrated health and social care teams
viii. Have clearly defined roles and responsibilities within urgent and emergency care pathways
ix. Deliver a new jointly commissioned service model that delivers shared outcomes for patients across the system
x. Provide 7 day working in health and social care

c. Moving resources, via the Better Care Fund, to support :
    i. More personalised home support which removes short visits
    ii. Dementia support
    iii. Family carer support
    iv. Equipment and assistive technology
    v. Information and advice
    vi. Discharge to assess care service
    vii. Increased spend on reablement and rehabilitation
    viii. Increased investment in carers breaks
    ix. Investment to support people to die at their usual place of residence
    x. Sharing of data
    xi. Data co-ordination (dementia and co-morbidities)
    xii. 7 day working
    xiii. Increased demand for funded nursing care and continuing healthcare
    xiv. Integrated support for hospital admission avoidance

1.13 The key themes which arose from the Call to Action engagement programme that have been used to shape the vision

a. Our public Call to Action consultation on our draft 5 year strategy identified that the issues of major concern to the public are that:

    i. We be open and transparent about the financial challenge we face – this plan is realistic about the scale of the financial challenge facing the organisation

    ii. If we have to cut services to make savings , we are up front about that – this plan does not propose cutting any services, but does set out ambitious plans for service transformation that will make us more efficient

    iii. Whilst there is support for the patient outcomes in our outcomes based commissioning plans, we shouldn't rush into this new form of contracting – we are undertaking a rigorous review of this work and that will inform our next steps in relation to commissioning for outcomes. We are committed to ensuring that the good work we have done with our partners to date to understand our joint responsibility for delivering better outcomes for patients in a more efficient way is reflected in our use of the standard contracts for 14/15.

    iv. Care closer to home is supported, but not to the detriment of the quality of care – our plans for development of integrated community teams and EMUs will deliver enhanced quality of care and enhanced outcomes to patients.

    v. We need to change the attitude of the public from "fix me now" to individuals taking joint responsibility for their health with their GP – this is a longer term goal, and we will strive to deliver this via the work of our equality and access teams in each locality, through our PPGs and through the self management components of our Better Care Fund and Long Term Condition programmes.

    vi. We need a comprehensive all ages education programme about how to use the NHS – our Equality and Access teams are beginning to address this with some early work to raise awareness in those communities least familiar with the NHS, in partnership with key general practice partners in areas of high immigration and deprivation.

vii. We should maximise the potential of technology to free up GPs time to deliver face to face care – our Better Care Fund plan will see increased investment in the County Council's Alert service, and our LTC programme proposes that we look again at how we can work with our partners in the AHSN to exploit the potential of new, and potentially more effective telehealth solutions. Our locality teams are actively supporting development of patient cess to record, on line appointment booking, text message appointment reminders etc .

viii. We should reduce duplication and waste – our achieving integration improvement intervention is designed to reduce hand offs between organisations and so to eliminate bureaucracy and waste - both for the system and for individual patients and service users.

1.14 Our clear 'you said, we did' framework to show those that engaged how their perspective and feedback has been included

a. Oxfordshire has a well established "you said, we did" framework. The report on our Call to Action programme will be uploaded on our website and actively promoted via Talking Health.

b. When our Governing Body receives and adopts this strategic plan in March the covering paper will formally note how this plan addresses the feedback from the public - and this information will then be widely in the public domain.

c. Our newly defined PMO will require all programmes to demonstrate how they have engaged patients and service users in service re-design, and how they have provided feedback to those who took the trouble to engage with us.

d. We will continue to use our patient engagement structures (Lead NED working with 6 lay chairs of locality fora, who represent PPGs in their locality, who in turn represent patients) to cascade information from the CCG to patients and to ensure patient views inform decision making.

e. The CCG will continue to work with Healthwatch Oxfordshire to identify and address areas of patient and public concern about healthcare.

Chapter 2: Outcomes

2.1 Our current position on outcomes as set out in the NHS Outcomes Framework

a. The CCG routinely monitors its performance against the Outcomes Indicator set and the Constitution standards, as well as a broad range of quality, activity and financial outcomes. Current performance against the Constitution standards is summarised in chapter 13.

b. To inform this plan the CCG has also reviewed its position on national benchmarks and trends to date as released in the NHS Atlas of Ambition.

c. In addition to known areas of concern as set out in the opening chapter (see section 1.3) specific areas for improvement have been identified as:
   i. Patients reporting very bad care in hospital (in the bottom end of the 3rd quintile)
   ii. Emergency admissions (in the top quintile but the aggregated measures hides some trends that need to be addressed)
   iii. Patients experience of GP and Out of Hours services (in the bottom end of the top quintile)

2.2 The actions we need to take to improve outcomes

Please See section 1.10 above for the mapping of our Improvement Interventions to the national outcome ambitions.

2.3 How community and clinician views have been considered in developing plans and quantifying ambitions

a. Our plan has its roots in early consultation with member practices and our Call to Action consultation (see section 1.13).

b. As the plan has developed each business case that has been developed to inform the sub components of each improvement intervention has had a clinical owner.

c. Our Locality Clinical Directors have met to discuss and agree the plan at each stage of its iteration, including:
   i. All Locality Directors meeting in December 2013
   ii. Governing Body workshop in January 2014
   iii. Locality Clinical Directors planning workshop in January 14
   iv. All locality Clinical Directors meeting in February 2014

2.4 Data , intelligence and local analysis explored to inform planning decisions

a. Performance against Outcome Measures has been cross referenced with NHS Constitution indicators performance. This clearly indicates that pressures are building within the planned care system for our main provider. There are issues with cancer waiting times, issues with RTT targets, diagnostics wait and cancelled operations.

b. There are also pressures within the urgent care system. In spite of apparent lower volumes of activity this autumn and early winter compared to the previous year, the 4 hour wait performance target is not met and ambulance handover performance remains an issue.

c. Both planned care and urgent care will have an impact on patients reporting bad care in hospital. Addressing these issues is fundamental to improving the outcome measure.

d. The emergency admission composite measure has been disaggregated and associated trends examined so that the individual components can be addressed. The likely demographic impact has been examined and has highlighted particular pressures for the under 19s in Oxford.

2.5 Alignment to JSNA and Health and Wellbeing Strategy

a. Please see para 1.4 for more information on priorities identified in the JSNA.

b. Our plan is also fully aligned to the Joint Health and Wellbeing Strategy for Oxfordshire which can be seen at: http://www.oxfordshire.gov.uk/cms/sites/default/files/folders/documents/aboutyourcouncil/plansperformancepolicy/oxfordshirejointhwbstrategy.pdf

c. The Health and Wellbeing strategy is based on analysis of the data captured in the JSNA and current priority areas agreed in the Joint Health and Wellbeing Strategy are:

1. Children and Young People

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

2. Adult Health and Social Care

Priority 5: Living and working well: Adults with long term conditions, physical or learning disability or mental health problems living independently and achieving their full potential

Priority 6: Support older people to live independently with dignity whilst reducing the need for care and support

Priority 7: Working together to improve quality and value for money in the Health and Social Care System

3. Health Improvement

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

d. Actions being taken by OCCG to meet these agreed system priorities are woven through our 6 improvement interventions and our key areas of business as usual described in the quality, parity of esteem and health inequality chapters of this plan.

2.6 Involvement of HWB in agreeing outcome-

a. OCCG has shared the content of the draft plan at the Health and Wellbeing Board Steering Group and will be taking it for formal approval by that body in March.

2.7 Anticipated impact on providers

	% impact of Improvement Interventions 14/15		% impact of Improvement Interventions 15/16	
	Activity	Finance	Activity	Finance
Accident and Emergency	0.13%	0.10%	5%	5%
Day Cases	1.69%	3.14%	0%	0%
Elective	5.04%	0.44%	5%	8%
Excess bed days EL	17.07%	18.19%	0%	0%
Excess bed days Non-Elective	tbc	tbc	tbc	tbc
Non-Elective	5.43%	1.25%	2%	0%
Outpatient First Attendance	5.31%	5.51%	0%	0%
Outpatient Follow-Up	0.00%	0.00%	0%	0%

FOR SPLIT BY PROVIDER PLEASE SEE SEPARATE OPERATIONAL PLAN TEMPLATE

2.8 Aggregation of whole systems plans and how they contribute to 5 year vision

a. The CCG is working with all partners to progress the improvement interventions. These interventions build upon ongoing clinical and service dialogue between the organisations and will be contractualised in accordance with the national timetable. In determining the finance and activity consequences of the interventions, due cognisance has been taken of Provider impact by point of delivery and where applicable HRG.

b. By cross referencing the interventions to specific providers, the risk of duplication or cost pushing is minimised. This will be further tested within the final plans which are post contract agreement.

c. The service impacts of the BCF have also been considered in terms of finance, activity and outcome impacts across all organisations.

2.9 Our 5 year ambition for the 7 NHS Outcome ambitions

BENCHMARK COLUMN TO BE ADDED FOR FINAL SUBMISSION

NHS National Outcome ambition	Measure	Baseline	2018/19	Calculated by
Securing additional years of life for the people of England with treatable mental and physical health conditions	Potential years of life lost from conditions considered amenable to healthcare (no of amenable deaths divided by population)	1779.7	1722.7	Rate per 100,000 of population
Improving the health related quality of life for the 15m+ people with 1 or more LTC, including MH conditions	Health related quality of life for people with LTCs (measured using the EQ5D tool in the GP patient survey)	76.9	77.20	Percentage of people responding yes definitely or yes to some extent to q32 of GP patient survey
Reducing the amount of time spent avoidably in hospital through better integrated care in the community, outside of hospital.	Composite rate: - Unplanned hospitalisation for chronic ACS conditions and for u19s with asthma, diabetes or epilepsy - Emergency admissions for children with lower respiratory tract infections and adults with acute conditions not usually requiring admissions	1471.7	1056.4	Admissions per 100,000 of population
Increasing the proportion of older people living independently at home following discharge from hospital	See BCF table below			
Increasing the number of people having a positive experience of hospital care	Patient experience of inpatient care (friends and family test)	149.7	149.2	Total number of poor responses divided by total no of respondents, expressed as average no of negative responses to multiple questions per 100 patients.
Increasing the no. of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community	Composite indicator comprised of GP and GP OOH services	4.80	4.85	Average number of negative responses per 100 patients
Making significant progress towards eliminating avoidable deaths in hospital caused by problems in care	Indicator in development nationally			

2.10 **Our 1 & 2yr plan to support the long-term ambition**

NHS National Outcome ambition	Measure	Baseline	2014/15	2015/16	Calculated by
Securing additional years of life for the people of England with treatable mental and physical health conditions	Potential years of life lost from conditions considered amenable to healthcare (no of amenable deaths divided by population)	1779.7	1807	1804	Rate per 100,000 of population
Improving the health related quality of life for the 15m+ people with 1 or more LTC, including MH conditions	Health related quality of life for people with LTCs (measured using the EQ5D tool in the GP patient survey)	76.9	76.9	77	Percentage of people responding yes definitely or yes to some extent to q32 of GP patient survey
Reducing the amount of time spent avoidably in hospital through better integrated care in the community, outside of hospital.	Composite rate: - Unplanned hospitalisation for chronic ACS conditions and for u19s with asthma, diabetes or epilepsy - Emergency admissions for children with lower respiratory tract infections and adults with acute conditions not usually requiring admissions	1471.7	1414.1	1329.1	Admissions per 100,000 of population
Increasing the proportion of older people living independently at home following discharge from hospital	See BCF table below				
Increasing the number of people having a positive experience of hospital care	Patient experience of inpatient care (friends and family test)	149.7	149.6	149.5	Total number of poor responses divided by total no of respondents, expressed as average no of negative responses to multiple questions per 100 patients.

NHS National Outcome ambition	Measure	Baseline	2014/15	2015/16	Calculated by
Increasing the no. of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community	Composite indicator comprised of GP and GP OOH services	4.80	4.81	4.82	Average number of negative responses per 100 patients
Making significant progress towards eliminating avoidable deaths in hospital caused by problems in care	Indicator in development nationally				

2.11 Our outcomes ambitions for the additional Better Care Fund Indicators

Metrics		Current Baseline (as at....)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	534	N/A	473
	Numerator	582		546
	Denominator	109000		115000
		(April 2012 - March 2013)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	71.70%	N/A	80%
	Numerator	345		400
	Denominator	480		500
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	26.9	21.8	17.0
	Numerator	140	115	90
	Denominator	521000	528000	528000
		(April 2012 - March 2013)	(April - December 2014)	(January - June 2015)
Patient / service user experience [for local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used]			N/A	
Achieve above the national average of people very satisfied with the care and support they receive from adult social care	*Metric Value*	62.7%	N/A	64.1%
	Numerator	4236.8		n/a
	Denominator	6760.6		n/a
Increase the proportion of older people (aged 65 and over) with an ongoing care package supported to live at home	*Metric Value*	60.0%	N/A	TBC
Numerator: Number of people receiving home care or an on-going direct payment from an older person's budget	*Numerator*	2122		TBC
	Denominator	3537		TBC
Numerator + people funded Number of people funded in a permanent care home place from a council pudget		*Mar-13*	*(insert time period)*	*Mar-15*
increase the proportion of older people (aged 65 and over) with an on-going care package supported to live at home	*Metric Value*			
	Numerator			
	Denominator			
		(TBC)		

Chapter 3 : Values and principles

3.1 6 themes characterise our approach to addressing the challenges we face to achieve our vision of a healthier Oxfordshire:

i. Clinicians and Patients working together to redesign how we deliver care
ii. Reducing health inequalities by tackling the causes of poor health
iii. Commissioning Patient Centred High Quality Care
iv. Promoting integrated care through joint working
v. Supporting individuals to manage their own health
vi. More care delivered locally

3.2 Our Call to Action Consultation challenged the organisation to live these values and principles more effectively, but did not suggest that they need to be amended.

3.3 This is a brief summary of how these principles are embedded within our improvement interventions:

a. *Clinicians and Patients working together to redesign how we deliver care*
   - Each of our improvement interventions has been informed by consultation with clinicians and patients through our Call to Action consultation, our Locality Planning Workshops , our work to develop PPGs and discussion at existing programme boards. Ongoing involvement will be delivered via the same mechanisms.

b. *Reducing health inequalities by tackling the causes of poor health*
   - Please see chapter 4

c. *Commissioning Patient Centred High Quality Care*
   - Please see chapters 6 and 14 for a brief description of our embedded mechanisms for managing and maintaining quality in all our services

d. *Promoting integrated care through joint working and more care delivered locally*
   - Our Achieving Integration Improvement Intervention is focussed on realising this – please see chapter 8

e. *Supporting individuals to manage their own health*
   - Our LTC Improvement Intervention will deliver improved self care over the later years of this plan .

Chapter 4: Improving health and reducing health inequalities

4.1 OCCG , OCC and NHS England have agreed a joined up approach to improving health and tackling health inequalities in Oxfordshire, which is described briefly below. This model follows the 5 steps recommended in Commissioning for Prevention and is designed to support delivery of agreed Health and Wellbeing Board targets and trajectories, which can be found here: http://www.oxfordshire.gov.uk/cms/sites/default/files/folders/documents/aboutyourcouncil/plansperformancepolicy/oxfordshirejointhwbstrategy.pdf

4.2 The agreed approach can be summarised as follows:

a. Each OCCG locality will identify a small number of practices where there are populations that have been agreed as priorities for this work in the Health and Wellbeing Strategy, based on data in the JSNA. These are:

i. Children in poverty
ii. Ethnic minorities
iii. Carers
iv. Lonely old people
v. High number of mental health service users
vi. People with physical and learning disabilities

b. These practices will then be reviewed using OCC, NHS England and practice data to identify those which also have :

i. Low uptake of core PH interventions (smoking cessation, breastfeeding, weight loss, screening, immunisations , healthchecks)
ii. Populations with potential to benefit from improved blood pressure, cholesterol, anti-coagulation and blood sugar control. (NAO recommendations)
iii. Low carer registration

c. Those practices which fit both categories (and which we expect to include practices in areas of deprivation) will form the target group for offers of intensive support to tackle health inequalities and provide early intervention and prevention services from OCC's providers , NHS England's providers and locality teams .

d. Local PPG fora will be asked to endorse the proposed selection of target practices

e. Then OCC, NHS England provider and locality teams will work together in joint teams as below:

i. Locality Support Pharmacists will work in priority practices to identify individuals who would benefit from individualised outreach to encourage take up of prevention and early intervention measures (taking burden off Practice Managers)
ii. CCG (City team)will work with CSU and OCC to get a flag on all GP systems for members of the countywide Troubled Families initiative and will ensure GPs have access to contact information for case workers for each member of a Troubled Family, to assist with this identification/outreach work and to support whole system working around our most disadvantaged citizens.
iii. CCG Locality Equality and Access teams will undertake targeted outreach work to encourage identified individuals/families and or communities to take up these services
iv. ADLs / Locality Clinical Directors will work with GPs in these priority practices to encourage increased delivery of following clinical interventions in locality work plans for the year:
    - Increased prescribing of drugs to control blood pressure;

- Increased prescribing of drugs to reduce cholesterol;
- Increased anticoagulant therapy in atrial fibrillation;
- Improved blood sugar control in diabetes
- Registration of carers

v. OCC/OCCG joint commissioning lead for children and maternity will be asked to get Health Visitor and breast feeding support services to target work with the priority practices

vi. OCC will target smoking cessation, etc at priority practices/identified individuals

vii. NHS England will prioritise support to increase uptake of screening and immunisations within targeted practices

viii. CCG locality teams will manage relationships with practices on behalf of joint OCC/NHSE/CCG so practices not bombarded

ix. CCG locality teams will focus PPG development work on same priority practices

f. In addition to the above, CCG Equality & Access teams will only focus on neighbourhood based strategic partnership programme work, work with carers and work with military and veteran communities .

g. For children and families OCC and OCCG will deliver:

i. Joined up services to prevent, detect and intervene early where children are being exploited or at risk of being exploited.

ii. A 'core offer' for all children who are Looked After or Leaving Care so that there is consistent assessment of their health needs, early intervention where necessary and speedy access to more specialist services (such as CAMHS) when required.

iii. Targeted action in areas where breastfeeding initiation rates are low (e.g. Banbury) and where continuation rates have declined in order to target support and evidence based interventions in very local areas.

iv. Work with primary care in Oxford City to develop and implement a 'flag' system in practices so that families who are part of the Council's 'Thriving Families Programme' are identified in practices and clear routes of referral back to family case workers are identified. This will support delivery of the Troubled Families programme to turn around lives of the most vulnerable families.

v. Exploring the potential for co-commissioning with NHS England to meet the primary and community care needs of our homeless population

h. The outcomes we expect to realise across the system from this approach within 2 years are as set out in chapter 2.

4.3 **Implementing EDS2**

a. EDS2 is a useful tool that **s**upports OCCG Statutory Duties under Equality and Human Rights legislation (Equality Act 2010, Human Rights Act 1998) and the Health and Social Care Act (2012)

b. It requires us to embed equality & diversity within the organisations mainstream processes to support :

i. Better health outcomes;
ii. Improved patient access and experience
iii. A representative & supported workforce
iv. Inclusive leadership.

c. Proposals to carry forward EDS2 IN OCCG will go through the appropriate governance processes.

d. Meanwhile an Equality Impact Assessment will be conducted on this plan before submission to the OCCG Governing Body in March.

Chapter 5: Parity of esteem

5.1 5yr year ambition:OCCG is committed to achieving parity of esteem for mental health services and the people who use them in Oxfordshire by 2019. We will achieve that through 3 key initiatives:

i. Outcomes Based Commissioning for adult mental health services
ii. Improved integration of mental health and physical health services to improve patient and system outcomes around co-morbidities
iii. Improved identification and support for children and young people with mental health problems

5.2 Outcomes Based Commissioning for adult mental health services

a. We will deliver the following outcomes for people over the age of 18 living with mental health problems by 2019 via a joint commissioning approach with Oxfordshire County Council.

Outcome	Measured by
People will live longer	Mortality rate Suicide rate
People will have an improved level of wellbeing and recovery	Improved score against recovery star Reduction in intensity score against HoNOS PbR cluster tool Sustained recovery 6 months post discharge
People will receive timely access to assessment and support	Time from referral to establishment of care plan Timely support in crisis
Carers will feel supported in their caring role	Carer Strain Index Carer satisfaction
People will maintain a role that is meaningful to them	Increased numbers of people in work Increased numbers of people volunteering Increased numbers of people in education Numbers of people able to perform caring/home management role
People will continue to live in suitable and stable accommodation	Increased numbers of people living independently Increased throughput of people from hospital to supported housing
People will have better physical health	Improved scores for people with severe mental illness against key health screening (BMI, smoking cessation etc) Reduced use of urgent care system

b. These outcomes will be delivered via outcomes based contracting that is resourced from an s75 NHS Act 2006 Pooled Commissioning Budget. The budget for these services in 2013-14 is £38m of health and social care money.

5.3 Improved integration of mental health and physical health services to improve patient and system outcomes around co-morbidities

a. OCCG will improve outcomes for people with physical health and other co-morbid conditions by commissioning the following psychological interventions:

i. CBT for people with Heart Failure, COPD and other long-term conditions which supports self-management and reduces readmission
ii. A revised and extended emergency department psychological medicine service that supports clinicians in the urgent care pathway and avoids admission and readmission by diverting/referring people into those outcomes-based services set out above in (1)

iii. A community psychological medicine service that supports the management of people with complex long-term conditions and medically unexplained symptoms to increase capacity and capability in primary care and reduce unplanned admissions and unnecessary planned care including diagnostics

iv. An improved response to the needs of complex people such as those with acquired brain injury, co-morbid autistic spectrum disorders and/or learning disability which will reduce use of the urgent care system (particularly in relation to Mental Health Act) and mitigate potential costs of rehabilitation and social care

The current budget for psychological interventions is £3.7m

5.4 Improved identification and support for children and young people with mental health problems

a. OCCG will improve identification, support and outcomes for children and young people with mental health problems by achieving the following ambitions as set out in our Joint Commissioning Strategy with the County Council

Ambition	What will we do to achieve this?
Improve transitions from children's to adult mental health services	• Evaluate new service model by April 2014. • Continue review of gaps in provision for young people aged 16-24 years resulting from eligibility thresholds and transition from CAMHS to adult services, particularly young people with ADHD, ASD or with conduct disorders
Better outcomes for children with Autism	Co-ordinate the review the ASD diagnostic pathway for 5-18 year olds across all relevant providers including schools. • Prioritise actions in the Oxfordshire Autism Strategy • Implement Improving Access to Psychological Therapies (IAPT) for children and young people.
Ensure support is available to children and young people with mental health issues	• Develop mental health support in community settings such as schools, clubs, hubs (Youth counselling and joint working with Public Health) • Implement IAPT for children and young people.
Improve existing mental health services for children and young people	• Review of PCAMHS/CAMHS against overall strategy direction and in preparation for end of Oxford Health NHS contract (2014 / 2015) • Roll out of Performance By Results for CAMHS (2014/15)
Improve targeted support for children and young people at particular risk of developing mental health problems	• Commission effective support for young carers.

5.5 Our 1 & 2yr plan to support the long-term ambition (*by organisation and to be finalised by 4th April*)

Parity of Esteem initiative	**2 year implementation plan**
Improved outcomes for people living with severe mental illness	• Agreement on outcomes and measures (OCCG) by April 14 • Negotiation into OH contract and CQUIN and/or implementation plan April 14 • Design/procurement solutions June 14 (OCCG) • New OBC services in place April 15 • Evidence of impact from April 15
Improved mental health of people living with physical health problems	• Evaluation of current IAPT/LTC projects (OCCG and OH) April 14 • Pilot community psychological medicine service (OCCG and OH) to Sep 14; evaluation by Dec 14 (OCCG) • Implementation of revised urgent psychological medicine service from April 14 (OH) • Design and implementation of evaluated services by April 15
Identification and support for young people with MH problems	• Evaluate new transition model from April 14 • Design and procurement solutions to Sep 14 • Implement new model from April 15 • Review of PCAMHS/CAMHS against overall strategy direction and in preparation for end of Oxford Health NHS contract (2014 / 2015) • Roll out of Performance By Results for CAMHS (2014/15)

Chapter 6: Patient services

6.1 **Patient Services**

a. OCCG has developed a pro-active approach to patient and public engagement, designed to ensure that the commissioning process and decision making is informed by citizen participation. The CCG uses a number of approaches, reflecting the fact that patients, the public and stakeholder groups have differing preferences regarding how they wishes to be involved. Key approaches include supporting the development of Patient Participation Groups (PPGs) at practice level, and the establishment of patient and public forums at locality level. Each of the six localities now has a forum in place, with a lay chair. The Governing Body of the CCG has a lay member with responsibility for patient and public engagement and regular meetings are held with the lay chairs.

b. This approach is supported by the use of Talking Health, an innovative online engagement and consultation tool. There are currently 2,000 public members of Talking Health, who, on signing up, are asked which issues they are interested in and how they would like to be engaged/involved. This includes invitations to meetings, participation in surveys and in online discussions. The Talking Health system allows for rapid analysis of responses, to feed real time decision making. Members are given feedback on the overall responses and are kept up to date through a Talking Health newsletter.

c. The Governing Body meetings in public are seen as an opportunity both to demonstrate transparency of decision making and to hear and reflect on feedback from patients and the public. Meetings are held at different locations around Oxfordshire. Questions are invited in advance of the meeting and answered during the meeting. The questions and written answers are published on the CCG website.

d. In addition to this ongoing approach, the CCG undertakes specific programmes of engagement to support decision making on particular issues. For example, the CCG has over the past twelve months engaged with users of mental health and maternity services and services for frail elderly people in order to co-design outcomes measures which, it is hoped, will begin to be built into the commissioning process. This has involved close working with voluntary sector and patient groups as well as with individuals. Over the past three months the CCG has led an active programme of work under the Call to Action banner to hear feedback on the strategy which will inform the five year plan.

e. The CCG works in close partnership with healthcare providers and Oxfordshire County Council and a number of engagement exercises are run jointly.

6.2 **How we will promote transparency in local health services**

a. The CCG promotes transparency in local health services in a number of ways. Senior CCG staff meet regularly with the medical and nursing directors of its major providers to discuss key issues and operate a “memorandum of understanding” to ensure potential clinical concerns can be raised and intelligence shared between organisations. Ongoing discussion take place promoting provider board reports to be more explicit particularly where services fall below acceptable standards.

b. All serious incidents are reviewed by the CCG prior to their closure to ensure lessons are learned and that patients and relatives have been fully informed of the incident and the preventative action taken.

c. The CCG patient experience team contact details are displayed in GP practices as is a CCG web site address if people wish to contact the CCG to discuss aspects of healthcare.

d. The CCG produce a Quality and Performance report every 2 months which describes the quality of health services good and bad which is available on the CCG web site.

6.3 **Our 5yr year ambition**

a. Our 5 year ambition is to build on this work improving citizen engagement and widening participation to realise the goal of people being partners in healthcare.

6.4 **1 & 2yr plan to support the long-term ambition (by organisation and to be finalised by 4th April)**

a. The CCG plan to further promote transparency in local health services in a number of ways:

   i. The CCG will develop a "candour statement" that describes how both commissioners and providers should communicate with each other and with the public. It is intended that this document will be signed by all Chief Executives and displayed on both provider and commissioner web sites.

   ii. The CCG will develop its web site to include a section on the "quality of healthcare services" that are being provided in Oxfordshire. This will include clinical audit reports, quality and performance reports and links to other websites such as Dr Foster and NHS England that show performance of acute hospitals and GP practices respectively.

   iii. The CCG will continue to work with stakeholders such as Health Watch and CCG Localities to share information on the quality of health services and how they are being improved.

Chapter 7: Wider primary care provided at scale

7.1 OCCGs aim is to provide as much care as possible to where patients live and work. Developing primary care so that general practice is at the heart of integrated and wider out-of-hospital services is fundamental to achieving this aim.

7.2 **Our 5 year ambition is** to develop primary care across Oxfordshire which is high quality, cost effective, sustainable, and capable of playing a strong role at the heart of more integrated out-of-hospital services.

7.3 Our desired outcomes are:

a. Primary care which can deliver better health outcomes, including more personalised care which addresses the increasing complex needs of people with multi-morbidity
b. General practice which provides high quality care, including excellent patient experience
c. Efficient use of resources within primary care
d. Increased integration of primary, community, and intermediate care, and with out-of-hours services
e. Primary care which has the capacity to be an effective player in the market, bidding for a range of contracts to deliver a wider range of out-of-hospital care at scale across the county

As a result, people will:

f. Receive more care at home or in community settings, rather than in hospital
g. Know who is co-ordinating their care and will be involved in planning their care
h. Feel well supported to manage their long-term condition
i. Have wider and more flexible access to appointments with GPs and practice staff through extended opening hours and increased use of email, Skype and phone consultations
j. Experience high quality primary care

7.4 The objectives of our 1 and 2 year plan are:

a. To produce an agreed vision and five year strategy for the development of primary care in Oxfordshire which addresses the role of practices in:

    i. Providing more proactive coordination of care, particularly for people with long term conditions including dementia
    ii. Providing more holistic, integrated care in the community
    iii. Ensuring fast, responsive access to urgent care needs
    iv. Preventing ill health, including more timely diagnosis and early identification of people at greatest risk of becoming unwell
    v. Involving patients and carers more fully in their self care
    vi. Ensuring high quality care, in particular the patient experience

b. To produce and support the delivery of a plan for federated working in Oxfordshire which articulates the preferred function and form of federated working in the county so that primary care is in a position to:

    i. Enter the market as a provider of services operating at scale across the county
    ii. Develop more innovative and integrated primary and community services which deliver improved access and increased continuity of care
    iii. Support effective urgent and emergency care pathways
    iv. Address health inequalities more effectively in areas of both urban and rural deprivation

c. To develop the leadership capacity of primary care so that leaders are identified and supported to act as strategic partners in provider discussions around changes in service delivery. This will ensure that primary care views are clearly voiced and considered in any

system level change, particularly in the development of models of integrated care provided out-of-hospital.

d. To support improvement of the quality of general practice, working closely with the Local Area Team, to ensure that core GMS/PMS services as well as enhanced services improve and to address adverse performance variation.

e. To develop change management capacity within general practice, through a programme of organisational development and incentives to ensure that changes are made at the practice level which will transform out-of-hospital care and improve access to services.

f. These objectives will be achieved through:
    i. A county wide project team with GP and practice manager representatives from each locality to develop the vision and strategy for the development of primary care in consultation with partners and the public
    ii. Locality based engagement events with practices to discuss the need to develop primary scale and to consider the options for how they might work together at scale to offer a wider range of services
    iii. Provision of seed-corn funding to support federated working in the county
    iv. Working with health and social care commissioners to identify contractual opportunities for primary care to bid to provide more integrated out-of-hospital care
    v. Local investment schemes which support practices to provide more co-ordinated care, particularly for those people with multi-morbidity

Chapter 8: A modern model of integrated care

8.1 **Our 5 year ambition for integration is to** :

a. Deliver joined up health and social care to the frail elderly, patients with multi-morbidities (particularly the top 2% of cost risk), patients with physical and mental health needs (including those with dementia), and patients on the palliative care register through the creation of integrated, locality based, health and social care teams.
b. Deliver anticipatory care plans and care co-ordination when unstable for those patients.
c. Develop locality based 'hubs' that are community facing and offer rapid access, multi-disciplinary health and social care team assessment for diagnosis and care planning.
d. Move to acute hospital stays that are as brief as needed, so the patient moves to the most appropriate place as soon as possible without delay
e. Help primary care develop to work better together and improve joint working with community, social care and secondary care.
f. Develop the primary care provider community so that GP services can contribute and potentially lead integrated care services
g. Have named social and community healthcare link workers assigned to each general practice and embedded within locality based integrated health and social care teams
h. Have clearly defined roles and responsibilities within urgent and emergency care pathways
i. Deliver a new jointly commissioned service model that delivers shared outcomes for patients across the system
j. Provide 7 day working in health and social care
k. Improve the integration of physical and mental health care
l. Integrate prevention work commissioned and undertaken by OCC, NHS England and OCCG

8.2 **The actions we are taking to progress delivery of this vision over the next two years are:**

a. Supporting a comprehensive primary care development programme (see chapter 7)
b. Contracting for outcomes for the frail elderly, those with complex LTCs and MH patients within the framework of the standard NHS contract across our provider community, to ensure integrated delivery by our community and acute providers
c. Developing and contracting for a sub acute pathway designed to support admission avoidance and early discharge
d. Specifying the functions, outcomes and characteristics we require of integrated health and social care community teams within our contract with OHFT and our Better Care Fund agreement with OCC
e. Moving resources, via the Better Care Fund to support :
    i. More personalised home support which removes short visits
    ii. Dementia support
    iii. Family carer support
    iv. Equipment and assistive technology
    v. Information and advice
    vi. Discharge to assess care service
    vii. Increased spend on reablement and rehabilitation
    viii. Increased investment in carers breaks
    ix. Investment to support people to die at their usual place of residence
    x. Sharing of data
    xi. Data co-ordination (dementia and co-morbidities)
    xii. day working
    xiii. Increased demand for funded nursing care and continuing healthcare
    xiv. Integrated support for hospital admission avoidance

f. Strengthening the availability of psychiatric liaison in primary, community and secondary care settings to ensure integration of physical and mental health care teams; embedding older adult mental health care within integrated health and social care community teams;

supporting the local MH triage pilot in partnership with Thames Valley Police; working with Oxfordshire Safer Communities Partnership to improve rapid access to physical and mental healthcare for vulnerable adults.

g. Developing and delivering an integrated approach to prevention and early intervention with OCC, NHS England and our third sector partners.

8.3 **Measuring progress**

a. Please see chapter 2 for the Outcomes we want to achieve from delivery of a modern model of integrated care.

Chapter 9: Access to the highest quality urgent and emergency care

9.1 Alignment of our vision with Professor Keogh's report

Our vision aligns with the Keogh report in that we are:

a. Scoping the provision of Ambulatory Care Pathways (ACPs) to support the management of patients with urgent care needs without recourse to admission for diagnosis or treatment. The development of ACPs will coincide with the further expansion of Emergency Multidisciplinary Units (EMUs) and EMU pathways, which offer community based management of frail elderly adults. These services will support the rapid care of patients and return to their home, reducing the number of patients with a length of stay of less than 24 hours.

b. Analysing the need for a model to refer patients presenting at ED whose need is not urgent and could be safely signposted to community based or primary care services, which will enable patients suitable for management within the community to be assessed, treated if appropriate or signposted to services, avoiding inappropriate attendance and queuing in A&E. This work will be supported by the continuation of Choose Well and other patient education campaigns, to support patients in accessing the right care, first time.

c. Reviewing the provision of Minor Injury and First Aid Units across Oxfordshire to ensure that patients can optimise their access to care outside of A&E. A planned needs assessment will determine how best to deliver care within the county and in particular within Oxford and inform whether a MIU should be developed for patients within the city.

d. Supporting OUH in its role as a regional stroke and trauma centre, consolidating expertise and services to manage patients with more serious or life threatening emergency needs. OCCG will work with partner organisations to consider how to most effectively provide such care across the county and the delivery of urgent care across two acute sites- the John Radcliffe and the Horton.

e. Developing patient transport services to further support effective discharge of patients, following the provision of Winter monies to enable additional evening journeys.

f. Exploring the potential to provide transportation to GP practices for patients requiring rapid assessment in the community. This may enable earlier referral to hospital for patients requiring such care, reducing the 'bunching' of admissions in the afternoon and increasing the likelihood that patients can be discharged on the same day, improving the patient experience.

g. Increasing the number of patients receiving appropriate care and management by telephone through 111 and Out of Hours consultations, reducing the number of patients required to travel to a primary care base, particularly during evenings and weekends, for care.

9.2 Developing the footprint for our urgent and emergency care network

a. OCCG will work with partners across a variety of fora to determine the footprint of the urgent and emergency care network

b. Principally this will be led by the Urgent Care Working Group, which comprises senior representation from organisations across health and social care in Oxfordshire, who ensure the delivery of the system wide improvement plan. This covers programmes across all stages of patient flow including caring for patients closer to home, admission avoidance and facilitation of discharge.

c. These groups will link with the Health and Wellbeing Board to determine the most pressing needs for the population identified within the Joint Strategic Needs Assessment. Whole system programme boards will use evidence based analysis and recommendations, as well as local needs assessments to determine and deliver commissioning intentions. The Urgent

Care Working Group will oversee the flow of patients in the community, into ED and through to discharge to ensure that the development of services are aligned across all organisations.

9.3 Beginning the process of designation for all facilities within our network

a. The Urgent Care Working Group will co-ordinate the development work to designate all facilities within the urgent and emergency care network during 2014/15. A programme of provider and patient engagement, furthering the work within the Joint Strategic Needs Assessment, will inform the shape of urgent and emergency services within the county.

9.4 5yr year ambition for urgent care

a. The ambition is to develop an urgent and emergency care strategy for Oxfordshire based on the full Urgent and Emergency Care review (including unpublished phases). This will include a full analysis of relevant health and social care services across the county and the refining of such services in line with Prof Keogh's vision of specialised centres to manage emergency cases.

9.5 1 & 2yr plan to support the long-term ambition

a. Support appropriate management of patients in the community via the development of:
    i. Primary care triage at ED
    ii. Ambulatory care pathways
    iii. Minor Injury and First Aid Units
    iv. Emergency Multidisciplinary Units and pathways
    v. Patient Transport services
    vi. 111 and Out of Hours services

Chapter 10: A step-change in the productivity of elective care

10.1 There is a two year plan to take approx. £4million out of the local spend on elective activity. Given the current national trend for referrals into elective services to be increasing nationally there are limits to the reductions that can be achieved locally. It is recognised that the tensions between better patient care, less resource and increasing demand given local demographics makes it harder to reduce spend.

	2 year net savings
Diagnostics	292485
Pathway review	3488602
1st Outpatient	249944
Dementia	-17806
Total	4013225

10.2 The reduction will be achieved through a combination of the following actions:

a. The CCG will invest in primary care capacity to continue thorough peer review of first outpatient referrals, in order to drive down variation.

b. The OUH have a project running until Sept 14 to completely redesign all their outpatient clinic templates. This will increase the efficiency of clinics and create additional capacity in specialties with the greatest flows in.

c. The CCG planned care team has a number of GP leads across key specialties who are able to audit adherence to thresholds and referral guidelines both in primary and secondary care. Specialities with GP leads are:

   i. T/O
   ii. Gynae
   iii. Urology
   iv. Gastro
   v. Dermatology and Plastics
   vi. Cancer
   vii. Diagnostics – pathology and imaging
   viii. Ophthalmology
   ix. ENT

d. In 2010 the then PCT worked with OUH on ensuring that those procedures that could be carried out as outpatient procedures but were being done as day case were charged to the commissioner at the lower outpatient tariff. These business rules will now be reapplied.

e. It is key to ensuring efficiency that patient pathways are clear and lead to the patient being treated at the right time, in the right place and in the right way. The CCG is using its planned care GP leads to refresh existing patient pathways and develop new ones. Clear patient pathways help go against the default position that referral to a surgeon will result in a surgical procedure in all cases.

f. The introduction of DXS will make it much easier for GP's to access these on practice systems alongside patient decision aids

g. The CCG is also planning to expand its use of the wider healthcare market in the next five years. Given pressures on the main acute provider in terms of capacity and demand, making better use of the private provider facilities in the county makes sound sense. There is recognition that prices may not be lower in the independent sector but that there is more will to discuss and agree total price patient pathways across specialties. This would make it easier to project spend across the financial year .Specific elective pressure points sit within the following specialities:

i. Trauma and orthopaedics
ii. Ophthalmology
iii. ENT
iv. Gynaecology
v. Dermatology
vi. Plastics
vii. Gastroenterology

h. Two of the independent sector providers that the CCG contracts with have expressed an interest in expanding the services they offer via Choose and Book. Recent guidance from Monitor allows CCG's to effectively accept qualification to provide services through contracts held by other CCG's (but only if local site is qualified through CQC for that speciality)

i. The CCG is aware of both the opportunities that the expansion of the independent sector brings but also the challenges. Cost pressures created in podiatry and audiology provision under Any Qualified Provider have been challenging.

10.3 **5yr year ambition**

5 year endpoint	**2 year implementation plan**
Reduction in follow up model applied to all seven high volume specialities to reduce follow up	2014/15 Reduction in follow ups in T/O
	2015/16 Reduction in follow ups in ophthalmology
Move from 0.06% elective spend within private providers to 5% in 2019	2014/15 Expansion of services offered by private providers
All specialities have access to consultant led e mail advice services by 2019	2014/15 Expansion of email services to expanded range of specialties

10.4 **1 & 2yr plan to support the long-term ambition**

a. In 13/14 projected £112 million full year spend projected 13/14 across elective points of delivery.

b. Plan from 2014 to 2016 to reduce by £3 million (2.75% reduction)

c. Plan from 2016 to 2019 to reduce by £2 million

d. Total reduction 2014 – 2019 from 112 to 106 million

Chapter 11:Specialised services concentrated in centres of excellence

The CCG is working closely with NHS England to ensure appropriate alignment of assumptions and improvement interventions within specialist services. The significant level of tertiary services present within Oxfordshire presents a real opportunity and risk for the system as a whole.

Chapter 12: Access

12.1 Convenient access for everyone

a. Oxfordshire CCG is committed to improving access for patients to the right service, first time 24 hours a day 7 days a week. More services will be accessed outside of acute hospitals in a closer to home community setting.

b. Patients will have improved access to a full range of providers in an emergency, urgent or planned care episode. They will have greater support in making these decisions should they need it through an improved 111 service and access to locality based information on finding the right service first time through a variety of sources including posters, local media and social media type solutions.

c. Patients may initially access health care through primary care (in and out of hours), ambulance and A&E for the first step in their patient journey. However all too often the next steps have been too complex and difficult for patients to navigate.

d. In the community settings the Single point of access to community care will expedite the next steps to ensure rapid 0 to 2 hour response times.

e. Mental health services and community services will have extended opening times and will be available 7 days a week.

f. Patient's from minority groups will have better information and will be actively supported to access services, such as screening programmes. Patients with mental health needs often find it difficult to access services and as such their physical and mental health may suffer, we will work closely with voluntary sector organisations and providers to change this.

12.2 Primary Care

a. ***5 year Ambition:*** As part of our ambition to develop more innovative and integrated primary and community services, we will develop primary care across the county so that it has the capacity to deliver improved access to patients. This will include:

i. Increased access to appointments with GPs and practice staff through extended opening hours
ii. Increased use of on-line booking of appointments
iii. More flexible access to treatment and advice through increased use of email, Skype and phone consultations
iv. Increased support to people experiencing poverty and socio-economic disadvantage and recent immigrants who may need particular help in accessing health services effectively

b. 1 & 2yr plan for primary care to support the long-term ambition

i. Supporting practices to work together at scale to provide increased access to care, using seed-corn funding to promote federated working.
ii. Sharing the learning from practices that secure Challenge Funding to test new models of providing access to primary care.
iii. Using Local Investment Schemes to enable practices to review and if appropriate restructure how they use their clinical resources so that GPs are able to offer a wider range of appointments
iv. Working with voluntary services and local authority partners to provide information and advice to those in greatest need of support to access health services appropriately

v. Supporting the development of PPGs , so that they have the capacity and capability to help practice improve access

12.3 Community Care

a. *5 year Ambition*

i. We will be completing the multidisciplinary transformation programme to support admission avoidance pathways with a specific focus on people with multimorbid long term conditions who are of older age.
ii. For the more rural areas this will be through GPs and other healthcare services (e.g. Outpatients, Out Of Hours) referring to specific units (Abingdon and Witney).
iii. For people living in or close to Banbury and Oxford we will be working with the current providers of emergency services to make optimal use of the ambulatory care pathway. This will ensure adaptation of the current services in line with the needs of people with multimorbid long term conditions who are of older age and ensure the avoidance of unnecessary admissions

b. 1 & 2yr plan to support the long-term ambition

i. We will commission community services that are accessible on a seven day a week basis with a two hour response time for the people in need of urgent care.
ii. There will be a single point of access for the whole county and in addition there will be an access point in each locality.
iii. The Single point of contact will provide a responsive service though a multidisciplinary service, (specifically this means all health and social care) which will completes a whole person assessment, inclusive of mental and physical health needs.
iv. There will be timely access to an appropriate care package co-ordinated and monitored by a named lead clinician as required.

12.4 Mental Health

a. 5yr year ambition: People will have 7 day a week, 24 hour responsive mental health services that are viewed as an integral part of the whole health care system. Patients with mental health needs will have greater support to ensure they have full access to all of the mainstream services such as NHS health checks and screening programmes.

b. 1 & 2yr plan to support the long-term ambition

i. There will be improved information and advice about mental health through a
ii. Mental Health Information Service that is available on-line 24/7 (http://www.oxmindguide.org.uk/) and during office hours by telephone.
iii. Psychological Therapies - Oxfordshire's IAPT service is accessible by GP and self-referral. Appointments are offered within 28 days of referral. Services are available during office hours which are extended to 8.30-7.30 Tues/Weds/Thurs.
iv. Community Mental Health Services- Services are accessible by self, third party and GP referral. From April 2014 services will be accessible from 0700-2100 7 days a week. Services are accessible by phone and at a network of local hubs.
v. OCCG commissions a Well Being service from Oxfordshire Mind that offers advice, information and practical support from a wide range of locations across the county which act as an additional front door located in local communities for people with mental health problems.

vi. Acute Mental Health Services GPs needing a psychiatric opinion will be contacted within 15 minutes of their call. Oxfordshire is piloting a joint DH/Home Office pilot to embed mental health nursing staff alongside police to support responsiveness to people in crisis. People in crisis will be assessed by the assessment teams between 0700 and 2100 and by the emergency duty team outside of these hours. Patients will be able to access crisis day services as an alternative to admission.

vii. Psychiatric liaison will be provided from 0800 to 0800 in the Emergency Department of our local general hospitals, with extended hours on Sundays and Mondays to reflect the patient flow through the ED department.

12.5 Access for minority and vulnerable groups

a. 5yr year ambition

Our ambition is to:

i. Reduce health inequalities, to ensure that the most vulnerable in society get better access to health improvement initiatives and care, better quality of services, and improvement in their health outcomes.

ii. Ensure all of our commissioned services will continue to be performance managed in line with the Equality Act 2010 to ensure that barriers to access are overcome eg alternative communication, physical and attitudinal barriers.

iii. Develop outcomes based commissioning for people with mental health problems that will deliver personalised care planning that delivers outcomes through a focus on the individual's practical, emotional and cultural needs.

iv. Continue to provide dedicated community mental health services based in homelessness hostels and to work with our providers to identify and support military veterans with mental health problems in the community.

v. Continue to deliver specific programmes around the needs of children and young people transitioning into adult services, carers, people with co-morbid drug and alcohol and mental health problems and groups such as the local Chinese and Polish communities.

vi. Ensure that our Equality and Access Teams support targeted health improvement initiatives with minority communities and vulnerable group – for example by leading on health partnerships in five Regeneration Partnerships in Oxford City; targeted campaigns with minority communities eg dementia awareness, Choose Well, Public health campaigns, implementation of the Oxfordshire Carers Strategy and delivering targeted approaches to improve uptake of screening and immunisations and life-style services.

12.6 Access to Urgent Care

a. 5yr year ambition: Oxfordshire CCG will continue to work with its partners across health and social care to provide the right care, first time and support the effective management of patients seeking urgent care services

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b. 1 & 2yr plan to support the long-term ambition:

i. Following the successful introduction of 111 locally in September 2012 and a national review of the 111 service by NHS England due in 2014, OCCG will tender for a revised 111 service during 2014-15 to begin during 2015-16. 111 supports patients to access the most appropriate care based on their need and location

ii. OCCG will make greater use of the data 111 provides about service access to inform future commissioning decisions, ensuring that urgent care services are available at times and in places that are convenient to patients

iii. OCCG will continue to work with South Central Ambulance Service (SCAS), the provider of 111 across Oxfordshire, Buckinghamshire, Berkshire, Hampshire,

Southampton and Portsmouth and the relevant CCGs to manage the service in a cohesive and streamlined way.

iv. Ambulance demand continues to increase year on year; the volume of total Ambulance Service activity is up 8.3% year to date compared with the same period last year (April to November).

v. OCCG will continue to incentivise SCAS to increase the number of patients managed without an ambulance arriving on scene- 'hear and treat' or managed within the community- 'see and treat' while reducing inappropriate conveyances to hospital.

vi. OCCG will support SCAS to implement NHS Pathways as the triage tool within the 999 service, which will enable ambulance staff to use their resources more effectively to meet the needs of patients by determining the type of response required prior to arrival on scene.

vii. OCCG will work with its commissioning partners across South Central to ensure SCAS are managed in a co-ordinated manner. Focus continues on ensuring patients arriving at hospital are transferred to the care of hospital staff in a timely manner, providing optimal patient care and ensuring that ambulances are able to respond to the next call as quickly as possible.

viii. OCCG will continue to offer patients alternatives to A&E for their urgent care needs. The national review of A&E services by Professor Bruce Keogh will inform the provision of Minor Injury and First Aid Units across the county, to ensure that patients are able to access services that will care for them rapidly and in convenient locations.

ix. OCCG will review the need for a Minor Injury Unit within the city of Oxford, where patients currently have to travel outside of the ring road if they wish to access such services. This work will be supported by the continuation of the Choose Well campaign, which empowers patents to identify which service would best meet their needs, such as accessing a pharmacy for medication advice.

x. The CCG will work with Oxford University Hospitals (OUH) to scope and further develop ambulatory care pathways, which enable patients to be treated with access to necessary diagnostic tests without being required to be admitted to a bed. Ambulatory care not only improves the patient experience, as they are supported to return home as quickly as possible, but also supports hospitals in managing demand for beds. This work will integrate with the further development of Emergency Multidisciplinary Units (EMUs). These measures will support OUH to achieve the four-hour standard and ensure that patients are assessed in a timely manner when seeking urgent care.

12.7 Planned Care Access

a. The CCG will work closely with localities to ensure that elective activity services are accessible to all sections of the Oxfordshire population. It will ensure that services meet the required equality legislative standards and be appropriate for the diverse population the CCG serves.

b. Whilst recognising that not every market town can have access to every elective procedure the CCG supports the use of peripheral clinic sites where appropriate.

c. When procuring new elective services or agreeing to clinic or service site moves access is a key criteria for the CCG and this includes access for those reliant on public transport.

d. The main provider Trust operates an access policy for its elective services setting out its commitment to meet NHS Constitution requirements. Where this fails, the CCG will invoke the measures outlined in the NHS Constitution Standards section including the use of contract levers and fines.

e. The CCG is aware of the barriers to services that can be in place for disadvantaged and minority groups and makes active use of advocacy services.

Chapter 13: Meeting the NHS Constitution standards

13.1 Baseline position

Measure	Definition	Standard	Lower Threshold	Reporting period	Month Actual	13/14 YTD Actual	Indicator RAG
RTT waiting time for non-urgent consultant-led treatment	RTT - admitted % within 18 weeks	90%	85%	Dec-13	88.86%	91.35%	
	RTT - non-admitted % within 18 weeks	95%	90%	Dec-13	96.30%	96.99%	
	RTT - incomplete % within 18 weeks	92%	87%	Dec-13	90.77%		
	Number of patients waiting more than 52 weeks	0	10	Dec-13	1		
	RTT - admitted pathways greater than 52 weeks.	0		Dec-13	2		
	RTT - non-admitted pathways greater than 52 weeks.	0		Dec-13	0		
	RTT - incomplete pathways greater than 52 weeks.	0		Dec-13	1		
Diagnostic Waits	% waiting 6 weeks or less	99%	94%	Dec-13	98.17%		
A&E - OUHT	% of patients who spent 4 hours or less in A&E - OUHT	95%	90%	Jan-14	87.13%	93.41%	
	Patients who have waited over 12 hours in A&E from decision to admit to admission	0		Dec-13	0	0	
A&E - RBFT	% of patients who spent 4 hours or less in A&E - RBFT	95%	90%	Jan-14	88.13%	93.51%	
Cancer 2 week waits	Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer	93%	88%	Dec-13	94.90%	94.86%	
	Percentage of patients seen within two weeks of an urgent referral for breast symptoms where cancer is not initially suspected	93%	88%	Dec-13	98.48%	94.85%	
Cancer 31 day waits	Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis	96%	91%	Dec-13	97.44%	97.74%	
	Percentage of patients receiving subsequent treatment for cancer within 31-days where that treatment is Surgery	94%	89%	Dec-13	90.00%	97.18%	
	Percentage of patients receiving subsequent treatment for cancer within 31-days where that treatment is an Anti-Cancer Drug Regime	98%	93%	Dec-13	100.00%	99.46%	
	Percentage of patients receiving subsequent treatment for cancer within 31-days where that treatment is a Radiotherapy Treatment Course	94%	89%	Dec-13	80.72%	91.30%	
Cancer 62 day waits	Percentage of patients receiving first definitive treatment for cancer within 62-days of an urgent GP referral for suspected cancer	85%	80%	Dec-13	80.29%	83.21%	
	Percentage of patients receiving first definitive treatment for cancer within 62-days of referral from an NHS Cancer Screening Service	90%	80%	Dec-13	96.46%	94.71%	
	Percentage of patients receiving first definitive treatment for cancer within 62-days of a consultant decision to upgrade their priority status.	No Targets		Nov-13		100.00%	No Targets
Category A ambulance calls	Cat A response within 19 mins	95%	90%	Dec-13	94.50%	95.43%	
	Cat A response within 8 mins - Red 1	75%	70%	Dec-13	81.40%	78.89%	
	Cat A response within 8 mins - Red 2	75%	70%	Dec-13	71.94%	74.77%	
MSA Breaches	Mixed Sex Accommodation	0	10	Dec-13	0	5	
Cancelled operations	All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another bining date within 28 days, or the patients' treatments to be funded at the time and hospital of the patient choice	0	0	Sep-13	2.63%	10.90%	
	Urgent Operations cancelled for a second time	0	0	Dec-13	0	0	
Mental Health	Care Programme Approach (CPA) The proportion of people under Adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period	95%	90%	Sep-13	97.70%	96.74%	
Local Priorities	Increase flu immunisations for at risk under 65's (excl. pregnant women and carers)	55%		Dec-13	51.93%	51.93%	
	Increase the % of radiology requests made via the ICE system as a proportion of the total number of requests made by GPs to the OUH radiology service	80%		Jan-14	85.75%	68.41%	
	Reduction of average length of delay for those OUHT patients classed as DTOC: baseline 15 days	13.5		Apr-13 to Dec-13	N/A	16.6	
Ambulance Handover Time (JRH)	Percentage of Ambulance handovers within 15 mins	85%		Jan-14	73.11%	65.85%	
Ambulance Handover Time (HGH)	Percentage of Ambulance handovers within 15 mins	85%		Jan-14	92.40%	81.81%	

The table above summarises the baseline position in terms of performance against constitution standards in Oxfordshire at the end of January 2014. Our ambition is to be meeting all standards by the end of year 2, and to be sustainably compliant by the completion of this plan.

13.2 RTT

a. The main provider Trust is struggling to meet RTT consistently across the following specialities:
b. ENT, Ophthalmology, Neurology, Plastics, Gynae
c. The predicted clearance time is running at 12 weeks across the Trust with over 10.000 patients on the outpatient waiting list.
d. The CCG intends to take action to offer to move patients from the main Trust if there is no assurance that patients will be treated within the standards set out in the constitution.

13.3 DIAGNOSTIC TEST WAITING TIMES

a. The CCG monitors the 6 week diagnostic target as part of the 18 week referral to treatment pathway.
b. The CCG has worked closely with providers in 13/14 to ensure accurate timely information is available to ensure this target is monitored and consistently met. In 14/15 the CCG will meet regularly with the OUH diagnostic teams to ensure early action is taken to remedy poor performance.
c. In 2014/15 the CCG will jointly implement an improvement intervention plan with the OUH to improve diagnostic imaging capacity in localities, reduce unnecessary imagining and improve turnaround times. The CCG will work with the laboratories and GPs to ensure clinicians request the most appropriate investigations for patients and it is hoped that this will reduce demand in other clinical areas.
d. Diagnostic tests are continually changing and improving and over the next 5 years the CCG will continue to work with its providers to ensure patients receive appropriate investigations in a timely manner.

13.4 A&E 4 hour WAITS

a. OCCG works closely with partners across health and social care to manage patients appropriately in the community and avoid unnecessary attendances at A&E. The focus for the system is to create flow and capacity within A&E for those patients whose acuity requires care in an acute setting by providing community based alternatives to patients with lower needs in locations closer to home. Such services lead to reduced 4 hour waits for patients by reducing the volume of patients attending A&E.

b. The Urgent Care Working Group leads the development of services to ensure that patients access the right care, first time. The Working Group comprises senior representation from organisations across health and social care in Oxfordshire, who ensure the delivery of the system wide improvement plan. This covers programmes across all stages of patient flow including caring for patients closer to home, admission avoidance and facilitation of discharge. The Urgent Care Working Group co-ordinates actions to increase flow and capacity and prioritises development according to the greatest benefit such work will bring to the system.

c. Organisations across the health and social care system actively work to maintain patients in the community, providing services to support independence, such as the Single Point of Access, which provides health and social care through one referral point. Patients with chronic conditions, or those experiencing an acute episode of illness, can be assessed, managed and maintained in their home or a community setting without requiring admission to an acute bed, through the provision of social care equipment, domiciliary or nursing care. During 2013/14, Emergency Multidisciplinary Units (EMUs), and pathways which provide rapid care for the frail elderly by specialist medical staff such as gerontologists, were expanded to four locations across the county, further supporting the management of patients in the community.

d. The availability of Minor Injury and First Aid Units across the county support patients to access care without attending ED. The further development of such services will be reviewed as part of OCCG's response to the Urgent and Emergency Care Review Phase One Report. The flow of patients to alternatives to A&E is further supported by the development of 111, which was successfully implemented in Oxfordshire in September 2012. 111, supported by a comprehensive Directory of Services, enables patients to be directed to the most appropriate, local service to meet their needs. OCCG will make greater use of the data 111 provides about service access to inform future commissioning decisions, ensuring that urgent care services are available at times and in places that are convenient to patients. This work will be supported by the continuation of the Choose Well campaign, which empowers patents to identify which service would best meet their needs, such as accessing a pharmacy for medication advice.

e. OCCG will continue to benchmark performance against similar health and social care systems and learn from best national practice. OUH invited the Emergency Care Intensive Support Team (ECIST) to review its practice and identify where further benefits for patients could be achieved. The learning from such best practice has been included in the system wide improvement plan.

f. Health and social care organisations worked jointly prior to Winter to identify where additional resources could most effectively support flow during periods of increased pressure. A robust programme management approach was taken to assure performance each week. Senior decision makers across the system regularly reviewed the allocation of resources and were empowered to move capacity to where it would have the greatest effect.

13.5 CANCER WAITS

a. There are targets being missed by the main provider trust relating to cancer waits. The CCG will continue to work closely with the Trust to ensure patients are being treated within the standards of the constitution.
b. It will continue to use the levers within the contract to ensure performance is recovered to meet these targets. Plans for 2014 include strengthening of the MDT with all tumour sites covered.
c. The roles of the patient tracker team are being revised and an overseeing audit and validation post is being recruited to ensure the standards they work to.
d. Additional radiotherapy sessions are being run at weekends.

13.6 CAT A AMBULANCE CALLS

a. OCCG commissions emergency ambulance services in partnership with other CCGs across South Central (Milton Keynes, Buckinghamshire, Berkshire, Hampshire, Southampton and Portsmouth from South Central Ambulance Service NHS Foundation Trust (SCAS). OCCG ensures that the rights and pledges within the NHS Constitution are met through robust contract management and quality monitoring with monthly meetings to monitor and address both aspects of performance.

b. Year to date, SCAS have met the key performance indicators for ambulance calls, which require an ambulance vehicle to arrive on scene within 8 minutes in 75% of cases and for an ambulance capable of conveying the patient to hospital to arrive on scene within 19 minutes in 75% of cases. SCAS are contracted to meet these targets across Oxfordshire and Buckinghamshire.

c. OCCG works closely with SCAS to support performance at district council level (e.g. Vale of the White Horse), where due to the low number of emergency calls and the rural nature of the road network, performance can be more challenging. SCAS are increasing the number of Community First Responders, who are equipped with defibrillators, in rural areas to ensure patient safety. In addition, commissioners are incentivising SCAS to increase the number of patients managed appropriately by phone- 'hear and treat', while reducing the number of patients taken to hospital where they might be managed in the

community- ‘see, treat and convey’. This will support the availability of ambulance vehicles to attend patients with life threatening conditions and patient flow through the urgent care system.

d. During the next year, SCAS will implement NHS Pathways, the triage tool used within the 111 telephony service, within 999. This change will allow SCAS to determine the type of response that the patient requires, the most appropriate service to meet their needs and if an ambulance is required, the type of vehicle to attend on scene. This will allow them to make more efficient use of their resources, further supporting achievement of the ambulance call standards.

13.7 MIXED SEX BREACHES

a. OCCG recognises that eliminating mixed sex accommodation has a key role to play in supporting patients privacy and dignity. Providers report breaches to delivering single sex accommodation to the CCG on a monthly basis as part of contractual arrangements. This includes an explanation as to whether these breaches are clinically justified or not.

b. Where non clinically justified breaches occur the CCG will enforce contractual penalties and escalate through the contract performance clauses where required

c. Where clinically justified breaches occur the CCG will work with providers to review demand and capacity. In 2014/15 we will jointly review capacity on Stroke Units to assess if improvements can be made.

d. Our plan over 5 years would be eliminating clinically justifiable breaches as well as sustaining improvements in non-justifiable breaches.

13.8 MENTAL HEALTH

a. We will continue to manage within our contract with Oxford Health NHS Foundation Trust’s Oxfordshire’s performance against the proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period – 95%

13.9 A&E WAITS FOR ADMISSION

a. OCCG continues to support partners across health and social care to manage patient flow and support the safe, effective and timely discharge of patients from bedded care to ensure that those attending A&E requiring admission are cared for within the national standards.

b. Providing holistic care for the frail elderly within Emergency Multidisciplinary Units (EMUs), where patients have rapid access to specialist medics, social workers and community nursing to arrange care within their home, enables patients at risk of admission to be cared for within the community. During 2013-14 OCCG expanded the number of EMUs from one, in Abingdon, to four, at Witney, Oxford and Banbury. These units will be supported to continue treating patients in the community.

c. Where possible, OCCG will encourage OUH to manage appropriate patients along an ambulatory care pathway, where patients have rapid access to diagnostic assessment and care without recourse to admission within the acute setting. Such ambulatory care pathways allow patients to be triaged, treated and returned home without staying overnight.

13.10 CANCELLED OPERATIONS

a. There has been an issue with the Trust providing validated data on cancelled operations. Ensuring that the CCG is commissioning using accurate data and intelligence is key.

b. If the main trust cannot provide assurance that it can treat patients within the standards set within the constitution for listing and then treating patients then the CCG will look to move cohorts of patients to alternative providers.

13.11 AMBULANCE HANDOVERS

a. OCCG continues to support SCAS and OUH to achieve ambulance handover targets. During 2013/14 this included:
   i. The introduction of dual verification to improve the accuracy of recording when ambulances arrive and transfer a patient to the care of hospital staff
   ii. The provision of Hospital Ambulance Liaison Officers (HALO) over Winter to support ED staff receiving ambulance patients and efficient transfer of care
   iii. The reconfiguration of receiving bays within the Emergency Department, to increase the capacity and responsiveness of ED staff to take incoming patients.
   iv. The provision of additional nursing and medical staff during Winter and other periods of high demand to increase capacity.

b. The delivery of Ambulance services is part of the wider plan to increase patient flow through the urgent care system. The strategies to decrease inappropriate attendance at ED, through the use of community alternatives such as Minor Injury Units or Ambulatory Care Pathways, will reduce overall demand for ED services. Indirectly, such strategies support the achievement of ambulance handover, by increasing the capacity of ED staff to receive incoming ambulances. Specific focus on the handover process will continue over the next two years, such as a review of the benefit of HALO staff.

13.12 5yr year ambition

a. The ambition is to ensure we are sustainably compliant with all constitution standards by year 5.

13.13 1 & 2yr plan to support the long-term ambition

a. Deliver the planned and urgent care improvement interventions described in this strategic plan, in order to ensure full compliance within 2 years.

Chapter 14 : Quality

14.1 Quality of Healthcare

a. The centrality of quality to NHS commissioners has been eloquently and amply set out, most recently in the reviews of Berwick, Keogh and Francis. Put simply the quality of NHS commissioned services should influence everything we do.

b. All Oxfordshire Health and Social care organisations recognise that any organisation will have quality and safety issues. We accept this and will focus on learning from incidents in order to improve quality continuously. We acknowledge that systems and process, not individuals, are predominantly the cause of safety incidents and quality concerns.

c. Cultures in which staff are supported, empowered and trusted are crucial for the delivery of high quality care. Increasing resource constraints and demographic pressures may have an impact on the quality of services

d. OCCG aims to:
   i. develop a focus on quality that transcends organisational boundaries and covers all aspects of care, from birth to death;
   ii. ensure quality is integral to all healthcare services across Oxfordshire
   iii. ensure quality is everybody's business: public, patients, NHS staff, family and carers;
   iv. support all stakeholders to raise concerns and/or lead improvement;
   v. use measurement for quality where possible while acknowledging that not everything which is important can be measured;
   vi. strive for continuous quality improvement.

e. These aims have been agreed by the governing body and are detailed in our Quality Statement approved in November 2013.

f. The CCG operate a "Clinical Assurance Framework, approved January 2104. This framework sets out the mechanisms used by Oxfordshire CCG to ensure patients using NHS services in Oxfordshire receive safe, good quality care with a positive patient experience, and the actions the CCG will take where quality and performance does not meet acceptable standards. It supports the CCG vision "By working together we will have a healthier population, with fewer inequalities, and health services that are high quality, cost effective and sustainable."

g. We will continue to develop this framework and where possible in 14/15 publish all quality and performance reports and related documents on the CCG web site.

14.2 Patient safety

a. The CCG review a wide range of information relating to patient safety and it would be impractical to detail all initiatives, but key areas of improvement for 2014/15 are detailed below:
   i. Zero tolerance to avoidable MRSA bacteraemias, by undertaking RCAs on all cases and taking corrective action when it is identified;
   ii. Reduce the number of C. diff cases below the NHS England trajectory by implementing the action from the CCG Risk Summit in November 2013;
   iii. Reduce the number of medication errors by working with key providers;
   iv. Reduce the number of avoidable pressure ulcers utilising the patient safety thermometer and implementing actions from serious incidents;
   v. Improve the quality of care for inpatient diabetic patients by improving staffing levels and roll out of "Think Glucose"
   vi. Improve the safety and effectiveness of diagnostic imaging services by improving staffing and roll out of an independent quality management system.

14.3 Clinical Effectiveness

a. The CCG review a wide range of clinical audits and NICE guidance and it would be impractical to detail all initiatives; key areas are of improvement for 2014/15 is detailed below:

   i. Continue to reduce mortality rates in the acute sector by enhancing mortality review meeting process;
   ii. Improve nutrition for patients in hospitals by working with providers;
   iii. Ensure patients with complex mental health needs receive appropriate care by redesigning mental health services in Oxfordshire;
   iv. Improving care for inpatients suffering from pneumonia by redesigning the patient pathway.

14.4 Patient experience

a. The CCG review a wide range of information relating to patient experience and it would be impractical to detail all initiatives; key areas are of improvement for 2014/15 is detailed below:
   i. Continuously review and improve the ways in which we seek, collect and respond to patient experience information.
   ii. Ensure clear link between knowledge about patient experience and action, both macro and micro, taking to address areas for improvement
   iii. Use patient experience data as a lever to drive up quality
   iv. Improve quality of care for patients using the district nursing services;
   v. Improve access to elective care at the OUH and increase access to directly bookable services by reprofilling outpatient capacity to match demand.
   vi. Enhancing the discharge process for patients

14.5 Compassion in practice

a. OCCG is working with all provider organisations to ensure compassionate care is central to the work of clinicians. Compassion, care,communication and competence are frequently mentioned in patient feedback and complaints. Addressing these areas with clinical staff will have an impact on complaints and ensure an improved patient experience which should ultimately be reflected in an improvement in Friends and family score.

b. There are active discussions with senior leaders in nursing to develop a culture of partnership with patients and carers where the patient /carers needs are central to care. All Trusts have nursing strategies which includes the 6 c action areas (Care, Compassion, Competence, Communications, Courage, Commitment) OCCG will work with the Trusts to turn aspirations into action and to include all staff groups in the agenda. This will be enabled by the DoN & MD NHS England supporting this approach.

c. 5 Year ambition for this work is to have this embedded across all staff groups achieving an outcome of where communication, care, communication and competence are sighted less frequently in patient feedback and complaints.

14.6 Staff satisfaction

a. OCCG recognises the importance of staff satisfaction to the delivery of high quality services. There is good evidence that happy, well-motivated staff deliver better care and that their patients have better outcomes. Trust Boards recognise that staff satisfaction is key to delivering high quality care. CCG reviews staff surveys and benchmarks across similar providers. OCCG encourages trusts to learn from other Trusts and other organisations to adopt innovative initiatives to improve staff satisfaction. A Friends and family question will be asked of staff in 2014 asking them if they would recommend their organisation.

b. OCCG uses the results of staff surveys alongside patient surveys in conjunction with other quality metrics to evaluate the quality of services being provided.

14.7 Seven day services

a. We are committed to delivering 7 day access to health and social care services, and have already implemented 7-day working across a number of elements of the health and social care system. This includes social work teams in hospitals, covering wards and all front doors (Accident and Emergency, community and acute hospitals, and Emergency Medical Units). We have also incentivised social care providers to pick up clients within 72 hours, including Fridays and over the weekend. The Emergency Duty Teams also ensure there is support available 24 hours a day, 7 days a week.

b. This will be developed further with OCC through our Better Care Fund plan and is being progressed by the CCG through contract development and negotiation with providers.

14.8 Safeguarding

c. The mandate from the government is that we are expected to support and safeguard the vulnerable through a more joined up approach to addressing their needs, working across organisations and in partnership with others involved in the provision of health and social care. To achieve this we are required to prevent and reduce the risk of abuse or neglect through continuing to improve safeguarding practice.

d. It is the aim of OCCG that we will ensure consistent, safe, effective and respectful care is provided to every patient. All staff will be able to accurately assess patients to identify those at risk of harm. Primary care services, alongside other commissioned providers, will be supported by the CCG to make improvements in local quality health care. Where a child or adult is identified as at risk or vulnerable then safe care of the highest possible standard will be provided. This will be achieved through strong local leadership, investment in effective co-ordination as a committed partner in care provision, and robust quality assurance of safeguarding arrangements

e. <u>1 & 2yr plan to support the long-term ambition (by organisation and to be finalised by 4th April)</u>

i. Identify and agree what is required to ensure a safe system that safeguards children and adults at risk of abuse or neglect across the NHS community locally.
ii. Ensure active involvement in the functioning and development of the OSCB, OSAB of all health commissioners and providers.
iii. Ensure that representation and involvement in the work of the Health and Well-Being Board is integrated into safeguarding.
iv. Develop and agree clear and robust arrangements between CCG, Thames Valley Area team and OCC Health Promotion Commissioning teams to ensure that the health commissioning system as a whole is working effectively to safeguard and improve outcomes for children and adults at risk and their families, thus promoting their welfare.
v. Review and develop assurance frameworks that demonstrate all providers have effective safeguarding arrangements.
vi. Review and develop assurance frameworks that demonstrate all providers are using the Mental Capacity Act appropriately and whenever it is required.
vii. To ensure all providers are complaint with the Prevent Agenda.
viii. Work with partners and colleagues to develop a learning and development framework that enables lessons to be learnt and shared across the locality

14.9 Innovation

a. The CCG has a duty under Section 14Y NHS Act 2006 to promote research and the use of evidence obtained from research. To this end, the Quality and Performance Committee (a subcommittee of the Governing Body) has a specific role to promote a culture of continuous improvement and innovation with respect to safety of services, clinical effectiveness and patient experience.

b. The NHS Chief executive report, 'Innovation Health and Wealth', published in December 2011, committed the NHS to spread at pace and scale the number of existing technologies and innovations, with the potential to transform both quality and value across the NHS. This is reflected in the CCG creativity value (visionary, resourceful, excellent) which informs how the CCG works and makes decisions. Our plans have been based on these principles.

c. Oxfordshire CCG is a founding partner of the Oxford Academic Health Science Network. The Medicines Optimisation network project initiation documents has been developed by the Thames Valley Lead Pharmacists and links to local plans around medicines waste reduction and reducing unwanted variation in medicines.

d. **Translation of research into practice:** A priority area has been a county wide evidence-implementation project to enhance the number of patients with atrial fibrillation who are anti-coagulated in order to prevent stroke (which is a highly effective intervention to prevent an expensive and disabling condition). The average number of high risk Oxfordshire patients who are now anticoagulated has risen from 55% in March 2011 to 64% in March 2013. This improvement might be expected to prevent around 20 strokes annually in Oxfordshire. As a result of our success, we are part of a national working group led by Sir Muir Gray to inform and improve stroke prevention across the UK.

e. As well as collaborating in undertaking applied health research, the CCG is committed to rapid implementation of best practice - for instance in rolling out and evaluating the local implementation of patient self-management of their blood pressure, shown to be more effective than usual care. We have started using text messaging to facilitate patient engagement. This is being piloted in the city locality then planned to roll out countywide.

f. **Collaborations for Leadership in Applied Health Research (CLAHRC):** The Oxford CLAHRC comprises a new collaboration of leading applied health researchers, alongside the users of research, including commissioners, clinicians, patients and the public.

g. This collaboration spans several boundaries between primary and secondary care, between commissioners and providers, and across the translational continuum by linking with the Oxford Academic Health Consortium, the Oxford AHSN and the Oxford NIHR Biomedical Research Centre.

h. With science excellence and strong collaborative leadership, the Oxford CLAHRC will address areas of high importance and relevance for patients as well as key NHS priorities: delivering the most effective and best value services and focussing on those with greatest need - the frail elderly presenting to acute medical services, people with dementia in care homes, and those with chronic enduring illnesses and comorbidities, the highest users of NHS services.

i. We will research new ways of providing services, the potential for patient self-management, and more integrated care across organisational boundaries. We will provide robust evidence of the effectiveness and efficiency of these services and facilitate rapid implementation of evidence based changes for the benefit of patients.

Importantly, we also plan the Oxford CLAHRC as enhancing UK applied research training capacity and ensuring local priorities factor into the research agenda and implementation of evidence in the service agenda.

j. Oxfordshire CCG will use the Thames Valley Priorities Committee to assess the evidence and make local commissioning recommendations for innovative treatments and technologies not covered by NICE. OCCG has a lead for NICE guidance responsible for making commissioning recommendations based on NICE guidance. OCCG will continue to implement the NICE Compliance Regime in IH&W. OCCG will make full use of other NICE guidance in accordance with the NICE Policy including identified disinvestment opportunities. New interventions and technologies recommended with NICE will be assessed for local implementation as they are published. OCCG will be proactive in the use of the IH&W CoLab Portal.

k. 5yr year ambition (*Unit of Planning*): Oxfordshire CCG's aspiration, in line with that of NHS England. is for a local health economy to be defined by its commitment to innovation, demonstrated both in its support for research and its success in the rapid adoption and diffusion of the finest, transformative, ,most inventive idea, products, services and clinical practices.

l. 1 & 2yr plan to support the long-term ambition (*by organisation and to be finalised by 4th April*)
   i. Use the Area Prescribing Committee (APCO) to embed automatic incorporation of NICE TAG recommendations into local formularies.
   ii. Regularly monitor compliance with Technology Appraisals including national benchmarking information when this is available, for example the Innovation Scorecard.
   iii. Use available metrics to monitor procedures defined by Dr Foster as Ineffective Procedures (Groups 1, 2 and 3).
   iv. Implement an organisational assessment of local relevance of innovative technologies including those recommended by NICE
   v. Innovation CQUINs from the 13/14 contract will be integrated into service delivery plans for each contract including initiatives relating to "digital by default" and telehealth

Chapter 15: Delivering Value and sustainability

15.1 This is the first submission of the plan to NHSE following early draft submission to the Area Team on 24th January.

15.2 The key drivers of the CCG's financial plan for 14/15 are as follows:

a) 13/14 Underlying Recurrent Position

i. In managing its 13/14 position and as mitigation against the cost pressures on acute contracts and continuing healthcare spend the CCG has utilised a number of non-recurrent benefits and underspends. Adjusting for these means that the CCG under-lying, recurrent baseline for 14/15 is a deficit position of £18.5m.

b) Changes to the CCG's allocations.

i. The CCG has received a significant increase is its programme allocation for 14/15. This reflects the transition to the new national funding arrangements for CCG's and the CCG's distance from its target allocation. For 14/15 this results in an additional £4.5m of growth funding above the expected level.

ii. Based on the increasing population in Oxfordshire the CCG expected to receive an increase in its running costs allocation. Due to the national methodology adopted this has not been the case and the running cost allocation is below the 2013-14 allocation (£0.1m)

c) 13/14 Deficit Recovery

i. Any deficit the CCG makes in 13/14 will be repayable in 14/15 as a non-recurrent adjustment to our allocation. The current forecast outturn deficit is £6.1m.

d) Delivery of CCG operational planning assumptions

i. Financial planning good practice would dictate that the CCG should set its plans with sufficient headroom to be able to manage and mitigate in-year risks as and when they crystallise. This good practice is contained within the operational planning guidance issued to CCG's by NHS England. The key elements of this and impact on the financial plan are:

- 1.0% planned surplus, £6.2m.
- 1.5% non-recurrent headroom, £9.3m.
- 0.5% contingency reserve, £3.1m.
- 1.0% 'Call to Action' Fund, £6.2m.

ii. It has not been possible to comply with good practice guidance in full in either 2014-15 or 2015-16 The plan for 2014-15 is a deficit plan of £7.6m with a contingency held of 1%. The plan for 2015-16 is for breakeven with a contingency held of 0.5% and 1% NR headroom. By 2016-17 the CCG is able to comply in full with the requirements and deliver a 1% surplus.

iii. A bridge from the £6.1m forecast outturn deficit for 2013-14 to the underlying deficit of £18.5m and then to the £7.6m forecast deficit for 2014-15 is shown below:

Source / Application of Funds

14/15 Sources of Funds	%	£'m
13/14 Month 8 Allocation		629.8
Less Non Recurrent - Winter pressures allocation		-10.2
Less Non Recurrent - PCT surplus b fwd		-5.6
14/15 Recurrent allocation baseline	96.7%	614.0
Programme costs growth	3.1%	19.8
Running costs growth (population)	0.0%	-0.1
Debt Repayment	-1.0%	-6.2
	98.8%	627.6

14/15 Application of Funds	%	£'m			
13/14 Month 8 FOT		635.9		Deficit	-6.1
Remove winter pressures NR		-10.2			
Remove QIPP investment NR		-1.0			
Run rate adjustments 1		4.7			
Non recurrent adjustments 2		3.1			
14/15 Baseline before CQUIN out	99.6%	632.6		Deficit	-18.5
Inflation	2.3%	14.6			
Efficiency	-3.2%	-20.2			
Demographic Growth	0.8%	5.4			
Identified QIPP (Investment)	0.3%	2.0			
Identified QIPP (Gross Saving)	-2.2%	-14.0			
Manual Adjust - running costs/prescribing	1.4%	9.0			
Contingency	1.0%	6.2			
Other Reserves	0.0%	0.0			
CQUIN in	1.8%	11.5			
CQUIN out	-1.9%	-11.8			
	100.0%	635.2		Deficit	-7.6

e) 14/15 Demand and Activity Growth

i. The current estimated impact of demand related activity growth in Oxfordshire is 0.9%, £7.8m. If this is unmitigated and not funded in contracts with providers then it would materialise as in-year activity over-performance.

f) Ability of the CCG to drive cost savings or limit financial risk in contracts.

i. The development of the 2014-15 schemes has been overseen by the Financial Recovery Board with input from Deloitte. Schemes totalling £7.7m have business cases and have been subject to detailed external challenge. Further additional/stretch schemes have been identified - these have a potential value of £12 - £29m. The financial plan for 2014-15 currently assumes these additional schemes deliver only £6.3m. The CCG continues to work with its partners in the CSU and Deloitte to identify opportunities for savings and to work these through to delivery.

ii. The CCG will seek to limit or transfer financial risk to providers through procurement contracting, and use of business rules.

Taking all these into account at this stage of the financial plan the current position of the CCG is shown in the table below:

Financial Position

Revenue Resource Limit

£ 000	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Recurrent	614,023	633,762	660,693	662,130	673,386	684,833
Non-Recurrent	15,781	(6,161)	(7,575)	(0)	7,244	8,749
Total	629,804	627,601	653,118	662,130	680,630	693,582

Income and Expenditure

Acute	345,001	348,648	339,685	336,299	333,149	328,850
Mental Health	63,588	62,111	59,954	59,250	58,178	56,912
Community	63,836	62,678	59,480	58,059	61,048	64,349
Continuing Care	33,722	35,506	64,759	68,515	77,009	84,705
Primary Care	88,121	89,268	96,879	100,076	106,179	112,607
Other Programme	26,238	14,637	14,577	14,606	14,489	14,358
Total Programme Costs	**620,506**	**612,848**	**635,333**	**636,804**	**650,052**	**661,782**
Running Costs	15,393	16,159	14,510	14,539	14,557	14,623
Contingency	-	6,169	3,276	3,311	6,806	6,936
Total Costs	**635,899**	**635,176**	**653,118**	**654,653**	**671,416**	**683,342**

£ 000	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Surplus/(Deficit) In-Year Movement	(11,669)	(1,480)	7,575	7,244	1,505	838
Surplus/(Deficit) Cumulative	(6,095)	(7,575)	(0)	7,244	8,749	9,586
Surplus/(Deficit) %	-0.97%	-1.21%	-0.00%	1.09%	1.29%	1.38%
Surplus (RAG)	RED	RED	RED	GREEN	GREEN	GREEN
Net Risk/Headroom		(3,001)	(4,691)	(4,458)	1,782	2,359
Risk Adjusted Surplus/(Deficit) Cumulative		(10,576)	(4,691)	2,786	10,531	11,946
Risk Adjusted Surplus/(Deficit) %		-1.69%	-0.72%	0.42%	1.55%	1.72%
Risk Adjusted Surplus/(Deficit) (RAG)		RED	RED	AMBER	GREEN	GREEN

Chapter 16 – IM&T

16.1 IM&T Strategy

a. OCCG is developing a full IM&T strategy, which is available in draft form on request. The following tables relate the CCG's IM&T plans, as set out in its IM&T Strategy, to the CCG's overall strategy and plans.

b. In support of ALL topics listed below, IM&T plans include:
   i. improvements to data quality, analytical tools and support services - to better monitor and forecast activity, costs, outcomes;
   ii. becoming smarter in the use of information and knowledge (the evidence-base) to inform decision-making;
   iii. ensuring IM&T requirements and opportunities are routinely considered as an integral part of any proposed improvement plans.

c. To avoid repetition, these generic enablers are not mentioned again in the table below, although specific aspects are, where relevant.

d. Further explanation of the approach to integration / interoperability is provided below this table.

16.2 How the strategy supports delivery of Improvement Interventions

Improvement Intervention	Further Relevant Detail	IM&T Enablers
New approach to contracting	Outcome based commissioning	Linking records along care pathway
Efficiency & effectiveness of prescribing	Improve primary care prescribing	*Nothing specific*
Efficiency & effectiveness of planned care	Optimise referrals, care pathways	Clinical decision support tools
Improving emergency & urgent care	111 and OOH to deliver improved and integrated service with enhanced clinical input	Records sharing / access between 111, OOH, GPs, Emergency Depts Urgent Care Dashboard – to help reduce avoidable A&E visits and non-elective admissions for high-risk patients
Achieving integration	GP led integration of care around the patient Integrated community health hub - health and social care services	Interoperability, Oxfordshire Care Summary, Cross-organisational initiatives – see Integration, below
Managing long-term conditions	Reducing unnecessary emergency hospital admissions Integrated local multidisciplinary teams Self care	ACG risk stratification; support integrated local teams - see Integration, below Telehealth – to support greater self care

Strategic Objectives	IM&T Enablers
Clinicians and patients working together to plan and deliver better patient care	Patient / carer access to their own records Telehealth Further use of e-technology (websites, apps, social media, …) to empower citizens / patients
Reducing health inequalities by tackling the causes of poor health	*Nothing specific*
Outcomes based commissioning	Linking records along care pathway
Commissioning patient centred high quality care	Full adoption of Commissioning Intelligence Model
Promoting integrated care through joint working	See Integration, below
Supporting people to manage their own health	Patient / carer access to their own records Telehealth Further use of e-technology (websites, apps, social media, …) to empower citizens / patients
More care delivered locally	Telehealth

16.3 Integration

a. Integrated working between organisations / teams is highly dependent upon sharing patient / client information – hence OCCG's IM&T strategy emphasises the importance of interoperability. The cross-organisational Oxfordshire Care Summary has been live for over a year, and it is being further developed. It is intended to establish a cross-organisational steering group (which will include social services representation), to guide and oversee the further development of interoperability solutions

Chapter 17: Organisational development

17.1 Developing Our Approach to the New World of Clinical Commissioning

a. As a very young organisation, OCCG has a number of key capabilities to develop in addition to establishing an organisational culture which will support the very highest standards of health care commissioning. It has also already adjusted its governance and leadership structure, following a period of review. In February 2014 and with the support of NHS England the Governing Body implemented its new arrangements, replacing the post of Clinical Accountable Officer and Lay Chair, with those of Clinical Chair supported by a lay Vice-Chair and a full time executive Accountable Officer.

b. In January 2014, following three months' operation of the Financial Challenge Board and establishment of its sub- programmes, with the support of its financial recovery consultants, Deloitte UK and following a period of internal consultation, OCCG strengthened its business core. It had identified two key challenges:
   - Improving capability to deliver agreed goals
   - Improving key skills especially in programme and project management , contracting, procurement and formulation of business questions and subsequent adept utilisation of business intelligence

c. It established a revised Directorate under the leadership and direction of the Chief Financial officer, adding to the existing senior professional finance support posts, the following:
   - A re –shaped post of Head of Business Intelligence
   - A new post of head of Acute Contracting and Procurement
   - A new post of Head of Programme management Office

d. A further review of organisational structure was initiated in February 2014 and key objectives have been identified as follows:
   i. Ensuring proportionality between the size and scale of programmes of delivery for this plan and the clinical and managerial resources identified to deliver them
   ii. Ensuring that the full potential of clinical leadership and sound management combine for the CCG and that each group makes its distinct and critical contribution in partnership with the other
   iii. Ensuring that there is a transparent flow of good enough data demonstrating concordance with agreed measures and behaviours, variation (both warranted and unwarranted) and performance at practice and locality level – good enough meaning in which practising clinicians have confidence and sufficient to make good business decisions
   iv. Ensuring that the workforce – managerial and clinical – has the skills and expertise to commission to the very highest standards
   v. Establishing fit for purpose arrangements with our co-commissioners, notably Oxfordshire County Council

17.2 Our Organisational Development Priorities

a. In October 2013, OCCG established its organisational development priorities and in the ensuing months began to execute them. Whilst they have been revised slightly to take into account emerging priorities and new leadership structures, they remain our key priorities :

   i. **Executive Team** development: a six month plan was put in place in late October 2013
   ii. **Clinical Leadership** : two away days have taken place on October 22nd and on 4th February 2014 and organisational development interventions have now been agreed; these include coaching and mentoring for Locality Clinical Directors, coaching and

mentoring for succession plan candidates for the LCD and key clinical commissioner roles; and LCD group organisation

iii. **Governing Body**: the Governing Body is restructuring following the revision of chairmanship arrangements and once these are implemented, including for example the addition of a new lay member, organisational development initiatives will be put in place to ensure that it functions effectively. The Governing Body continues to spend workshop time together between formal meetings and this has continued to serve both a business and developmental purpose

iv. **Intermediate Tier**: following the decision to restructure the CCG, an organisational development programme will be put in place to embed the new structure and it is anticipated that agreement of the programme and starting its implementation will take place in the first quarter of 2014/15

b. Because organisational structures in the NHS are revised on a frequent basis, especially in the commissioning of healthcare and given that system levers and incentives are also subject to frequent changes along with regulatory systems, the CCG is aware that organisational shelf life is too short to accommodate long term organisational development plans and is committed to their frequent revision.

c. We aspire to be an adaptive organisation with a workforce capable of rapid adaptation, the acquisition of new skills and a culture that supports high aspiration for our communities and for the professionals who work with us.

17.3 System Leadership and Organisational Development

a. The Oxfordshire health and social care system is facing significant financial and performance pressures in recent years and in particular has been overtrading in acute care for many years. The goal of a sustainable Oxfordshire – living within its allocation and performing highly is shared by the leadership of the CCG,OCC, OUHT and OHFT and the CCG is committed to playing a leading role in facilitating processes which will enable this goal to be achieved – for example through new ways of organising care and incentivising creativity and better care, through initiatives such as Outcomes Based Commissioning.

b. In order for this commitment to be enacted, the consent and shared positive commitment of our much valued providers and co-commissioners is essential and we plan to invest in the development of our shared leadership community, with this goal in mind.

Chapter 18: Governance Overview

a. The CCG has established a Financial Challenge Board, reporting to its Finance and Investment Committee, to govern some of the key programmes of delivery in 2014/15. One of these programmes is the development and agreement of this plan.. The Senior Responsible Owner, the Interim Chief Operating Officer and the Clinical Responsible Owner, the Locality Clinical Director (Oxford City) with the support of a Programme Manager (the Interim Associate Chief Finance Officer) and supporting managers, were charged with the establishment of the a sub- programme to develop this plan. The Financial Challenge Board receives reports on the sub-programme's :

- Project milestone achievement against target date
- RAG status for the current period and previous period
- Work completed in the previous period
- Expected achievements in the forthcoming period, and
- A report on the key risk and issues facing the sub programme and how they will be managed

b. Because of the importance of the plan to the achievement of financial balance, its development has been considered at Governing Body level both in informal workshops and in public meetings.

c. The CCG has agreed governance arrangements with its partner commissioner Oxfordshire County Council, to ensure the endorsement of the plan by the Health and Wellbeing Board; and specific arrangements to ensure that the Better Care Fund is shaped and agreed at Joint Management Group and Health and Wellbeing Board levels.

d. It is a key corporate objective of the CCG that the plan is delivered and achieves its intended impacts. The organisational development implications of this goal are considered elsewhere in this plan. The governance of delivery has also been considered. In the first quarter of 2014/15 it is intended that the Financial Challenge Board's existence will be reviewed in the light of progress towards financial balance and the establishment of a new senior clinical and managerial leadership group - the Clinical Executive or CE. The CE will replace the former Senior Management Team and will report directly to the Governing Body and account to it, and to partners, for the delivery of the plan.

e. An organisational restructure commencing in February 2014, will establish accountabilities for the major programmes of work in the plan – both improvement initiatives and enabling initiatives such as improved contracting and procurement- , and align managerial job roles and clinical roles to them. The establishment of reporting lines within the management structures and resourcing and leadership within clinical ranks along with the flow of business intelligence, will ensure that the CE remains sighted and in control of delivery at all times. As part of the organisational restructure, delivery, accountability and reporting lines to our partner commissioner in Oxfordshire County Council will also be established.

f. Commentators have turned their attention in recent years to the contrast in command and control as opposed to co-cooperative governance models in the industrial and commercial setting. In the wake of the Mid Staffordshire Inquiries, there has also been a rightful focus on the behaviours that characterise a system delivering care which commands the confidence of patients, the public and professionals. The move from the governance model of PCTs and their forebears to the distinct membership model of CCGs has also attracted much thought and attention. The CCG has reflected on the means by which it secures good governance given its particular make up and geography and its previous performance in delivery.

g. The CCG is dependent on concordance by its member practices with the key levers which will deliver best care at best value. Thus the demand management, pathway leaning, contractual controls and evidence based practice measures established in the plan, are subject to the consent of clinical professionals. Each of the six localities established in Oxfordshire, operates autonomously in organising its precise means of governance and holding to account

of practices. As part of delivering this plan, agreement on a consistent, assured and good enough data flow has been identified as one of the critical objectives of the CCG and Locality Clinical Directors with the support of the Business Intelligence function and locality teams will address this as a matter of priority. By ensuring proactive dissemination and transparency of data demonstrating concordance, variation (both warranted and unwarranted) and practice level performance, the CCG will engage with and serve its member practices and this will give the CCG a powerful adjunct to its improved business capability as intelligence is the equal of controls in achieving good governance.

Chapter 19: Conclusion

This draft plan is the culmination of much work within the CCG, supported by colleagues in the CSU and external consultants. The organisation has grasped the magnitude of challenge that it is facing in terms of service and financial pressures. Significant progress has been made in identifying appropriate opportunities to meet the challenge but there is further work to be done. The focus between the submission of this plan and subsequent submissions will be on current levels of ambition, partner engagement and system leadership. It will also be crucial to align all challenges and opportunities across the system such that resources are maximised for the benefit of Oxfordshire and there is no risk of pressure shunt or double count/ommission of opportunity.

Appendix 1 – improvement intervention summaries

Please see separately submitted document

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Health and Wellbeing Board – 13 March 2014

Better Care Fund

Purpose

1. The purpose of this paper is to seek agreement from the Health and Wellbeing Board on the proposed use of the Better Care Fund in Oxfordshire, prior to submission to NHS England (as an integral part of the Oxfordshire Clinical Commissioning Group's Strategic and Operational Plans) by 4 April 2014.

Background to the Fund

2. The Better Care Fund will total approximately £37 million in Oxfordshire from 2015/16 onwards, and is not new money as it will be reallocated from within the health and social care system.

3. However, a significant proportion may be newly accessible to adult social care, and can be used to protect services where it can also be demonstrated that there are benefits to health.

4. The remainder of the Better Care Fund includes existing funding for carers breaks, reablement and capital (including Disabled Facilities Grants), and these will be protected. It also includes some elements of funding to meet the impact of changes on adult social care proposed in the Care Bill.

5. The Better Care Fund forms a key element of the Clinical Commissioning Group's planning framework, and links closely to the operational and strategic plan (also on the agenda of this meeting for approval). The proposed plan also aligns closely to the Joint Health and Wellbeing Strategy 2012-2016, Joint Strategic Needs Assessment, Older People's Joint Commissioning Strategy 2013-2017 and the Directorate Business Strategy for Adult Social Care 2014/15-2017/18.

6. It is important to understand that the resources for the Fund have to come from existing spending on health and social care. This will be a significant challenge for the health and social care system in Oxfordshire given the current pressures it faces.

7. There is an element of the Better Care Fund for Oxfordshire that comes from other Clinical Commissioning Groups. This reflects differences in County and Clinical Commissioning Group boundaries, and includes £356,000 from Swindon Clinical Commissioning Group as Shrivenham is in their area and £415,000 from Aylesbury Vale Clinical Commissioning Group as Thame is in their area. Discussions have been held with both Groups, and proposals in our plans have been aligned with their intentions to ensure that both areas benefit equally and are not adversely affected by falling across more than one Better Care Fund plan.

8. As well as the Health and Wellbeing Board, the plan for use of the Better Care Fund will be agreed formally by the County Council's Cabinet and Clinical Commissioning Group's Governing Body in March 2014 prior to submission to NHS England by 4th April 2014.

9. The proposals were agreed in principle by the Chairman and Vice-Chairman of the Health and Wellbeing Board prior to submission to NHS England 14th February as part of the assurance process. Some minor changes have been made as a result of feedback, and further work has been done to refine the financial and performance elements of the plan, but the proposals remain largely unchanged.

Our Approach

10. Attached as appendices are the national templates that set out the Better Care Fund plan for Oxfordshire, including narrative, financial and performance information.

11. We are proposing that the focus of the Better Care Fund is predominantly on meeting the needs of older people, given this is the most significant pressure facing both health and social care in Oxfordshire. However, some cross-cutting initiatives will benefit adults of all ages including people with mental health needs.

12. It is proposed that over time the Clinical Commissioning Group and the Council create a Joint Commissioning Unit, better able to target services to give the greatest impact on outcomes, produce financial efficiencies by reducing duplication and focusing on value for money for every pound spent.

13. We will also develop and implement a single assessment process reducing the need for people to be assessed more than once when transitioning between health and social care services and making the process smoother for service users.

14. It is proposed that the Council front line social work and occupational therapy teams join up with the community provision delivered by Oxford Health and further develop links with primary care including GPs. This will avoid duplication, reduce waste and bureaucracy, minimise delays in care and give people the right support at an earlier stage so they are less likely to experience worsening of their condition. This is not a new development – it reflects discussions that have been taking place over the last two years. It is also reflected in one of the targets in the current Health and Wellbeing Strategy.

15. There are a number of key performance indicators already identified as priorities in Oxfordshire that are required to meet Government guidance on the outcomes the Fund should achieve:

    - Reduce the number of older people per year permanently admitted to a care home Increase proportion of people who complete reablement who need no on-going care

- Reduce the number of patients delayed for transfer or discharge from hospital so that Oxfordshire's performance is out of the bottom quartile
- Reduce the number of emergency admissions to hospital for older people aged 60+
- Achieve above the national average of people very satisfied with the care and support they receive from adult social care
- Achieve above the national average of people satisfied with their experience of hospital care
- Achieve above the national average of people 'very satisfied' with their experience of their GP surgery
- Increase the proportion of older people with an ongoing care package supported to live at home

16. Most of these are already within the Joint Health and Wellbeing Strategy, and the target for reablement will be added when the Strategy is refreshed later this year to ensure alignment.

17. We are therefore proposing the Fund is used to invest in the following areas:
    - Information and advice
    - Equipment and assistive technology
    - Creating a more personalised approach to home support which will include removing short visits for personal care for older people
    - Integrated support for hospital admission avoidance
    - Investment in Carers Breaks jointly funded and accessed via GPs
    - Support to people with dementia
    - Reablement and rehabilitation
    - Support for people to die at home / in residential care

18. Further detailed work will be required throughout 2014/15 to develop these proposals fully, including quantifying the financial benefits of each. The plan will also be reviewed and updated to reflect performance in the year, and any emerging pressures and priorities. It is therefore proposed that the plan will be brought back to the Health and Wellbeing Board in March 2015 prior to implementation.

19. The proposals include a contingency of approximately £4.6m, equivalent to just over 1% of the total fund. It is intended that this will be used to fund emerging priorities, and allow further investment in areas that are proving particularly effective in achieving the outcomes in the fund.

20. Progress in implementing the Better Care Fund Plan will be monitored through the outcomes reporting to Health and Wellbeing Board, Adult Health and Social Care Partnership Board and through the performance reports presented to the Older People's Joint Management Group on a regular basis.

Transfer of Funds in 2014/15

21. There is an existing section 256 agreement to transfer funds from health to social care to support the delivery of social care objectives, approved by the Health and Wellbeing Board in July 2013. The value of this transfer was £8.2m in 2013-14,

and in particular the funding is targeted towards Priority 6 of the outcomes in the Joint Health & Wellbeing Strategy. It is used to fund a range of activity including the alert service, crisis response, care homes, home support, equipment and to protect spending in adult social care.

22. The value of this transfer will increase in 2014-15 to £10.5m. This increase includes an additional £0.4m that will be used to fund intermediate care, and an additional £1.9m that will be used to protect spending in adult social care by investing further in equipment to support people to stay at home and in helping to discharge people from hospital as soon as possible. It will also essentially act as 'seed funding' to help prepare for the implementation of the full Better Care Fund plans from April 2015.

23. This transfer will be subject to a new section 256 agreement between NHS England and the County Council, and will be supported by the Clinical Commissioning Group through the close alignment with their strategic plans. Implementation will be monitored by the Older People's Joint Management Group and reported by exception to the Adult Health and Social Care Board and the Health and Wellbeing Board.

Financial and Staff Implications

24. The use of the some of the funds in the Better Care Fund has already been agreed as part of the County Council budget and has been applied to provision of services. If the Health and Wellbeing Board choose to determine a different allocation, the services provided will need to alter which may result in reduced packages of care depending on the decisions made.

Recommendations

The Health and Wellbeing Board is RECOMMENDED to:

(a) agree the Better Care Fund Plan for Oxfordshire for submission to NHS England by 4th April 2014, subject to subject to the inclusion of any necessary changes which may be required following consideration by County Council Cabinet and Clinical Commissioning Group Governing Body as agreed by Chairman and Vice Chairman of the Health and Wellbeing Board;

(b) in so doing, to agree the use of the Health Transfer to Social Care Funding in 2014/15 as set out in the financial template, and for this to form the basis of a section 256 agreement following legal review by the County Council and NHS England and as agreed by the Director for Social & Community Services following consultation with the Cabinet Member for Adult Services; and

(c) to receive an updated plan in March 2015 prior to implementation, reflecting performance in 2014/15 and any emerging pressures and priorities.

John Jackson
Director for Social &
Community Services
Oxfordshire County Council

Gina Shakespeare
Chief Operating Officer & Interim
Director of Commissioning &
Partnerships
Oxfordshire Clinical Commissioning Group

March 2014

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Better Care Fund planning template – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Oxfordshire County Council**
Clinical Commissioning Groups	**NHS Oxfordshire Clinical Commissioning Group**
	NHS Swindon Clinical Commissioning Group
	NHS Aylesbury Vale Clinical Commissioning Group
Boundary Differences	**Thame, Shrivenham – addressed by sharing plan with relevant CCGs for these areas and proposing to deliver same schemes / benefits across the county as a whole**
Date agreed at Health and Well-Being Board:	**To be reported 13 March 2014**
Date submitted:	**TBC**
Minimum required value of ITF pooled budget: 2014/15	**£10,503,000.00**
2015/16	**£37,153,000.00**
Total agreed value of pooled budget: 2014/15	**£10,503,000.00**
2015/16	**£37,153,000.00**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	**NHS Oxfordshire Clinical Commissioning Group**
By	Dr Joe McManners
Position	Clinical Chair

Date	<date>

Signed on behalf of the Clinical Commissioning Group	**NHS Swindon Clinical Commissioning Group**
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Clinical Commissioning Group	**NHS Aylesbury Vale Clinical Commissioning Group**
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Council	**Oxfordshire County Council**
By	Cllr Ian Hudspeth
Position	Leader of the Council
Date	14 February 2014

Signed on behalf of the Health and Wellbeing Board	**Oxfordshire Health and Wellbeing Board**
By Chair of Health and Wellbeing Board	Cllr Ian Hudspeth
Date	14 February 2014

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

Oxfordshire County Council and the Oxfordshire Clinical Commissioning Group already have well established and effective working relationships, and an ongoing commitment to further integrate services to ensure all the available funding is used to best effect, improves quality and improves outcomes for service users / patients and carers.

The Council and the Clinical Commissioning Group have worked together in establishing strong governance arrangements, including the Health and Wellbeing Board and Joint Management Groups overseeing the pooled budgets that engage commissioners, GPs, clinicians, providers and service users / carers in decision making. In addition, Oxfordshire has had an effective Urgent Care Working Group in operation since 2012 with membership from Oxfordshire Clinical Commissioning Group (OCCG) Oxfordshire County Council (OCC) Oxford University Hospitals NHS Trust (OUHT) South Central Ambulance Service (SCAS)

Specifically Oxford Health have played a key role in shaping some of the proposals in this plan, as we have already been working with them as a key delivery partner for locality based integrated teams, shared care coordination and shared data

Social care providers have been involved in the development of the plan through their roles on the Older People's Partnership Board, and as part of the full and wide consultation / engagement activity to develop the Joint Older People's Commissioning Strategy that underpins the proposals for this Fund.

The plan will be shared widely with providers once agreed, as they will have a key role in shaping the proposals further and ensuring they are implemented successfully.

d) Patient, service user and public engagement
Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

Service users are represented on the Older People's Joint Management Group and the Older People's Partnership Board, both of which have been involved in developing the proposals and will have roles in implementation.

An additional workshop was held with representatives of older people, learning and physical disability, mental health and carers to discuss and develop proposals.

There was full and wide consultation as part of developing the Joint Older People's Commissioning Strategy that sets the context for the proposals in this plan. This included online consultation, focus groups, workshops with a wide representation of older people and providers, and a reference group comprised of and chaired by older people alongside commissioners.

This plan also aligns closely to the Oxfordshire Clinical Commissioning Group 5 Year Strategic Plan, that was subject to public consultation in late 2013.

e) Related documentation
Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Health and Wellbeing Strategy 2012-2016	**https://www.oxfordshire.gov.uk/cms/sites/default/files/folders/documents/aboutyourcouncil/plansperformancepolicy/oxfordshirejointhwbstrategy.pdf**
Joint Older People's Commissioning Strategy 2013-2016	**http://www.sourceoxfordshire.org.uk/cms/sites/source/files/folders/documents/OlderPeoplesJointCommissioningStrategy.pdf**
Adult Social Care Business Strategy 2014/15 – 2017/18	**http://mycouncil.oxfordshire.gov.uk/documents/s24264/Section%203.pdf (see pages 21-39, subject to approval by Council on 18 February)**
Section 75 for all client groups	**Attached**
Existing S256 Transfer Agreement	**Attached**

2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

The current vision for Oxfordshire through to 2018/19 is that articulated through the Oxfordshire's Joint Health and Wellbeing Strategy 2012-2016, Adult Social Care Business Strategy 2014/15-2017/18 and the Clinical Commissioning Group's five-year strategic plan:

i. More children and young people will lead healthy, safe lives and will be given the opportunity to develop the skills, confidence and opportunities they need to achieve their full potential
ii. More adults will have the support they need to live their lives as healthily, successfully, independently and safely as possible, with good timely access to health and social care services
iii. Everyone will be given the opportunity to voice their opinions and experiences to ensure that services meet their individual needs
iv. The best possible services will be provided within the resources we have, giving excellent value for the public
v. Be delivering fully integrated care, close to home, for the frail elderly and people with complex multi-morbidities.
vi. Have a primary care service that is driving development and delivery of this integrated care, and is itself offering a broader range of services at a different scale.
vii. Support choice and control in the belief that people themselves, regardless of age or ability, are best placed to determine what help they need.
viii. Routinely enable people to live well at home and to avoid admission to hospital when this is in their best interests.
ix. Be continuing to provide preventative care and to tackle health inequalities for patients and carers in both its urban and rural communities
x. Be providing health and social care that is rated amongst the best in the country for all its citizens in terms of quality, outcomes and local satisfaction with services

Oxfordshire County Council and the Oxfordshire Clinical Commissioning Group already have well established and effective working relationships, and an ongoing commitment to further integrate services to ensure all the available funding is used to best effect, improves quality and improves outcomes for service users / patients and carers.

The Council and Clinical Commissioning Group have worked together in establishing strong governance arrangements, including the Health and Wellbeing Board and Joint Management Groups overseeing the pooled budgets that engage commissioners, GPs, clinicians, providers and service users / carers in decision making.

Over £330m is currently committed to pooled budget arrangements across all client groups, representing a third of Clinical Commissioning Group resources and 99% of adult social care funding. This includes a significantly expanded pool covering care for older people, and others to improve care and outcomes in physical disability, learning disability and mental health and wellbeing. .

We have joint commissioning strategies that set out our shared intentions and mature risk sharing arrangements that mean we have truly pooled budgets, that in the case of older people we believe this to be unique in the country. Existing pooling of funds is being used to protect adult social care services by paying for the discharge to home service, increase spending on equipment and meeting an increased number of home care packages in response to the demographic challenges.

We are working together to implement an outcomes based contract for services for older people; in 2014/15 we are targeting the acute assessment/admission/discharge / reablement pathway incorporating both community and acute health services. Given our pooled budget arrangements we are working together to determine whether it makes sense for some social care funded services to be incorporated in this approach and are making positive progress.

- In order to support the Clinical Commissioning Groups vision of patient-centred high quality care, which is integrated, cost effective and efficient, it is proposed that the CCG and the County Council work together to join up commissioning and integrate the provider services for the benefit of patients.

- The key points where organisations will join up to deliver the most benefit to people are in the commissioning of services, in individual assessment and in care co-ordination, leading to a coordinated and seamless response to need at both a population level and at an individual level.

We are considering whether:

- The CCG and the Council create a Joint Commissioning Unit for management of the pooled budget.
- A single assessment process is implemented
- Community providers including GPs integrate to deliver care co-ordination.

Following assessment, where people need ongoing care and support, a diversity of health and social care service provision will be maintained to facilitate choice, innovation and sustainability.

Under the leadership of the Health & Wellbeing Board, joining up commissioning will mean that commissioners in the CCG and the local authority will develop shared vision, plans and pooled budgets. This creates the opportunity to design coherent, reliable and efficient patient pathways, and ensure the incentives are right for providers to provide interoperable services within these pathways. We will share best practice, expertise and intelligence about needs.

The benefits of joint commissioning are that it will help to:

- Target services to give the greatest impact on outcomes
- Share expertise and best practice
- Share intelligence on needs in a systematic way

- Break down silos and gaps between healthcare and social care
- Co-ordinate services by encouraging providers to work together (and with commissioners).
- Produce financial efficiencies by reducing duplication and focusing on value for money for every pound spent.
- Effective and efficient ways of planning leading to major service transformation.

Provider Integration

It is proposed that the Council front line social work and occupational therapy teams join up with the community provision delivered by Oxford Health. GPs, hospitals, health workers, social care staff and others will work side-by-side, sharing information and taking a more coordinated approach to the way services are delivered. At the moment, if someone needs to arrange care from a district nurse, for example, but also needs help to bathe or prepare a meal, they might have two or three different professionals arriving at their door and asking similar questions before help can be put in place. This will be replaced by a single assessment process that is controlled where possible by the patient and reduces unnecessary duplication.

With these changes, the process will become much smoother. Staff such as district nurses, community matrons, social workers and other professionals will be in a position to communicate with each other on a regular basis and share information to support people better. Some patients will have a single care coordinator who is their main contact point.

Staff from all sides can more easily identify which patients are most at risk – for example, of going into hospital – and then put together a combined package of care, support and lifestyle advice designed to keep them healthier and independent for longer. If someone ends up in hospital, staff from the hospital can work with those in the community to help them leave with the right support in place. Joint working will:

- help to get rid of out of date processes that are duplicated across both health and social care
- reduce waste and bureaucracy by working as a more efficient, combined unit
- minimise delays in care and give people the right support at an earlier stage so they are less likely to experience worsening of their condition
- reduce the need to go into hospital and enable people to better manage their condition and live as independently as possible
- improve the sense that services are 'fragmented' by reducing the number of professionals that need to be involved in one person's care, and ensuring those who do are working more closely together.

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

Our approach will be based on furthering the aims and objectives in Oxfordshire's Joint Health and Wellbeing Strategy 2012-2016 and the Clinical Commissioning Group and Oxfordshire County Council Older People's Commissioning Strategy 2013 – 2016. Both of these are based in part on the Joint Strategic Needs Assessment and were developed in partnership with wide partner and user engagement.

The Joint Health and Wellbeing Strategy includes the following priorities for adults:

- Living and working well: Adults with long-term conditions, physical disabilities, learning disabilities or mental health problems living independently and achieving their full potential
- Support older people to live independently with dignity whilst reducing the need for care and support
- Working together to improve quality and value for money in the Health and Social Care System

There are 6 priorities in the Older People's Commissioning Strategy, which are shaped to reflect the patient voice and experience – these seek to achieve the following outcomes:

1. I can take part in a range of activities and services that help me stay well and be part of a supportive community.
2. I get the care and support I need in the most appropriate way and at the right time.
3. When I am in hospital or longer term care it is because I need to be there. While I am there, I receive high quality care and am discharged home when I am ready.
4. As a carer, I am supported in my caring role.
5. Living with dementia, I and my carers, receive good advice and support early on and I get the right help at the right time to live well.
6. I see health and social care services working well together.

These also have resonance across all client groups, so although the focus will be primarily on older people there will be wider benefits for all – particularly when combined with other funding streams in the Better Care Fund that protect existing spending on Disabled Facilities Grants and carers breaks.

In keeping with the aims in the Oxfordshire Clinical Commissioning Group Five Year Strategy, the need for our patients is to have joined up care that provides better care at home and reduces unnecessary time spent in hospitals and care homes. It will;

1) Deliver joined up health and social care to the frail elderly, patients with multi-morbidities (particularly the top 2% of cost risk), patients with physical and mental health needs (including those with dementia), and patients on the palliative care register.

2) Deliver anticipatory care plans and care co-ordination when unstable for those patients.

3) Develop locality based 'hubs' that are community facing and offer rapid access, multi-disciplinary team assessment for diagnosis and care planning (see below)

4) Move to acute hospital stays that are as brief as needed, so the patient moves to the most appropriate place as soon as possible without delay

5) Help primary care develop to work better together and improve joint working with community, social care and secondary care.

6) Develop the primary care provider community so that GP services can contribute and potentially lead integrated care services

7) Have named social and community healthcare link workers assigned to each general practice

8) Have clearly defined roles and responsibilities within urgent and emergency care pathways

9) Delivery of a new jointly commissioned service model that delivers shared outcomes for patients across the system

10) Provide 7 day working in health and social care

The current priorities in the Oxfordshire's Health and Wellbeing Strategy already include a focus on the national measures required by the Better Care Fund (see below) – these indicators are also included in the Older People's Commissioning Strategy and will be used to measure how effectively we achieve the aims and objectives given above:

Better Care Fund Metric	**Local Metric**
Admissions to residential and care homes	Reduce the number of older people per year permanently admitted to a care home (Health and Wellbeing Strategy indicator 6.5)
Effectiveness of reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services (This will be added as a Health and Wellbeing Strategy indicator for 2014/15)
Delayed Transfers of Care	Reduce the number of patients delayed for transfer or discharge from hospital so that Oxfordshire's performance is out of the bottom quartile (Health and Wellbeing Strategy indicator 6.1)
Avoidable Emergency Admissions	Reduce the number of emergency admissions to hospital for older people aged 60+ (Health and Wellbeing Strategy indicator 6.3)
Patient / Service User Experience	Achieve above the national average of people very satisfied with the care and support they receive from adult social care (Health and Wellbeing Strategy indicator 7.3) Achieve above the national average of people satisfied with their experience of hospital care (Health and Wellbeing Strategy indicator 7.4) Achieve above the national average of people 'very satisfied' with their experience of their GP surgery (Health and Wellbeing Strategy indicator 7.5)
Locally determined	

measure: People with high level care and support needs supported to live at home	Increase the proportion of older people with an ongoing care package supported to live at home (Health and Wellbeing Strategy indicator 6.7)	

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

We are in a strong position to build on our existing relationships and joint working that has seen us develop (for example) integrated locality teams, a single point of access for health and social care, and Winter Pressures pilots in winter 2013-14 - the evaluation of which will inform an overall model of integration. We have also initiated the South East GP pilot that provides an Adult Social Care Link Worker in six GP practices to share information, signpost and discuss appropriate care for high risk patients requiring both health and social care services.

However, we also recognise the need to do more to address the increasing number of frail older people as the most significant challenge that faces health and social care in the county. There are increasing demands for care from a relatively small proportion of the population. Financial resources are not increasing in line with those demands so we need to focus on intervening early and quickly to limit the extent to which care needs increase.

We also need to do more to address key areas of under-performance, notably the number of people who are admitted to hospital when they didn't need to be, the number who spend longer in hospital than they need to, and the number of people who are placed in care homes rather than being supported to stay at home.

It is proposed that the Better Care Fund is used to protect services in adult social care where there is a clear benefit to the wider health and social care sector and contribution to reducing activity/costs in acute health care, as defined by the aims of the Joint Older People's Commissioning Strategy and the nationally determined metrics for the Better Care Fund. There will be an emphasis on ensuring the right care in the right place, first time, and the vital links between intermediate community care and hospitals.

Through the mechanism of the pooled budgets we will continue to move resources between health and social care to spend on those services which have greatest impact on the demand for health and social care, including bed-based care in particular.

These proposals have been developed in response to the priorities identified in Oxfordshire's Joint Health and Wellbeing Strategy, which is based on the highest priorities for action identified through the Joint Strategic Needs Assessment. This has identified demand for social and health care, particularly from an increasing number of frail older people, as the most significant challenge facing the county – and this is

reflected in the financial and strategic plans of both the Clinical Commissioning Group and the County Council.

Proposals are therefore designed to build on the existing commissioning and activity happening across the health and social care system, individually and collectively amongst partner organisations and providers. A proportion of the funding is already being utilised as part of the existing transfer from health to social care on a range of preventative measures to support people to live independently in their own home for as long as possible. This includes a range of home support packages, equipment and assistive technology, crisis response services, reablement, and carers breaks. All these will continue from 2014 onwards. We will also continue to invest in meeting increased demand across social care and health (including Funded Nursing Care and Continuing Healthcare), and make sure that resources are focused on care in the community rather than in hospitals.

The Better Care Fund will also include capital funding currently used by District Councils to support adaptations to property to support people to stay at home (Disabled Facilities Grants) and additional capital funding used by adult social care to support Extra Care Housing schemes. These will continue to be funded at the same levels as currently, as there is evidence that these are effective in supporting the ambitions in this plan and meeting aims of the Fund.

Adult social care is preparing for the implementation of the Care Bill from April 2015 onwards, and a proportion of the funding within the Better Care Fund is assumed to support this. In particular it will be used to support improved information and advice, including for self-funders, and for improved IT systems to support management and tracking of care accounts once funding details are finalised.

There are also a number of proposals that will be delivered from April 2015 onwards that both support / protect adult social care and will bring reduced activity and costs in the acute sector. These flow across the whole health and social care pathway:

- **Information and advice**
  The provision of good quality information and advice is critical in enabling people to make best use of their resources, empowering and enabling people to assess and then take control of their own support needs and to use information on the quality of provision to make informed choices about their lives.

  We will invest in a new online marketplace for care, building on existing systems to enable people to people to resolve their own problems. This will provide people with a menu of options for how their needs could be met, along with prices, and allow them to choose between without the need for the Council to broker the service. The service will provide real time quality feedback and ratings, and real time availability of care with the ability for providers to upload and maintain their own information.

- **Equipment and assistive technology**
  There is extensive evidence that the use of equipment and assistive technology is an effective way to support independence and allow people to live at home for longer. We will continue to invest in this as an alternative to residential and domiciliary care provided by care workers where suitable.

  There is also evidence that this can help reduce admissions and represent savings in

the wider system. A recent review showed that over 30% of calls to the emergency services for clients of the Alert Service in Oxfordshire (a countywide service providing telecare alarm equipment to vulnerable and older adults) were handled by a mobile responder rather than needing to refer for an ambulance. This equates to a saving of over £300k per year, plus avoiding further costs for the NHS had the users been admitted to hospital.

- **Create a more personalised approach to home support which will include removing short visits for personal care for older people**

  We will ensure that no home care visit offering personal care is too short for the person to be treated with dignity and respect. Often home support for older people has become too focused on time and task, as opposed to good outcomes for the person. Sometimes visits are too short for the person to be treated with dignity and respect. We will link this funding to an improvement in performance for home support based on the needs of the older person.

  We will continue to invest in new approaches to providing domiciliary care. We will develop a mainstreaming approach that builds reablement into all home care provision rather than seeing it as a separate service.

  We will ensure seven day working in social care and amongst providers of services to avoid the need for hospital admissions at weekends that would be avoided during the week, support effective discharge from hospital, and improve pick up times in intermediate community care.

  We will implement Individual Service Funds that promote a more personalised approach to home support. Home support providers will receive the Individual Service Fund directly from the local authority and work with the older person to organise their care based on a support plan. Individual Service Funds have the benefit of reducing the number of short visits and improving the experience of both the older person and the home support worker – thus they will have a positive impact on both outcomes (including pick up times) and workforce. While they require up-front investment in systems and training, there is potential to save money in the long run.

  We will implement changes over a two year period from October 2014 onwards, to allow time to work with providers to affect any changes that are needed in the range of services or how they operate.

- **Integrated support for hospital admission avoidance**
  Linked to personalisation of home care, we will fundamentally review the provision and accessibility of community services provided across health and social care that support people outside of hospital. This will support our ambition to support people as close to home as possible, and ensure that the right services are available in the local area to enable this.

  We will also invest in improving a range of community-based services that reduce emergency admissions of vulnerable and frail older people by supporting them at home, and to return home as soon as possible after an admission. This will include further development of emergency multidisciplinary assessment pathways, to ensure appropriate medical, nursing, social and therapeutic capabilities in both acute and community sectors.

We will develop primary care services to enable better management of complex patients with multiple-morbidity/frailty. These services will provide enhanced medical and nursing support for these patients and will work with integrated health and social care teams on localised populations based around GP practice populations.

We will focus on reducing the number of repeat admissions, Accident and Emergency attendances and primary care attendances for younger adults with high needs, often as a result of mental health problems or drug/alcohol dependency. The cost of supporting this relatively small number of individuals is disproportionately high, and investment in services across public health, social care and primary care to address the underlying causes of these admissions will reduce costs and improve outcomes for these individuals.

We will also invest to improve the quality and range of medical and nursing services for care homes through our Quality in Care homes programme, ensuring that residents benefit as much from the development of modern integrated services as people still living in their own home. This is currently being developed into a business case for organisational approval.

We will work to broaden the role of GPs in supporting and delivering a whole systems approach, having input along the whole pathway as with interface medicine capability. This will include the development of an agreed vision and five year strategy for the development of primary care in Oxfordshire which addresses the role of GP practices in:

i. Providing more proactive coordination of care, particularly for people with long term conditions including dementia

ii. Providing more holistic, integrated care in the community

iii. Ensuring fast, responsive access to urgent care needs

iv. Preventing ill health, including more timely diagnosis and early identification of people at greatest risk of becoming unwell

v. Involving patients and carers more fully in their self care

vi. Ensuring high quality care, in particular the patient experience

We will also produce and support the delivery of a plan which articulates the preferred function and form of federated working in Oxfordshire so that primary care is in a position to:

i. Enter the market as a provider of services operating at scale across the county

ii. Develop more innovative and integrated primary and community services which deliver improved access and increased continuity of care

iii. Support effective urgent and emergency care pathways

iv. Address health inequalities more effectively in both urban and rural areas in order to support GPs to increase their role in driving development and delivery of integrated care in the community, the leadership capacity of primary care will be

developed so that leaders are identified and supported to act as strategic partners in provider discussions around changes in service delivery. This will ensure that primary care views are clearly voiced and considered in any system level change.

- **Investment in Carers Breaks jointly funded and accessed via GPs**
  Carers already play an essential role in the development of health and social care services in Oxfordshire. 61,131 of Oxfordshire's residents (9.4% of the population) provide some unpaid care to family or neighbours with ill health or disability.

  There will be continued investment to support family carers, further investment to build on the existing success of carers breaks (where demand exceeds budget) as well as training and support for carers, and intensive support for carers when the person they care for is in hospital.

- **Support to people with dementia**
  We will invest further in supporting people with dementia, building on improved rates of diagnosis and recognising the increased numbers of older people living with the condition. This will be a theme running through a number of the proposals, including targeted training for home care providers to ensure their staff are trained in recognising and supporting people with dementia living in the community.

  We will also build capacity to support people with dementia in nursing homes, including block purchasing beds that are developed to reflect the learning from existing work to create more dementia-friendly environments in health and social care settings. We will also work with the Order of St John to increase their capacity to provide specialist dementia care in care homes, and with other providers to encourage them to do the same.

- **Reablement and rehabilitation**
  The Council will focus on improving the key first response services such as crisis response and reablement. We will also work with the Clinical Commissioning Group to develop multi-disciplinary, integrated front end services that include key clinical inputs such as nursing and therapy as part of the service model.

  Through locality and outcome based contracts we will offer seamless "one stop shop" solutions for crisis, rapid response and enabling support at home which respond more effectively to the needs individual service users to move between service functions without hand-offs between providers. It will also help meet the needs of the wider social and health care system by reducing duplication and improving coordination of care across agencies.

  We will significantly grow the capability of the domiciliary care market to deliver effective enabling care, by working with providers to identify, develop and train care workers to deliver care that restores and enables people to maintain their independence.

- **Support for people to die at home / in residential care**
  Oxfordshire's joint strategy for end of life care aims to improve the quality of end of life care and support more people to die in their place of choice, which will often be in their own home or place of residence. The integration, capability and responsiveness of social care services is essential for ensuring that people receive the holistic and

humane support that they need at the end of their lives, and that family carers are supported both before and after someone dies.

The Council will continue to support OCCG in developing and delivering the end of life care strategy for Oxfordshire, and will lend practical support to the strategy through a range of initiatives. Particular emphasis will be on working with care providers to ensure that care workers and family carers are trained to recognise and supported to respond to the needs of people who are dying. We will also clarify guidance for service users with an end of life diagnosis and their family carers on the support available to them.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

At this point of submission, the CCG is working with Providers to secure signed contracts by 28 February 2014. A key component of these discussions is the CCG's proposed improvement interventions, including the levels of ambition and monitoring arrangements. It is acknowledged that the Better Care Fund is an integral theme within this process and this submission will be shared with Providers in the same way that other opportunities are being shared. The Oxfordshire system acknowledges the need for full alignment of plans through this process and is committed to principles of long term sustainability for the system as a whole which delivers best outcomes for its population within a challenged resource envelope.

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

Implementation of the Better Care Fund plan will be overseen by the various organisational governance structures, reporting to the Health and Wellbeing Board and constituent Clinical Commissioning Group and County Council.

The Older People's Joint Management Group meets in public bi-monthly, and has a key role contributing to the delivery of the priorities in the Joint Health and Wellbeing Strategy by monitoring and managing the implementation of the Joint Older People's Commissioning Strategy through the Older People's Pooled Budget, including and performance indicators, activity and spending. It reports regularly and by exception to the Health and Wellbeing Board and Clinical Commissioning Group and County Council.

The Joint Management Group comprises senior officer and member representatives of the County Council and Clinical Commissioning Group, as well as District Councils, health providers, and service user representatives. It is supported by an Older People's Partnership Board that comprises wider representation from service users and providers, that has an advisory role to the JMG, and a Commissioning and Finance officer group that meets monthly to manage and monitor implementation, activity and spending.

3) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services.

We define protecting adult social care as prioritising the services that have the biggest impact on meeting the shared need to reduce demand for health and social care services by ensuring high quality, joined up services that support people to live independent and successful lives for as long as possible.

Please explain how local social care services will be protected within your plans.

It is proposed that pooled funding is used to protect services in adult social care where there is a clear benefit to the wider health and social care sector and contribution to reducing activity/costs in acute health care, as defined by the aims of the Joint Older People's Commissioning Strategy and the nationally determined metrics for the Better Care Fund. There will be an emphasis on ensuring the right care in the right place, first time, and the vital links between intermediate community care and hospitals.

Through the mechanism of the pooled budgets we will continue to move resources between health and social care to spend on those services which have greatest impact on the demand for health and social care, including bed-based care in particular.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

We are committed to delivering 7 day access to health and social care services, and have already implemented 7-day working across a number of elements of the health and social care system. This includes social work teams in hospitals, covering wards and all front doors (Accident and Emergency, community and acute hospitals, and Emergency Medical Units). We have also incentivised social care providers to pick up clients within 72 hours, including Fridays and over the weekend. The Emergency Duty Teams also ensure there is support available 24 hours a day, 7 days a week.

This will be developed further in accordance with the improvement intervention and principle of resource maximisation, and as part of our commitment to shared care coordination.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

See below

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

Oxfordshire County Council are working with Oxford Health to ensure we are able to use the NHS number as the primary identifier for health and care services by April 2014, and this will be built into routine processes from then on.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

We are already working with health colleagues to ensure our respective tender processes for the SWIFT (ASC) and RIO (Health) replacements are aligned. Integration requirements have been appropriately specified within both statement of requirements.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

Appropriate Information Governance controls are broadly in place for information sharing in line with Caldicott 2. We will undertake further work to build these controls into all training materials, and ensure they are included in work already underway to communicate new information governance policies and procedures to staff.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

Shared care coordination will form a key part of our commitment to establishing integrated health and social care providing patients, service users, GPs and acute service providers with a single, straightforward route to well joined up, locality based care. This will enable people to stay in their usual place of residence (or as close to it as possible)– for as long as possible, regardless of how many different community based health and social care specialists are involved in providing them with care

Oxfordshire County Council are working with the Clinical Commissioning Group, Oxford Health and primary care to establish an appropriate and efficient model of joint assessments and care planning, including an accountable lead professional for integrated packages of care. Pilot work is underway, targeting the patients within 5 localities with the highest levels of need and risk (including risk of unnecessary admission) and with particular focus on people with a diagnosis of dementia. This aligns with the emphasis in the new GP contract on the 2% of patients at highest risk.

A detailed model of service provision will be confirmed by all partners, using the outcomes of the pilot work to develop shared patient assessment and patient records, protocols and business processes which support the identification of the accountable lead professional, and 7 day service access.

In addition to dementia, this model of provision will also focus on individuals with co-morbidities, in recognition that the risk of admissions increases significantly for this group.

4) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	Risk rating	Mitigating Actions
Increasing demand for services could outstrip benefits accrued from planned schemes	High	Modelling of demand Close scrutiny of proposals and monitoring of implementation. Mature risk sharing.
Proposals are not effective in reducing demand, activity or spending in health and/or social care	Medium	Close scrutiny of proposals and monitoring of implementation, appropriate remedial action to be taken
Financial pressures facing the system mean ambitions in plan cannot be implemented	Medium	Close scrutiny of proposals and monitoring of implementation, appropriate remedial action to be taken, open and transparent conversations
Market capacity may not increase in line with demand and appropriate levels of care are not forthcoming in the right place, at the right price and of the right quality	High	Production of market position statement giving clear signal to providers on how much care we expect to purchase Close working with providers in further development of community based care provision Agreeing a charter with clients and providers about care standards Reviewing new personalised home support contracts based on individual needs
Enough people will be willing to work in the health and social care sector at a time of increasing financial pressure for the sector, and in an area of high employment	High	Work with providers and others to develop a workforce plan for the county. Investment in workforce and training as part of Better Care Fund proposals (dementia, carers)

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Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Actual contribution (15/16)
Oxfordshire County Council - Adult Social Care Capital Grant and Disabled Facilities Grant	Y		*3,677,000*	
NHS Oxfordshire Clinical Commissioning Group	N		*33,120,000*	
NHS Swindon Clinical Commissioning Group	N		*356,000*	
NHS Aylesbury Vale Clinical Commissioning Group	N		*415,000*	
BCF Total			***37,568,000***	

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

This will be managed through the joint management groups / use of the pooled budget, with reference back to appropriate risk share arrangements - currently these are proportionate to the level of funding contributed to the pool, with overspends / underspends being taken back to each organisation accordingly

Contingency plan:		2015/16	Ongoing
Outcome 1	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		
Outcome 2	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand the table if necessary.

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent (£'000)	Non-recurrent	Recurrent	Non-recurrent
Alert Service		300				300		*More people supported to stay at home, fewer admissions to care homes and emergency admissions*	
Long term Care Packages		4352				4352		*More people supported to stay at home, fewer admissions to care homes, improved worforce, better patient experience*	
Equipment		750				750		*More people supported to stay at home, fewer admissions to care homes and emergency admissions*	
Crisis response		500				500		*Reduced emergency admissions*	
Existing Protection of ASC		2300				2300		*More people supported to stay at home, fewer admissions to care homes, improved worforce, better patient experience*	
Increased transfer in 2014/15 - Intermediate care		391				391		*More people supported to stay at home, fewer admissions to care homes, improved worforce, better patient experience*	
Protecting ASC - discharge to assess, investment in equipment		1910				1910		*More people supported to stay at home, fewer admissions to care homes, improved worforce, better patient experience*	
Carers Breaks						1300		*Reduced carer brekadown, more people supported at home for longer, reduced admissions to care homes or emergency admissions*	
Existing Investment in reablement						3000		*More people supported to stay at home, less admissions to care homes and emergency admissions, reduce delays*	
Capital Funding - Disabled Facilities Grants						2401		*More people supported to stay at home, less admissions to care homes and emergency admissions*	
Capital funding - Oxfordshire County Council						1267		*Additional ECH sche,mes, alternative to Care Home admissions*	
Capital Funding - care bill						500		*IT system able to deliver Care Bill functionality*	
Other Care Bill Implementation costs						1350		*Successful implementation of Care Bill*	
Create a more personalised approach to home support which will include removing short visits for personal care for older people						4000		*More people supported to stay at home, fewer admissions to care homes, improved worforce, better patient experience*	
Equipment and assistive technology						1000		*More people supported to stay at home, fewer admissions to care homes and emergency admissions*	
Support for people to die at home / in residential care						500		*Fewer emergency admissions, better patient experience*	
Information and advice						500		*Savings in customer service Centre, through reduced assessments and income from site advertising and revenue fees*	
Discharge to assess care service						1000		*More people supported to stay at home, fewer admissions to care homes and emergency admissions, reduce delays*	
Improving performance of reablement and rehabilitation						1000		*More people supported to stay at home, fewer admissions to care homes and emergency admissions, reduce delays*	
Increased investment in Carers Breaks jointly funded and accessed via GPs						200		*Reduced carer brekadown, more people supported at home for longer, reduced admissions to care homes or emergency admissions*	
Support to people with dementia						500		*More people supported to stay at home, fewer admissions to care homes, reduced emergency admissions, better patient experience*	
Investment in support for people to die at home / in residential care						500		*Fewer emergency admissions, better patient experience*	
Shared data						100		*Better patient experience and joined up care*	
Shared care coordination - particularly for dementia and comorbidities						200		*Better patient experience and joined up care*	
7 day working (including management costs)						500		*Better patient experience, more people supported to stay at home, fewer emergency admissions, reduced delays*	
Investment to meet increased demand for Funded Nursing Care and Continuing Healthcare						1100		*More people supported to stay at home, fewer admissions to care homes and emergency admissions, reduce delays*	
Integrated Support for hospital admission avoidance						1500		*More people supported to stay at home, fewer admissions to care homes and emergency admissions, reduce delays*	
Contingency (approx 1%)						4647			
Total		10503				37568			

Total BCF	37568.00
Balance to allocate	0.00

Outcomes and metrics

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

1. Reduce permanent care home admissions to 10.5 per week; or 546 in the year - a rate of 473. This would be the 17th lowest in the country last year based on last year's figures; lower than any point in the last 5 years and reflects a 17% increase on the expected 2014/15 value. This will be supported by additional investment in community based service and additional personalised home support.

2. Increase the number of older people supported to leave hospital with reablement to 500 between October and December. The current contract expects around 450 episodes. (3750 episodes; 50% from hospital for ¼ of a year). The present estimate for this year is 437 (all ages). 500 would imply 4000 episodes per year at current rate. It will be over 15% increase on this year. Increase the proportion of people still at home 90 days after leaving the service to 80%. This would place us close to the national average. So far this year at the point of leaving the service 18% of people have gone back into hospital; 3% of people have gone into a care home and 2% die. The clear issue is the level of people returning to hospital and reflects the levels of dependency people have when leaving hospital and the entrance criteria for the service. These measures will be supported by additional investment in rehabilitation and reablement and additional personalised home support.

3. Delayed transfers of care should average no more than 90 across the year (140 in 2012/13 and 144 in the first 9 months of 2013/14). This reflects a 37.5% improvement next year. The increase in performance will be shared equally across all 3 responsiblities (NHS; Social Care and both) with an expectation of no more than 43 NHS delays 30 social care and 17 both. Many of the investments support improved patient flow including reducing hospital admissions by high intensity users; increased 7 day working including pick up for providers; improved information flows; improved co-ordination of shared care and increased market capacity

4. Avoidable emergency admissions: the aggregate measure includes emergency admissions for ambulatory care sensitive conditions, admissions for acute conditions not normally requiring hospitalisation, and two measures of preventable admissions for the under 19 years old.
i. Our integration and LTC Improvement Interventions will deliver integrated health and social care close to home for the elderly and those with LTCs and integrated physical and mental health care in year 1 of the plan
ii. Our primary care development programme will ensure we can deliver the evolution required in primary care to ensure general practice is contributing fully to this priority from the beginning of year 2.
iii. Our urgent and emergency care improvement intervention will remodel our emergency and sub-acute pathway so that it delivers :
☐ Primary care assessment at ED to improve referral straight to community based services
☐ A dedicated Clinical Decision Unit for Paediatrics, co-located with the Emergency Department at the JR
☐ Enhanced MIU provision
☐ Access to urgent ambulatory care pathways in the acute
☐ Roll out of Emergency multidisciplinary units to provide 1 stop shop alternatives to A&E for those needing a speedy assessment and same day package of community health and social care in order to remain at home.

5.Patient experience. Improving patient experience is a current health and wellbeing priority and is measured by 3 indicators on satisfaction with social care; hospital care and GP care. We will continue to use these measure until the new national metric is developed and will review the existing measure once the new metric is agreed

6. The local measure is to increase the proportion of older people with an on-going care package supported to live at home. This is monitored via reports to the department of health in the national RAP and ASC-CAR submission. The scheme will assist the delivery of this objective by increasing the numbers of people supported via home care (or direct payments) as an alternative to care homes

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

Patient expericence is currently measured in the health and wellbeing strategy vis 3 separate national measures. These are:
Achieve above the national average of people very satisfied with the care and support they receive from adult social care (Health and Wellbeing Strategy indicator 7.3)

Achieve above the national average of people satisfied with their experience of hospital care (Health and Wellbeing Strategy indicator 7.4)

Achieve above the national average of people 'very satisfied' with their experience of their GP surgery (Health and Wellbeing Strategy indicator 7.5)

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

Assurance of the performance plans for the Better Care Fund plan will be provided by the Older People's Joint Management Group, reporting to the Health and Wellbeing Board. The Older People's Joint Management Group meets in public bi-monthly, and has a key role contributing to the delivery of the priorities in the Joint Health and Wellbeing Strategy by monitoring and managing the implementation of the Joint Older People's Commissioning Strategy through the Older People's Pooled Budget, including performance indicators, activity and spending. It reports regularly and by exception to the Health and Wellbeing Board and Clinical Commissioning Group and County Council.

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

N/A

Metrics		Current Baseline (as at….)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	534	N/A	473
	Numerator	582		546
	Denominator	109000		115000
		(April 2012 - March 2013)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	71.70%	N/A	80%
	Numerator	345		400
	Denominator	480		500
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	26.9	21.8	17.0
	Numerator	140	115	90
	Denominator	521000	528000	528000
		(April 2012 - March 2013)	(April - December 2014)	(January - June 2015)

Avoidable emergency admissions (composite measure)	*Metric Value*	1471.7	N/A	1414.1
	Numerator	N/A		N/A
	Denominator			
		2012-13		*2014-15*
Patient / service user experience [for local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used]			N/A	
Achieve above the national average of people very satisfied with the care and support they receive from adult social care	*Metric Value*	62.7%	N/A	64.1%
	Numerator	4236.8		n/a
	Denominator	6760.6		n/a
Achieve above the national average of people satisfied with their experience of hospital care	*Metric Value*	149.7	N/A	149.6
	Numerator	N/A		N/A
	Denominator			
		2012		*2014-15*
Achieve above the national average of people 'very satisfied' with their experience of their GP surgery	*Metric Value*	4.8	N/A	4.81
	Numerator	N/A		N/A
	Denominator			
		2012		*2014-15*
		Metric value relates to E.A.7 (Outcomes Template) which includes OOH & encorporates "Very Good" & "Fairly Good".		
Increase the proportion of older people (aged 65 and over) with an ongoing care package supported to live at home *Numerator: Number of people receiving home care or an on-going direct payment from an older person's budget* *Numerator + people funded Number of people funded in a permanent care home place from a council budget*	*Metric Value*	60.0%	N/A	TBC
	Numerator	2122		TBC
	Denominator	3537		TBC
		Mar-13	*(insert time period)*	*Mar-15*
increase the proportion of older people (aged 65 and over) with an on-going care package supported to live at home	*Metric Value*			
	Numerator			
	Denominator			
		(TBC)		

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Oxfordshire Local Information Steering Group (LISG)

Vision and Terms of Reference

For submission to Oxfordshire Health and Wellbeing Board 13.3.14

Version 1.0 PP 6.2.14

Version 1.1 ML 10.2.14

Version 1.2 PP 11.2.14

Background

As of the Sustainable Oxfordshire Information Management and Technology (IM&T) workshop on the 12th of December 2013, the main health and social care organisations in Oxfordshire – including Oxfordshire Clinical Commissioning Group (OCCG), Oxford University Hospitals Trust (OUHT), Oxford Health Foundation Trust (OHFT), and Oxfordshire County Council (OCC), NHS England Area Team – met and agreed the need for a new mandate to work together county-wide on IM&T strategy. All present agreed that Oxfordshire was in a strong position to progress collaboratively because of the long history of cross-organisation collaboration, common network infrastructure, common projects such as Oxfordshire Care Summary, and the common political will to work together and share data and strategy.

It was agreed that the shared vision of collaborative IM&T strategy would be presented to the Oxfordshire Health and Wellbeing Board (HWB) which, in turn, would mandate the above organisations to work together, supported by a new cross-organisational Steering Group which will oversee the implementation of the shared vision.

LISG Vision

The main health and social care organisations in Oxfordshire agreed that:

- All the organisations fully wished to collaborate on IM&T strategy county-wide, and would contribute to a common mandate to work together, share data, and develop collaborative and sustainable projects to meet the health needs of the population of Oxfordshire;
- The common mandate to collaborate in IM&T strategy, planning and implementation should be in the name of the patients and public, many of whom assume that information sharing and collaboration is already happening;
- If Oxfordshire is to address the fundamental transformation to health and social care provision required for sustainability, early local planning and implementation will often be needed, which will supersede waiting for national guidance of solutions;
- LISG should derive its mandate from its parent organisations and the Health and Wellbeing Board, and thus take its priorities from the needs of the whole health and social care system for Oxfordshire.

LISG Terms of Reference

Purpose

- To work with the common information mandate from the main health and social care organisations in Oxfordshire:
    - Oxfordshire Clinical Commissioning Group (OCCG)
    - Oxford University Hospitals Trust (OUHT)
    - Oxford Health NHS Foundation Trust (OHFT)
    - Oxfordshire County Council (OCC)
    - NHS England Area Team

    - South Central Ambulance Service (SCAS)
    - Southern Health NHS Foundation Trust (SHFT)
    - Oxford Academic Health Science Network (OAHSN)
- To ensure effective plans around IM&T are delivered by all relevant organisations, together and separately, across the county, reporting to the Oxfordshire Health and Wellbeing Board (HWB), to improve the quality and experience of care for patients, to permit secure and timely sharing of information between organisations, and to empower patients in understanding and determining their own care.

Objectives

1) To support the above organisations and the Health and Wellbeing Board in developing appropriate IM&T strategic plans;
2) To receive and discuss the IM&T plans of each organisation, and to advise and feed back to the organisations on possible collaboration, overlap, and conflict;
3) To serve as a common forum to develop collaborative bids for funding to national funds and initiatives;
4) To serve as a common forum for the collaboration of the organisations on national IM&T requirements and programmes, including training;
5) To report to the HWB on the progress of common IM&T strategic plans in health and social care.

Membership (suggested)

- Paul Altmann, CCIO, OUHT
- Maggie Lay, clinical transformation lead, IMT planning and programmes, Central Southern Commissioning Support Unit (CSCSU)
- Lois Lere, director of strategic systems and technology, NHS England Area Team
- Dominic McKenny, director of Informatics, OHFT
- Fiona Robertson, head of IMT planning and programmes, CSCSU
- John Skinner, director of Oxford University Hospitals IM&T (OUHIMT)
- Tony Summersgill, assistant director of Quality, OCCG
- Martyn Ward, head of ICT, OCC
- Other members as invited from SCAS, OAHSN, SHFT, and other organisations.

Meetings

- Every two months, depending on HWB schedule

Healthwatch Oxfordshire

Update for the Oxfordshire Health and Wellbeing Board – 13th March 2014

1 Future operation of Healthwatch Oxfordshire

1.1 The current grant for the delivery of Healthwatch Oxfordshire (HWO) was awarded to Oxfordshire Rural Community Council (ORCC) until 31st March 2014. Following a subsequent tender process the operation of HWO will be taken over by a Community Interest Company which was specifically created to act as a vehicle for the delivery of HWO. The Community Interest Company (CIC) will take over responsibility for the delivery of the service from 1st April 2014. Arrangements are underway to complete the transition of the service from ORCC to the CIC.

1.2 A CIC is a new type of company designed for social enterprises that want to use their profits and assets for the public good. CICs are intended to be easy to set up, with all the flexibility and certainty of the company form, but with some special features to ensure they are working for the benefit of the community

2 Board

2.1 10 people from a range of backgrounds have now been appointed to act as the Board for Healthwatch Oxfordshire. A gap has been identified in the skills available to the Board and a recruitment process for an additional Board member with recent and relevant financial experience is underway. The current Board will all be transferring to the new CIC as Board members.

3 Director

3.1 David Roulston was appointed as an interim Director in November 2013. The process of appointing his successor is underway with a view to appointing a permanent replacement early in the next financial year.

4 Project Fund

4.1 A project fund was established to support project work and research into different areas affecting people in respect of health and social care. HWO launched the Project Fund in September 2013. The purpose of the fund is to enable HWO to better understand the experiences and needs of people in Oxfordshire and to identify good practice and areas for improvement in local Health and Social Care services. The Healthwatch staff team have been actively supporting the development of applications and proposals from frontline projects, including from 'seldom heard' groups.

4.2 The Project Fund is overseen by a sub-committee of the Healthwatch Board and projects funded include:

4.3 Research in partnership with the Patients Association into people in Oxfordshire's experience of access to GPs (further detail below).

4.4 Research by Oxfordshire Family Support Network into the health service experiences of people with learning disabilities and their families.

4.5 Research by Oxford Asian Women's Project into the health and social care experiences of Asian women in Oxford with a particular focus on primary care, mental health and domiciliary care

4.6 Research by Oxford Mental Health Forum into young people's perception of the information available to them about mental health support services.

4.7 Research by Community Glue to provide information and gather perspectives from a range of organisations about the introduction of Personal Health Budgets based on the personal experience of service users and carers, projects in other parts of the country and evaluations.

4.8 A project with Sign Lingual to explore the underlying communication issues affecting deaf people in accessing health and social care services leading to the production of a video describing their experiences.

4.9 A project by My Life, My Choice to explore the experiences of people with learning disabilities of their healthcare treatment at their local GP surgery.

4.10 Partial funding support for a Quality of Life survey to be undertaken by Oxford City Council's neighbourhood team.

5 Research into the Healthcare Experiences of students of Oxford University

5.1 In October 2013 Healthwatch offered an opportunity to a team of 4 students to work on a project which would collect intelligence about Oxford University Student's experience of and impact on local publicly funded Health Services.

5.2 The Student Consultancy team conducted a survey of 317 Oxford University students in November 2013, attempting to gain an insight into varying student experience and perceptions of the quality and ease of access of the different public health services they used.

5.3 A subsequent report has been compiled and the results shared with Oxford University Hospitals NHS Trust and Oxfordshire Clinical Commissioning Group for attention.

5.4 There were 4 main findings from the report:

5.5 High usage of A and E services –a surprisingly high number of students surveyed (13.88%) claimed to have used A&E services whilst at Oxford. Of particular concern was that over 20% of males surveyed has used A and E services.

5.6 Problems of access for UK students: In comparison with UK students problems with knowing how to access public services was far more prevalent amongst international students. More than half of the international students surveyed had no idea how to access listed health services (such as GPs and the 111 service) and the numbers of international students using services was lower. This provided a strong suggestion that information about local health services for international students is inadequate and accordingly they do not know how to properly use services.

5.7 Mental health services: From a comparison of students perceptions of quality and access to the services they used mental health services came out lower than their perception of other health services. It also came out as more polarised with many responses extremely positive but also many negative responses. The research recognised that further research needs to be collected concerning the different types of mental healthcare provision and how improvements could be made.

5.8 Centralisation: each college at Oxford provides certain health services such as a privately employed nurse and NHS GPs present once or twice a week. However the system is decentralised with no college mandated to do anything and little or no centralised authority or provision for student healthcare. This came up both in the analysis of current services and issues surrounding were raised in many of the personal comments made by respondents.

5.9 A follow up study to examine some of these issues in greater depth is currently being designed in conjunction with the Student Consultancy.

6 Initial Priorities Set by Healthwatch Oxfordshire

6.1 The following four initial priorities for attention were set by the Board of HWO:

- Access to GPs
- Setting up representative groups for relatives in care homes
- 15 minute visits in domiciliary care
- Whistleblowing

6.2 In order to explore the issue of GP access a questionnaire was designed in conjunction with the Patients Association to build on an earlier report they compiled during 2013 called ‘Access Denied’ which found a variety of evidence of patient experiencing difficulties in accessing community based healthcare.

6.3 A survey was launched during February and is about to close at the time of compilation of this report. There has been a healthy response to the questionnaire

with over 600 having been returned. The results of the survey will be analysed during March with a view to completing and subsequently issuing a report.

6.4 HWO wrote to every care home in Oxfordshire during February and has had discussions with different parties about the establishment of representative groups for relatives. We plan to establish a pilot set of such groups in 4 care homes facilitated by HWO's Engagement Officer with a view to compiling a subsequent best practice guide to promulgate the establishment of such groups more widely in care homes.

6.5 HWO welcomes the additional resources which have been found to reduce the number of 15 minute visits being commissioned by Oxfordshire County Council. We are in the process of designing a study into domiciliary care to further this priority area.

6.6 HWO is reviewing a range of literature which has been issued in respect of whistleblowing in health and social care with a view to designing how best to take this priority area forward. The ultimate objective is to seek reassurance that whistleblowers in health and social care services in Oxfordshire are being actively listened to and their concerns are acted upon.

7 Contacts made with Healthwatch

7.1 Awareness of the existence of HWO as gradually increased over the course of the year as evidenced by contacts made to the office and requests to participate in a range of activities.

7.2 Healthwatch England (the parent body for local Healthwatch organisations) is finalising a relationship database for use by local Healthwatch like HWO in capturing the range of comments about health and social care services for national compilation and to enable local Healthwatch to provide more detailed feedback to local organisations. The database is expected to 'go live' shortly and HWO will be seeking to introduce the system in the first quarter of the next financial year.

7.3 It is anticipated that this will be supplemented by the promotion of the use of a dedicated website to support the public in giving feedback about health and social care services in Oxfordshire.

8 Future Events

8.1 An annual social care engagement event called 'Hearsay' will be being held on 14th March. This will build on previous events which have taken place since March 2010. The purpose of the day is to ask the users of services and their carers what changes the most want to see made to adult social care services and come up with suggestions about how to make these changes. A report will be compiled following the event to support commissioners and providers in responding to the points raised.

8.2 HWO plans to hold an event later in the year to enable a range of stakeholders to help shape its future priorities in respect of areas requiring attention in respect of the commissioning and delivery of health and social care.

9 Care.data

9.1 HWO contacted Healthwatch England regarding concerns which had been raised by patients and other patient groups regarding the introduction of the care.data programme. This echoed concerns which had been raised by a range of other local Healthwatch organisations. Subsequent work included participating in a mystery shopper exercise of the NHS care.data telephone helpline. Healthwatch England subsequently raised concerns about the failure to adequately inform the public about this measure. HWO has welcomed the use of Healthwatch England's statutory powers to raise such concerns and the subsequent delay of the programme to enable better engagement and information for members of the public.

10 Additional matters for attention by the Health and Wellbeing Board

10.1 HWO is concerned that there needs to be monitoring of the impact of the combined effect of changes taking place at present associated with social care cuts, health efficiency savings and other changes (for example to benefits) and would encourage the Health and Wellbeing Board to take steps to monitor the impact of the changes so that this can be used to inform future priorities.

10.2 Homeless Pathways has given a good example of how the impact of cuts could be monitored in respect of homeless services. Potential measures could include:

- Numbers of rough sleepers
- Length of stay in homelessness services
- Rate of return to homelessness services
- Referrals to floating support teams
- A&E visits by people with No Fixed Abode
- Number of days of Delayed Transfer from hospital due to lack of suitable accommodation to be discharged to
- Number of homeless people detained under S136 for their own/others' safety, because there is nowhere else for them to go
- Number of people using food banks
- Petty crime stats, e.g. anti-social behaviour, shoplifting, drinking on the streets, begging
- Methadone prescribing because there likelihood of prescribing for longer and higher doses because someone is homeless.

10.3 Recent research has highlighted that people with a learning disability and/or mental health problems live, on average, fifteen to twenty years less than the general population of the UK. It is a priority of the local strategy that early death be prevented, particularly for those most at risk. Valuable work and targets are in

place but it appears to Healthwatch that the enormity of the mortality gaps is not fully reflected in either. HWO would encourage the Health and Wellbeing Board to take steps to address the mortality gaps as reported and address the health inequalities experienced by people with a learning disability and/or mental health issues.