Public Document Pack

To: Members of the Oxfordshire Health & Wellbeing Board

Notice of a Meeting of the Oxfordshire Health & Wellbeing Board

Thursday, 17 July 2014 at 2.00 pm in Meeting Rooms 1 & 2

County Hall, New Road, Oxford

Peter G. Clark
County Solicitor

July 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*(Oxfordshire County Council)*	Cabinet Member for Public Health & Voluntary Sector
John Jackson	Director for Social & Community Services
Vacancy	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
Jean Nunn-Price	Chairman of Healthwatch Oxfordshire

In Attendance: Joanna Simons, Chief Executive, OCC and David Smith, Chief Executive, OCCG

Notes:• Date of next meeting: 13 November 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 - 12)

To approve the Note of Decisions of the meeting held on 13 March 2014 (**HBW5**) and to receive information arising from it.

6. Performance Report (Pages 13 - 40)

2:05

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

There will be a review of current performance **(HWB6**) against all the outcomes for 2013 – 14 set out in the Health & Wellbeing Strategy.

Performance for each Partnership Board will be presented in turn:

- Children & Young People Partnership Board (Lucy Butler and Cllr Melinda Tilley)
- Adult Health & Social Care Partnership Board (John Jackson and Cllr Mrs Judith Heathcoat
- Health Improvement Partnership Board (Dr Jonathan McWilliam and Cllr Mark Booty)

7. OCCG 5 Year Strategy and Plan 2014/15 - 2018/19 (Pages 41 - 124)

2:15

Board Members responsible: Clinical Chair, Oxfordshire Clinical Commissioning Group (OCCG), Director for Social & Community Services
Persons giving report: Chief Executive, OCCG and Director for Social & Community Services

The OCCG 5 Year Strategy for 2014/15 – 2018/19 and Implementation Plan is before

the Board at **HWB7** for sign off prior to its approval by the OCCG Board.

A position paper on the Better Care Fund is also attached at **HWB7.**

Action Required: to

(a) agree the OCCG 5 Year Plan prior to its approval at the OCCG Board;

(b) note the changes to the Better Care Fund and the implications for plans in Oxfordshire;

(c) agree to hold an additional meeting of the Board at an appropriate time to consider an updated Better Care Fund Plan that reflects updated guidance prior to submission to Government.

8. Refreshed Joint Health & Wellbeing Strategy, Targets and Indicators (Pages 125 - 154)

2:25

Persons Responsible: Members of the Health & Wellbeing Board
Persons giving reports: Director of Public Health, Director for Children's Services and Director for Social & Community Services.

A revised draft version of the Strategy **(HWB8**) is presented for discussion and decision. This will include proposed outcomes for 2014-15 to show progress in delivering improvement in priority areas.

Comments from the Oxfordshire Joint Health Overview & Scrutiny Committee which met on 3 July are attached at **HWB8**.

Action Required: to approve the revised Health & Wellbeing Strategy for 2014 - 15

9. Reports on Quality Issues (Pages 155 - 192)

2:45

Board Members responsible: Clinical Chair, OCCG; Director for Social & Community Services and Director for Children's Services.
Persons giving reports: As indicated below.

(a) Review of Adult Learning Disability Health & Social Care Services – A report outlining the review of Adult Learning Disability Health & Social Care Services (**HWB9**) will be presented by the Director for Social & Community Services and the Clinical Chair, OCCG.

The Health and Wellbeing Board is asked to note the background and reasons for proposing to review learning disability services in Oxfordshire and agree the approach being taken by Oxfordshire County Council and

Oxfordshire Clinical Commissioning Group. The majority of learning disability health and social care services in Oxfordshire are currently provided by Southern Health NHS Foundation Trust (Southern Health).

(b) Care Quality Commission (CQC) - A summary report of the recent CQC inspection on Oxford University Hospitals NHS Trust (OUHT) will be presented by Sir Jonathan Michael, Chief Executive, OUHT (**HWB9**).

(c) OFSTED Inspection of Children's Services – A report (**HWB9**) and presentation will be given by the Deputy Director for Children's Social Care & Youth Offending Service on the outcomes of the recent OFSTED inspection of the County Council's Children's Services.

The full report can be found at the following link:
http://www.ofsted.gov.uk/local-authorities/oxfordshire

(d) Winterbourne View – A summarised shared Improvement Plan and covering report is before the Board (**HWB9**).

The Health and Wellbeing Board is asked to note the strategic intentions of the Winterbourne Improvement Plan for Oxfordshire and monitor delivery of the action plan.

Action Required: to receive the reports and to approve any recommendations contained within them, as indicated above.

10. Healthwatch Oxfordshire - update (Pages 193 - 208)

3:35

Board Member responsible: Jean Nunn - Price, Chair of Healthwatch Oxfordshire
Person giving report: Jean Nunn - Price

Jean Nunn - Price will present the report of Healthwatch Oxfordshire **(HWB10**) which includes findings from recent research and issues of concern.

Action Required: to note the report.

11. Reports from Partnership Boards (Pages 209 - 212)

3:50

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

- The Vice - Chairman of the Children & Young People Partnership Board;
- 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

The Board is asked to consider a report **HWB11** on the future of the Adult Health & Social Care Partnership Board.

Action Required: to

(a) receive updates from each Partnership Board; and

(b) consider the recommendations contained in the report HWB11 with regard to the future of the Adult Health & Social Care Partnership Board.

12. Protocol between the Health & Wellbeing Board and the Children's and Adult's Safeguarding Boards (Pages 213 - 218)

4:05

Board Members Responsible: All Members of the Health & Wellbeing Board
Person presenting report: Director of Public Health

A protocol between the Health & Wellbeing Board and the Adult and Children's Safeguarding Boards is presented for agreement **(HWB12).**

Action Required: to agree the principles and further work required as set out in this paper to formalise and improve the relationships between the Health and Wellbeing Board and two Safeguarding Boards, and to delegate responsibility to the Director for Children's Services and the Director for Social and Community Services to work with the respective Chairs of the Safeguarding Boards to take this forward.

13. Pharmaceutical Needs Assessment (Pages 219 - 220)

4:15

Board Member Responsible: Director of Public Health
Person giving report: Director of Public Health

A report is before the Board at **HWB13**.

Action Required: to note progress with this work and to delegate the authority to approve the draft PNA document for consultation to the Director of Public Health, following consultation with the Chairman and Vice – Chairman of this Board.

14. PAPERS FOR INFORMATION ONLY (Pages 221 - 222)

A written summary of communications received by the Chairman of the Board since the last meeting and responses given (attached).

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OXFORDSHIRE HEALTH & WELLBEING BOARD

OUTCOMES of the meeting held on Thursday, 13 March 2014 commencing at 2.00 pm and finishing at 4.20 pm

Present:

Board Members:	Councillor Ian Hudspeth – in the Chair Dr Joe McManners (Vice-Chairman) District Councillor Mark Booty Councillor Mrs Judith Heathcoat Councillor Hilary Hibbert-Biles John Jackson Dr Jonathan McWilliam Councillor Melinda Tilley City Councillor Ed Turner Larry Sanders James Drury (In place of Matthew Tait) Frances Craven (In place of Jim Leivers)
Other Persons in Attendance:	Ian Wilson CBE (Interim Chief Executive, Oxfordshire Clinical Commissioning Board)
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
1/14 Welcome by Chairman, Councillor Ian Hudspeth (Agenda No. 1)	
The Chairman extended a welcome to: • Dr Joe McManners in his role as the Oxfordshire Clinical	

Commissioning Group's (OCCG) Clinical Chair and Vice - Chairman of the Board; • Ian Wilson, interim Chief Executive, OCCG, who is 'in attendance' to the Board alongside Joanna Simons; • Larry Sanders in his new formal role as Chairman of Healthwatch Oxfordshire and member of the Board. The Chairman took this opportunity to thank Dr Stephen Richards on behalf of all the members of the Board 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.	Julie Dean
2/14 Apologies for Absence and Temporary Appointments (Agenda No. 2)	
James Drury attended for Matthew Tait, Frances Craven for Jim Leivers, and apologies were received from Dr Mary Keenan and Joanna Simons.	
3/14 Declarations of Interest - see guidance note opposite (Agenda No. 3)	
There were no declarations of interest submitted.	
4/14 Petitions and Public Address (Agenda No. 4)	
There were no petitions submitted or any requests to address the meeting.	
5/14 Note of Decisions of Last Meeting (Agenda No. 5)	
The Note of Decisions of the meeting held on 21 November 2013 (HWB5) was approved and signed as a correct record.	
6/14 Terms of Reference (Agenda No. 6)	
The Board were asked to approve an amendment to the Oxfordshire County Council Constitution (Health & Wellbeing Membership) to reflect the changes which had recently occurred within the Oxfordshire Clinical Commissioning Group.	

It was **AGREED** that in order to reflect these changes: (a) to amend the current wording of the Terms of Reference for the Board 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 '<u>either the Chief Executive of the Oxfordshire Clinical Commissioning Group or its Clinical Chair as notified to the Monitoring Officer of Oxfordshire County Council'</u> (b) that a nomination be sought from the OCCG for a GP representative to join the Adult Health & Social Care Partnership Board.	)))))))) Head of Law & Culture (Glenn Watson)))) Interim Chief Executive (OCCG)
7/14 Joint Strategic Needs Assessment (Agenda No. 7)	
The Board considered the Joint Strategic Needs Assessment report (HWB7) on trends in local data which impact on health & wellbeing. The report also included recommendations for updating the Joint Health & Wellbeing Strategy. In response to a question on population, John Jackson highlighted the work the County Council were doing with Oxford City Council looking at projections of housing growth, which had informed the strategic housing market assessments. There was general support amongst the Board for the need in the future to analyse all data at a local level in order to produce a clearer picture of how service needs could be met in local areas. The Board **AGREED** 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.	)) Director of Public Health (Jackie Wilderspin/Ben Threadgold))))
8/14 Pharmaceutical Needs Assessment for Oxfordshire (Agenda No. 8)	
The Board considered a report (HWB8) which advised on work in progress to produce a Pharmaceutical Needs Assessment for Oxfordshire on behalf of the Health & Wellbeing Board. The Board **RESOLVED** 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.	))) Director of Public Health (Jackie Wilderspin))))
9/14 Performance Report (Agenda No. 9)	
The Board had before them a Performance Report (HWB9) which reviewed the third quarter (1 October – 31 December 2013) performance against all the outcomes set out in the Health & Wellbeing 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.	

It was **AGREED** to note the report.	Director of Public Health (Ben Threadgold)
10/14 Oxfordshire Clinical Commissioning Group 5 Year Plan (Agenda No. 10)	
Ian Wilson, interim Chief Executive of the Oxfordshire Clinical Commissioning Group (OCCG), gave a presentation on the draft OCCG 5 Year Plan. The Board were requested to comment on it and endorse it prior to its submission to the OCCG Governing Body and then to NHS England on 4 April. Mr Wilson reassured members of the Board on the robust nature of the Plan to eradicate the CCG's budget deficit adding that a rigorously tested project management approach had been adopted. Mr Wilson gave his reassurance that the OCCG was looking closely at where the areas of need were and how the public could best be served. The OCCG had initiated plans to help primary care to develop networks which would enable enhanced access. This included a variety of solutions suited to different areas in the localities. Members of the Board welcomed the ambition contained in the Plan to tackle inequalities, asking if there were similar ambitions to raise the quality of mental health services. Mr Wilson pointed out that the mental health area was leading the way in the new Outcome Based Commissioning method in contracting services, leading to a more integrated way of working with other mental health services. The Board noted that the outcomes of a recent survey of access to GP's by Healthwatch Oxfordshire was currently being analysed. In addition, a survey of Oxford University students had also been carried out by Oxfordshire Healthwatch on their experiences of the Accident & Emergency service during 2013. Information on these surveys would be passed to the appropriate people/organisations on completion. It was **AGREED** to: (a) approve the OCCG Quality & Performance Committee's two possible measures for improving the quality of commissioned services which were: • developing a measure to improve prescribing; • developing a measure to improve electronic	)

clinical communication and to delegate to the OCCG Governing Body any final decision on which measure to adopt; and (b) approve the draft OCCG 5 Year Plan, taking the above comments of the Board into account and to delegate the sign off of the final document to the Chairman & Vice-Chairman of this Board.	) Interim Chief Executive OCCG/ Chairman of Health & Wellbeing Board
11/14 Better Care Fund Plan (Agenda No. 11)	
The Board had considered a background paper on the Better Care Fund Plan at its previous meeting. Formal approval was now sought on the proposed use of the Fund in Oxfordshire, prior to its submission to NHS England (as an integral part of the OCCG's Strategic and Operational Plans) by 4 April 2014. John Jackson introduced the Plan (HWB11) which had its focus on the pressures arising from the rising numbers of older people with complex conditions. It had been built on the existing Older People Joint Commissioning Strategy 2012 - 2016 and produced together with the Oxford University Hospitals NHS Trust and a number of users and carers. Larry Sanders commented that it had been found that there were better results from the reablement service when people were helped to connect with local networks. He added that he had been very encouraged by the community development work carried out by Age UK. He called for a greater emphasis on care for the carers via short breaks etc. John Jackson responded that discussions were ongoing with the OCCG with regard to the Community Health Service (Reablement) and a review of the community service interface with patient coming out of acute care was progressing. A report would be made to a future meeting. The County Council were also looking to carry out a review of information and advice. Its focus was also to reach more carers. The Care Bill would make it a legal requirement for carers to have an assessment and it was anticipated that this would be addressed through the Better Care Plan. A plea was made for GPs, Schools and Social Workers to give more help and support to young carers and also for patients to be discharged to facilities near to their families on leaving acute care. It was **AGREED:** (a) to agree the Better Care Fund Plan for Oxfordshire for	)

submission to NHS England by 4th April 2014, 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**.**	Director for Social & Community Services/ Clinical Chair OCCG/Chairman Health & Wellbeing Board
12/14 Local Information Steering Group (Agenda No. 12)	
Dr Paul Park, OCCG, presented a proposal to set up a multi-agency group to enable collaboration on Information Management and Technology (HWB12). It was **AGREED** to endorse the proposal.	Interim Chief Executive OCCG (Dr Paul Park)
13/14 Local Healthwatch (Agenda No. 13)	
Larry Sanders, Chair of Healthwatch Oxfordshire presented an update on recent developments (HWB13). He undertook to take any comments and suggestions from the Board to the Healthwatch Board. Members of the Board were very supportive of 10.2 – to encourage the Health & Wellbeing Board to take steps to monitor the impact of the changes taking place associated with social care cuts, Health efficiency savings and other changes (for example, to benefits) on homeless services. They were also supportive of the initiative to establish a pilot set of representation groups for relatives in four care homes with a view to compiling a subsequent best practice guide to promulgate the establishment of such groups more widely in care homes.	Chair of Healthwatch Oxfordshire

It was suggested that Healthwatch may wish to also work with groups who represent users and carers in various care networks, reporting on the patient and carer perception of services. Board members were very appreciative of the paper and wished Healthwatch all the very best in the future under his chairmanship.	))))))))
14/14 Reports from Partnership Boards (Agenda No. 14)	
Councillors Melinda Tilley, Mrs Judith Heathcoat and Mark Booty each gave an oral progress report on recent activity of each of the Partnership Boards. <u>Children & Young People's Partnership Board</u> Councillor Tilley, Vice Chairman, reported the following: • The February meeting had been cancelled due to sickness and adverse weather conditions; • The new Terms of Reference for the Partnership Board had now been agreed and work was ongoing to clarify the relationship the Board had with the Oxfordshire Children's Safeguarding Board, their roles and responsibilities and how they differed, particularly with regard to performance management; • Interviews had been held for a representative from the voluntary sector on the Partnership Board, the outcome of which was not yet known; • The Partnership Board had held an extended meeting to begin development of the new Children & Young People's Plan 2014 – 18 which had been attended by over 20 representatives from the public and the voluntary sector, the outcomes of which were: - a proposal to extend the existing Plan until November 2014 (to take account of a range of complex issues which would impact on its development in the next few months); - to establish a multi-agency sub – group to develop a new Plan for 2014 – 18 to ensure that it had true 'buy – in' from a range of partners; and - the Partnership Board to agree the Plan in October 2014 and then submission to the Health & Wellbeing Board in November 2014. • The Partnership Board had decided to look at methods of working in light of the extra social workers taken on to lessen social worker caseloads. This was explained by	

rising levels of children on care plans and increased referrals from schools; and • The Partnership Board were looking forward to the establishment of a multi – agency Safeguarding Hub (MASH). <u>Adult Health & Social Care Partnership Board</u> Councillor Mrs Judith Heathcoat, Chairman of the Partnership Board, reported the following: • The OCCG were in the process of finding representatives to sit on the Board following recent staffing changes; • A refreshed Joint Commissioning Strategy would guide how OCC and the OCCG pooled budget for Adults with a Learning Disability was spent over 2015 – 18. A Learning Disability workshop had been held on 19 December 2013 on the next 'Big Plan' for the support of adults with a learning disability in Oxfordshire. A good mix of people had attended, including users carers, service providers, commissioners and other partners. Several areas of action were identified which included working with support provider employers and Councils to increase employment opportunities and more promotion of healthy lifestyles, for example through sporting opportunities and healthy eating education; • In January the Board had held a joint workshop with the Health Improvement Partnership Board on prevention of premature death and enabling healthy older age. Loneliness was identified as a key issue which the Board agreed to take forward. Paul Cann (Age UK Oxfordshire and the Campaign to End Loneliness in Older Age) set the context for discussion and Ann Nursey, OCC, provided an overview of the situation in Oxfordshire and the various ways in which it was currently being addressed. Suggestions for moving forward included working with partners such as the Fire & Rescue Service, social landlords and GPs to identify individuals at risk. The importance of accessible transport, day service opportunities and luncheon clubs were also discussed. It was agreed that the new Community Information Networks would play a pivotal role in identifying individuals at risk of loneliness and signposting them to locally available opportunities and services. The Partnership Board undertook to ensure that the discussions were linked in with the work already underway and progress would be reviewed at a future meeting; • The Partnership Board was updated on progress in implementing the Joint End of Life Care strategy and the short and medium term plans for the care of people towards the end of their lives. Discussion led to the	

identification of a key area for action which was to increase coordination amongst GP Champions for End of Life Care and ensuring their work feeds into the strategy. The Partnership Board endorsed the plans, agreed to monitor progress and proposed to hold a workshop on End of Life Care in the Autumn. This would provide an important opportunity to report back on these actions and identify further opportunities for improvement through partnership working.

<u>Health Improvement Partnership Board</u>

Councillor Mark Booty reported the following:

- The Partnership Board had met in November 2013 but had cancelled its January meeting;
- At its November meeting it had received detailed reports on performance on two areas in particular:
    - Health Checks – an ambitious target of 65% had been set. The Partnership Board heard about plans to target particular groups in the population to increase take-up;
    - Breastfeeding at 6-8 weeks – another ambitious target of 62% had been set. The Partnership Board heard about targeted work to improve the current rate.
- Updates were received at the November meeting on fuel poverty and the work of the Affordable Warmth Network; and the impact of welfare reform and outcomes of the pilot work in the City'
- The agenda for the 27 March meeting included:
    - the final draft of the Healthy Weight Strategy. The Partnership Board were planning a joint workshop with the Children & Young People's Partnership Board on this topic later in the year;
    - the Joint Public Health Strategy between OCC and OUHT;
    - An Annual report from the Public Health protection Forum (which would give an overview of performance on immunisation, screening and other health protection issues).
- A workshop had been arranged for April 2014 which would include attendance from housing portfolio holders from District Councils and officers, OCCG and Probation representatives who were working on options for housing related support in the future. This meeting replaced the January workshop which was postponed.

Councillors Tilley, Mrs Heathcoat and Booty were thanked for their reports.	

..... in the Chair

Date of signing .....

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Oxfordshire Health and Wellbeing Board
17 July 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. End of year performance can be summarised as follows:

   39 indicators are Green
   15 indicators are Amber (defined as within 5% of target)
   12 indicators are Red
   4 indicators are not possible to RAG rate
   6 indicators expected to report in Q4 do not have information available – explanation is included in the notes column in the appendix.

3. Current performance is generally good, with just over half (51%) of targets being met and exceeded for the year. Appropriate action is being taken where performance did not meet expected levels to improve this. This has been summarised in the notes column of the appendix.

4. It is worth noting that performance on the indicators for the proportion of children who go missing from home 3 or more times in a 12 month period (indicator 3.4) has dropped from Green to Red during the year, with the numbers of children going missing remaining similar but an increasing number have gone missing more than once.

5. It is also worth noting that the proportion of young people not in education, employment or training (indicator 4.9) has improved from Red to Green throughout the year, and is the lowest for a number of years. In addition the number of autism awareness training events (indicator 5.8) has also increased from Red to Green.

6. End of year performance information has not yet been received for six indicators
   - physical health assessments for patients with schizophrenia (5.3)
   - annual physical health checks of people with learning difficulties (5.4)
   - number of people with a learning disability having seen their GP (5.5)
   - employment of people with mental health needs (5.9)
   - adults who do at least 150 minutes of physical activity a week (9.2)
   - proportion of girls receiving all 3 doses of human papilloma virus vaccination (11.4).

   If the data becomes available by the time of the meeting this will be updated verbally.

In addition it wasn't possible to RAG rate a further four indicators

- proportion of women who have seen a midwife by 13 weeks of pregnancy (1.1)
- emergency admissions to hospital for older people (6.3)
- bereaved carers' views on quality of care (6.17)
- fuel poverty (10.4).

Ben Threadgold
Policy and Performance Service Manager, Joint Commissioning, Tel: (01865) 328219

July 2014

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** 91.9% (1727 out of 1873 maternities)	G	**Expected** 91% **Actual** 1798		**Expected** 91.5% **Actual** 1765		**Expected** 92% **Actual** nya		Nationally validated data is published quarterly on the NHS England website on a quarterly basis. The number of women who have seen a midwife or maternity health care professional by 13 weeks of pregnancy has been published for Q1-3 but due to low coverage the numbers of maternities have not been published meaning that it is not possible to calculate a percentage. Figures are for Oxfordshire CCG area.
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** **94.7%**	G	During the Q4 period, 2050 children were eligible for review and 1942 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** 130.1	G	**Expected** 168.7 **Actual** 122.3	G	**Expected** 164.3 **Actual** 148.4	G	**Expected** 159.8 **Actual** 152.2	G	This is good progress although we know that there are always significant seasonal fluctuations in admissions for infection. It is also noted that the reduction in rate of admissions for infection in under 18s

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
										is mirrored in a similar reduction in the overall rate of emergency admissions for under 18s.
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** Options considered and report produced	G	Separate report was provided for the June CYP partnership board relating to this measure
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** **1036**	A	This represents a significant increase from 2012/13 when take up would have been 777 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** **83%**	G	

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
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 **50 (234 cumulative)**	G	The annual rate for the calendar year 2012 was 20.7%
2.4	Maintain the current low level of persistent absence from school for looked after children (2012 persistent absence figures were supressed by the Department for Education, however they indicated that the number of children was small, i.e. less than 4%).			**Expected** < 5% **Actual** 4.7% (7 pupils) Reported cohort 9.8% (31 pupils) Whole cohort	G					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. The whole cohort refers to any looked after child for the period of time that the child was in care only.
2.5	Maintain the number of looked after children permanently excluded from school at zero (12/13)			**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** completed	G					19.8% of children in need were persistently absent from school during the 2013/14 academic year. The figure for Oxfordshire as a whole was 4.7%. Target to reduce this figure.

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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** Not yet established	R					It has not yet been possible to establish a full baseline of young people on the autistic spectrum. A baseline will be set for the 2013/14 academic year once a full set of data is available.
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** na		**Expected** 810 **Actual** 830	G	
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			

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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 medium or low through Multi-Agency Risk Assessment Conferences (currently 85% for 2012/13 based on a single-agency)							**Expected** 85% **Actual** **83%**	**A**	This is currently a single agency measure. A multi-agency measure indicator has been developed for 14/15 that can be reported on a monthly basis, if required.
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** 100%	**G**	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 **Actual** Prevalence reported and action taken as appropriate	G	**Expected** Prevalence reported and action taken as appropriate **Actual** Prevalence reported and action taken as appropriate	G	**Expected** Prevalence reported and action taken as appropriate **Actual** Prevalence reported and action taken as appropriate	G	**Expected** Prevalence reported and action taken as appropriate **Actual** **Prevalence reported and action taken as appropriate**	**G**	Prevalence report has been submitted and discussed by the CSE sub-group for the last 4 quarters. All reported incidents of CSE have received an appropriate police and social care response. 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

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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 **Actual** **7.9%**	G	**Expected** 10.0% or less **Actual** **10.5%**	G	**Expected** 11.0% or less **Actual** 12.6%	A	**Expected** 12.0% or less **Actual** 15.3%	**R**	The numbers of children going missing remains similar to last year (636 in 2013/14, compared to 630 in 2012/13) but an increasing number have gone missing more than once - 97 compared with 77 this time last year. The mitigating actions include: ○ Staff notified immediately a child goes missing rather than when they return ○ Implementation of return interviews within 72 hours ○ Introducing monitoring the reasons why people go missing ○ Ensuring that multi agency risk assessments are completed on the most vulnerable children ○ Improved reporting on those most at risk
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** **Over 76%**	**G**	Performance exceeded the target of 50% in all agencies which submitted quantitative evidence of the overall impact of safeguarding activity in children's cases.

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
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** 83% or 9376 children	**G**	
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 children	G					
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** 78% or 4666 children	A					This was a redefined performance measure this year and although this has not met the aspirational target set, performance remains above national (78% 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			**Expected** 61% or 3840 children	**G**					Although performance remains slightly below target, the proportion of children meeting this key measure in Oxfordshire increased from 57.9% in 2012 and is

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	2012/13 (currently 57.9% or 3474 children)			**Actual** 60.6% or 3776 children						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					
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** na		**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** Primary: 77% (38,696 pupils) Secondary: 80% (28,790 pupils)	A	

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
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) 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)			**Expected** Primary: 2.6% (1070 pupils) Secondary: 7.2% (2250 pupils) **Actual** Primary: 2.9% Secondary: 6.9%	**A**					
4.9	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** 4.7% (813) March	**G**	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.

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** **66%**	**R**	Although the number of people saying they find information very or fairly easy to find, has overall remained constant, there has been a drop in the figure for working age adults to 66% (128/193). Work to improve information in 2013/14 included • Setting up the Oxfordshire Community Network to provide face to face advice • Improving the council's online information • Providing printed copies of Support Finder for people who cannot access it online Contracted an Independent Care and Financial Service to offer people advice about their care and support options
5.2	Maintain the proportion of people with a long-term condition who feel supported to manage their condition at 85%.							**Expected** 85% **Actual** **90%**	**G**	
5.3	100% patients with schizophrenia are supported to undertake a physical health assessment							**Expected** 100%		

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
	during 2013/14 (this is a new indicator and the baseline will be established this year)							**Actual** **nya**		
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** **nya**		CSCSU is unable to obtain the end of year figures from the Learning Disability Directed Enhanced Service (DES) returns. Request has been made to Area Teams have to provide the data but this has yet to be received.
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** **nya**		CSCSU is unable to obtain the end of year figures from the Learning Disability Directed Enhanced Service (DES) returns. Request has been made to Area Teams have to provide the data but this has yet to be received.
5.6	Reduce the number of emergency admissions for acute conditions that should not usually require hospital admission for people of all ages (2012/13 baseline: 956.2 DSR for all ages per 100,000 population)	**Expected** Less than 956 per 100,000 **Actual** 948.8	G	**Expected** Less than 956 per 100,000 **Actual** 958.4	A	**Expected** Less than 956 per 100,000 **Actual** 964.2	A	**Expected** Less than 956 per 100,000 **Actual** **951.4**	**G**	
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** **565.4**	**G**	

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
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** **524**	G	
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** nya		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									
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** **144**	R	At the end of March there were 144 delays. Only one authority had more per capita, however across the year Oxfordshire had the highest rate of delays. The average number of people delayed rose by 1% in the year, but the number of days people were delayed dropped by 6%. Although delays across the year rose, they are now 20% lower than this time last year reflecting the work to improve patient flow. This work is being maintained and is overseen by weekly

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										urgent care summit meetings.
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** 16.5	**R**	**Expected** Less than 14.8 **Actual** **17.1**	**R**	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** 5,899	G	**Expected** **Actual** 11,770		**Expected** **Actual** 17,577		**Expected** **Actual** **23,389**		Data has not been received from all hospitals and so it is not possible to rate against the target. For the Oxford University Hospital Trust the numbers have increased by less than 1%, which is below the demographic growth rate.
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** **Model developed**	G					
6.5	No more than 400 older people per year to be permanently admitted to a care home (currently 582)	**Expected** 100	R	**Expected** 200	R	**Expected** 300	**R**	**Expected** 400	**R**	626 people were permanently placed in a care home last year compared to 582 in the previous year where the aim was to reduce admissions by developing community services, such as extra care

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		Actual 156		**Actual** 311		**Actual** 479		**Actual** **626**		housing. Within the year the number of admissions dropped when we stopped using assessment beds (care home placements for people from hospital where they could be assessed). New placements in assessment beds stopped in August and all people in assessment beds were transferred to permanent placements by November. During this period there were 13 permanent admissions per week, but since then this has dropped to 10 admissions per week. Despite this drop in admissions, waiting lists and specifically delayed transfers of care have not risen.
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**	A	**Actual** Service options being developed	A	**Actual** Service options being developed	**A**	The community services review has now developed into 2 strands of work. One of these has become part of the outcome based contract work - bringing together Supported Hospital Discharge Service and reablement and how this aligns with other community services such as hospital at home, community therapy, district nursing. The other strand is the re-commissioning of home support and the discharge to assess at home service. This is being taken forward by the County Council as part of the work to improve the availability and responsiveness of home support and to commission a model which is incentivised for outcomes, has an enabling focus, and includes individual

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										service funds.
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% **Actual** 60.4%	A	**Expected** 61.5% **Actual** 60.9%	A	**Expected** 62.25% **Actual** 61.0%	A	**Expected** 63% **Actual** **61.9%**	**A**	There has been a 9.2% increase in the number of people supported at home this year, but a small increase in people supported in care homes, means that a lower proportion of people are supported 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)	NCI	**Expected** 54.9% **Actual** 42.9% (3815 people)	R	**Expected** 57.4% **Actual** 43.2% (3843 people)	R	**Expected** 60% **Actual** **44.2%**	**R**	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**	NCI	**Expected** 45% (48 homes) **Actual**	NCI	**Expected** 67.5% (71 homes) **Actual** 20% (21 homes)	A	**Expected** 90% (95 homes) **Actual** 24% (25 homes	**A**	The target is 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 204 registered champions including 74 from 25 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

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										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** 2759	**R**	The number of people starting reablement increased by 26% in the year, but remains 20% below the target. A communications plan to target potential referrers to the service (e.g. GPs, housing providers, Age UK workers) is being drawn up. We are reviewing the exclusion criteria for the service to ensure that people who could benefit aren't being excluded. 13 people are still receiving a service from reablement whilst they await long-term care. This figure needs to be kept to a minimum. To incentivise timely pick up of care revised payments have been agreed whereby the service can bill the council for each day that someone is delayed more than two weeks.
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%	R	**Expected** 55% **Actual** 52%	R	**Expected** 55% **Actual** 54%	A	**Expected** 55% **Actual** **54%**	**A**	

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
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** **93.5%**	G	215 out of 230 people reported that they were treated with dignity in the way they received their care.
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** **84.4%**	G	205 out of 243 respondents reported that they have adequate social contact or as much social contact as they would like
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, which 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 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			**Expected** Analysis completed	A					A draft analysis of demand for alternative housing options for older people within Oxfordshire to inform future targets was presented in

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
	by September 2013			**Actual** Draft analysis completed						September 2013. Completion and agreement of the above was delayed until the Strategic Housing Market Assessment (SHMA) was completed, which it was in April 2014 Discussion on the implementation and adoption of the Strategic Housing Market Assessment is still on-going but a workshop is being planned for September to consider a revised strategy for older persons housing given the implications of the Strategic Housing Market Assessment. A report on the outcome of the workshop and plans to take forward a strategy on older persons housing will now be deferred until the November full Health & Wellbeing Board.
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** **80.2%**	**G**	Improvement in the year. 134/167 older people said they found information fairly or very easy to find
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 **Actual** **47.1**		

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
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** **88%**	**G**	198 out of 225 people said they receive their care and support in a timely way
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** Timetable currently being developed	**A**	An initial cross partner workshop has been held to agree a joint timetable for integration. This work will draw together the various partner projects in to a composite plan although there are differing timetables for delivery. This transparent and single plan will enable a greater degree of and understanding of the dependencies and issue across primary, community and social care services. To this effect provider and commissioner development meetings have been scheduled
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.

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
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** **64.5%**	**G**	
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 (75.6%) **Actual** **77.2%**	**G**	
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 (86%) **Actual** 90%	**G**	
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	**Expected** 14,224 carers known	G	**Expected** 14,571 carers known	G	**Expected** 14,918 carers known	**G**	**Expected** 15,265 carers known	**G**	

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
	1,388)	**Actual** 14,255		**Actual** 14,656		**Actual** 15,100		**Actual** 15,474		
7.7	880 carers breaks jointly funded and accessed via GPs (currently 881)	**Expected** 220		**Expected** 440		**Expected** 660		**Expected** 880		
		Actual 409	G	**Actual** 633	G	**Actual** 737	**G**	**Actual** **880**	**G**	

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
Priority 8: Preventing early death and improving quality of life in later years										
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** 58.1%	A	**Expected** 60% **Actual** 54.9%	R	**Expected** 60% **Actual** nya		Updated with Q3 data – Q4 due end July.
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** 30,206	G	**Expected** 39,114 Actual 41,368	G	.
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** 46.0% (9351 of 20,329)	R	**Expected** 65% **Actual** 46.5% (14148 of 30206)	R	**Expected** 65% **Actual** **45.9% (19006 of 41,368)**	R	
8.4	At least 3800 people will quit smoking for at least 4 weeks (last year target 3676, actual 3703)	**Expected** 851 **Actual** 909	G	**Expected** 1639 **Actual** 1735	G	**Expected** 2523 **Actual** **2672**	G	**Expected** 3800 **Actual** **3622**	A	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**					
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** **Nya**		
9.3	62% of babies are breastfed at 6-8 weeks of age (currently 59.1%)	**Expected** 62% **Actual** 58.7%	A	**Expected** 62% **Actual** 59.5%	A	**Expected** 62% **Actual** 60.4%	A	**Expected** 62% **Actual** **60.3%**	**A**	

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
Priority 10: Tackling the broader determinants of health through better housing and preventing homelessness										
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** **197**	G	The majority (57%) are in Oxford City.
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** 83.9%	G	**Expected** 75% **Actual** **93.1%**	G	This figure does not include information from mental health services.
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** nya		**Expected** 80% **Actual** **81%**	G	

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
10.4	Fuel poverty outcome to be determined							**Expected** **Actual** **Oxfordshire 8.7% are fuel poor according to the Low Income, High Cost definition**		A new national indicator has been introduced and this reports levels of fuel poverty in Oxfordshire of 8.7%. In England the rate is 11%. Under this new Low Income High Cost definition a household is considered to be fuel poor when: • they have required fuel costs that are above average (the national median level) • were they to spend that amount, they would be left with a residual income below the official poverty line. Plans are being drawn up by the Affordable Warmth Network for 2014-15 to target action to reduce fuel poverty. It is suggested that this indicator is not RAG rated as more information is still needed.

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
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** 95.0%	G	**Expected** 95% **Actual** 95.8%	G	**Expected** 95% **Actual** **95.1%**	G	
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%	0	**Expected** 95% **Actual** 93.7%	A	**Expected** 95% **Actual** **92.7%**	A	
11.3	At least 55% of people aged under 65 in "risk groups" receive flu vaccination (currently 51.6%)							**Expected** 55% **Actual** **55%**	G	
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** **nya**		Annual data available June

Oxfordshire
Clinical Commissioning Group

Oxfordshire Health and Well Being Board

Date of Meeting: 17 July 2014	

Title of Presentation: Refreshed OCCG Plan 2014/15-2018/19

Is this paper for	**Discussion**		**Decision**	X	**Information**

Purpose and Executive Summary

The attached document is the refreshed strategy and plan for Oxfordshire CCG for the period 2014/15-2018/19 which was previously presented to the Health and Well Being Board and which now incorporates the CCG's response to feedback from NHS England following the initial submission. The fundamentals of the plan are not changed; after CCG Governing Body discussion we have now added additional information about:

- Revised financial situation
- Parity of esteem in mental health
- Provider market strategy
- Better Care Fund
- Organisational development plan

The ambition on years of life lost, which was challenged by NHS England, has been retained at the original levels following internal review, Governing Body debate and advice from Dr Jonathon McWilliam. As Oxfordshire Director of Public Health, Dr McWilliam has advised that the suitability of the data in question for planning purposes is questionable on a number of points, concluding that unless a longer time trend can be found, his view is that the CCG's plan is reasonable.

The HWB Board agreed the Oxfordshire Clinical Commissioning Group Strategic Plan at its March 2014 meeting, the Board is now asked to agree the refreshed plan but in so doing we draw attention to one outstanding area.

Following the national assurance process, the Better Care Fund plan for Oxfordshire has been red rated and did not achieve satisfactory sign off. This Fund is referred to in the Strategic Plan. A meeting of key partners is planned for July 16th to progress this work.

There have been recent national announcements on Better Care Fund which are referred to in an accompanying briefing paper. It is intended to update the Board on any progress with the Better Care Fund plan at this meeting.

Financial Implications of Paper: These are addressed in Chapter 7.

Action Required: The Health and Well Being Board is asked to: i. RECOMMEND to agree the refreshed Oxfordshire Clinical Commissioning Group Strategic Plan ii. NOTE the actions and agreements outstanding which will be taken forward

NHS Outcomes Framework Domains Supported (please tick ✓)	
/	Preventing People from Dying Prematurely
/	Enhancing Quality of Life for People with Long Term Conditions
/	Helping People to Recover from Episodes of Ill Health or Following Injury
/	Ensuring that People have a Positive Experience of Care
/	Treating and Caring for People in a Safe Environment and Protecting them from Avoidable harm

Equality Analysis completed *(please tick and attach)*	Yes *	No	Not applicable
Outcome of Equality Analysis	Equality Impact Assessment is available on the CCG's public website.		

Author: Regina Shakespeare Interim Director of Commissioning and Partnerships and Interim Chief Operating Officer, Oxfordshire CCG	**Clinical Lead:** Dr Joe McManners, Clinical Chair, Oxfordshire CCG

Oxfordshire CCG strategy for 2014/15-2018/19

and implementation plan for 2014/15-2015/16

Introduction

This document is the strategy and plan for Oxfordshire CCG, for the period 2014/15-2018/19. It sets out our strategy for the next five years, and the actions we will be taking to deliver that strategy in the next two years – so combining our 5 year strategic plan and 2 year operational plan in one document.

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, and reflects our joint plans with our commissioning partners in NHS England, Oxfordshire County Council and the local district councils.

This plan focusses on reducing demand; streamlining and integrating care to deliver improved quality and greater financial efficiency, and ensuring the system works collaboratively in the best interests of the patient.

All our improvement interventions will contribute to integrating services more effectively around the patient – wherever possible pulling services closer to the patient's home. Over the next five years OCCG and its partners will deliver: improvements in the integration of health and social care; improvements in the integration of people's physical and mental health care and 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.

This plan will also result in a significant improvement in our performance against the key pledges in the NHS constitution. This will give people a much better 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.

Dr Joe McManners, Clinical Chair, OCCG

Chapter 1: Ambition & Vision

1.1 Our Strategic Objectives for the Oxfordshire Health and Social Care System

a. In five years' time, the Oxfordshire health and social care system will:

   i. Be financially sustainable.
   ii. Be delivering fully integrated care, close to home, for the frail elderly and people with multiple physical and/or mental health needs.
   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. Over the next two years we will start to deliver this transformation in the patient experience and to achieve financial sustainability through 5 major, detailed, service transformation programmes; development and delivery of a joint Better Care Fund plan with social care; aligned commissioning with NHS England; and a series of important supporting measures:

   i. 5 Programmes of Transformation:
      - Primary care
      - Urgent care
      - Planned care
      - Mental health
      - Medicines Management.

   ii. Development and delivery of integration, underpinned by our Better Care Fund Plan.

   iii. Supporting measures:
      - Improving health and reducing health inequalities
      - Delivering parity of esteem in mental and physical health care
      - Engaging the public and promoting transparency
      - Delivering quality, safety and innovation
      - Organisational development, David Smith arrival as Chief Executive in June 2014.
      - Provider market strategy

c. In order to deliver the ambitions of this plan we will need to shift activity and resources into different parts of the system. By 2018/19 we will have reduced the amount of time spent avoidably in hospital through the provision of better integrated care in the community by approximately 31% [1]

d. To achieve this we will have increased investment in primary care and in community services. We will have maintained levels of spending in mental health and our running costs by 4%.

[1] National composite measure (EA4) of: unplanned hospitalisation for ACS conditions and u'19s with asthma, diabetes and epilepsy; emergency admissions for acute conditions not normally requiring admission and children with lower respiratory tract infections.

e. Our strategy and plan have the full support and endorsement of the Health and Wellbeing Board and align fully with the agreed Oxfordshire Health and Wellbeing Strategy.

f. The specific changes this plan will deliver for patients are:

i. Improved urgent access to primary care.
ii. Rapid access to same day multi-disciplinary assessment services designed to reduce the likelihood of admission.
iii. Support from locality based, integrated health and social care community teams that:

- Deliver joined up health and social care to the frail elderly, patients with multi-morbidities (particularly the 2% of the population who make most use of health and social care services), patients with physical and mental health needs (including those with dementia), and patients on the palliative care register.
- Enable people to return home from hospital in a timely manner and then to regain their independence.
- Provide same day home based treatment and care services to vulnerable older people, patients with complex co-morbidities and those at end of life, following referral from the rapid access multidisciplinary assessment service.

iv. Access to a primary care led whole person model of care for patients with several long term conditions (including those with mental health needs), focused on the proportion of patients who make the highest use of health and social care.

v. Reductions in inappropriate use of A&E.

vi. Streamlined urgent care pathways resulting in fewer emergency admissions for people with conditions that can be treated without being admitted.

vii. Improved end of life care.

viii. Streamlined planned care pathways, with more opportunities to access planned care closer to home and fewer outpatient referrals.

ix. A reduction in the offer of treatment where it is known to be of limited clinical value.

x. Less medicines waste and more cost effective prescribing in all settings.

xi. Better integration of physical and mental health care across all sectors and in all settings, to ensure better health outcomes for all patients wherever they are receiving treatment.

xii. Reduction in health inequalities, particularly for those groups identified as priorities in the DPH annual report for Oxfordshire.

xiii. Care provided by a system that is working really collaboratively in the best interests of the patient and their carer's.

OXFORDSHIRE CCG PLAN ON A PAGE		
BY WORKING TOGETHER, WE WILL HAVE A HEALTHIER POPULATION, WITH FEWER INEQUALITIES, AND HEALTH SERVICES THAT ARE HIGH QUALITY, COST EFFECTIVE AND SUSTAINABLE.		
OCCG OBJECTIVES	**MAKING MEASURABLE CHANGE**	**HOW WE WILL MAKE THIS CHANGE**
1. Be financially sustainable. 2. Primary care driving development and delivery of integrated care, and offering a broader range of services at a different scale. 3. Provide preventative care and tackle health inequalities for urban and rural patients and carers. 4. Deliver fully integrated care, close to home, for the frail elderly and people with multiple physical and mental healthcare needs. 5. Enable people to live well at home and to avoid admission to hospital when this is in their best interests. 6. Be providing health and social care that is rated amongst the best in the country.	1. Compliance with all NHS financial planning rules within 3 years. 2. Reduce years of life lost from conditions amenable to healthcare by 3.2% in 5 years. 3. Meet all agreed Health and Wellbeing Board targets every year. 4. Reduce the amount of time spent avoidably in hospital by 31% in 5 years. 5. Reduce the number of people delayed on any given day from 155 to below 100 by October 2015. 6. Reduce A&E activity by 10 % in 5 years. 7. Increase the proportion of older people living independently at home after discharge from hospital by 8% in 2 years. 8. In the top 20% nationally for people satisfied with their experience of hospital care in 5 years. 9. Reduce outpatient activity by 4% and planned inpatient activity by 17% in 5 years. 10. Meet all NHS Constitution measures in full. 11. Increase the no. of people with mental and physical health problems having a positive experience of care by 5.2% in 5 years.	1. Deliver more efficient, better quality care in all settings. 2. Integrate commissioning and provision of all aspects of physical and mental health care. 3. Help GP practices work together to improve access and quality. 4. Increase GP capacity to deliver care to most complex patients. 5. Provide community based planned and urgent care services. 6. Provide community and home based integrated health and social care to the most complex patients, including those with mental health needs. 7. Deliver partnership programme with Councils, 3rd sector and NHS England to tackle health inequalities and their underlying causes. 8. Reduce inappropriate A&E attendances by providing viable alternatives and improving 111. 9. Reduce avoidable admissions by: a. Improving pathways for people with chronic conditions needing urgent care b. Improving support to care and nursing homes c. Improving end of life care. 10. Reduce lengths of stay by working together to improve discharge and by contracting across providers for an integrated acute pathway of care. 11. Improve access to diagnostics. 12. Ensure only appropriate outpatient referrals are made. 13. Streamline planned care pathways. 14. Reduce activity known to be of little clinical value. 15. Improve integration of physical and mental health care. 16. Improve dementia diagnosis and care.
ROBUST GOVERNANCE ARRANGEMENTS: 1. Programme Management Office in place in the CCG Partnership programme boards for major change programmes. 2. Effective locality level patient, public and stakeholder forums. 3. Oversight by the Health and Wellbeing Board.		**PRINCIPLES UNDERPINNING DELIVERY** 1. Clinicians and Patients working together to redesign how we deliver care. 2. Reducing health inequalities by tackling the causes of poor health. 3. Commissioning Patient Centred High Quality Care. 4. Promoting integrated care through joint working. 5. Supporting individuals to manage their own health. 6. More care delivered locally.

Chapter 2: Oxfordshire Context

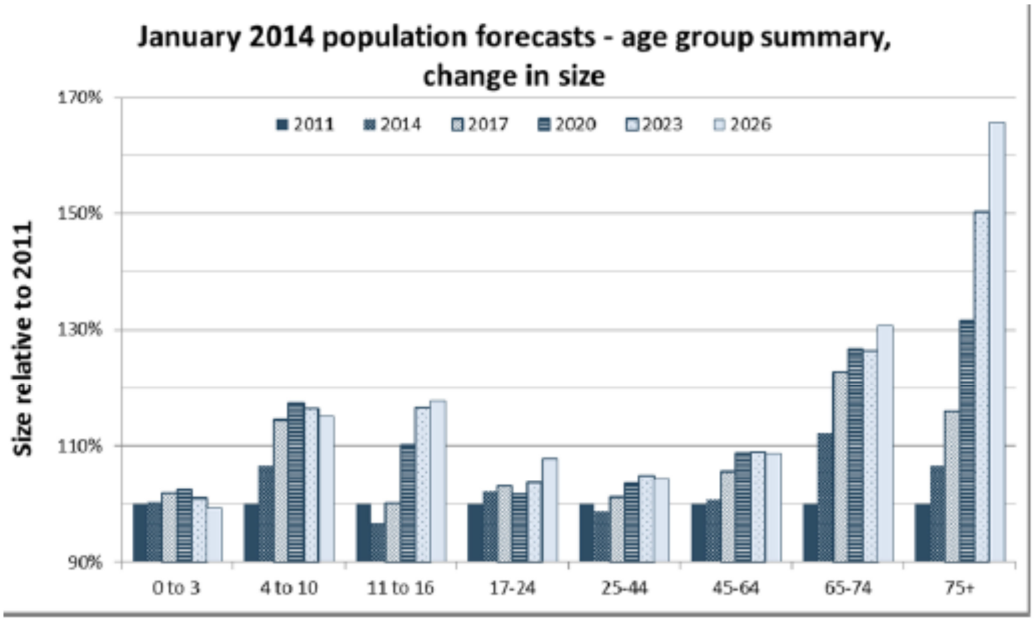
2.1 Our plan has been developed in response to :

i. The data and analysis set out in our JSNA, the joint priorities we have agreed with the Health and Wellbeing Board and the issues identified in the Director of Public Health's Annual Report.
ii. An analysis of the current strengths and weaknesses in the local health and social care economy.
iii. The views of our member practices.
iv. The views of local people.

2.2 Key messages from our JSNA 2014 Annual report , Health and Wellbeing Strategy and DPH Annual Report

a. Analysis of 2011 census data for Oxfordshire 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.

b. 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.



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

c. 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.

d. 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.

e. 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.

f. 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.

g. Further to analysis of the updated JSNA, the Oxfordshire Health and Wellbeing strategy 2012-2016, and the DPH Annual Report we have identified a number of priority areas for development. These are the need to:

i. Make the patient's journey through all services smoother and more efficient.
ii. Join 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.
iii. Reduce inequalities, break the cycle of deprivation and protect the Vulnerable – by working with a wide range of district council, county council and third sector partners on delivery of key prevention interventions
iv. Treat people's mental and physical health needs equally
v. Give children a better start in life.
vi. Reduce unnecessary demand for services.
vii. Help people and communities help themselves.
viii. Improve the quality and safety of services.
ix. Streamline financial systems, especially those pooled between organisations, and align all budgets more closely.

2.3 Five domains and outcome measures

Delivery across the five domains and outcome measures:

The systematic approach to ensuring our delivery on the five domains and national outcomes has been achieved through a prioritisation and development process.

This process comprised:

An analysis of the current strengths and weaknesses in the local health and social care economy including: NHS Constitution measures, national outcomes measures for the five domains of the outcomes framework, local Health and Wellbeing Board outcomes, activity levels and financial performance against contract; benchmarking with national and comparative peers.

There then followed review and development of our initial programme proposals against clear prioritisation criteria:

- Delivery of national outcomes
- Delivery of CCG objectives
- Delivery of financial savings
- Scale of anticipated impact
- Viability of initial proposal

The Health and Wellbeing strategy over seen by the Health and Wellbeing Board has been designed to ensure comprehensive coverage across the Oxfordshire system. Later this report describes the OCCG specific contributions to the Well-Being approaches.

Following agreement of business cases and approval by the Project Management Office our plan will contribute to delivery of the improvements against a set of 7 nationally defined outcome measures as set out below. Delivery is being tightly managed through programme management processes.

	NHS Outcome ambition	**Actions in the plan that will impact**
1	*Securing additional years of life for the people of England with treatable mental and physical health conditions*	• Improved psychiatric liaison in all settings • Pro-active identification and care management of those 2% of patients who are the highest users of the system • Integrated health and social care teams • Outcomes based contracting for mental health • Ambulatory care acute pathways
2	*Improving the health related quality of life of the 15 million + people with one or more long term condition, including mental health conditions*	• Improved psychiatric liaison in all settings • Pro-active identification and care management of those patients who are the 2% highest users of the system, • Integrated health and social care teams • Outcomes based contracting for mental health • Improved dementia diagnosis and care
3	*Reducing the amount of time spent avoidable in hospital through better and more integrated care in the community, outside of hospital*	• Practices working together to support patients with planned, urgent and complex care needs • Pro-active identification and care management of the proportion of the population, who make the highest use of health services (2% highest users). • integrated health and social care teams • Rapid access community based MDT assessments • Consultant and specialist GP led community based clinics • Improved dementia diagnosis and care • Full sub-acute care functionality from community health and social care community bed providers • Better Care Fund initiatives.
4	*Increasing the proportion of older people living independently at home following discharge from hospital*	• Pro-active identification and care management of those patients who are the 2% highest users of the system • integrated health and social care teams • Provision of ambulatory care pathways between acute And community remove need for an admission • Home care support services with built in re-ablement • Enhanced ALERT services • 7 day working in social care
5	*Increasing the number of people having a positive experience of hospital care*	• Fully functioning directly bookable choose and book service supported by streamlined planned care pathways • Ambulatory care acute pathways • Sustainable delivery of all NHS constitution standards • Continuity of care for pregnant women and maximising capacity at the Freestanding Midwifery Led Units. • Will move us up 1 quintile in 2 years and into top quintile in 5 years
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*	• Development of psychiatric liaison services in primary, community, emergency and inpatient settings • Increased access to psychological therapies for patients with ACS conditions • Multidisciplinary community teams that incorporate older adult mental health workers.
7	*Making significant progress towards eliminating avoidable deaths in hospital caused by problems in care*	• Continue 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.

We have quantified, in the outcome template our expected impact on national outcome ambitions from our five programmes of transformation.

2.4 The strengths and weaknesses of our local health economy

a. The Oxfordshire health and social care system is under significant financial pressure and proposing a deficit budget of £1m for 2014/15.

b. There are key areas where significant improvement is required, and these are:

   i. The increase in A&E attendances and emergency admissions, particularly for the share of patients with multiple attendances and admissions which is growing fastest.
   ii. The unacceptably high numbers of patients experiencing delayed transfers of care.
   iii. Meeting waiting time targets for elective care and improving the quality of outpatient referrals.
   iv. The pressure on primary care.
   v. Achieving financial balance.

c. The NHS Constitution makes a set of commitments to patients and the public about the core standards they can expect from the NHS and the NHS Outcomes Framework provides a means of measuring local performance against a set of fundamental outcomes that the NHS should deliver. The extent to which these standards are being met is a good measure of how well any health and social care system is getting the fundamentals right.

d. OCCG monitors a comprehensive range of indicators on a monthly basis. These include: NHS Constitution measures, national outcomes measures for the five domains of the outcomes framework and local Health and Wellbeing Board outcomes.

e. Oxfordshire is doing well against most national measures. The table below summarises areas where improvement is needed and the proposed improvement actions incorporated in this plan and the programmes which are defined in the CCG's delivery arrangements.

Measures where performance is sub-optimal	Proposed action to address
Delivery of 18 week waiting time targets for planned care	Significantly improve planned care pathways; improve referrals; increase choice; and develop options for accessing planned care in the community.
99% of people waiting less than 6 weeks for diagnostics	Ensure greater choice of diagnostic provider and work with providers to ensure core standards are met.
98% of people spending 4 hours or less in A&E	Reduce the estimated % of A&E attendances that could be treated elsewhere, more appropriately, by addressing the underlying behaviour of frequent attenders and providing acceptable and suitable alternatives that people will use.
Percentage of patients receiving cancer treatments within 31 days of diagnosis or 62 days of urgent referral by their GP with suspected cancer	Work with our providers to ensure performance is recovered to meet these targets. Plans for 2014 include strengthening of the MDT with all tumour sites covered; revising the roles of the patient tracker team; and recruiting to an overseeing audit and validation post, to ensure standards are met; and providing additional radiotherapy capacity at weekends.
Some ambulance call time and hand over standards	Commissioners are incentivising South Central Ambulance Service (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 and treat'). SCAS will implement NHS Pathways, the triage tool used within the 111 telephony service, within 999.

Provision of timely alternatives when operations are cancelled for non-clinical reasons	If the provider in question cannot provide assurance that it can meet the Constitutional standards for listing and then treating patients, then the CCG will look to move cohorts of patients to alternative providers.
Estimated diagnosis rates for people with dementia	The Mental Health Programme and the Better Care Fund Plan set out actions to improve the memory clinic pathway and to build the capacity of local communities and local services to support people with dementia.

2.5 The priorities identified by our member practices

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 of our 6 localities 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.

Priorities identified by localities	Action Incorporated in plan
Developing primary care to enable it to drive a shift of care from hospital into the community, and to meet changing national expectations	• Primary Care Transformation Programme
Improving the range and accessibility of community based services to support admission avoidance and to speed discharge	• Deliver locality based integrated health and social care community teams • Outcomes based contract for the acute assessment/admission/discharge/re-ablement pathway incorporating community , acute and potentially social care, providers • Roll out of EMUs or equivalent pathways across County
Tackling health inequalities by offering targeted support to address lifestyle behaviours and choices	• Partnership plan to tackle health inequalities agreed with Public Health teams in OCC and NHS England • Support to be focussed on small number of practices in each locality where it is agreed need is greatest
Improving the quality of care provided by care and nursing homes	Develop project during 14/15 to: • Review and rationalise care home support services • Increase medicines management support to Care homes • Review care home contracts with Oxfordshire County Council to drive up quality • Improve medical support to care and nursing homes
Developing a “whole person” model of care to support patients with multiple long term conditions	• Development of a pro-active, primary care led, multi morbidity service focussed on those patients who are the top 2% of service users – supported by integrated health and social care teams and improved ambulatory care pathways in the acute

Priorities identified by localities	Action Incorporated in plan
Reducing inappropriate use of A&E	• Agree preferred option for achieving this with providers in Q1 of 14/15 – e.g. primary care at front door of A&E , development of navigator system • Communications programme to improve appropriate use of NHS services
Reducing first OP activity	• On-going support for peer review in primary care • Improved clinic management • Roll out of a GP desktop system that helps ensure referrals comply with best practice
Improve access to, and quality of, diagnostics	• Ensure radiology services meet national and local standards by March 2016 and increase community radiology provision
Improve End Of Life care	• Review and rationalise current End Of Life support services • Increase percentages of patients registered as requiring palliative care • Improve use of Advanced Care Planning and special notes
Improve access to and quality of mental health services, particularly for people with addictions	• Outcomes based contracting for some elements of mental health care • Enhanced psychological support in primary, community and secondary care settings

2.6 What local people told us

a. OCCG is committed to responding fully to the views and concerns of local people. An extensive consultation with the public through a Call to Action consultation programme in the late autumn of 2013 gave rise to a number of commonly shared priorities. The table below sets out the key themes which emerged and summarises how this plan responds to them:

THE PUBLIC SAID	OUR REPONSE
Be open and transparent about the financial challenge	We have set a deficit budget in full recognition of the complexity of our financial situation.
They like the idea of outcomes based commissioning, but we shouldn't rush into it wholesale	We are working steadily with our local providers to develop this approach for mental health and acute care for older people.
They want care closer to home as long as that care is high quality care	We will ensure that community based: urgent care, integrated health and social care and planned care are all of the highest quality and that you get the right care in the right place – which will be hospital when you need it.
The NHS needs to change the public's attitude from "fix me now" to people accepting joint responsibility for their health	We have committed our locality teams to doing targeted outreach, education, patient participation group and other development work to help deliver this long term goal.

We need a comprehensive all ages education programme about how to use the NHS	Our locality teams are working 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.
The NHS should maximise the use of technology to free up GP time for face to face care	The Better Care Fund plan includes increased investment in the ALERT service; our LTC programme commits us to on-going work with the academic community on identifying telehealth solutions and our locality teams are working with local practices to support provision of patient access to records online; on line appointment and repeat prescription services, and text message appointment reminders.
The NHS should reduce duplication and waste	We are improving integration of care around the patient –for example our Better Care Fund plan will deliver a single health and social care assessment and a single health and social care plan with 1 care co-ordinator managing its delivery.

2.7 System values and principles

a. 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.

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

2.8 Summary of our key priorities for change

a. Analysis of this range of perspectives on where the important issues are in the Oxfordshire health and social care system has given rise to a focus in this plan on:

   i. Making major, transformational changes in:
      - Primary care
      - Urgent care
      - Planned care
      - Mental health
      - Medicines management

   ii. Development and delivery of integration, underpinned by our Better Care Fund Plan.

   iii. Delivering an important set of supporting work programmes:

      - Enduring work to tackle health inequalities
      - Delivering parity of esteem in mental and physical health care
      - Engaging the public
      - Delivering quality, safety and innovation
      - Organisational development

b. The remainder of this plan sets out the main components of each of these change programmes for the period 2014/15-2015/16, and the change we want to have delivered by the end of five years.

c. Ensuring we deliver the change we need in the system will be dependent on the CCG working closely with its commissioning partners, Oxfordshire County Council and NHS England, to broker and enable truly collaborative working between all local health and social care providers in the best interests of the patient. A strong partnership with our providers is also our goal.

Chapter 3: Our 5 Major Change Programmes for the Period 14/15-15/16

3.1 Introduction

a. This chapter summarises our main change programmes. More detail on each of the change programmes can be found in Appendix 1.

b. Subsequent chapters of this plan provide more detail on our Better Care Fund plan and supporting improvement measures.

c. These change programmes were arrived at through a prioritisation and development process which comprised:

i. Review of initial programme proposals against clear prioritisation criteria:

- Delivery of national outcomes
- Delivery of CCG objectives
- Delivery of financial savings
- Scale of anticipated impact
- Viability of initial proposal
- Contribution programme makes to improving access.

ii. Work up of selected full business cases.
iii. Review of each of these at several development stages by a Programme Management Board.
iv. Sign off of finalised business cases by the Finance and Investment Committee.

3.2 Primary Care Transformation Programme

This programme aims to build the capacity of primary care to operate at scale, so reducing pressure on individual practices whilst improving patient access, improving the quality of primary care and increasing out of hospital care. The programme will address the five core ambitions identified in NHS England's Improving General Practice, Call to Action Phase 1 report, and will be developed and delivered through a ground breaking co-commissioning partnership with NHS England. A Primary Care programme board will oversee planned initiative.

The primary care programme aims to:

- Deliver fully integrated care, close to home, for the frail elderly and people with complex multi-morbidities.
- 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.
- Routinely enable people to live well at home and to avoid admissions to hospital when this is in their best interests.

This will be delivered by building the capacity of practices to:

- work together to improve access
- work closely with integrated teams to improve management of patients with multi-morbidity,
- enable access to more consultant led clinics in the community
- enable clinical commissioning champions in each practice to engage in locality work and lead work to reduce variation in their practice
- Enable practices to work together on back office efficiencies within and across the 6 locations.

The primary care programme will use a range of contractual levers, service improvement tools, and membership engagement to deliver this programme within a strategic framework which will be monitored by the primary care programme board. Progress already achieved includes the creation of a co-commissioned local improvement scheme with Thames Valley Area Team to maximise benefits from investment in primary care in 2014/15. The CCG plans to build on this experience and develop other co-commissioning opportunities which will support the development of a primary care which both sustains general practice and offers more flexible services.

Working with partners and the public to develop an integrated approach to primary and community services, with joint commissioning as appropriate:

A robust and sustainable primary care is fundamental to achieving the CCG's key objectives of driving development and delivery of integrated care. Local acute and community providers recognise that primary care needs to be actively involved in the design and delivery of services which are wrapped around the patient and primary care. Engagement of primary care as providers will be supported by the establishment of a county wide primary care federation which can offer services at a wider scale than the individual practice level. 88% of practices have signalled their intent to participate in a federation and the CCG plans to use co-commissioning opportunities to support new, more flexible ways of working in primary care.

Local Clinicians have collaborated with CSU statisticians to define selection criteria which GP practices have found effective in identifying a relevant patient cohort. Clinical judgement has been found to be the key ingredient to enhance capabilities of a risk stratification tool to bring a wide range of conditions into the 2% cohort, e.g. frail, elderly, palliative, mental health, asthmatic children. Working relationships amongst local providers has improved collaborating around identifying their shared care planned cohort and agreeing a way forward for care coordination.

Practices are expressing interest and curiosity in learning how to more proactively manage ‘at risk’ patients more pro-actively, as they begin to think through and recognise their practice processes around the DES requirements. OCCG regards this as a positive step toward improving care for this patient cohort and avoiding unplanned admissions.

How we will enable primary care to operate at greater scale to improve access and continuity of care and enable our urgent and emergency care network to function effectively:

The CCG is working on a number of fronts to improve access to urgent/same day appointments in primary care. Analysis has been undertaken to identify patients who frequently and inappropriately attend A&E and locality based support is being targeted to help practices address this problem. Additionally, the CCG is working with general practitioners to identify and test different ways of working which enable practices to manage demand so that patients with complex long term conditions can see their usual doctor and avoid unnecessary admissions. Opportunities to offer extended access through federated working will be considered as part of this process. Enhanced primary care support to 111 is also being explored to reduce attendances at A&E.

One of the CCG QIPP programmes will look at different procurement options around 111 and out of hours, E.g. benefits of horizontal or geographical capacity, the benefits of greater access to clinical advice in 111 and the benefits of greater GP or other clinical input in the SCAS call centre. We are also reviewing the recommended destinations from certain 111 dispositions with a view to increased use of minor injuries and other services with greater capacity, and with increased level of telephone consultations.

The urgent care working group (Whole Systems Programme Board) has identified that information could be provided more easily through web based access points and that the scope of choices for GPs to support their patients outside hospital can be better laid out. This should enable GPs to more reliably source alternatives when visiting patients in their own homes.

3.3 Urgent Care Programme

This programme aligns with the Keogh report[2], in that it comprises 7 projects which will:

i. Reduce activity in A&E by optimising access to alternative local services
ii. Reduce avoidable admissions for patients with conditions that can be treated without an admission
iii. Improve the efficiency and effectiveness of the 111 and Patient Transport Services.
iv. Improve end of life care
v. Improve the management of patients with complex long term conditions in primary care
vi. Support OUHT in its role as a regional stroke and trauma centre
vii. Improve access to the right service in the right place at the right time
viii. Improve the urgent care pathway, particularly at the interface between acute and community
ix. Deliver a net saving of £2.84m in 2014/15.

Additional projects that will reduce avoidable admissions from care and nursing homes and reduce healthcare expenditure on long term nursing care placements will be submitted to the Programme Management Board during 2014/15.

a. Urgent Care Project 1: OOH and 111

The 111 service requires re-procurement for a new service to begin during 2015.

OCCG is considering the most effective manner in which to commission 111 in the future and whether to jointly commission with other CCGs for a regional service, or seek to develop 111 with other urgent care services locally.

There is also the opportunity to consider the future delivery of Out of Hours primary care and Minor Injury / First Aid Units as part of a strategic review of urgent care services with partners across the system, including OUH, Oxford Health, SCAS, OCC and the LMC.

OCCG will consider the optimum strategy for commissioning these services in the future, which may include integration of services.

An integrated service across primary care and 111, or between primary care and Minor Injury Units, could enable:

- Further triage or management of patients once they have been assessed by the NHS Pathways triage tool, for those requiring more investigation;
- Reduction in the number of Out of Hours base visits, where such patients could be managed by telephone
- Reduction in the proportion of patients referred on to other services, particularly A&E and emergency ambulance response;
- Improvement of flow within services;
- As a result, release of associated savings arising from reductions in activity.

[2] Transforming Urgent and Emergency Care Service in England, Urgent and Emergency Care Review End of Phase 1 Report, Nov. 2013. http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf

A 111 service commissioned across Thames Valley could allow for increased resilience of call handling and clinical advice within the call centre and offer efficiencies in terms of costs per call being negotiated at large scale.

b. Urgent Care Project 2: PTS

Non-Emergency Patient Transport Services (PTS) will require re-procurement in 14/15 for a new contract to commence during 2015. OCCG and partners are exploring the optimal model for delivery of PTS in the future, including the potential to formally tender across Thames Valley with Buckinghamshire and Berkshire CCGs, to offer a seamless service to patients across boundaries and offer cost efficiencies due to scale.

OCCG is undertaking a public consultation on the current eligibility criteria for PTS between May and August, to determine the future shape of transport and ensure patient transport is both sustainable and supports those with greatest need.

While determining the optimal model for PTS, consideration will also be given to:

- The management of GP urgents via PTS rather than emergency ambulance, for patients that have been assessed by a GP as requiring rapid admission to hospital for further management
- Patients requiring urgent transportation to a GP practice for assessment, including those requesting a home visit, for whom transport to the practice would enable the GP to assess them earlier in the day
- Additional discharge journeys from acute and community bedded settings, to support bedded care flow
- Reducing the current level of aborted journeys, where patients are absent or not ready to travel when transport arrives.

Commissioners will also seek to increase 'Hear and Treat' management of patients within 999, decrease the number of ambulances that are dispatched but do not subsequently convey ('See and Treat'), and improve response to life-threatening conditions (Category RED 8 calls) in rural areas in the South and West of Oxfordshire.

c. Urgent Care Project 3: Minor A&E avoidance

i. OCCG will work with its main acute provider to explore and agree alternative provision (by end Q2) to reduce A&E attendances by 16% by 2015/16. This will incorporate:
   - Measures that prevent inappropriate attendances
   - Measures to redirect rather than treat in the event of an inappropriate attendance, with appropriate contractual protections in place to ensure the service that treats is the service funded to treat
   - Measures to divert to more appropriate services.

d. Urgent Care Project 4: End of Life

i. This project will deliver:
   - Full adoption and implementation of the care plans developed in existing projects (including Advanced Care Plan summaries being accessible Out Of Hours)
   - The moving of community contracts for hospices from activity based cost & volume contracts to block contracts.

e. Urgent Care Project 5 : Improve management of patients with LTCs

i. This project will ensure that:
   - GPs are enabled to deliver the new GMS contract requirement that they identify their 2% highest risk patients and case manage them to avoid unplanned admissions, and that this is informed locally by use of the ACG risk prediction tool.

- GPs are enabled to utilise the full range of interventions to manage patients, for example reshaping practice time to support case management as proposed in the Primary Care Programme; using integrated health and social care teams as defined in our community contract and Better Care Fund plan; and accessing the community psychological medicine service, as set out in the Mental Health Programme).
- We implement revised LTC models/pathways for key conditions in the acute and primary care settings (as described in the Primary Care Programme and Ambulatory Emergency Care pathway project below).
- Patients are effectively supported to manage themselves, where this is appropriate.

f. Urgent Care Project 6: Develop an Ambulatory Emergency Care pathway

i. This project will see further development of pathway in acute hospitals for patients who come to A&E with ambulatory care sensitive conditions, in order to ensure those patients are seen, treated and sent home, rather than being admitted.

g. Urgent Care Project 7: Urgent Care Outcomes Based Contracting for Older People

i. In agreement with our partners, OCCG will continue to apply the principles of outcomes based commissioning across the older people's pathway to capture an improved level of integration (rather than discrete services with boundaries) and delivering the right patient outcomes (rather than focussing on detailed separate clinical service specifications). This will both support the delivery of integration and deliver an overall improvement in cost effectiveness and quality.

3.4 Planned Care Programme

Overview

The planned care programme comprises 5 projects to deliver to provide continuous improvements in health outcomes by:

I. Directing our resources to the services which evidence shows are effective
II. Driving out waste and duplication
III. Describing to patients how they can support themselves to live well improve their wellbeing.
IV. Developing models of care that supports the lives of our local population
V. Delivering a net saving to the system of £8.98m in 2014/15

Underpinning all projects in this programme is a clear commitment to ensure that wherever care is provided it offers value, quality and ease of patient access.

a. Planned Care Project 1: Diagnostics

This project will:

- Optimise GP usage of pathology and radiology imaging services by September 2014
- Improve the quality of radiology performance, access and turnaround times to meet national and local standards by March 2016
- Increase community provision of radiology through commissioning services in a competitive landscape.

b. Planned Care Project 2: Elective Care

We will improve the provision of elective care by refining how, when and where care is delivered through:

- Improving the quality of referrals between professionals
- Optimising efficiency of care pathways once patients have been referred to hospital;
- Maximising the opportunity to deliver care in alternative settings for appropriate conditions
- Expanding of consultant led email advice & guidance
- Expanding of specialist GPs in ways that support intra practice referrals

- Reducing those out-patients where a secondary care assessment provides little or no additional value to the patient

c. Planned Care Project 3: Integrated MSK Pathway

We will undertake a comprehensive review of planned care pathways, starting with Orthopaedics, in order to:

- Design a model of care that explores the various stages of the pathway, identifies potential inefficiencies and variation across inpatient and outpatient activity, as well as scope the effectiveness of wider support services and potential to deliver care in alternative settings. The outcomes of the various work-streams will be considered collectively with potential mechanisms for implementation and realising any opportunities identified. This could include the implementation of robust contracting levers, focussing on service transformation, may include the re-procurement of services.

d. Planned Care Project 4: Secondary Care Prescribing

- We will ensure the most cost effective prescribing in secondary care for diabetic macular oedema; retinal vein occlusion and age related macular degeneration by unbundling a package of eye treatment for which drug costs have been reduced.

e. Planned Care Project 5: Procedures of Limited Clinical Value

This project will:

- Reduce the use of resources to undertake procedures known to be of limited clinical value, thereby releasing funds to be spent where the greatest benefit is realised by the most people.

- Improve the contract disciplines supporting this so that providers and the CCG are assured that all partners are working to the same principles.

- Review the procedures currently regarded as of limited clinical value in Oxfordshire and update guidance and policies in line with national recommendations.

OUHT is the main provider for Oxfordshire patients and has experienced both steep activity growth and performance challenges. OCCG has joined the weekly OUHT meetings to support the on-going work to bring the Trust back within the RTT targets. The teams have worked hard to deliver increased capacity and this is reflected in the improvement against majority of targets. With the exception of completed pathways – admitted. The Trust is committed to maintaining this level of clinical and managerial resource until all targets have been met. OUHT and OCCG have agreed to work together to develop an early warning protocol that will give confidence to the system that we understand capacity and demand fluctuations and have plans in place to support them.

3.5 Mental Health Programme

This programme aims to ensure the integration of phyiscal and mental healthcare along the care pathway and to make improvements in dementia diagnosis and care. It will ensure we meet national targets on dementia and IAPT diagnosis. In addition the programme will focus on the development of an Outcomes Based Contracting Model for Mental Health. The programme is expected to deliver savings of £0.8m in 2014/15, further detail is set out in section 5.2.

a. Mental Health Project 1: Integrated psychological services

i. This project will:
- Pilot anxiety and depression interventions for Chronic Obstructive Pulmonary Disease and cardiac patients
- Provide access to community psychological medicine services for people with complex Long Term Conditions and Medically Unexplained Symptoms.
- Improve identification and management of people presenting with mental health problems in A&E and as inpatients
- Ensure we build on current service provision to gain benefits realised in other areas by improving rapid access to psychological services in the acute hospital setting
- Meet national targets on IAPT referral and recovery
- Support the development of the multimorbidity care model in primary care.

b. Mental Health Project 2: dementia

i. This project will:
- Review and develop the memory clinic pathway to streamline roles and responsibilities for diagnosis and care in primary, community and secondary care settings
- Prioritise investment in carer support to carers of patients with dementia
- Seek further investment in dementia advisors to support newly diagnosed patients
- Enable localities to engage with relevant local partners to develop dementia friendly communities.

ii. This project will take us from a dementia diagnosis rate (against expected rate per 100,000 of the population as defined by the National Dementia Calculator) of 43% in 2013/14, we plan to meet the national target of 67% by the end of 2015/16. We are confident that we can meet this challenging, but realistic, trajectory over two years, by enhancing the ability of Primary Care to offer opportunistic diagnosis through the use of GPCOG or an equivalent tool (in line with the national Dementia DES), and by streamlining the memory clinic pathway so that diagnosis can be rapildy confirmed.

3.6 Medicines Management Programme

This programme wil deliver savings on our drugs bill of £2.46m in 2014/15.

a. Medicines Management Project 1: reducing waste

i. Reduce medicines waste by:
- reviewing “when necessary” and “not dispensed” items
- Pilot “costs on bags” project
- Pilot “not dispensed” project
- Reviewing of repeat prescribing and dispensing (including in carehomes)
- Synchronisation of medications.

b. Medicines Management Project 2: primary care prescribing

i. The focus of this year’s medicines optimisation programme in primary care will be on:
- Chronic Obstructive Pulmonary Disease
- New Oral Anticoagulant Agents (NOACs)
- Diabetes.

c. Medicines Management Project 3: wound care

i. Derive savings from supply of wound care dressings by retendering contract and issuing new useage guidelines in 2014.
ii. Agree other dressings savings with tissue viability team for roll out in 2015.

3.7 Quality Impact Assessment

a. OCCG has an established system of quality assurance of commissioned services in Oxfordshire. Where possible we use validated tools to measure quality and combine this with the 'soft intelligence' we receive. When necessary we take decisive action to address situations where quality falls below the required standard.

b. In order to ensure that our strategic and operational goals are aligned with this approach OCCG undertakes a quality impact assessment on all new business cases. In line with good practice, each project is assessed against 3 criteria: patient safety; clinical effectiveness; and patient experience. The assessor determines the seriousness of potential adverse consequences and assesses the likelihood of the risk being realised.

c. For 2014/15 all projects in our major transformational programmes (as summarised in this chapter), have been assessed by the CCG's quality team in line with the above process.

d. This process has identified:
   i. The need to review the safety elements of the Minor A&E avoidance project once implementation is underway.
   ii. Further consideration of the elective care business case to ensure that the quality of patient care is not affected.

   iii. The need for enhanced patient engagement around medicine waste

e. Recommendations arising from this assessment will be reviewed by the CCG's Programme Management Board.

Chapter 4: Better Care Fund and Delivering a Modern Model of Integrated Care

4.1 Introduction

a. Our major change programmes as described above rely on the delivery of integration of care around the patient throughout the patient pathway.

b. Over £330m is currently shared within a pooled budget arrangements with Oxfordshire County Council across all client groups. This includes a significantly expanded pool covering care for older people and care and outcomes in physical disability, learning disability and mental health and wellbeing.

c. The Better Care Fund investments offers new scope for Integrating social community and acute pathways.

d. We have joint commissioning strategies with our social care partners 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 to be unique in the country. We will be building further on this in our outcome based commissioning programme.

e. We are working closely with our commissioning partners in NHS England to ensure alignment of our respective strategies and investments and delivery of integrated services – particularly in relation to primary care and public health.

f. Our 6 localities each have strong relationships with their local District Councils and we will continue to ensure joint working with them to integrate service provision in areas such as health and housing and prevention and early intervention.

g. The March 2014 Health and Well Being Board for Oxfordshire recognised social care investment is required through the Oxfordshire BCF to protect adult social care. It has been agreed that the investment in protecting adult social care is to be tested through the development and approval of business cases and that this should be on a whole system basis since the implications for acute funding and non-elective activity are profound. The risk to the whole system of removal of social care service would have been significant had the BCF not been available to support it. The role of social care in enabling the acute and community hospital sector to function efficiently and effectively is considerable and has been demonstrated through urgent care summits.
Business cases on the use of funding to protect adult social care will be presented in July and enhancements needed in social care to support system change have been proposed. Anticipated benefits in the business cases include an increase in planned home care packages of 35% over 5 years. We will continue to use the BCF to ensure seven day services to support discharge, data sharing, joint assessment and accountable lead professional. The business cases will demonstrate that this investment will enable acute activity to reduce.

h. **Risk**
OCCG's recently submitted financial plan for 2014/15 to 2018/19 sets out a QIPP requirement of £17.3m in 2015/6, of this £8-10M is not currently supported by detailed QIPP schemes. Around £10M of this requirement is driven by the BCF requirement to protect adult social care. The £17.3M assumes CCG QIPP schemes are delivered in full in 2014/5. This is compounded in that the outcomes based contracting approach to older people, which the CCG plans, subject to contract, relies significantly on reductions in non-elective acute activity (albeit with sub- acute activity also anticipated to reduce through an overall more efficient pathway).

It is clear therefore that the system faces significant challenges and that early identification of the risks of non-realisation of these benefits along with system wide strategies to address them, is a critical piece of whole system work that we are undertaking.

i. **Provider engagement in the discussions on the Better Care Fund**

Providers involved in the discussion to date (OUHT, OHFT, SCAS) are concerned to demonstrate that the business cases supporting the £10M protection of social care generate real net benefit which can be used to improve health and social care in Oxfordshire and reduce costs in non-elective admissions. The level of reduction in non-elective care implied is unprecedented and will require a step change in the whole system response which will need to be modelled and agreed with the OUHT in particular as the acute provider.

j. The whole system programme board has agreed a series of programmes to further source the overall resource envelope these cover

- Primary care
- Integration
- Personalisation/ co-production of personal health and well being

The further development of programmes and joint programme management will oversee implementation; investment in BCF will be tested through business case approval.

k. Our ambition is to build on these very strong foundations to deliver a model of integrated care across the whole patient pathway. The integrated model – as described below – has been built up in consensus with our provider and commissioner partners in health and social care, and each of our major improvement interventions will contribute to its delivery.

4.2 Model for a Pathway of Integrated Care

i. **Prevention and early intervention**

We will work closely with our partners in Oxfordshire County Council, the District Councils and NHS England to deliver an integrated approach to preventing ill health and reducing health inequalities.

We will ensure closer working with NHS England and our partners in the Community Safety Partnership on the care of people in the criminal justice system and other vulnerable groups (see Chapter 5).

ii. **Primary care**

During year 1 of the plan, we will be working with NHS England to support the development of increased capacity in primary care to:

- Enable greater continuity of care to be delivered by GPs to patients with long term conditions
- Develop ways practices can work together to provide better support for patients planned and emergency care needs

The Better Care Fund plan will ensure that each practice will have named community health and social care link workers in its local integrated team.

iii. **Management in the community**

GPs will be supported to develop a whole person approach to provision of care for people with complex long term conditions who are at the highest risk of needing hospital care.

These patients will have access to integrated health and social care community services that ensure each patient has:

- A single health and social care assessment
- A single integrated and personalised care plan (including palliative care where appropriate.)
- A named care-co-ordinator responsible for the delivery and updating of that care plan (who can also link to District Council commissioned services as appropriate).
- The support as required of: specialist sub-acute medical and nursing care, sub-acute therapy care and/or therapist led rehabilitation.
- Increased use of intensive community support, as required to reduce admission to learning disability assessment and treatment services, in line with the Winterbourne View recommendations.

iv. **Urgent care**

In the event that someone with complex health and care needs requires emergency or urgent care, they will be able to get same day access to a multidisciplinary health and social care assessment, and where they can be cared for at home will be discharged to the care of their accountable GP and a named care co-ordinator in the integrated community team.

v. **Admission to a community facility**

In the event that a planned or unplanned admission is required we will ensure that patients can access:

- Intermediate social care and/or sub-acute health care which comprise: Skilled sub-acute medical and nursing care, sub-acute therapy care and/or therapist led rehabilitation.
- Appropriate mental health care

When an individual needs to be admitted the focus will be on returning them to optimal levels of health and getting them back home as soon as possible.

We are building brand new community facilities to deliver sub-acute ambulatory care which will be operational in Bicester in year 1 and in Henley in year 2 of this plan.

vi. **Admission to the acute hospital**

In the event of an admission to an acute hospital bed by patients with physical and mental health care needs, the interplay of those needs will be recognised in the development of treatment plans. So for example, a cardiac patient with anxiety will have access to psychological therapy and an older person with a fracture and dementia will have their dementia needs recognised in the planning and delivery of their orthopaedic care.

vii. **End of Life**

We will work to ensure that:

- All parts of the health and social care system know, and are able to respond to, a patient's palliative care wishes.

- Patients and their families experience seamless end of life care, regardless of the number of voluntary, health or social care organisations are involved in the provision of that care.

4.3 Better Care Fund Plan

a. Our Better Care Fund plan will be an important enabler of delivery of this vision for full Integration.

b. The plan commits us to:

i. Working together to implement an outcome based contract for services for older people. In 2014/15 we are targeting this work on the acute assessment/admission/discharge/reablement pathway - incorporating both community and acute health services.

ii. Exploring the added value that might derive from the CCG and the County Council working together to join up commissioning and integrate the provider services for the benefit of patients.

iii. Delivering locality based integrated health and social care community teams.

iv. Investing money transferred from health to social care to support people to live independently in their own home for as long as possible.

v. Maintaining existing levels of funding in disabled facilities grants and extra care housing.

vi. Investing in:

- Improved information and advice services (including for those who fund their own care)
- Equipment and assistive technology
- A more personalised approach to home support that removes the need for short visits for personalised care, integrates care and rehabilitation and bases care on individual service funds
- 7 day working in social care
- Implementation of a Discharge to Assess care service
- Further development of emergency multidisciplinary assessment pathways to ensure appropriate medical, nursing, social and therapeutic capabilities in both acute and community sectors.
- Preventative work with younger adults with mental health and /or drug/alcohol dependency who are frequent repeat attenders at A&E
- Careers' training, intensive support and breaks
- Building the capacity of care home, nursing home and home care support services to provide care for people with dementia
- Seamless "one stop shop" solutions for crisis, rapid response and enabling support at home
- Support for people to die in their usual place of residence where this is their choice
- Improvements in reablement and rehabilitation services
- Sharing of data.

c. The CCG and OCC as co-commissioners, along with our key acute provider OUHT, are considering how best to ensure:

   i. Good governance of the Better Care Fund and in particular the role of the Joint Management Group for Older People in identifying and managing the risks of reliance upon reduction in acute activity to pursue developments through the BCF.
   ii. Good programme oversight of the initiatives set out in the BCF plan and in particular the role of the Whole Systems Programme Board.
   iii. Production of high quality business cases for the initiatives in the BCF so that they demonstrate 'clear benefits to the wider health and social care sector and reduce costs in acute health care'.

Chapter 5: Key Supporting Measures

Delivery of the transformational change we want to make in the Oxfordshire system will be dependent not only on major change programmes and a formal focus on integration, but will also require the CCG to deliver a number of fundamental supporting work programmes:

i. Improving health and reducing health inequalities
ii. Delivering parity of esteem in mental and physical health care
iii. Engaging the public and promoting transparency
iv. Delivering quality, safety and innovation
v. Organisational development.
vi. Provider marketing strategy

These are all described in this chapter.

5.1 Supporting measure 1: Improving health and reducing health inequalities

5.1.1 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 close the gap for those population groups who experience worse outcomes, by supporting 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. These priorities are derived from the data in the JSNA.

5.1.2 Health inequalities issues have been broadly identified through the Joint Strategic Needs Assessment for Oxfordshire. Further work will be undertaken early in the first year of implementation to identify practices where a combination of poor health in the practice population and relative deprivation mean that work should be targeted to close the gap. Plans will then be drawn up based on the identified needs of each practice population in these target areas. This includes implementation of the 5 most cost effective high impact interventions recommended by the NAO report on health inequalities.

A Health Needs Assessment of Offenders in Thames Valley has been published by the Local Criminal Justice Board. This will be used in the detailed planning for reducing health inequalities, particularly in respect of mental health, (substance misuse services issues are commissioned by the local authority).

5.1.3 The detailed steps we will take are:

a. Each OCCG locality will identify a small number of practices where there are populations that have been agreed as priorities because they have worse outcomes. These populations include:

   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 prevention interventions (smoking cessation, breastfeeding, weight loss, screening, immunisations, health checks)
ii. Populations with potential to benefit from improved blood pressure, cholesterol, anti-coagulation and blood sugar control. (National Audit Office 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 screening and immunisation providers and locality teams.

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

e. An implementation group will be established to ensure that OCC, NHS England provider and locality teams will work together in joint teams supported by an equality delivery system.

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.

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 specific clinical interventions , including those recommended by the National Audit Office to reduce health inequalities:
- 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
- Increased referral to healthy lifestyle interventions
- Early interventions and prevention for maternal and child health.

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, and other prevention measure 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 jointly on behalf of OCC/NHSE/CCG so practices are not overwhelmed.

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

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

g. For vulnerable children and adults, NHS England, OCC and OCCG will:

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

ii. Deliver 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 Child and Adolescent Mental Health Services) when required.

iii. Explore the potential for co-commissioning with NHS England to meet the primary and community care needs of our homeless population and to develop services for vulnerable adults in frequent contact with the criminal justice system.

5.2 Supporting Measure 2: Delivering Parity of Esteem in mental and physical healthcare

a. OCCG is committed to achieving parity of esteem for mental health services and the people who use them in Oxfordshire by 2019. We will
    a. Ensure that the experience of patients with mental illness meets the same standards that we expect for patients with physical health problems. This will include responsiveness of service in terms of waiting times and quality of care both in planned and urgent care situations
    b. Ensure that the physical health of people with mental health problems receives the same attention as their mental health needs: we will eliminate "diagnostic overshadowing" and begin to reduce the mortality gap for people with severe mental illness
    c. Ensure that the mental health needs of people with physical health problems are addressed to support recovery and self-management of physical health needs.

b. To achieve these outcomes we will
    a. Implement outcomes based contracting for adult mental health services for those people assessed as meeting the thresholds for HoNOS PbR clusters 4-17
    b. Integrate primary care based psychological therapy services into one service that can act as a more preventative service for both mental and physical health care
    c. Develop psychological medicine services that will improve outcomes for people with co-morbid mental and physical health problems in acute, community and primary care settings
    d. Improve the rates of dementia diagnosis and support better management that allows patients to live as long as possible independently in their own homes
    e. Improved identification and support for children and young people with mental health problems.

c. We aim to demonstrate parity of esteem in mental and physical health in our plan and we set out in detail for the first two years and in outline in the final years of our plan, how we intend to do this through our investment decisions: this will be reflected in spending in specialist mental health services as well as at the primary care level where we know that for example, patients with long term conditions commonly also experience mental health problems.

5.2.1 Outcomes Based Contracting 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.

b. These outcomes will be delivered using outcomes based contracting funded through a Section 75 NHS Act 2006 Pooled Commissioning Budget, driving the following objectives.

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

5.2.2 Psychological therapy services in primary care

We will redesign and procure our primary care based psychological therapy services for people with mild to moderate anxiety and depression to

- Achieve national targets around meeting morbidity and recovery
- Improving mental and physical outcomes for people with long term conditions
- Improve the capacity of the Oxfordshire system around preventing escalation of mental health problems

5.2.3 Integrated psychological medicine services that address co-morbid physical and mental health problems

- OCCG will review and develop the range of integrated psychological medicine services that support people with co-morbid conditions to reduce impact on planned and urgent care pathways

5.2.4 Improved rates of dementia diagnosis and care that enables people to live longer in their own homes

- OCCG will create a dementia register to identify people who can be supported in dementia friendly communities to live in their own homes and avoid unnecessary admission to hospital and reduce the need for a longer term placement in nursing or residential care
- OCCG will support carers so that they are more able to support people with dementia to remain in their own homes

5.2.5 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 Oxfordshire County Council.

Ambition	What will we do to achieve this?
Improve transitions from children's to adult mental health services	• Review of gaps in provision for young people aged 16-24 years resulting from eligibility thresholds and transition from Child and Adolescent Mental Health Services to adult services, particularly young people with Attention Deficit Hyperactivity Disorder, Autistic Spectrum Disorder, or with conduct disorders.
Better outcomes for children with Autism	• Co-ordinate the review of the ASD diagnostic pathway for 5-18 year olds across all relevant providers including schools. • Prioritise actions in the Oxfordshire Autism Strategy.
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).
Improve existing mental health services for children and young people	• Develop an outcomes based approach to contracting for CAMHS services from 1st April 2015.
Improve targeted support for children and young people at particular risk of developing mental health problems	• Identify clear pathway of prevention, early intervention, treatment and support for young people Looked After and those leaving care (up to 25 years).

5.2.6 Milestones

a. The major milestones for these two initiatives and our major mental health improvement intervention are:

	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 July 14 (OCCG) • New OBC services in place Jan 15 • Evidence of impact from April 15
Psychological medicine services in primary care	• Evaluation of current IAPT/LTC projects (OCCG and OH) July 14 • Procurement activity to Sep 14 • New services in place April 15
Improved mental health of people living with physical health problems	• Implementation of revised urgent psychological medicine service from April 14 (OH) • Review of current psychological medicine services across acute and community settings • Evaluation of the mental health needs of high cost and frequency users of services in the urgent care pathway • Design and implementation of evaluated services by April 15
Improved rates of dementia diagnosis that supports people to live at home	• Increase the number of people with dementia supported to live at home via the creation of a dementia register from July 14 • Identify people to be supported in the community from August 14 • Improve the level of memory assessment services in Oxfordshire by June 2016 • Increase the number of carers breaks by 200 per year by March 16
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)

5.2.7 Further developments to support parity of esteem

OCCG will explore how it might further support the drive towards parity of esteem and support the wider system resilience that is needed in Oxfordshire. Commissioners have reviewed "*Closing the Gap: priorities for essential change in mental health"* and identified the following initiatives that will be developed and delivered to 2019:

- Develop an outcomes based contracting approach to Children and Young People's mental health services.
- Implement the Crisis Concordat for Oxfordshire.
- Increased integration of psychological medicine in primary, planned and acute care to improve efficiency of urgent and planned care pathways.
- A focus on psychological medicine to improve outcomes for people with severe mental illness
- A renewed focus on the most complex mental health presentations (e.g. people living personality disorder, who are homelessness and who have drugs and alcohol co-morbidities).
- More dementia screening and management closer to primary care.
- Increasing the range of housing and support options for people with severe mental illness.
- Exploring further preventative approaches for people at risk of hitting mental health payment by results cluster thresholds.

5.3 Supporting Measure 3 : Engaging the Public and Promoting Transparency

5.3.1 Engaging the public

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 wish to be involved.

b. 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.

c. 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.

d. 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. Questions are invited in advance of the meeting and answered during the meeting. The questions and written answers are published on the CCG website.

e. In addition 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 will begin to be built into the contracting 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 has informed this five year plan.

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

5.3.2 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.

e. The CCG plans 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.

5.4 Supporting measure 4: Delivering Quality, Safety and Innovation

5.4.1 Quality of Healthcare

A. The centrality of quality for NHS commissioner's priorities has been eloquently and amply set out, most recently in the reviews by Berwick, Keogh, Winterbourne view reports and Francis inquiry. 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. Learning Disability services are commissioned by Oxfordshire County Council under a section 75 pooled budget arrangement. OCC and OCCG have increased the scrutiny of this type of service and are using service users and their families to co-design pathways of care and to quality assure commissioned services.

E. Oxfordshire patients had been placed in Winterbourne view prior to the exposure of abuse. Commissioners have sought to understand the systems and pressures which contributed to the abuse. We have looked at the placement of patients out of area and are, wherever possible repatriating patients and increasing the quality assurance for this type of service, in area as well as out of area

OCCG aims to:

- Develop a focus on quality that transcends organisational boundaries and covers all aspects of care, from birth to death;
- Ensure quality is everybody's business: public, patients, NHS staff, family and carers;
- Support all stakeholders to raise concerns and/or lead improvement;
- Use measurement for quality where possible while acknowledging that not everything which is important can be measured;
- Strive for continuous improvement.

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

G. In order to capture the learning from recent NHS reviews of service quality, The CCG operates a "Clinical Assurance Framework, approved in January 2014. 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."

H. We will continue to develop this framework and where possible in 2014/15 publish all quality and performance reports and related documents on the CCG web site.

5.4.2 Patient safety

a. The CCG reviews 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 Root Cause Analysis 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. Increase the number of medication errors reported by working with key providers including primary care. The CCG will work with NHS England to increase the reporting and collating of medication errors with GPs, Pharmacists and Dentists. Plans are in place with Oxford Health to increase reporting by community nursing and community hospital staff;

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.

5.4.3 Clinical Effectiveness

a. The CCG reviews a wide range of clinical audits and NICE guidance. Key areas of improvement for 2014/15 are detailed below:

i. Continue to reduce mortality rates in the acute sector by enhancing the mortality review 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, as detailed above.

iv. Improve care for inpatients suffering from pneumonia by redesigning the patient pathway.

5.4.4 Patient experience

a. The CCG reviews a wide range of information relating to patient experience. Key areas of improvement for 2014/15 are 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 action to address areas for improvement;

   iii. Use patient experience data as a lever to drive up quality; (for instance the OCCG governing body begin each meeting with a patient's story.)

   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 re-profiling outpatient capacity to match demand;

   vi. Enhance the discharge process for patients.

5.4.5 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 scores.

b. There are active discussions with senior leaders in nursing to develop a culture of partnership with patients and careers 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, and 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 Director of Nursing & Medical Directors of NHS England supporting this approach.

c. The 5 Year ambition for this work is to have this embedded across all staff groups achieving an outcome of where difficulties with communication, care and competence are cited less frequently in patient feedback and complaints.

5.4.6 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. The 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 and patient surveys in conjunction with other quality metrics to evaluate the quality of services being provided.

5.4.7 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 to services (Accident and Emergency, community and acute hospitals and Emergency

Medical Units). We have also incentivised social care providers to begin care to clients within 72 hours of referral, including on Fridays and over the weekend in order to reduce delays. The Emergency Duty Teams also ensure there is support available 24 hours a day, 7 days a week. This will be developed further in partnership with OCC as part of our Better Care Fund plan.

B. The primary care programme will improve urgent access to primary care in normal and extended hours. Adjustments to 111 and Out of Hours contracts will further improve 7 day access to primary care.

C. Seven day working in our main community and acute providers is being progressed by the CCG through negotiation and collaboration with our providers. Service Delivery Improvement Plans will have clear objectives and milestones incorporated into contracts with our main providers. The CCG will monitor progress through contractual arrangements to assure itself that robust 7 day working plans are implemented as per agreed timescales.

D. The development of 7 day working plans is being informed by evaluation of the projects delivered under the Winter Pressures Programme 2013/14 under the leadership of our Whole System Programme Board (formerly the Urgent Care Working Group).

5.4.8 Safeguarding

A. We plan to work in partnership with the local children and adult safeguarding boards 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. OCCG will achieve this by ensuring it focuses on quality, acting swiftly to eliminate poor care to make sure that care is centred on patient's needs and protects their right.
B. OCCG will provide leadership to all provider organisations and support clinical decision making within the organisation. We will ensure that all organisations from which we commission have effective safeguarding arrangements in place, and that there are clear lines of accountability within organisations and across health services in line with the accountability and assurance framework.
C. It is the aim of OCCG that consistent, safe, effective and respectful care is provided to every patient. All staff must be able accurately to 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 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
D. Learning and developments in safeguarding will be disseminated with support of OCCG to inform and drive quality improvement in safeguarding practice, informing training programmes learning activities and service developments.

c. The actions we will take in the next two years are:

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 of all health commissioners and providers in the functioning and development of the Oxfordshire Safeguarding Children Board and the Oxfordshire Safeguarding Adults Board.
iii. Ensure that representation and involvement in the work of the Health and Well-Being Board is integrated into safeguarding.
iv. Working closely with the Oxfordshire Community Safety Partnership Board, ensure health services are effectively contributing to the delivery of whole system strategies to meet the health and care needs of vulnerable adults and children, particularly where they are in contact

with the criminal justice system, are vulnerable to exploitation and/or have a drug or alcohol dependency.

v. 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.
vi. Review and develop assurance frameworks that demonstrate all providers have effective safeguarding arrangements, using safeguarding schedules to be assured that they are meeting their safeguarding responsibilities. We will monitor how these roles are fulfilled through our assurance processes by assessing their compliance with national and local standards.
vii. Review and develop assurance frameworks that demonstrate all providers are conversant with the Mental Capacity Act, using it appropriately and whenever it is required. Providing an Adult Safeguarding leadership and supporting policy and training developments alongside the local adult safeguarding board.
viii. Ensure all providers are complaint with the Prevent Agenda, monitoring provider activity and contributing to the local panel as appropriate.
ix. Work with partners and colleagues to develop a learning and development framework that enables lessons to be learnt and shared across the locality.

5.4.9 Innovation

Oxfordshire CCG's aspiration is for the 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 ideas, products, services and clinical practices.

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's 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's 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 document has been developed by the Thames Valley Lead Pharmacists and links to local plans for 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 a disabling and expensive 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. 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.

f. 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 Academic Health Science Network and the Oxford Biomedical Research Centre.

g. 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 and nursing homes, and those with chronic enduring illnesses and comorbidities, the highest users of NHS services.

h. 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.

i. OOxfordshire 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 Innovation, Health and Wealth. OCCG will make full use of other NICE guidance in accordance with the NICE Policy including identified disinvestment opportunities. New interventions and technologies recommended by NICE will be assessed for local implementation as they are published. OCCG will be proactive in the use of the IH&W CoLab Portal.

j. The actions we will take to progress this agenda in the next two years are:
    i. Use the Area Prescribing Committee (APCO) to embed automatic incorporation of NICE 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.

5.5 Supporting measure 5- Organisational development.

5.5.1 Our Approach – Embracing Clinical Commissioning as a New Force for Change and Sustainability across the Oxfordshire System as a Whole

a. The role of Organisational Development

i. Our OD Plan must be in complete service of the successful delivery of our core purpose; a healthier population with fewer inequalities alongside health services that are high quality, cost effective and sustainable. Quality and affordability has to be achieved both by doing our business as usual better in the here and now - especially ensuring consistent delivery of the core NHS pledges - and in the future as we build an integrated care system across Oxfordshire, underpinned by primary care operating at scale and more intensive and acute services closer to home.

ii. One year on from our formation, our firm belief is that we will only succeed if we truly embrace and unlock the power of clinical commissioning by embedding it properly into a professional commissioning organisation.

iii. This means forging strong complementary working between clinicians and managers within the CCG itself, so that vision, strategy and delivery plans are linked and followed through, whilst also playing our part as broker with all partner organisations in Oxfordshire, building better trust, support and challenge to turn our joint vision and plans into a truly owned, accountable and tangible joint venture in which we can engage our population.

iv. We need to challenge ourselves to draw together the aspirations of our member practices in the localities into one overall compelling narrative for the future heath and care system, be explicit about how we will implement the changes in practice and how county-wide sustainability and appropriate local differences will be balanced and reconciled. By getting this balance right with our GP membership and with our partners, we will be much better able to work with and gain the confidence of local people.

v. This means that we are now explicitly regrouping to make our own organisation effective and fit for purpose as well ensuring that we have the credibility to inspire and execute across the wider system. We are intent on becoming an organisation with a clear and engaging vision, grounded strategy and excellent delivery. A detailed OD plan is in production which will ensure that we take a structured approach to developing our CCG, with clear programmes and milestones that will be led at Director Level on behalf of the Governing Body and which will be monitored as a key element of our delivery by it.

b. **OD Action Taken so Far**

As a very young organisation, OCCG therefore 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. We have already taken a number of clear and pragmatic actions to develop the organisation whilst we firm up our OD strategic priorities:

i. We have already adjusted our 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.

ii. In January 2014, following three months' operation of our 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 team.

We 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.

We have therefore 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 Contract and Procurement
- A new post of Head of Programme Management Office.

iii. A further review of the organisational structure was initiated in February 2014 and key objectives have been identified as follows:

- Ensuring proportionality between the size and scale of programmes of delivery for this plan and the clinical and managerial resources identified to deliver them.
- 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.
- Ensuring that locality based plans strike a fair balance between supporting the agreed county-wide major priorities & implementing them in the way that best suits the local environment – along with addressing any priority local needs that are genuinely different and disseminating locality level innovation across the CCG as a whole.
- 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.
- Ensuring that the workforce – managerial and clinical – has the skills and expertise to commission to the very highest standards.
- Establishing fit for purpose arrangements with our co-commissioners, notably Oxfordshire County Council, NHS England's Direct Commissioning Team and the Wessex Specialised Commissioning Team.

iv. In October 2013, we established our immediate organisational development priorities and in the ensuing months began to execute them as follows:

- **Executive Team Development:** a six month plan was put in place in late October 2013. Once the new structure is implemented, a development programme for the **Intermediate Tier** will also put in place a coaching offer.

- **Clinical Leadership**: two away days have taken place on October 22nd 2013 and 4th February 2014. Organisational development interventions have since been agreed; these include coaching and mentoring for Locality Clinical Directors (LCDs), coaching and mentoring for succession plan candidates for the LCD and key clinical commissioner roles; and LCD group organisation.

- **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.

v. The aims of this review were to test the degree of consensus and buy-in to the current OD priorities within the CCG, whilst opening up to feedback from partner organisations, as well as describing in more detail what the programmes of intervention will look like in practice. in March 2014 we also commissioned a rapid "support and challenge" review of these priorities by an experienced former PCT Chief Executive who has just completed interviews with 23 top and senior managers and clinicians from within the CCG, organisations across Oxfordshire, including the Local Medical Committee, County Council and NHS providers, as well as the Local Area Team and Commissioning Support Unit.

The CCG new Chief Officer and Chair have agreed to lead the OD personally giving it the weight it needs to engage the whole system across Oxfordshire and create a community of senior leaders with a common vision and practical risk sharing to turn the five year plan into tangible delivery. Further information on the OD Is set out on Appendix 3, A business case to fund the OD Plan interventions will be produced by the end of July to fund a mutual programme of peer leadership OD for CEOs and top clinical leaders across Oxon that will enable them to align all organisations' 5 year plans/strategies, the Better Care Fund proposals, also working with HEE to draw together a common workforce strategy and practical plan.

Our Sustainable OD Priorities for 2014/15 – 2018/19

i. The table in Appendix 3 sets out the core components of our OD Plan. This will be further refined and firmed up by the CCG's OD Steering Group chaired by the Interim Chief Operating Officer – by the end of June 2014, following further dialogue with stakeholders who contributed to the Support and Challenge review.

ii. The Oxfordshire wide component of the plan in particular will be developed with partners following the arrival of the new Chief executive in June 2014 to ensure effective peer dialogue, support and challenge. Initial 2014/15 milestones and example interventions are included.

5.6 OCCG Provider Market Strategy

1. Oxfordshire CCG's current provider landscape

OCCG commissions the majority of healthcare services for Oxfordshire residents from two organisations – Oxford University Hospitals Trust (OUHT) for acute services and Oxford Health Foundation Trust for community and mental health services. However, for some services other providers of healthcare services are offered, for example the Royal Berkshire Foundation Trust, or private sector providers such as Ramsay or BMI. Due to geographical proximity, patients in the South East of Oxfordshire tend to choose Royal Berkshire Foundation Trust for their acute care needs.

For community services, for example District Nursing and Health Visiting, OCCG's main provider is Oxford Health Foundation Trust. The Trust is also the provider of mental health services.

The remaining element of OCCG's service expenditure is directed to continuing care which largely funds individuals in non-NHS care homes, or home-based packages of NHS care. Oxford County Council undertakes regular market assessments of the local care home providers.

2. Current contracting mechanisms

OCCG has historically worked to achieve change with its two principal providers through negotiation and contract variation, however alternatives are being sought to the traditional contract construct to enable an innovative outcomes based approach to commissioning. OCCG is liaising with Monitor and the Trust Development Authority to support these for the purposes of older people and mental health services. The new approach to contracting is intended to support improved clinical and quality outcomes for patients by encouraging providers to work more closely together with payment made on clinical outcomes being met. Development of outcomes based contracting will require the engagement of existing and new partners to secure services that meet local needs.

OCCG has developed relationships with other key partners including Oxfordshire County Council to ensure we pool our commissioning efforts to secure good quality services for our residents. In some instances OCCG and Oxfordshire County Council have pooled health and social care budgets to deliver better services for patients to improve capacity and resilience. Through this mechanism partners have also worked and contracted with a number of voluntary sector organisations and this is an area OCCG would like to develop further, recognising the benefits and support voluntary sector organisations can offer local residents.

3. Developing the market and the Provider Market Strategy

To secure the best available services to the local residents of Oxfordshire, OCCG acknowledges work is required to develop the provider market. This is particularly important in light of work underway to;

- Review best clinical practice that may generate new service models, for example; the Keogh report on the future of Emergency Care; a move to seven day working; delivery of outcomes-based commissioning for older people's services; increased use of information technology to support and inform care delivery; local and national models of managing elective care through Integrated Clinical Assessment & Treatment Services and; Referral Support Services.

- Establish clinical collaboration between practices within localities to develop 'centres of excellence', supporting enhanced delivery of local diagnostics and integrated care teams. OCCG's work with NHS England to co-commission general practice services will support this.

- Deliver the existing Quality, Innovation, Productivity and Prevention (QIPP) programme and support the development of new QIPP schemes that maximise efficiencies in service delivery going forward, particularly through models of integration.

To support this, OCCG has instigated a 3 month programme of work due to conclude in September to:

- Establish a comprehensive baseline of existing provision which includes organisations which deliver or support the delivery of healthcare services. Not all of these are directly commissioned by OCCG, for example Pharmacies, however it is important that these are reflected to ensure OCCG is in a position to influence change and work in partnership with lead commissioners as appropriate, particularly NHS England and Oxfordshire County Council.

- Map providers in terms of service provision and geographical coverage.

- Establish any fixed estate/infrastructure that may need to be considered when scoping any changes to existing service models/provider landscape.

- Create a vision of the provider landscape required to support Oxfordshire's five year strategic plan, highlighting any gaps that may need addressing. To support commissioning decisions a summary of the contracting and procurement options available will be included, reflecting the requirements of Monitor's publication "Substantive guidance on the Procurement, Patient Choice and Competition Regulations". In addition, a summary of public/patient engagement activities will

be provided for consideration, recognising the importance of co-design and the patient voice to informing the services we commission.

- Develop a market engagement strategy to ensure OCCG attracts the most capable providers to deliver services to local residents. This will require OCCG to clearly articulate the service requirements, be clear on the anticipated outcomes, including clearly defined performance measures.

The development of the provider market strategy will be informed by a number of engagement activities, the first of which was a Governing Body workshop held on the 10th June 2014.

Until this work has concluded it is difficult to clearly articulate the provider landscape envisaged through the duration of the plan, however it is acknowledged that the existing provision may not be the most sustainable or clinically effective in its current form.

OCCG is keen to ensure services, wherever possible, reflect patient need and preferences in terms of service model and mode of access. With the development of information technologies, OCCG plans to develop a market which is encouraged to respond flexibly and quickly to these opportunities.

OCCG will continue to work closely with providers and partners to understand the impact of any service changes, as demonstrated through the work undertaken to support the outcomes based commissioning proposal for older people and mental health services and Better Care Fund plan.

Chapter 6: Impact

This plan will deliver:

i. Financial sustainability
ii. Changes in activity levels and the balance of activity provided in different care settings
iii. A new and deeper commitment to collaboration in the interests of patients and the tax payer between providers and commissioners
iv. The 6 characteristics every system must have to be sure it can deliver sustained transformational change
v. Local improvements against the 7 national outcomes defined for the NHS in England
vi. The outcomes being sought from integration between health and social care as defined in the Better Care Fund scheme.

6.1 Leading change across the system landscape

a. Our plans for Oxfordshire are ambitious and they will require the CCG and its partners to work in concert to change the landscape of our system in order to deliver the improvements we seek together. Over the next three months we will work with our partners to ensure that we have the relationships, the shared expectations about investment and activity shifts and the governance structures in place, to assure the public that we will deliver our plans.

b. In particular we will:

i. Implement the agreed partnership structure with our colleagues at Oxford University Hospitals NHS Trust (OUHT) to ensure that the plans underpinning our changes in demand and location of services are truly shared, are overseen by a joint group of clinicians and managers and achieve their intended impact.

ii. Progress negotiations on an Outcomes Based Contract in mental health services with our partners in Oxford Health Foundation Trust (OHFT) and their partner providers with the goal that a highly coordinated service delivers the outcomes local patients need and the activity and financial ramifications are well understood by all partners.

iii. Progress negotiations on an Outcomes Based Contract in Older People's Care with our co commissioners at Oxfordshire County Council (OCC) with the goal that a stream lined and high quality pathway is in place and the activity and financial ramifications are well understood by all partners.

iv. Establish effective programme delivery arrangements for our Better Care Fund Plan and ensure that they are highly coordinated within the governance of our Whole System Programme Board (the former Urgent Care Working Group) which already oversees implementation of our Urgent Care Improvement Plan and the Older People's Programme Plan and that the activity, financial and risk management ramifications are well understood by all partners.

v. Work closely with NHS England to develop our primary care transformation programmes in concert with each other so that clear and practical signals can be given to primary care in Oxfordshire to enable them to play a leading role in system re-design and the activity and financial ramifications are well understood by all partners.

vi. Develop the CCG's Procurement Strategy so that we can give clear signals to our providers and prospective providers about our commissioning and procurement intentions over the period of the plan and the activity and financial ramifications are well understood by all partners.

vii. Develop our whole systems leadership role as set out in our organisational development plan so that there is a vibrant leadership forum in place for jointly leading improvement in our County's services.

c. This will enable the CCG to resubmit its Strategic Plan in June 2014, with confidence that the implications have been fully worked through and understood across the system.

6.2 Delivering financial sustainability

a. The Oxfordshire health and social care system is challenged financially, and this plan sets out to achieve run rate balance within the next two years, and then a sustained financial balance thereafter.

b. The full financial plan is set out in chapter 7. The estimated financial impact of our major programmes in 2014/15 is :

Programme	Executive Owner	Clinical Lead	Programme Manager	Project	Project Manager	Planned Net Savings	Planned Invest-ment
MED MGMT	Sula Wiltshire	Miles Carter	Julie Dandridge	1. MEDS WASTE	Claire Critchley	£39K	£3K
				2. PRIMARY CARE PRESCRIBING	Hannah Copus /Louisa Griffiths	£2.4M	£0
				3. PROCURING MEDS	Nikki Shaw	£25K	£0
					PROGRAMME TOTAL: £2.47M		
PLANNED CARE	Gina Shakespeare	Stephen Attwood	Philippa Mardon	4. DIAGNOSTICS	Beccy Clacy	£221K	£0
				5. FIRST OUTPATIENTs	Sarah Bright	£900K	£723K
				6. PLANNED CARE	Ruth McNamara	£2.82M	£0
				7. SECONDARY CARE PRESCRIBE	Julie Dandridge	£664K	£0
				20. PLCV	Jackie Masters	£4.38M	£100K
					PROGRAMME TOTAL: £8.99M		
URGENT CARE	Ian Wilson	Andrew Burnett/ Gavin Bartholomew	Diane Hedges	8. OOH & 111	Matt Staples	£515K	£0
				9. PTS	Matt Staples	£325K	£23k
				10. MINOR A&E AVOIDANCE	Lisa Foweather	£223K	£0
				11. END OF LIFE	Damian Haywood	£82K	£0
				12. CARE HOMES	Sara Wild	£TBC	£TBC
				13. LTC MANAGEMENT	Terri Brunne	£739K	£35K
				17. OLDER PEOPLE OBC	Catherine Mountford	£TBC	£TBC
				19. AEC PATHWAY	Lisa Foweather	£253K	£0
				21. FUNDED NURSING CARE	Diane Hedges	£TBC	£TBC
				UNIDENTIFIED	TBC	£636K	£0
					PROGRAMME TOTAL: £2.77M		
MENTAL HEALTH	Gareth Kenworthy	David Chapman	Ian Bottomley	14. INTEGRATED PSYCH SERV	Juliet Long	£801K	£0
				16. DEMENTIA	Sonja Janeva	£0	£0
				22. MENTAL HEALTH OBC	Ian Bottomley	£TBC	£TBC
					PROGRAMME TOTAL: £0.80M		
PRIMARY CARE	Gina Shakespeare	Joe McManners	Rosie Rowe	18. GOING FURTHER FASTER	Rosie Rowe	£43K	£22K
					PROGRAMME TOTAL: £0.04M		
EFFICIENCY	Gareth Kenworthy	Paul Park	Head of Contracting / Procurement	23. CSU SLA	Head of Contracting/ Procurement	£630K	£0
				24. EoL Contract	Damian Haywood	£75K	£0
				24. Procurement Register	Hannah Mills	£TBC	£TBC
					PROGRAMME TOTAL: £0.71M		
					OVERALL TOTAL: £15.14M		

c. This plan will deliver a substantial shift in activity and resources from acute services into community and primary care.

d. Over five years we will shift resources as follows:

	13/14 actual investment '000	18/19 planned investment, '000	% change
Acute	342,117	349,344	2%
MH	63,588	63,588	0%
Community	63,836	63,457	-1%
Continuing care	33,722	88,310	162%
Primary care	89,621	117,540	31%
Running costs	15,093	14,440	-4%

6.3 Delivering a sustainable NHS for future generations in Oxfordshire

a. As described in our Organisational Development Programme (see chapter 5.5 and Appendix 3) OCCG is fully aware that achieving and maintaining a sustainable financial position is about more than delivery of major cost saving programmes: it requires a step change in the way providers and commissioners in the Oxfordshire system work together in a mature and interdependent way.

b. The current state of readiness of the local system to deliver this change is good:

i. The CCG and Oxfordshire County Council 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 this plan.

ii. The CCG and OCC are building on these existing arrangements to work closely together to agree and deliver a Better Care Fund plan along with providers, to ensure that the overall impact of the plan is maximised and that risks are maturely managed.

iii. Oxford Health Foundation Trust and Oxford University Hospitals Trust are continuing to work actively with the CCG and OCC to achieve integrated, outcomes based contracts in 2014/15 to support service transformation for patients and improved sustainability for the system as a whole.

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 month and the CCG and Thames Valley Area team are working closely together to ensure that their respective commissioning of primary care is joined up and makes sense to practices as they rise to the challenge of working in a constantly better integrated health and social care system.

v. Work to develop an outcomes based approach to contracting 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.

c. Ensuring this potential is exploited will require strong system leadership by the CCG.

d. The CCG's internal capacity and capability building programme has delivered a highly capable interim leadership team, who are now helping to secure the formation of a new permanent leadership team for the organisation.

e. The CCG has successfully appointed a Clinical Chairman, Chief Executive and Lay vice Chair. Early in 2014/15 this team will then extend the review of the organisation structure and skill set.

f. The interim leadership team is laying strong foundations for the new team to build on, in terms of:

   i. Defining expectations, with co-commissioners and providers across the system about the kind of system leadership the CCG will be providing over the life of this plan.
   ii. Improving the core business skills and capabilities within the CCG, with help from independent advisers, to provide the basis for sustained financial and reputational recovery.

6.4 The 6 characteristics of a high quality and sustainable system

a. This plan will help move Oxfordshire towards being a system that has the six nationally defined characteristics of a high quality and sustainable system.

	Characteristic	Change we have promised in this plan
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*	• Continuous consultation with the public as we annually refresh this plan • Engagement of patients, carers and other members of the public in programme boards • Continuous support to develop PPGs
2	*Wider primary care, provided at scale*	• Long term strategy for federation and capacity building • Short term programmes to improve joint practice working to: reduce non elective admissions, A&E attendances and Out Patient referrals
3	*Modern model of integrated care*	• Care integrated along the pathway from prevention to palliative care
4	*Access to the highest quality urgent and emergency care*	• Meeting NHS constitution standards sustainably • Reduction in the estimated 40% of A&E attendances that could be better cared for elsewhere • Service delivery that ensures people who need hospital care but don't need a bed after coming to A&E, are assessed and treated without being admitted
5	*A step change in the productivity of elective care*	• Improving Quality of first Out Patient referrals • Streamlining planned care pathways • Developing consultant and specialist GP led care in alternative settings • Delivering NHS constitution standards for diagnostics
6	*Specialised services concentrated in centres of excellence*	• We will work with NHS England to ensure patients requiring specialist care are treated by the most appropriate provider

6.5 Improving health outcomes in alignment with the seven NHS outcome ambitions

a. The whole of the NHS in England is working to deliver improvement against a set of 7 nationally defined outcome measures. Our plan will contribute as set out below:

	NHS Outcome ambition	Actions in the plan that will impact	Measure	% improvement in 2 years	% Improvement In 5 years
1	*Securing additional years of life for the people of England with treatable mental and physical health conditions*	• Improved psychiatric liaison in all settings • Pro-active identification and care management of those patients who are the 2% highest users of the system • Integrated health and social care teams • Outcomes based contracting for mental health • Ambulatory care acute pathways In accessing the level of ambition the CCG should target, Dr Jonathon McWillaim, Oxfordshire Director of Public health has advised the following: The suitability of this data for the planning purposes is questionable on a number of points 1. The data does not go back far enough in time to establish a reliable trend. 2. There is a considerable year on year variation in the data with wide confidence intervals. It is unwise to use such data for target setting. 'Good' results or 'bad' can easily be due to random statistical fluctuation. 3. One would normally combine this data into 3 year rolling averages to reduce the random fluctuation, but there are insufficient data points to do this. 4. Unless a longer time trend with their lower confidence can be found, the DPH view is that the CCG's plan is reasonable.	Potential years of life lost from conditions considered amenable to healthcare (no of amenable deaths divided by population)	-1.37%	3.20%
2	*Improving the health related quality of life of*	• Improved psychiatric liaison in all settings • Pro-active identification and care management of	Health related quality of life for people with LTCs (measured using the EQ5D	Various	Various

	NHS Outcome ambition	Actions in the plan that will impact	Measure	% improvement in 2 years	% Improvement In 5 years
	the 15 million + people with one or more long term condition, including mental health conditions	those patients who are the 2% highest users of the system, • Integrated health and social care teams • Outcomes based contracting for mental health • Improved dementia diagnosis and care	tool in the GP patient survey) 1. The reduction in unplanned admissions that will be delivered through the risk assessment and care management of LTC amongst the 2% highest risk primary care population. This is measured via the QIPP programme (Urgent Care, unplanned admissions) 2. % of mental health service users to have their cluster reviewed within the agreed timescale (target 95%): OH contract KPI 3. Percentage of people who have completed IAPT treatment having attended at least 2 treatment contacts and are moving to recovery. OH contract KPI and national measure (target 50%) 4. Percentage of initial assessments and working diagnosis of dementia that are completed within 8 weeks. OH contract KPI-target 95%		
3	*Reducing the amount of time spent avoidable in hospital through better and more integrated care in the community, outside of hospital*	• Practices working together to support patients with planned, urgent and complex care needs • Pro-active identification and care management of those patients who are the 2% highest users of the system, • integrated health and social care teams • Rapid access community based MDT assessments • Consultant and specialist GP led community based clinics • Improved dementia diagnosis and care • Full sub-acute care functionality from community health and social care community bed providers	Composite rate: -Unplanned hospitalisation for: • chronic ACS conditions • u19s with asthma, diabetes or epilepsy - Emergency admissions for : • children with lower respiratory tract infections • adults with acute conditions not usually requiring admissions	33%	31%
4	*Increasing the proportion of older people living*	• Pro-active identification and care management of those patients who are the 2% highest users of the system,	See Better Care Fund Further modelling is required in response	9%	BCF indicator so not developed to 5

	NHS Outcome ambition	Actions in the plan that will impact	Measure	% improvement in 2 years	% Improvement In 5 years
	independently at home following discharge from hospital	• integrated health and social care teams • Provision of ambulatory care pathways in the acute that remove need for an admission • Home care support services with built in re-ablement • Enhanced ALERT services • 7 day working in social care	to BCF and outcome based contract impacts from 2015/16.		years
5	*Increasing the number of people having a positive experience of hospital care*	• Fully functioning directly bookable choose and book service supported by streamlined planned care pathways • Ambulatory care acute pathways • Sustainable delivery of all NHS constitution standards • Continuity of care for pregnant women and maximising capacity at the Freestanding Midwifery Led Units. • Will move us up 1 quintile in 2 years and into top quintile in 5 years	Patient experience of inpatient care (friends and family test)	4.8%	9.8%
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*	• Development of psychiatric liaison services in primary, community, emergency and inpatient settings • Increased access to psychological therapies for patients with ACS conditions • Multidisciplinary community teams that incorporate older adult mental health workers.	Composite indicator comprised of GP and GP OOH services	2.08%	5.2%
7	*Making significant progress towards eliminating avoidable deaths in hospital caused by problems in care*	• Continue 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.	Indicator in development nationally		

6.6 Better Care Fund Outcomes

a. In addition the NHS and its social care partners across England are working to deliver change against a commonly agreed set of outcomes measures through each Better Care Fund Plan.

b. Our jointly agreed trajectories for these outcomes are set out below:

Metrics		Baseline*	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
		(Apr 2012 - Mar 2013)		(Apr 2014 - Mar 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services *NB. This should correspond to the published figures which are based on a 3 month period i.e. they should not be converted to average annual figures. The metric can be entered either as a % or as a figure e.g. 75% (0.75) or 75.0*	*Metric Value*	71.70%	N/A	80%
	Numerator	345		400
	Denominator	480		500
		(Apr 2012 - Mar 2013)		(Apr 2014 - Mar 2015)
Delayed transfers of care (delayed days) from hospital per 100,000 population (average per month) *NB. The numerator should either be the average monthly count or the appropriate total count for the time period*	*Metric Value*	13497.9	4896.4	3427.8
	Numerator	70324	25853	18099
	Denominator	521000	528000	528000
		Time period April 2012 to June 2013 15	Apr - Dec 2014 (9 months)	Jan - Jun 2015 (6 months)
Avoidable emergency admissions per 100,000 population (average per month) *NB. The numerator should either be the average monthly count or the appropriate total count for the time period*	*Metric Value*	1471.7	595	738.7
	Numerator	10031	4057	5035
	Denominator	681593	681593	681593
		(State time period and select no. of months) 12	Apr - Sep 2014 (6 months)	Oct 2014 - Mar 2015 (6 months)
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*		*(State time period and select no. of months)* 1	N/A	*(State time period and select no. of months)* 1
Local measure *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	61.9	62.4
	Numerator	2122	2301	2348
	Denominator	3537	3716	3763
		Snapshot figure for end of 2012/13 12	*Snapshot figure for end of 2014/15* 12	*Snapshot figure for end of Sept 2015* 6

6.7 Local Quality Premium Indicator

a. As part of the CCG drive to reduce healthcare associated infections, reduce antimicrobial resistance and improve the quality of care, OCCG together with its providers is actively promoting antimicrobial stewardship and cost-effective prescribing of antimicrobials. OCCG remains a low prescriber of antimicrobials when compared nationally and has done much work to reduce the prescribing of cephalosporins and quinolones. The CCG now wishes to ensure co-amoxiclav is prescribed appropriately and in line with guidance.

b. After due consultation with the Health and Wellbeing. Board, OCCG has therefore selected the following local QP indicator:

- To reduce the number of prescriptions of co-amoxiclav as a proportion of all antibacterial prescriptions to 8% measured at CCG level in Q4 14/15 (data available May 15) in line with current guidance, and to 6% in q4 of 2018/19.

- Q2 13/14 data indicate that the CCG is currently at 10%.

Chapter 7: Financial Plan

7.1 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's underlying, recurrent baseline for 14/15 is a deficit position of £18.9m.

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 may have expected to receive an increase in its running costs allocation. However, due to the methodology adopted nationally this has not been the case and the running cost allocation is slightly below the 2013-14 allocation (-£0.1m)

c) 13/14 Deficit Recovery
   i. Any deficit the CCG made in 13/14 would have been repayable in 14/15 as a non-recurrent adjustment to the allocation. The outturn reduced from a forecast £6.1m deficit to a small surplus of £0.3m. The CCG has not been allowed to carry forward the surplus generated.

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 £1.0m with a contingency held of £3.1m (0.5%) plus non recurrent headroom/Call to action fund/over 75's primary care funding of £3.1m (0.5%). The plan for 2015-16 is for a small surplus of £2.2m (0.3%) with a contingency held of 0.5% and 1% non-recurrent 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 £0.3m surplus generated in 2013-14 to the underlying deficit of £18.9m and then to the £1.0m forecast deficit for 2014-15 is shown in the following table:

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	96.6%	614.0
Programme costs growth	3.1%	19.8
Running costs growth (population)	0.0%	-0.1
Prior Year RAB Adjustment	0.0%	0.0
IAT Adjustment for specialised comm		0.7
	99.7%	634.4

14/15 Application of Funds	%	£'m			
13/14 Month 8 FOT		629.5		Surplus	0.3
Remove winter pressures NR		-10.2			
Remove QIPP investment NR		-0.9			
Run rate adjustments 1		9.2			
Non recurrent adjustments 2		4.9			
14/15 Baseline before CQUIN out	99.6%	632.9		Deficit	-18.9
Inflation	2.4%	15.1			
Efficiency	-3.2%	-20.2			
Demographic Growth	0.8%	5.4			
Identified QIPP (Investment)	0.3%	1.7			
Identified QIPP (Gross Saving)	-2.1%	-13.6			
Manual Adjust - running costs/prescribing	0.8%	5.3			
Contingency	0.5%	3.2			
Other Reserves	0.5%	3.4			
CQUIN in	2.2%	13.8			
CQUIN out	-1.8%	-11.5			
	100.0%	635.5		Deficit	-1.0

e) 14/15 Demand and Activity Growth

i. The current estimated impact of demand related activity growth in Oxfordshire is 0.9%, £5.4m. If this not funded in contracts with providers or unmitigated through QIPP initiatives 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 Programme Board with input from Deloitte. Schemes totalling £15m gross have business cases and have been subject to detailed external challenge. Further additional/stretch schemes have been identified - these have a potential value of £4 - £20m. The financial plan for 2014-15 currently assumes delivery of £9.6m savings from schemes with business cases and £4.0m from contract negotiations with providers. The additional savings identified from the business schemes are planned to mitigate increases in activity from main providers. The CCG continues to work with its partners in the CSU and Deloitte to work the identified opportunities for savings through to delivery.

ii. The CCG will seek to agree appropriate, balanced financial risk shares with providers through procurement, contracts, and use of business rules.

iii. An updated activity plan for 2015/16 will be uploaded to Unify by 27 June, in accordance with the NHSE timetable.

7.2 QIPP Programme

QIPP schemes totalling £15.75m for 2014/15, and £8.8m for 2015/16, have been identified. A Programme Management Office has been established, with Programme Managers in place for each of the 5 programmes (Planned Care, Urgent Care, Mental Health, Medicines Management, and Contract Efficiencies), and project managers have been appointed to lead each of the subsidiary projects. Progress is overseen by a monthly Programme Management Board, chaired by the Chief Finance Officer, with reports on progress against milestones and financial targets submitted to the Finance & Investment Committee and Governing Body.

A Joint QIPP Steering Group has been established between OCCG and OUHT to work on a shared programme of priority actions. The Terms of Reference include a commitment to:

- Develop a joint approach to the challenges we share across Oxfordshire – agreeing priorities, resourcing, implementation plans, and methods of delivery and communication
- Share a patient focus and commitment to improving quality of care while delivering better value
- Operate with transparency of costs and income for each party, in establishing QIPP schemes
- Prioritise schemes so that the overall capacity available to implement change at OCCG and OUHT (and other partners) is used to obtain the best impact

Further work is commencing shortly to expand the QIPP Programme for 2015/16. This will build on the foundations in 2014/15, and test OCCG's performance against a number of national and local comparator benchmarks, including NHS Network, Right Care, Atlas of Variation, and our comparator peers. The locality structure of our CCG also enables practices, with their clinical leads, to tackle unwarranted variations in performance at locality level.

7.3 Taking all these into account at this stage of the financial plan the current position of the CCG is shown in the table below:

NHS Oxfordshire CCG	10Q	Contents	Quality Checks			
Financial Position						
Revenue Resource Limit						
£ 000	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Recurrent	614,023	634,433	661,364	681,043	701,160	721,885
Non-Recurrent	15,781	-	(1,044)	2,161	6,866	7,112
Total	629,804	634,433	660,320	683,204	708,026	728,998
Income and Expenditure						
Acute	342,117	348,995	341,427	340,683	346,158	349,344
Mental Health	63,588	62,177	61,577	61,901	63,830	63,588
Community	63,836	61,521	59,341	57,967	59,353	63,457
Continuing Care	33,722	35,781	64,759	76,485	82,769	88,310
Primary Care	89,621	92,515	95,239	103,387	109,383	117,540
Other Programme	21,570	15,156	17,994	18,025	17,900	17,761
Total Programme Costs	**614,454**	**616,144**	**640,337**	**658,447**	**679,393**	**700,000**
Running Costs	15,093	16,159	14,510	14,475	14,440	14,407
Contingency	-	3,174	3,312	3,416	7,080	7,290
Total Costs	**629,547**	**635,477**	**658,159**	**676,338**	**700,914**	**721,697**

£ 000	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Surplus/(Deficit) In-Year Movement	(5,317)	(1,301)	3,205	4,705	247	189
Surplus/(Deficit) Cumulative	257	(1,044)	2,161	6,866	7,112	7,301
Surplus/(Deficit) %	0.04%	-0.16%	0.33%	1.00%	1.00%	1.00%
Surplus (RAG)	AMBER	RED	AMBER	GREEN	GREEN	GREEN
Net Risk/Headroom		(3,975)	(3,093)	(1,068)	2,797	3,215
Risk Adjusted Surplus/(Deficit) Cumulative		(5,019)	(933)	5,798	9,910	10,516
Risk Adjusted Surplus/(Deficit) %		-0.79%	-0.14%	0.85%	1.40%	1.44%
Risk Adjusted Surplus/(Deficit) (RAG)		RED	RED	AMBER	GREEN	GREEN

7.2 The context for the CCG requires a medium term approach to improving financial performance and standing. Taking into account the baseline activity pressures, national planning assumptions, cost of demand, investment requirements and the need to deliver financial turnaround, the CCG draft financial plan shows an improvement trajectory of a planned deficit of £1.0m in 2014/15, a return to a small surplus 2015/16 and a 1% surplus thereafter, including compliance with national financial planning requirements.

7.3 The plan demonstrates the clear incentive for the CCG to return to financial balance through its QIPP plans and contract agreements. Avoiding deficit repayment requirements in future years, means that there is a greater level of recurrent funding available to support the position.

7.4 In approving a financial plan that includes a deficit position in 2014/15 the CCG is declaring that it is likely to be in breach of its statutory financial duty, which is to operate within its notified allocation from NHS England. This requires approval.

Chapter 8: Conclusion

a. This plan is the culmination of much work within the CCG, supported by our colleagues in the CSU and independent advisers and based on our relationships with local providers to ensure that we understand their perspectives and recognise fully that without coherence across the whole system the desired changes to which we are all committed, cannot happen.

b. The CCG has grasped the magnitude of the challenge that it is facing in terms of service and financial pressures. It has recognised the change it must make in the way it operates in order to contribute the necessary system leadership to become truly sustainable. We will know we have been successful when the organisations that make up Oxfordshire's health and social care economy are truly collaborating and that as a result:

   i. Patients get high quality standards of health and social care in all settings, within a financially sustainable system.

   ii. Older people, people with chronic diseases and those suffering from the consequences of health inequality have better health outcomes.

   iii. Patients have access to the primary and community care, and the urgent and emergency services that they need to help them and unnecessary hospital admissions are avoided

   iv. Patients who need an admission to hospital return quickly to independent living

   v. GP practices are working together to drive integration of primary, community, secondary, mental health and social care around the needs of each patient and their family

   vi. People with complex health and care needs get "whole person care" instead of separate treatments with parity of esteem between physical and mental health

   vii. The CCG is doing its core business to the very highest standards

   viii. Health inequalities have reduced

   ix. The patient and public voice palpably informs everything that we do, and we are sustainably meeting NHS Constitution pledges and standards on access to services, safety and quality.

   x. The system is financially sustainable.

Appendix One; Change programmes (Detail required for national Key Lines of Enquiry Assurance)

1. Planned investment and savings from the 5 programmes

Programme	Executive Owner	Clinical Lead	Programme Manager	Project	Project Manager	Planned Net Savings	Planned Invest-ment
MED MGMT	Sula Wiltshire	Miles Carter	Julie Dandridge	1. MEDS WASTE	Claire Critchley	£39K	£3K
				2. PRIMARY CARE PRESCRIBING	Hannah Copus /Louisa Griffiths	£2.4M	£0
				3. PROCURING MEDS	Nikki Shaw	£25K	£0
					PROGRAMME TOTAL: £2.47M		
PLANNED CARE	Gina Shakespeare	Stephen Attwood	Philippa Mardon	4. DIAGNOSTICS	Beccy Clacy	£221K	£0
				5. FIRST OUTPATIENTs	Sarah Bright	£900K	£723K
				6. PLANNED CARE	Ruth McNamara	£2.82M	£0
				7. SECONDARY CARE PRESCRIBE	Julie Dandridge	£664K	£0
				20. PLCV	Jackie Masters	£4.38M	£100K
					PROGRAMME TOTAL: £8.99M		
URGENT CARE	Ian Wilson	Andrew Burnett/ Gavin Bartholomew	Diane Hedges	8. OOH & 111	Matt Staples	£515K	£0
				9. PTS	Matt Staples	£325K	£23k
				10. MINOR A&E AVOIDANCE	Lisa Foweather	£223K	£0
				11. END OF LIFE	Damian Haywood	£82K	£0
				12. CARE HOMES	Sara Wild	£TBC	£TBC
				13. LTC MANAGEMENT	Terri Brunne	£739K	£35K
				17. OLDER PEOPLE OBC	Catherine Mountford	£TBC	£TBC
				19. AEC PATHWAY	Lisa Foweather	£253K	£0
				21. FUNDED NURSING CARE	Diane Hedges	£TBC	£TBC
				UNIDENTIFIED	TBC	£636K	£0
					PROGRAMME TOTAL: £2.77M		
MENTAL HEALTH	Gareth Kenworthy	David Chapman	Ian Bottomley	14. INTEGRATED PSYCH SERV	Juliet Long	£801K	£0
				16. DEMENTIA	Sonja Janeva	£0	£0
				22. MENTAL HEALTH OBC	Ian Bottomley	£TBC	£TBC
					PROGRAMME TOTAL: £0.80M		
PRIMARY CARE	Gina Shakespeare	Joe McManners	Rosie Rowe	18. GOING FURTHER FASTER	Rosie Rowe	£43K	£22K
					PROGRAMME TOTAL: £0.04M		
EFFICIENCY	Gareth Kenworthy	Paul Park	Head of Contracting / Procurement	23. CSU SLA	Head of Contracting/ Procurement	£630K	£0
				24. EoL Contract	Damian Haywood	£75K	£0
				24. Procurement Register	Hannah Mills	£TBC	£TBC
					PROGRAMME TOTAL: £0.71M		
					OVERALL TOTAL: £15.14M		

2. Expected impact on national outcome ambitions from the 5 programmes

National outcome ambition	% Improvement in 2 years	% Improvement In 5 years
1	-1.37%	3.20%
2	0.13%	0.39%
3	33%	31%
4	9%	
5	4.8%	9.8%
6	2.08%	5.2%
7	Indicator in development	

3. The 5 programmes
   a. OCCG's 5 major transformational programmes are:

      i. Primary care
      ii. Urgent care
      iii. Planned care
      iv. Mental health
      v. Medicines management

   b. Each programme is summarised overleaf, in a format compliant with the national Key Lines of Enquiry Assurance Template. Our confidence levels on delivery for each programme were assessed as part of the process to complete business cases. Assessment was, on the basis of our ability to mitigate the potential barriers to delivery. A green rating indicates a high level of confidence in our ability to deliver al outcomes within the proposed timescales. Amber indicates that there is a moderate degree of risk on timescales/and or completeness of impact. Red indicates a high degree of risk on timescales/and or completeness of impact.

Intervention 1: Primary Care Programme

Overall aims of the intervention and who is likely to be impacted by the intervention

This programme aims to build the capacity of primary care to operate at scale, so reducing pressure on individual practices whilst improving patient access, improving the quality of primary care and increasing out of hospital care. The programme will address the five core ambitions identified in NHS England's Improving General Practice, Call to Action Phase 1 report.

Expected outcome in quality, activity, cost and point of delivery terms e.g. the description of the large scale impact the project will have

Programme is expected to deliver:
A net saving to the system of £43k by 31st March 2015

i. Improved management of patients with multiple long term conditions
ii. Provision of consultant led ENT and dermatology clinics in the community
iii. Improved urgent access to primary care
iv. Clinical commissioning champion in each practice who will:
    - address unwarranted variation in that practice
    - engage in locality work
    - ensure delivery of practice based targets required by the whole plan

Implementation timeline

i. Final agreement of business case March 2014
ii. Contract agreed and signed with primary care April 2014
iii. Programme board established April 2014
iv. New services commence by end q2
v. Long term development strategy agreed and launched Sept 2014

Enablers required

- Arrangement with primary care that wraps national unplanned admissions DES funding into single local "Des +" scheme
- Integrated health and social are teams in place and able to meet all requirements of this development
- Practice capacity to engage with change
- Support of LMC

Barriers to success

- Ability to get all practices to agree to a local DES+ scheme instead of the national DES
- Maintaining practice commitment
- Speed with which implementation can be achieved
- Patient satisfaction with planned changes

Confidence levels of implementation

Intervention 2 : Urgent Care Programme

Overall aims of the intervention and who is likely to be impacted by the intervention

This programme comprises 8 projects which will reduce A&E attendances and emergency admissions. They are:

i. Contract variation to improve interface of 111 and out of hours
ii. Retender PTS services to improve efficiency and reduce cost
iii. Agree model to reduce the c40% of patients attending A&E who would be better treated elsewhere
iv. Better integration of EOL services
v. Improving quality of care in care and nursing homes
vi. Improving management of patients with LTCs
vii. Developing an emergency care pathway for patients who need urgent care, but do not need admission to a bed
viii. Older people's Outcomes Based Contracting

Expected outcome in quality, activity, cost and point of delivery terms e.g. the description of the large scale impact the project will have

Programme is expected to:

i. Deliver a net saving to the system of £2.84m by 31st March 2015
ii. Reduce activity in A&E
iii. Reduce avoidable admissions for patients with conditions that can be treated without an admission improve the efficiency and effectiveness of the 111 and PTS services.
iv. Reduce no's of people admitted with LOS < 1 day
v. Improve end of life care
vi. Reduce avoidable admissions from care and nursing homes (beginning in year 2)
vii. Improve the management of patients with complex long term conditions in primary care
viii. Improve access to the right service in the right place at the right time

Implementation timeline

i. Final agreement of business cases March 2014
ii. Appropriate expectations agreed in contracts by end March 2014
iii. Preferred options and service spec for reducing A&E attendance and for AEC pathways agreed by end q2
iv. Preferred options for streamlining care home support services agreed and contract variations in place by end yr. 1 for roll out in year 2
v. Delivery plans for reducing A&E attendance and for AEC pathways finalised July 2014
vi. Implementation of plans for reducing A&E attendance and for AEC pathways from September 2014
vii. Roll out of NE pilot EOL ACP project across all localities from August 2014
viii. Have ACP plans for all patients on palliative care register by October 2014
ix. Hospice at Home service live by October 2014
x. Primary care risk stratification and identification of top 2% - from April 2014
xi. Integrated community teams fully functioning and meeting business case requirements – by end q1 2014
xii. New multimorbidity model to be delivered by primary care and integrated teams being implemented in full by end q2

Enablers required

- Agreement of public and HOSC to service changes
- Contract changes (including element of integrated OHFT/OUHT contract)
- Clinical engagement and commitment from all partners to deliver change
- Increase in primary care capacity
- Full implementation of ACG tool
- Electronic palliative care co-ordination system
- Integrated health and social care teams in place and able to meet all requirements of this development

Barriers to success

- HOSC do not agree changes to PTS threshold criteria
- Contract variations cannot be agreed
- Ability to get all practices to agree to a local DES+ scheme instead of the national DES
- Keogh Review identifies further required/recommended changes
- Changing patient behaviour
- Care and nursing homes not obliged to implement

Confidence level of implementation

Intervention 3 : Planned Care Programme

Overall aims of the intervention and who is likely to be impacted by the intervention

This programme comprises 5 projects which will improve the productivity of planned care. They are:

i. Diagnostics
ii. First outpatients
iii. Planned care pathways
iv. Secondary care prescribing
v. Procedures of limited clinical value

Expected outcome in quality, activity, cost and point of delivery terms e.g. the description of the large scale impact the project will have

Programme is expected to:

i. Deliver a net saving to the system of £8.98m by 31st March 2015
ii. Ensure compliance with national and local standards for diagnostic services
iii. Improve patient experience and access to services
iv. Reduce waste and duplication
v. Reduce first outpatient referrals by: 7902 by 31st March 2016

Implementation timeline

i. Primary care peer review of referrals – continuous
ii. Business cases approved March 2014
iii. Appropriate expectations agreed in contracts by end March 2014
iv. Sign off all relevant service specifications and contract variations by end q1
v. Start implementation of service changes from beginning q2
vi. Identify actions to reduce OUH internal radiology requesting by Sept 2014
vii. GP pathology dashboard in use by July 2014
viii. All referral guidelines updated and uploaded on DXS by July 2014
ix. All new and revised diagnostic guidelines completed by end Sept 2014
x. Transfer some services to new community radiology providers by start Dec 2014
xi. Independently accredited quality management system for OUH radiology services - March 2015
xii. Review MSK hub in time to implement conclusions by end July 2014
xiii. Agree policies and contracts for procedures of limited clinical value by April 1st 2014 and upload them onto DXS in time to realise savings by q2.

Enablers required

- Contract changes with OUHT, OHFT, private providers and primary care
- Completion and agreement of new guidelines
- Fully functioning DXS system
- Delivery of full ICE radiology requesting system by OUHT
- Clarity on criteria for day case vs. outpatient procedures
- Alternative qualified providers available in the local market
- Funding for new NICE indications
- Agreement of public to planned changes

Barriers to success

- Unexpected changes to tariff
- Contract variations cannot be agreed
- Inability to engage clinicians
- Inability to identify/train GPs with necessary skills
- Service capacity to change
- Ability to get all practices to agree to a local DES+ scheme instead of the national DES
- DXS and ICE do not get fully implemented
- NICE guideline changes impact on schemes

Confidence level of implementation

Intervention 4 : Mental Health Programme

Overall aims of the intervention and who is likely to be impacted by the intervention

This programme comprises 2 projects which will, between them, ensure much improved integration of people's physical and mental healthcare. They are :

i. The integration of psychological services with physical healthcare in primary, community, emergency and secondary care settings
ii. Improvements in dementia diagnosis and care

In addition the programme will develop an outcomes based contracting model for Mental Health.

Expected outcome in quality, activity, cost and point of delivery terms e.g. the description of the large scale impact the project will have

Programme is expected to:

iii. Deliver a net saving to the system of £0.80m by March 2015
iv. Enable the system to meet national dementia and IAPT diagnosis targets
v. Deliver improvements to the quality of life for people with MH and PH needs
vi. Reduce LOS/Excess bed days and avoidable admissions resulting from A&E attendances
vii. Reduce presentation at A&E
viii. Improve outcomes for people with mild-moderate anxiety, particularly where they also have an LTC
ix. Reduce volume of primary care support currently required by this patient cohort
x. Deliver the national target to reach 67% of the expected dementia diagnosis rate for the population by the end of 2015/16.

Implementation timeline

i. Complete spec for re-procurement of IAPT by end August 2014 and mobilise new service by April 2015
ii. Decision on future model of Psychological medicine support in acute and ED by end Sept 2014
iii. Agree future model for community Psychological medicine support by end Sept 2014
iv. Revisions to memory clinic pathway agreed by June 2014
v. Dementia advisors in place by July 2014

Enablers required

- Commitment of relevant partners to change
- Completion and agreement of new guidelines
- Agreement to new memory clinic pathway by OUHT, OHFT and primary care
- Fully functioning DXS system

Barriers to success

- Capacity of IAPT service to extend into LTC
- Main change programmes may have adverse unintended consequences
- Failure to re-procure and /or re-procurement complicated by OBC for MH.

Confidence level of implementation

Intervention 5 : Medicines Management Programme

Overall aims of the intervention and who is likely to be impacted by the intervention

This programme comprises three projects which are aims to deliver savings on the drugs budget:

i. Reduction in medicines waste
ii. Optimising primary care prescribing for COPD, new oral anticoagulant agents and diabetes
iii. Re- procuring wound care dressings

Expected outcome in quality, activity, cost and point of delivery terms e.g. the description of the large scale impact the project will have

Programme is expected to:

i. Deliver a net saving to the system of £2.46m by 31st March 2015

Investment costs (time, money, workforce)

This programme requires investment of £2700.

Implementation timeline

i. Complete and evaluate separate pilot "waste" projects by July , September and November 2014 respectively, with roll out if agreed from September 2014 and January and February 2015.
ii. Disseminate annual prescribing report to localities by April 2014
iii. Agree objectives and deliverables for primary care prescribing with each locality by April 2014.
iv. Initiate joint formulary by June 2014 and have fully functioning and visible to all prescribers by July 2015
v. New contract and guidelines for wound care in place by end May 2014
vi. Agreement to savings from other dressing categories with tissue viability team by May 2015

Enablers required

- Review of IT prescribing solutions
- Joint formulary
- Ability to recycle some savings from prescribing costs into incentives for prescribers
- Commitment of providers

Barriers to success

- Prescribing advice from secondary to primary care may be inappropriate
- National guidance may change practice
- Main change programmes may have adverse unintended consequences on prescribing behaviours
- CCGs can no longer use LES's to drive change in community pharmacies
- Failure to fund and/or achieve a CQUIN for the joint formulary
- Engagement of Oxford Health

Confidence level of implementation

Appendix 2 – National Key Lines of Enquiry Assurance template

Segment	Key Line of Enquiry	Organisation response	Supported by:
Submission details	Which organisation(s) are completing this submission?	Oxfordshire CCG	***All page refs refer to 5 year narrative plan document***
	In case of enquiry, please provide a contact name and contact details	Regina Shakespeare Gina.shakespeare@oxfordshireccg.nhs.uk	
a) System vision	What is the vision for the system in five years' time?	By 2018/19 the Oxfordshire health and social care system 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	*The plan on a page,*

<table>
<tr><th>Segment</th><th>Key Line of Enquiry</th><th>Organisation response</th><th>Supported by:</th></tr>
<tr>
<td></td>
<td>How does the vision include the six characteristics of a high quality and sustainable system and transformational service models highlighted in the guidance?
Specifically:
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
2. Wider primary care, provided at scale
3. A modern model of integrated care
4. Access to the highest quality urgent and emergency care
5. A step-change in the productivity of elective care
6. Specialised services concentrated in centres of excellence (as relevant to the locality)</td>
<td>[
<table>
<tr><th></th><th>Change we have promised in this plan</th></tr>
<tr><td>1</td><td>• Continuous consultation with the public as we annually refresh this plan
• Engagement of patients, carers and other members of the public in programme boards
• Continuing support to develop PPGs</td></tr>
<tr><td>2</td><td>• Long term strategy for federation and capacity building
• Short term programmes to improve joint practice working to: reduce non elective admissions, A&E attendances and OP referrals</td></tr>
<tr><td>3</td><td>• Care integrated along the pathway from prevention to palliative care
• Using contracting changes (OBC) to underpin integration</td></tr>
<tr><td>4</td><td>• Meeting NHS constitution standards sustainably
• Reduction in the estimated 40% of A&E attendances that could be better cared for elsewhere
• Pathways in the acute sector that ensure people who need hospital care but don’t need a bed after coming to A&E, are assessed and treated without being admitted</td></tr>
<tr><td>5</td><td>• Improving quality of first OP referrals
• Streamlining planned care pathways
• Developing consultant and specialist GP led care in alternative settings
• Delivering NHS constitution standards for diagnostics</td></tr>
<tr><td>6</td><td>• We will work with NHS England to ensure patients requiring specialist care are treated by the most appropriate provider</td></tr>
</table>
</td>
<td>Details provided within the activity and financial templates which will be triangulated.</td>
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</table>

<table>
<tr><th>Segment</th><th>Key Line of Enquiry</th><th>Organisation response</th><th>Supported by:</th></tr>
<tr>
<td></td>
<td>How does the five year vision address the following aims:
a) Delivering a sustainable NHS for future generations?
b) Improving health outcomes in alignment with the seven ambitions
c) Reducing health inequalities?</td>
<td>A) From a resources perspective, what will the position be in five years' time? Is this position risk assessed?
By 2018/19 the system will be fully compliant with all financial planning rules. We will have reduced avoidable admissions by 31% and planned care activity by 17%. To achieve this we will have increased investment in primary care by approximately 31% and in community services by approximately 5%. We will have reduced investment in acute care by some 6% and will have maintained existing investment in mental health.

B) You should explain how your five year strategic plan will improve outcomes in the seven areas identified, within the context of the needs of your local population and what quantifiable level of improvement you are aiming to achieve]
<table>
<tr><th>National outcome ambition</th><th>% Improvement in 2 years</th><th>% Improvement In 5 years</th></tr>
<tr><td>1</td><td>-1.37%</td><td>3.20%</td></tr>
<tr><td>2</td><td>0.13%</td><td>0.39%</td></tr>
<tr><td>3</td><td>33%</td><td>31%</td></tr>
<tr><td>4</td><td>9%</td><td>tbc</td></tr>
<tr><td>5</td><td>4.8%</td><td>9.8%</td></tr>
<tr><td>6</td><td>2.08%</td><td>5.2%</td></tr>
<tr><td>7</td><td>Indicator in development</td><td></td></tr>
</table>
</td>
<td>Please see financial plan submissions and the following sections of the overall plan:

Sustainable NHS

Health outcomes in alignment with 7 ambitions

Inequalities</td>
</tr>
</table>

Segment	Key Line of Enquiry	Organisation response	Supported by:
	Who has signed up to the strategic vision? How have the health and wellbeing boards been involved in developing and signing off the plan?	The strategic vision has been shared with our public, our providers and our Health and Wellbeing Board, which has formally approved it and our Better Care Fund plan and has asked to be kept regularly updated on the plan's implementation. Our partners in OUHT have asked to form a joint steering group to manage the implementation of business cases which impact on the hospitals' work and this has been formally agreed. There is active engagement with our key providers to deliver outcomes based contracting. The vision for primary care has been actively embraced by our Localities.	
	How does your plan for the Better Care Fund align/fit with your 5 year strategic vision?	Our 5 year strategic vision is absolutely dependent on achieving closer integration of services right along the care pathway. Our Better Care Fund Plan is a critical enabler of this change, as it will ensure delivery of: • Integrated health and social care in the patient's home and in the community • A joint OHFT/OUHT contract for an integrated older peoples acute pathway • A discharge to assess service • 7 day working in social care	Please see chapter 4,

Segment	Key Line of Enquiry	Organisation response		Supported by:
	What key themes arose from the Call to Action engagement programme that have been used to shape the vision?	Be open and transparent about the financial challenge	We have set a deficit budget because we know we can't get back in the black in 1 year	Please see https://consult.oxfordshireccg.nhs.uk/consult.ti/5yrstrat/consultationHome for full feedback on Call to Action Consultation
		They like the idea of outcomes based commissioning, but we shouldn't rush into it wholesale	We are working steadily with our local providers to develop this approach for mental health and acute care for older people	
		They want care closer to home as long as that care is high quality care	We will ensure that community based: urgent care, integrated health and social care and planned care are all of the highest quality and that you get the right care in the right place – which will be hospital when you need it.	
		The NHS needs to change the public's attitude from "fix me now" to people accepting joint responsibility for their health	We have committed our locality teams to doing targeted outreach, education, patient participation group and other development work to help deliver this long term goal	
		We need a comprehensive all ages education programme about how to use the NHS	Our locality teams are working 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.	
		We should maximise the use of technology to free up GP time for face to face care	The Better Care Fund plan includes increased investment in the ALERT service; our LTC programme commits us to on-going work with the academic community on identifying telehealth solutions and our locality teams are working with local practices to support provision of patient access to records online; on line appointment and repeat prescription services and text message appointment reminders	
		We should reduce duplication and waste	We are improving integration of care around the patient –for example our Better Care Fund plan will deliver a single health and social care assessment and a single health and social care plan with 1 care co-ordinator managing its delivery.	

<table>
<tr><th>Segment</th><th>Key Line of Enquiry</th><th>Organisation response</th><th>Supported by:</th></tr>
<tr><td></td><td>Is there a clear ‘you said, we did’ framework in place to show those that engaged how their perspective and feedback has been included?</td><td>Yes</td><td></td></tr>
<tr><td rowspan="3">a) Current position</td><td>Has an assessment of the current state been undertaken? Have opportunities and challenges been identified and agreed? Does this correlate to the Commissioning for Value packs and other benchmarking materials?</td><td>Yes</td><td>See chapter 2,</td></tr>
<tr><td>Do the objectives and interventions identified below take into consideration the current state?</td><td>Yes</td><td>See chapter 2 and 3,</td></tr>
<tr><td>Does the two year detailed operational plan submitted provide the necessary foundations to deliver the strategic vision described here?</td><td>Yes</td><td>See unify submissions</td></tr>
<tr><td rowspan="2">b) Improving quality and outcomes</td><td>At the Unit of Planning level, what are the five year local outcome ambitions i.e. the aggregation of individual organisations contribution to the outcome ambitions?</td><td><table>
<tr><th>outcome</th><th>2 years</th><th>5 years</th></tr>
<tr><td>1</td><td>-1.37%</td><td>3.2%</td></tr>
<tr><td>2</td><td>0.13%</td><td>0.39%</td></tr>
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<tr><td>7</td><td colspan="2">Indicator in development</td></tr>
</table></td><td></td></tr>
<tr><td>How have the community and clinician views been considered when developing plans for improving outcomes and quantifiable ambitions?</td><td>Our plans have their basis in the early consultation work undertaken with our member practices to identify and agree local strategic and service change priorities; our Call to Action consultation with the local community; joint work with our provider and commissioner partners, for example our weekly summits to improve urgent care delivery across the whole system; and our work with patients and carers to define the right outcomes for mental health and older people’s urgent care.</td><td></td></tr>
</table>

Segment	Key Line of Enquiry	Organisation response	Supported by:
	What data, intelligence and local analysis were explored to support the development of plans for improving outcomes and quantifiable ambitions?	• The data and analysis set out in our JSNA, the joint priorities we have agreed with the Health and Wellbeing Board and the issues identified in the Director of Public Health Annual Report. • An analysis of the current strengths and weaknesses in the local health and social care economy including: NHS Constitution measures, national outcomes measures for the five domains of the outcomes framework, local Health and Wellbeing Board outcomes, activity levels and financial performance against contract; benchmarking • The views of our member practices. • The views of local people.	See chapter 2,
	How are the plans for improving outcomes and quantifiable ambitions aligned to local JSNAs?	We have a growing population overall, and a rapidly growing older population with pockets of rural isolation and urban deprivation which impact particularly on health outcomes. Our strategy will deliver: • more integrated health and social care, close to where people live and driven by their GP • a targeted partnership programme to reduce health inequalities around practices in areas of high need • rapid access to same day assessment and care	See chapter 2,
	How have the Health and well-being boards been involved in setting the plans for improving outcomes?	The strategy has been approved by the Health and Wellbeing Board, and has been developed in close consultation with the Board's steering group.	See chapter 2,
c) Sustainability	Are the outcome ambitions included within the sustainability calculations? I.e. the cost of implementation has been evaluated and included in the resource plans moving forwards?	yes	See Unify submissions
	Are assumptions made by the health economy consistent with the challenges identified in a Call to Action?	yes	See Unify submissions and chapter 3.
	Can the plan on page elements be identified through examining the activity and financial projections covered in operational and financial templates?	yes	See Unify submissions

Segment	Key Line of Enquiry	Organisation response	Supported by:
d) Improvement interventions	Please list the material transformational interventions required to move from the current state and deliver the five year vision. For each transformational intervention, please describe the : • Overall aims of the intervention and who is likely to be impacted by the intervention • Expected outcome in quality, activity, cost and point of delivery terms e.g. the description of the large scale impact the project will have • Investment costs (time, money, workforce) • Implementation timeline • Enablers required for example medicines optimisation • Barriers to success • Confidence levels of implementation The planning teams may find it helpful to consider the reports recently published or to be published imminently including commissioning for prevention, Any town health system and the report following the NHS Futures Summit.	**See Appendix 1 to this plan** **Intervention One** Overall description [CCG to comment] Expected Outcome [CCG to comment with particular emphasis on the impact on the outcome ambitions or the six characteristics] Investment costs • Financial costs [CCG to comment] • Non-Financial costs [CCG to comment] Implementation timeline [CCG to comment] Enablers required [CCG to comment] Barriers to success [CCG to comment] Confidence levels of implementation [CCG to comment]	See separate tables at front of this appendix, and chapters 3 and 4,

Segment	Key Line of Enquiry	Organisation response	Supported by:
e) Governance overview	What governance processes are in place to ensure future plans are developed in collaboration with key stakeholders including the local community?	Future Plans will continue to developed in collaboration with key stakeholders through • Contract performance management review and variation • Collaborative outcomes based contracting with key providers • Health and Wellbeing Board • Health Liaison Committee • Oxford Strategic Partnership Board • Oxfordshire Safer Communities Partnership Boards • Joint Management Groups for older people, mental health and learning disabilities • Whole system governance arrangements on individual change programmes • Joint Quality, Innovation and Productivity Group with OUHT • Public involvement in programme boards • Work by localities to involve each of the 6 local stakeholder forums in evaluation and future planning	

Segment	Key Line of Enquiry	Organisation response		Supported by:
f) Values and principles	Please outline how the values and principles are embedded in the planned implementation of the interventions	Clinicians and Patients working together to redesign how we deliver care	Each major change programme has a GP Clinical Lead, who works closely with his/her counterparts in other parts of the system to develop the detailed business case and to drive its implementation	
		Reducing health inequalities by tackling the causes of poor health	We have a discrete programme to address this, and all our major interventions incorporate measures to improve access, particularly for people experiencing health inequalities	
		Commissioning Patient Centred High Quality Care	Please see our Quality Impact Assessment	
		Promoting integrated care through joint working	Many of our interventions are underpinned by specific objectives of improving integration along the pathway from prevention to palliative care ; and this is a fundamental unifying driver across interventions	
		Supporting individuals to manage their own health	This is fundamental to our Better Care fund plan and Long Term Conditions project	
		More care delivered locally	All our major interventions incorporate measures to provide more care close to home with significant reductions in levels of acute activity.	

Appendix 3: Outline OD Plan

OXFORDSHIRE CLINICAL COMMISSIONING GROUP (OCCG)

IMPLEMENTATION OF THE ORGANISATIONAL DEVELOPMENT (OD) PLAN

A. **1. WHERE WE ARE NOW**

Journeyman Support and Development Ltd. worked with OCCG throughout March and April 2014 through a series of 23 1:1, non-attributable interviews on a diagnostic that led to the development of the CCG's Organisational Development (OD) Plan, fleshing out the existing OD strategic framework that had been set towards the end of 2013/14. The work was completed satisfactorily and comprised two elements: -

- the OD chapter for OCCG's 5 year plan

- advice for the incoming CCG Chief Officer covering the twin aspects of internal OD/fitness for purpose and county-wide, whole system leadership shaping and OD. The purpose of the OD Plan is to support both internal and wider system development to create a professional, skilled professional organisation in the context of a county where system-wide strategy must be swiftly translated into clear and joint delivery plan, led and owned by a community of peer senior leaders who are aligned on trust and risk sharing.

The OD Plan aims to create the capacity needed to face the key challenges facing the system as follows:-

A. Maximising safety, efficiency and affordability now whilst transforming the strategic model of service delivery

B. Having one vision, strategy and delivery plan for the county as a whole whilst ensuring that it is shaped, owned and delivered in your localities

C. Driving better performance in our providers whilst building a common vision and service strategy through a virtual team of leaders across Oxfordshire as we take up your role as system leaders – this includes both aligning our 5 year plan with provider strategic and delivery plans and risk sharing around the implementation of our Better care Fund proposals. It needs to create capacity, financial and workforce aligned plans.

D. Being more agile and decisive now whilst building sustainable clinical and community engagement and effective collaborative commissioning with the County Council, NHS England, Commissioning Support Unit (CSU) and wider CCG partners

E. Making much needed changes to the CCG's structure now whilst supporting staff to grow and develop to meet the challenge

The OD journey we are on is in three stages:-

Stage 1- Achieved	Stage 2- Achieved	Stage 3- The present
Create OD Strategic Framework	Develop OD Plan	Implement the OD Plan

This implementation plan now covers **Stage 3** – making the business case for the investment needed to implement the OD Plan and secure the first priority interventions required, by **the end of July 2014.**

The OD Plan comprises 5 components:-

THEME	FOCUS
1. Sustainable Strategy and Delivery Plan for Oxfordshire 2014/15-2018/19	Aligned system-wide vision, strategy, implementation and peer top leaders
2. CCG Shape and Systems – Core Restructure	Needs-based design and transparent implementation of the CCG's restructuring
3. CCG Core Governance	Practical review of constitution and delegation arrangements
4. Learning, Development and Talent Management Plan	A professional, skilled, sustainable commissioning organisation with a clear operating model
5. Connected Commissioning	Effective joint, collaborative and co-commissioning with partners

12. DELIVERING THE WORK IN PRACTICE

The new CCG Chief Executive starts in June, with consultation on the CCG's new structure currently underway. He has signalled his intent that the OD strategy will be led personally by him and the OCCG Chair because of the importance of the CCG's rebuilding and the need for new consensus between top leaders across the county.

Implementation is likely to sit with two directors, with the clinical quality lead director leading on training whilst the lead director for strategy and

transformation will be leading on system wide OD and leadership development. The latter's team includes a Head of OD post, supported by an OD delivery post. This Stage 3 project will enable the CCG to start early, before the new structure is fully implemented. Early engagement with the Clinical Chair, new Chief Executive, lead Directors and County Top Leaders will be undertaken to ensure that ownership is tested and achieved. The work plan is set out below.

A. Briefly **stock take progress** to date against the OD Implementation Plan, including existing training programmes

PRODUCT: BRIEF SUMMARY OF EXISTING TRAINING AND GAPS

B. Review current funding arrangements for training, workforce development and OD, especially subscription or top-sliced related funding e.g. Wessex Leadership Academy, Heath Education England and Commissioning Support Unit to ensure maximum leverage for existing investment. In particular it will be important to secure HEE support for facilitation of workforce alignment strategies across the Oxfordshire system.

PRODUCT: SUMMARY OF FUNDING ARRANGEMENTS THAT CAN BE BROUGHT TO BEAR TO SUPPORT THE OD PLAN AND A PROPOSAL For JOINT WORK WITH HEE TO ALIGN COUNTY-WIDE WORKFORCE PLANS

C. Create the business case necessary to establish/fund the county-wide OD Programme and the internal development programme to deliver themes 1 and 4 above

PRODUCT:TWO PART BUSINESS CASE; 2 COMPONENTS – INTERNAL CCG DEVELOPMENT AND COUNTY WIDE PROGRAMME

D. Work with the Locality Clinical Directors lead **to shape, prioritise, cost and timetable the clinical leadership and localities element of theme 4**

PRODUCT: COSTED PROPOSAL TESTED WITH CLINICAL CHAIR AND LOCALITY CLINICAL DIRECTORS

E. Commence engagement with top leaders across the County **to determine the will, model, joint funding and commissioning arrangements for the County-wide programme.**

PRODUCT: OUTLINE PROPOSAL TO INFORM FUTURE PROCUREMENT FOLLOWING ENGAGEMENT WITH COUNTY TOP LEADERS TO SECURE OWNSERSHIP

Appendix 4 – IM&T Strategy

To insert into Oxon CCG 5-year Strategic Plan

Appendix 4– IM&T Strategy

The CCG will take advantage of the efficiency and effectiveness of information and information technology to achieve its objectives. To that end, OCCG has developed its draft IM&T strategy (available on request), which currently is being updated to better reflect the key themes in the 5-year Plan. The table below identifies IM&T dependencies or opportunities relating to these themes, and makes reference to specific IM&T components – many of which are covered in the current draft IM&T strategy.

Certain IM&T requirements are common dependencies for many of the 5-year Plan themes, including:

- Improvements to data quality, analytical tools and informatics support services - to better monitor performance and outcomes and to forecast activity and costs;
- Becoming smarter in the use of information and knowledge (the evidence-base) to inform decision-making;
- Sharing of records or access to records across organisational boundaries along the patient's care pathway, i.e. interoperability[3];
- Robust infrastructure – re technology, governance, information governance and effective mechanisms to deliver end-user awareness, training and support;
- Ensuring future IM&T requirements and opportunities are routinely considered as an integral part of any proposed improvement / service transformation plans.

Several of the IM&T components identified in the table below currently exist or are developments which are underway. Nonetheless, the breadth scale of the issues to be addressed means there is a considerable gap yet to be bridged. Bridging the gap over the coming years will require various challenges to be managed in terms of resources and effort, and also in terms of professional and organisational cultures.

[3] OCCG's draft IM&T strategy emphasises the importance of interoperability. The cross-organisational Oxfordshire Care Summary (OCS), which has been live for two years, and is being further developed, is a key component of OCCG's interoperability strategy. OCCG will continue to invest in the development and implementation of the OCS to enable the timely provision of integrated clinical information at the point of care.

Themes	IM&T Requirements / Opportunities	Key components of IM&T plans
Joined up patient-centred care; Seamless integration of services around the patient along the care pathway; Locality based integrated health and social care community teams	Access to shared records, care plans, assessments – amongst primary care, community teams, social care, acute care; Shared care plans especially for patients with complex needs / EOL care	Interoperability between systems; OCS; Summary Care Record (SCR); Mobile technologies; Tools to support single assessments and shared care plans; Shared Special Patient Notes for complex / EOL care
Primary care at scale, broader range of services, efficiencies	Use of technology to: enable more flexible working within and across practices; free up GP time; work more closely with other care services	Shared system access amongst general practices, and between practices and community teams (replacement community system planned); Mobile technologies for GPs and community staff; Online access by patients for booking, repeat prescriptions, viewing records; GP – specialist e-comms for advice; Extend e-requesting for all tests; Text messaging to patients
Streamline urgent care pathways, fewer emergency admissions	Information sharing between 111, OoH, ambulance service, GP, A&E; Identify patients at high-risk of avoidable A&E visits and urgent admissions	Care Pathways triage tool; Shared records via OCS and/or SCR, further interoperability developments; Urgent Care Dashboard
Avoid hospital attendance / admission; Care closer to home	Information / decision support tool to identify patients most at risk of hospital admission; Information sharing amongst urgent care partners (see above); Assistive technology to support patients at home	ACG risk stratification tool; Urgent care e-communications – see above; Telehealth
Engagement with public re appropriate use of NHS-funded services, resources and public health campaigns	Public communications programme to exploit e-communications wherever appropriate	Maintain and enhance CCG and practice websites; Greater use of social media and apps
Self-management; Help people and communities to help themselves	Exploit assistive technology and e-communications for education and support, wherever appropriate	Telehealth; Advice and support via websites, social media, apps, SMS, email, Skype, … Use of "Talking Health" online engagement and consultation tool
Reduce delayed transfers of care, allowing people to return home from hospital in a timely manner	Timely, efficient communications amongst those involved in a patients care before and after discharge	Shared assessments, care plans, e-communications, alerts, workflow - amongst hospital, community and social care teams
Improvement in performance re NHS Constitution pledges, outcomes, quality, national and local targets; Tracking progress on QIPP; Informed decision-making	Monitoring key indicators, including outcomes framework, patient experience feedback, quality indicators; Financial reporting; Identify warranted and unwarranted variations in performance	Consistent, assured quality of data; Health intelligence tools and reports, dashboards, benchmarking; Dr Foster data to identify ineffective procedures, potentially avoidable deaths, etc.; Analyst support services
Outcome based contracts	Analysis and monitoring of performance and outcomes along the whole care pathway	Linking records across episodes of care within and between organisations
Streamline planned care pathways, fewer outpatient referrals	Decision support tools to ensure referrals comply with best practice and guidance	DXS referrals / pathways guidance tool, integrated with GP systems; National e-referrals system; Pre-referral email advice from specialists

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Oxfordshire Health & Wellbeing Board – 17 July 2014

Better Care Fund – Position Paper

1. At its last meeting in March 2014 the Health and Wellbeing Board agreed the Better Care Fund plan for Oxfordshire that was submitted to NHS England on 4th April 2014.

2. Following the national assurance process, the Better Care Fund plan for Oxfordshire has been red rated and did not achieve satisfactory sign off. The Plan has since been updated to respond to feedback, which particularly focused on the engagement of providers, assurance of the deliverability of the schemes in the plan and the likely impact of the proposals on the acute sector. It was intended to update the Board on progress with the Better Care Fund plan at this meeting, along with the Clinical Commissioning Group Strategic Plan (of which it is an integral part).

3. However, within the past week there have been significant developments nationally on the Better Care Fund. Central Government has announced that up to £1 billion of the Better Care Fund (equivalent to around £10m of the original allocation in Oxfordshire) will be allocated to local areas to spend on out-of-hospital services according to the level of reduction in emergency admissions they achieve.

4. Local areas will agree their own ambition on reducing emergency admissions and they will be allocated a portion of the £1 billion performance money in the fund in accordance with the level of performance against this ambition. A guideline reduction in unplanned admissions of at least 3.5% is anticipated, and local areas will need to provide clear evidence of how this will be achieved through spending on adult social care.

5. The remaining money from the performance pot that is not earned through reducing emergency admissions will be used to support NHS-commissioned local services, as agreed by Health and Wellbeing Boards.

6. Revised guidance for local areas to shape the further development of local Better Care Fund plans will be set out shortly. This will include information on the revised performance payment scheme, as well as specific areas where local plans need to be strengthened through providing further detail on local plans.

7. It is still anticipated that the guidance will include the need for Better Care Fund plans to protect adult social care services, and funding for local authorities to implement the Care Act from 2015 onwards. If this is not funded it will have a significant impact on the level of resources available for adult social care and the ability to achieve the required reduction in unplanned admissions.

8. Local areas will be expected to submit revised plans later in the summer, ahead of a further process of national assurance and ministerial sign off. Better Care Fund plans will still be expected to launch from 1 April 2015, as set out in the 2013 Spending Review.

9. It has therefore become unrealistic to present an updated Better Care Fund plan to the Board at this meeting, given the guidance is yet to be published. Significant work will be needed between the County Council, Clinical Commissioning Group and NHS providers to develop robust schemes that meet these revised national conditions, and this work is already underway. A verbal update will be provided at the meeting.

RECOMMENDATION

(a) The Health and Wellbeing Board is recommended to note the changes to the Better Care Fund and the implications for plans in Oxfordshire; and

(b) The Board is also recommended to agree to hold a special meeting of the Board at an appropriate time to consider an updated Better Care Fund Plan that reflects updated guidance prior to submission to Government.

John Jackson
Director for Social & Community Services

Contact: Ben Threadgold, Policy and Performance Service Manager, Tel: (01865) 328219

July 2014

Oxfordshire's Joint Health & Wellbeing Strategy

2012 - 2016

Final Version July 2012,
Revised July 2013 and June 2014

CONTENTS

1. Foreword to the Revised Version of this strategy, July 2014

This revision of our joint strategy leads us into a third year of work together in Oxfordshire through the Health and Wellbeing Board. In the last year, now with statutory status, we have continued to build on the foundations we laid as a shadow board and have demonstrated progress in a wide range of areas. Working arrangements have bedded down, relationships have grown and our focus on improving health outcomes for the people of Oxfordshire has continued. Oxfordshire Healthwatch is very well established and continues to add a valuable contribution to the work of the Board.

We made good progress in 2013-14. Our approach of setting outcomes for all our Health and Wellbeing priorities and for receiving updates on performance each time we meet is working well. It has enabled us to keep our focus on the issues that matter and to drive improvement.

We have made progress on several issues during the year, including

- There have been improvements in the take up of free early education for eligible 2 years olds;
- Teenage pregnancy rates continued to fall;
- The "Thriving Families" programme has worked with over 800 families;
- We took more steps forward in establishing integrated, patient-centred services;
- The number of hospital admissions for acute conditions that would not normally require hospital admission fell for people of all ages.
- Work to reduce obesity and maintain a healthy weight has gathered momentum;
- More people with long term conditions received their winter flu immunisations;
- Even more people have quit smoking this year in Oxfordshire – still one of the best ways to improve your life expectancy;
- The Public Involvement representatives have brought a useful perspective to discussions in all the partnership boards.

However, we still have more to do. This revised strategy sets out our renewed intentions for the year ahead. We have proposed outcome measures so that we can continue to monitor improvements in 2014-15. We will hold each other to account, expect good results and continue to strive for good quality in all health and social care services.

Cllr Ian Hudspeth, **Chairman of the Board**
Leader of Oxfordshire County Council

Dr Joe McManners, Vice Chairman of the Board
Clinical Chair of the Oxfordshire Clinical Commissioning Group

2. Introduction

A Health and Wellbeing Board was set up in Oxfordshire to make a measurable difference to the health and wellbeing of its people. Oxfordshire has a rich history of partnership working which strives to improve the health of Oxfordshire's people and the care they are offered. This Board was, therefore, very much the next logical step for Oxfordshire to take, and through it we also fulfil a key requirement of the Health and Social Care Act (2012).

The Health and Wellbeing Board is the principal structure in Oxfordshire responsible for improving the health and wellbeing of the people of the County through partnership working.

The Board is a partnership between Local Government, the NHS and the people of Oxfordshire. Members include local GPs, Councillors, Health Watch Oxfordshire and senior officers from Local Government.

Early tasks for the board have been to look at the biggest challenges facing the wellbeing of Oxfordshire's people and to set out the Board's initial ideas in this strategy for improving the situation.

This strategy is the main focus of the Health and Wellbeing Board's work. We strive to make this a 'living document'. As priorities change, our focus for action will need to change with it. It is for this reason that, at the end of each year of operation, we review our performance, assess local need and are propose revised outcomes for the year ahead. We want to make sure that our planning stays 'alive' and in touch with the changing needs of Oxfordshire's people.

3. Vision

The vision of the Health and Wellbeing Board is outlined below. This sets out our aspiration in broad terms. It is fleshed out in the priorities which follow and the action plans that are now in progress.

By 2016 in Oxfordshire:

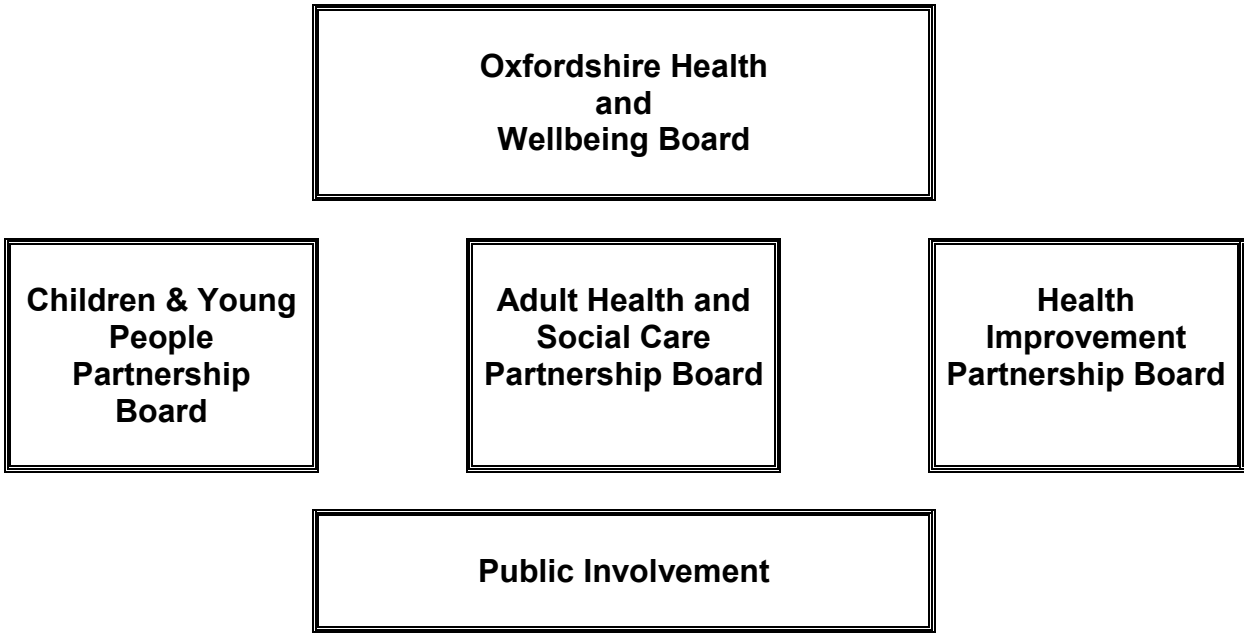
- more children and young people will lead healthy, safe lives and will be given the opportunity to develop the skills, confidence and opportunities they need to achieve their full potential;
- more adults will have the support they need to live their lives as healthily, successfully, independently and safely as possible, with good timely access to health and social care services;
- everyone will be given the opportunity to voice their opinions and experiences to ensure that services meet their individual needs;
- the best possible services will be provided within the resources we have, giving excellent value for the public.

The priorities set out in this document put flesh on these themes. The priorities are intended to run to 2016 while the measures and targets set out within each priority are for the financial year 2014-15.

4. The structure of the Health and Wellbeing Board

4.1 What does the Health and Wellbeing Board look like?

The Health and Wellbeing Board has three Partnership Boards reporting to it and a Public Involvement Network; each with responsibilities as outlined below:



The purpose of each of the Partnership Boards and for Public Involvement are outlined below:

Adult Health and Social Care Board
To improve outcomes and to support adults to live independently with dignity by accessing support and services they need while achieving better value for money, especially through oversight of our pooled budgets.

Children and Young People's Board
To keep all children and young people safe; raise achievement for all children and young people and improve the life chances for our most disadvantaged and vulnerable groups

Health Improvement Board
To add life to years and years to life, focusing on the factors underpinning wellbeing, while levelling up differences in the health of different groups in the County

Public Involvement

To ensure that the genuine opinions and experiences of people in Oxfordshire underpin the work of the Health and Wellbeing Board.

4.2 How do decisions get made?

The Health and Wellbeing Board is ultimately responsible for setting a direction for the County in partnership. Its members are committed to working with its three Partnership Boards and its Public Involvement representatives to agree that direction. They are also accountable to their constituent organisations – the Oxfordshire Clinical Commissioning Group, County, District and City Councils and HealthWatch Oxfordshire.

In turn, the Partnership Boards are committed to working with a wide range of health and social care providers, voluntary agencies, carers, faith groups, members of the public and advocacy groups. We invite these partners to formal meetings as 'expert witnesses' and to

workshops during the year as a means of engagement. In this way, the decisions of the Health and Wellbeing Board aim to be truly inclusive.

The Health and Wellbeing Board meets in public three times a year. Each of the three Partnership Boards also meet in public at least once each year and will also host workshops which will include many more service providers, partners, informal/ volunteer carers, faith groups, voluntary sector representatives, the public and advocacy groups.

While the Health and Wellbeing Board listens carefully to the views of many groups of stakeholders and of the public as a whole, it has to be acknowledged that:

a) they want to take careful account of the evidence base provided by the Joint Strategic Needs Assessment and scientific research, and
b) given that there will never be enough resources to meet all of people's needs, it is the duty of the Health & Wellbeing Board to balance needs carefully and to influence its constituent organisations to make difficult decisions about priorities.

Details of the Health and Wellbeing Board, including membership, be found through the link below-
http://www.oxfordshire.gov.uk/cms/content/about-health-and-wellbeing-board

4.3 The Work of Other Partnerships and Cross-Cutting themes

The Health and Wellbeing Board is not the only group of its type in Oxfordshire.
Public consultation suggested including topics which are already covered by other groups and strategies. We do not want to duplicate effort and the work of these groups therefore has a key role to play. Other key partnerships and plans include:

- Better Care Programme Board
- Better Mental Health in Oxfordshire
- Carers Strategy Oxfordshire
- Child Poverty Strategy
- Urgent Care Programme Board that covers the A&E Recovery Plan
- Civilian Military Partnership
- Corporate Parenting Panel
- Dementia Plan for Oxfordshire
- Alcohol and Drugs Partnership
- Education Transformation Board
- End of Life Care Strategy
- Joint Management Groups
- Oxfordshire Children's and Adults Safeguarding Boards
- Oxfordshire Domestic Violence Strategy Group
- Oxfordshire Safer Communities Partnership
- Oxfordshire Stronger Communities Alliance
- Oxfordshire Sports Partnership
- Partnership Boards and joint strategies for Physical Disability, Learning Disability, Older People, Mental Health and Autism
- Young People's Lifestyles and Behaviours Steering Group
- Thriving Families Steering Group
- Young Carers' Strategy Oxfordshire
- Youth Offending Service Board

A number of issues were identified in the major consultation in 2012 as ones that are of cross cutting interest to the adults, children's and health improvement boards. These were - safeguarding, carers, housing, poverty, mental health, drug and alcohol dependency, offender health, long term conditions, end of life care, co-ordination of good quality support and making a successful transition from children's to adult services. The action plans to deliver the improvements needed will take account of the cross cutting nature of these issues wherever possible.

Three of these cross-cutting issues are so fundamental and public support for them so strong, that the Health and Wellbeing Board will require that the implementation of this strategy across all priorities takes account of:

1) Social disadvantage
The aim here is to level up health and wellbeing across the County by targeting disadvantaged and vulnerable groups. This will vary from topic to topic but will include: Rural and urban disadvantaged communities, black and ethnic minority groups, people with mental health problems, members of the armed forces, their families and veterans and carers of all ages.

2) Helping communities and individuals to help themselves
As the public purse tightens, we need to find new ways of supporting people to help themselves. Since the early days of this approach there has been some progress including direct payments to people to buy their own care and the County Council's use of the 'Big Society Fund'.

3) Locality working
Local problems often need local solutions and Oxfordshire is a diverse County. The Clinical Commissioning Group, County Council and District councils all support locality working and we should expect to see locality approaches to the priorities in this County when they are the best way to make improvements.

5. A strategic focus on Quality

Discussion at the Health and Wellbeing Board has further fuelled our intention to build a strategic focus on quality issues. The role of the Health and Wellbeing Board is to set strategic concerns for the whole system and to receive assurance of good practice. We have been monitoring a range of quality outcomes measures and see a fairly good picture overall, but believe there is more to do. We consulted on a process for developing this area of our work and the responses received were supportive but called for specific action.

The Board is concerned that the issues uncovered by the Francis Report on the Mid Staffordshire NHS Trust should not be repeated in Oxfordshire and that the learning that is arising from the Child Sexual Exploitation cases locally will be implemented. In addition, the Joint Strategic Needs Assessment (JSNA), Director of Public Health Annual Reports and feedback of concerns from representatives of the public also indicate gaps in quality which need to be addressed.

The intention is to ensure that governance and assurance systems are joined up between organisations across the County. Performance measures which show patient and public satisfaction or dissatisfaction with services will be embedded in our performance framework again. The development of Healthwatch Oxfordshire has brought independent and informed views to the Board. .

A process has now been established for giving more assurance on quality issues across the system. This includes continuing to include a range of patient reported outcome measures in this strategy and monitoring performance closely. In addition there will be a joint annual report of quality issues which will highlight any particular concerns to the Health and Wellbeing Board for a common response.

6. The Bedrock of our Decision-making: Oxfordshire's Joint Strategic Needs Assessment

6.1 What is the Oxfordshire Joint Strategic Needs Assessment (JSNA)?

The Oxfordshire Joint Strategic Needs Assessment is a report that includes a huge wealth of information and intelligence from a number of different sources that cover the health and wellbeing of the population in its broadest terms. This information is shared between the NHS locally and Local Authorities and is available to the public. When added to local knowledge of services, it gives Oxfordshire a common and consistent evidence-base which allows us to pinpoint gaps and target improvements.

This analysis is the scientific bedrock on which this strategy rests. During 2013-14 the data collection was further improved and made more accessible. An annual summary report was accepted by the Board in March 2014. It can be found here:
http://insight.oxfordshire.gov.uk/cms/joint-strategic-needs-assessment

The JSNA highlights the following challenges which need to be met which are summarised in the following section:

6.2 What are the specific challenges?

1. **Demographic pressures** in the population, especially the increasing number and proportion of older people, many of whom need care and may be isolated or lonely. This is markedly higher in our more **rural districts** than in the City.
2. The **proportion of older people** in the population also continues to increase which means that every pound spent from the public purse has further to go.
3. There are a growing number of people with **dementia** in the County who require access to new emerging treatments.
4. The persistence of small geographical areas of **social disadvantage containing high levels of child poverty**, especially in Banbury and Oxford but also in parts of our market towns. These areas are also the most culturally diverse in the County **containing ethnic minority groups who have specific needs.**
5. The increase in **'unhealthy' lifestyles which leads to preventable disease**.
6. The need to ensure that services for the **mentally ill and those with learning disabilities and physical disabilities** are prioritised.
7. **Increasing demand** for services.
8. The need to support **families and carers of all ages to care.**
9. The need to encourage and support **volunteering**.
10. An awareness that the **'supply side'** of what we provide does not 'mesh' together as smoothly as we would like - (e.g. hospital beds, discharge arrangements, care at home and nursing home care).
11. The recent **tightening of the public purse** which has knock-on effects for voluntary organisations.

12. The need to work with and through a **wide patchwork of organisations** to have any chance of making a real difference in Oxfordshire.
13. The changing face and **roles of public sector organisations.**

6.3 What are the overarching themes required to meet these challenges?

A number of overarching themes required to improve health in Oxfordshire have been identified as follows –

- The need to shift services towards the prevention of ill health.
- The need to reduce inequalities, break the cycle of deprivation and protect the vulnerable.
- The need to give children a better start in life.
- The need to reduce unnecessary demand for services.
- To help people and communities help themselves.
- The need to make the patient's journey through all services smoother and more efficient.
- The need to improve the quality and safety of services.
- The need to streamline financial systems, especially those pooled between organisations, and to align all budgets more closely.

These themes will be overseen by the Health and Wellbeing Board and will be tackled by all of the three partnership boards.

6.4 What criteria have been followed in selecting priorities?

The priorities are based on the challenges and themes set out previously. We have also used the following criteria to help us focus our priorities:

a) Is it a major issue for the long term health of the County?
b) Are there some critical gaps to which we need to give more attention?
c) What are we most concerned about with regard to the quality of services?
d) On what topics can the NHS, Local Government and the public come together and make life better for local people?
e) Which issues are most important following consultation with the public?

7. What are the priorities for Oxfordshire's Health and Wellbeing Strategy?

A summary of the priorities can be found in Annex 1

Each of the priorities set out in this strategy has associated outcomes to be achieved in the current year. The Board examines progress against all of these outcomes at each meeting. At the end of each year of operation the Board reviews successes, analyses on-going need as identified in the Joint Strategic Needs Assessment and proposes revised outcomes to be achieved in the year ahead.

The section below examines each priority in turn. Building on the original rationale for agreeing each, we have updated this strategy to illustrate why this issue is still a priority and the areas of focus going forward. In addition to this narrative the Board considers specific outcomes for each priority and consults the public and stakeholders on their proposals. The agreed outcomes for the year ahead become the performance framework and progress is reported at every Board meeting.

A. Priorities for Children and Young People

Priority 1: All children have a healthy start in life and stay healthy into adulthood

A healthy start in life begins at conception, runs through pregnancy and on into the first few years of life. Where problems occur, we aim to provide the wide range of services that parents need to support them.

There is increasing evidence that demonstrates that outcomes across health, education and social care are determined from very early on in life. For this reason we will monitor areas that focus on a healthy pregnancy and progress up to the age of 2 years.

The number of children in Oxfordshire aged 4 and under has grown by 13% since the last census in 2001 whilst the Oxfordshire population as a whole has only increased by 8%. We know there is a year on year increase in the proportion of children and young people admitted to hospital in an emergency. The most common causes of emergency admission to hospital for young children (under 5) are respiratory tract infections, viral infections and gastroenteritis. We therefore need to continue to prioritise these children as a focus for our services in the community.

Young people tell us that there is much more we could do to improve the transition between young people's services and younger adults' services. This is particularly relevant to young people with mental health needs and we have already acted on this with a specific focus on looked after children. Young people also told us that they want more information and support around mental health issues and we made this a priority for the past year.

The public mental health strategy will be developed in the Autumn, The strategy will have a strong focus on promoting wellbeing and developing resilience, particularly in children and young people. Suicide risk reduction work is already underway. The working group is developing a coherent approach to this area, through the plan that was drafted with key stakeholders and in consultation with the safeguarding boards.

This priority should be read together with priorities 9 and 11 in the Health and Wellbeing Strategy which proposes the promotion of breastfeeding and improved immunisation for children as further priorities. The Health Improvement Board has also been working on the Healthy Weight Strategy for the county which also crosses over with this work.

Where are we now?

- A high number of women are seeing a midwife or maternity health care professional within the first 13 weeks of pregnancy, though data has not been available to show this as a percentage of all pregnancies.
- A very high proportion of children aged 2 – 2.5 years receive a Health Visitor Review.
- There has been good progress in reducing the rate of children admitted to hospital with infections as emergency cases.
- Oxfordshire continues to perform well against a range of indicators important for a healthy start in life monitored by the Health Improvement Board. This includes breastfeeding and immunisation.
- The increasing level of obesity in Year 6 children remains a cause for concern.

Outcomes for 2014-15

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%.

1.2 Reduce the rate of emergency admissions to hospital with infections, maintaining low rates through 2014-15 (currently 152.2 per 10,000)

Priority 2: <u>Narrowing the gap for our most disadvantaged and vulnerable groups</u>

Oxfordshire is overall a very 'healthy and wealthy' county but there are significant differences in outcomes across health, education and social care for some specific groups. We know that outcomes for children and families from vulnerable groups and disadvantaged communities can be worse than for their peers and is variable across the County.

Poverty and disadvantage are known to be strongly linked to poor outcomes and so work focused on reducing the gap between the most disadvantaged and most advantaged groups starting in 'early years' is seen as a key way of improving outcomes for children and families. We will therefore continue to monitor the take up of free early education places for 2 year olds.

There is a national focus on helping the most disadvantaged and challenged families to turn their lives around. The "Thriving Families" programme work with these families to reduce worklessness, antisocial behaviour, crime and school exclusions and to increase school attendance. The key focus is on our most resource intensive and vulnerable families with the aim of reducing the numbers needing the type of support offered by social care. This continues to be a vital strand in the on-going work locally to 'narrow the gap'.

There are attainment gaps for many 'vulnerable groups' of pupils at all key stages. Persistent absence from school is a key factor impacting on educational attainment of the most vulnerable groups of children and young people. Persistent absence rates in secondary schools are higher than the national average. The attainment gap at all key stages of education and the number of school exclusions are greater for specific pupil groups so there is a particular need to focus on specialist groups of vulnerable learners, in particular, children and young people eligible for free school meals; children and young people with autistic spectrum disorder and children and young people 'looked after' by the County.

Where are we now?

- The Joint Teenage Pregnancy Strategy has led to significant reductions in the teenage pregnancy and conception rates in Oxfordshire.
- The Thriving Families workers are exceeding their target of working with 810 families.
- Persistent absence rates from school generally improved and the target was met. A baseline of children in need who were persistently absent was established.
- Work was not completed on establishing a baseline of children and young people on the autistic spectrum who have had an exclusion from school due to difficulty in getting a full set of data from academies.
- The target to improve the attainment gap at all key stages for those entitled to free school meals was not met.

Outcomes for 2014-15

2.1 Increase the take up of free early education for eligible 2 year olds in 2014/15 to 1800 (from 1036 in 13/14)

2.2 Increase the take up of free early education for 2 year-old Looked After children to 80%

2.3 Maintain the current low level of persistent absence from school for looked after children. Target for 2013-14 academic year is 3.3%. A target for the 2014/15 academic year will be set in the autumn term.

2.4 Maintain the number of looked after children permanently excluded from school at zero.

2.5 Reduce the proportion of children in need who are persistently absent from school from 19.8% (baseline in 2012/13 academic year)

2.6 Establish a baseline of children and young people on the autistic spectrum who have had an exclusion from school (for the year 2013/14)) and work to reduce this number in the 2014/15 academic year.

2.7 Identify, track and measure the outcomes of all 810 families in Oxfordshire through the Thriving Families Programme, working with 90% of identified families and turning around 80% of families.

2.8 Improve the free school meals attainment gap at all key stages and aim to be in line with the national average by 2014 (currently the free school meal attainment gap in Oxfordshire is in line or above the gap nationally in all key stages)

Priority 3: <u>Keeping all children and young people safe</u>

Keeping all children and young people safe is a key Oxfordshire priority. Children need to feel safe and secure if they are to reach their full potential in life. “If we don’t feel safe we can’t learn”.

Safeguarding is everyone’s business and many different agencies work together to achieve it. The aim is to make the child’s journey from needing help to receiving help as quick and easy as possible.

In Oxfordshire we have done a great deal of work together – County Council, Police, Health, District Councils and other organisations to prevent child sexual exploitation and to protect and support its victims. This includes setting up the multi-agency dedicated Kingfisher team and increasing capacity by recruiting additional social workers. Nationally and locally there is

growing awareness about young people who are victims of sexual exploitation. There is a need to concentrate even greater emphasis on better recognition and prevention of such exploitation. We need to continue to focus on this important work in Oxfordshire and continue to work together as agencies to prevent this type of crime happening.

We know that going missing is a key indicator that a child might be in great danger and they are at very serious risk of physical and sexual abuse and sexual exploitation. Nationally 10,000 children are estimated to go missing from care in a year (UK Missing Persons Bureau 2012).

The safeguarding of children affected by domestic abuse is a core element of child protection. Domestic abuse affects children's resilience, emotional wellbeing, educational attainment, behaviour and longer term life chances. Domestic abuse is a factor in a number of Safeguarding Children Board serious case reviews of child death or injury.

Quality assurance audits look at the quality of the casework that agencies deliver to reduce the risk of abuse and neglect of children and young people. In 2013/14 a baseline was established by working with independent auditors to grade the multi-agency audits. In the year ahead a new indicator will be introduced.

Keeping children safe is a key priority for all agencies.

Where are we now?

- An Ofsted inspection of children's social care services has rated them as "good" across all 3 key categories - Children who need help and protection, Children looked after (including adoption performance and experiences and progress of care leavers) and Leadership, management and governance
- The reduction in risk for victims of domestic abuse was good, though the target of reducing 85% of high risk cases to medium or low risk was not quite achieved.
- The prevention of child sexual exploitation continues to be a key priority in Oxfordshire. Regular reports of prevalence and action taken have been made.
- There is a much greater focus on children who go missing from home but the number that go missing 3 or more times in 12 months is still similar to last year. Mitigating actions have been introduced.

Outcomes for 2014-15

3.1 Maintain the reduction in risk for victims of domestic abuse considered to be high risk to medium or low through Multi-Agency Risk Assessment Conferences (currently 83% for 2013-14 based on a single-agency assessment by the Independent Domestic Violence Advisor Service). In addition establish the baseline for a new multi-agency measure over 2014-15

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

3.3 Reduce prevalence of Child Sexual Exploitation in Oxfordshire – a new indicator is to be discussed and proposed.

3.4 Monitor the number of children who go missing and the proportion who go missing 3 or more times within a 12 month period.

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. A new indicator is to be discussed and proposed.

Priority 4: Raising achievement for all children and young people

The Health and Wellbeing Board aspires to see every single child being successful and reaching their potential, thriving in an outstanding learning environment throughout their education, wherever they live across the county, and to see the gap reduced between the lowest and the highest achievers. We aim for every single school to be rated at least as 'good' and to be moving towards 'outstanding'.

Early Years and primary school results are better than the national average and this can be built upon. There have been some signs of improvement in some subject areas at Key Stage 4 and we need to continue to improve with a particular focus on building on the achievements of specific groups. We know that specific pupil groups in Oxfordshire do not do as well as their peers in similar Local Authorities. This includes children receiving free school meals, children from some Black and Minority Ethnic Groups and those with special education needs.

There have been improvements in inspection outcomes and significant improvements in the performance of some schools though Oxfordshire has a greater proportion of schools judged by Ofsted as requiring improvement. Overall, the picture shows gradual improvement but there is inconsistency across Oxfordshire and for certain groups of children.

Where are we now?

- There has been a significant increase in the number of funded 2-4 year olds attending good and outstanding early years settings.
- The improvement in reading at Key Stage 1 has been maintained
- 78% pupils in Oxfordshire made expected progress in Key Stage 2 reading, writing and maths – not quite reaching the target of 80%
- Pupils achieving 5 or more A*-C GCSEs including English and Maths in Oxfordshire has increased in 2012-13 to 60.6%. (57.9% in 2011-12).
- The percentage of children taught in good/ outstanding primary schools has increased from 67% to 77% and in secondary schools from 74% to 80%
- The proportion of year 12-14s who are Not in Education, Employment and Training is down to 4.7% (from 5.4% in 2012-13) and the number whose status is unknown has dropped.

Outcomes for 2014-15

4.1 Increase the number of funded 2-4 year olds attending good and outstanding early years settings to 85% (currently 83%)

4.2 86% of children will achieve Level 2b or above in reading at the end of Key Stage 1 of the academic year 2013/14 (currently 81% or 5,791 children for the academic year 2012/13)

4.3 80% (or 4800) of children at the end of Key Stage 2 will achieve Level 4 or above in reading, writing and maths (currently 78% or 4666 children)

4.4 63% of young people achieve 5 GCSEs at A*-C including English and Maths at the end of the academic year 2013/14 (currently 61% or 3840 children)

4.5 At least 72% (4400 children)) of young people will make the expected 3 levels of progress between key stages 2-4 in English and at least 73%(4400 children) in Maths (currently 71% for English and 72% for Maths)

4.6 Increase the proportion of pupils attending good or outstanding primary schools from 73% to 75% and maintain the proportion attending good or outstanding secondary schools at 87% (currently 73% primary and 87% secondary).

4.7 Of those pupils at School Action Plus, increase the proportion achieving 5 A* - C including English and Maths to 17% (70 children) (currently 10% or 30 children)

4.8 Reduce the persistent absence rates in primary schools to 2.8% and secondary schools to 6.7% by the end of 2013/14 academic year. (The current rates are 3.2% for primary schools and 7.4% for secondary schools)

4.9 Reduce the number of young people not in education, employment or training to below 4% (currently 4.7% or 937 young people).

4.10 Reduce the number of young people whose NEET status is not known to less than 8% (currently 11%)

B. Priorities for Adult Health and Social Care

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

Adults living with a physical disability, learning disability, severe mental illness or another long term condition consistently tell us that they want to be independent and to have choice and control so they are able to live “ordinary lives” as fully participating members of the wider community. This priority aims to support the increasing number of adults with long term conditions to meet their full potential.

Both nationally and locally, people tell us that living ordinary lives means:

- Having improved access to information that supports choice and control
- Having improved access to housing and support
- Having improved access to employment, study, meaningful activity and involvement in the community and wider public life
- Having access to responsive, coherent services that help people manage their own care
- Having improved support for carers, to help them to help the people they care for to live as independently as possible

We will continue to monitor how easy people find it to access information and the quality of support offered to people with a long term condition. We recognise the importance of supporting people with mental health needs to find and stay in employment, and will develop a measure during this year that will help demonstrate how effectively we are in doing this.

Access to good health care is an area for improvement in Oxfordshire for people with learning disabilities and for people with mental health needs. The physical health check target we set, of at least 60% for adults with learning disabilities was seen as a step in the right direction.

Where are we now?

- Although the number of people who say they find information about health and social care easy to find has remained fairly constant there has been a drop in the satisfaction level for working age adults.
- A high proportion of those with a long term condition feel supported in managing their condition.
- There have been some reductions in the number of emergency admissions for acute conditions that should not usually require hospital admission for people of all ages.
- Targets for reducing unplanned hospitalisation for chronic conditions that can be actively managed were met.
- Over 500 front line health and social care workers received autism awareness training in the last year.

Outcomes for 2014-15

5.1 1800 people to receive information and advice about areas of support as part of community information networks

5.2 A new outcome will be determined based on reducing excess mortality in adults with serious mental illness who are aged under 75.

5.3 Access to psychological therapies to be improved so that more than 50% of people who have completed treatment having attended at least 2 treatment contacts are moving to recovery.

5.4 At least 60% of people with learning disabilities will have an annual physical health check by their GP (baseline 45.7%)

5.5 Reduce the number of emergency admissions for acute conditions that should not usually require hospital admission for people of all ages (baseline rate of 951.4 per 100,000)

5.6 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 (baseline rate of 565.4 per 100,000)

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

We know that living at home with dignity is key to the quality of life that older people want to enjoy and that older people and their carers require access to good quality information and advice.

In Oxfordshire we know that the proportion of older people in the population continues to increase and that the number of referrals for support are also increasing along with the cost of caring for older people which increases markedly with age. This is true for both health and social care.

In 2012/13 Oxfordshire had the highest level of delayed transfers of care from hospital in the country. All organisations continue to be committed to improving the situation and one of the best ways of doing this is to provide services which help people to learn or re-learn the skills they need to live more independently and to prevent ill health. These services are called “reablement services”. We are committed to offer these to more people.

For all these reasons our priority is to support older people to live at home whilst reducing the need for care and support. To achieve this we are focusing together on better use of

reablement; reducing emergency admissions to hospital for acute conditions; reducing the number of people permanently admitted to care homes; developing more integrated community services; improved diagnosis of people with dementia; providing additional extra-care housing units as well as ensuring there is a range of housing options for older people and that people can find the information they need. We believe we should also continue to set a challenging target for reducing the number of people admitted to a care home, because this is the ultimate test of whether these alternative services and options are working.

Loneliness and social isolation are increasingly acknowledged as root causes of poor health and wellbeing and we know they influence people's choices about staying at home. More local information is needed to identify the key issues in this area for Oxfordshire.

Another key issue is the increase in the number of people with dementia who need access to newly emerging treatments. To enable us to develop high quality care for people with dementia we need to diagnose it earlier. In Oxfordshire our ambition is for 60% of the expected population to have a diagnosis.

Where are we now?

- Delayed transfers of care remain a priority issue for the Board
- A model for matching capacity to demand for health and social care has been implemented across the system to support smooth discharge from hospital.
- The rate of permanent admissions to care homes has dropped though the overall number exceeded the target set for the year.
- A new national tool has been introduced for estimating the number of people with dementia and this has increased the estimate for Oxfordshire. A number of initiatives have been put in place to increase the number of diagnoses made.
- There have been increasing numbers of people starting reablement but the total remained below the target for the year.
- High numbers of people reported that they had been treated with dignity when they received care at home.
- The growth in supply of Extra Care Housing in on track.
- Service users report high levels of satisfaction with access to information and that they receive support and care in a timely way.

Outcomes for 2014-15

6.1. Reduce the number of days people are delayed in hospital by 38% from an average of 4688 per month in 2012/13 to 2908 per month in 2014/15

6.2 Reduce the number of emergency admissions to hospital for older people (aged 65+) per 100,000 population from a baseline of 23,389

6.3 Reduce the number of permanent admissions of older people (aged 65+) to residential and nursing care homes from 582 in 2012/13 to 546 in 2014/15

6.4 Increase the proportion of older people (aged 65+) with an ongoing care package supported to live at home from 60.0% in April 2013 to 61.9% by April 2015

6.5 60% of the expected population (4251 of 7086 people) with dementia will have a recorded diagnosis (currently 44.2% or 3516 people)

6.6 Increase the number of people referred to reablement from their own home (as opposed to a hospital stay) to 1875 in 2014/15 from a baseline of 881 in 2013/14

6.7 Increase the proportion of older people (aged 65+) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services to 80% by April 2015 from a baseline of 71.7% in April 2013

6.8 Maintain the number of organisations providing social care in Oxfordshire that meet the standard of treating people with respect and involving them in their care at above 95%.

6.9 Include the Better Care Fund national patient / Service User experience measure once this is developed.

6.10 Ensure an additional 523 Extra Care Housing places by the end of December 2015, bringing the total number of places to 768 by the end of March 2015 and 930 by the end of December 2015

6.11 Increase the proportion of people approaching the end of life who receive consistent care that is coordinated effectively across all relevant settings leading to patients dying in their preferred place of care.

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

Integrating the health and social care systems has been a goal of public policy for the past 40 years. The successful integration of health and social care offers important benefits e.g.

- Improved access to, experience of, and satisfaction with, health and social care services that place people at the centre of support.
- Development of different ways of working, including new roles for workers who work across health and social care.
- Ensuring that all health and social care providers deliver high quality safe services which ensure that those receiving their services are treated with dignity and respect
- Ensuring people receive the right quality care, in the right place at the right time and achieve more efficient use of existing resources and a reduction in the demand on expensive health and social care services.

The integration of services has progressed in Oxfordshire over the last year with the introduction of a joint single point of access to health and social care community services for health and social care staff. The next step is to integrate health and social care services in GP localities.

The County Council and Oxfordshire Clinical Commissioning Group are committed to working together to raise the quality and improve the value of health and social care services for both service users and for carers. This is what the people of Oxfordshire have said they want. Integrating health and social care is a priority because it gives us the chance to improve services, make better use of resources and meet the stated desires of the public.

Where are we now?

- Progress is being made in the integration of services and establishment of pooled budgets for older people.
- Patient Outcome measures show high levels of satisfaction with care and support received from social care, hospital care and GP surgeries.
- Over 15000 carers are now known and supported by adult social care.
- 880 carers received Carer Breaks accessed through their GP and jointly funded.

Outcomes for 2013-14

7.1 A measure of how the County Council and Clinical Commissioning Group and Oxford Health FT are responding to Better Care Fund national conditions for shared care coordination, 7 day access and accountable lead professionals will be added

7.2 A national measure of patient / service user experience will be added once developed (in line with the Better Care Fund)

7.3 Increase the number of carers known and supported by adult social care by 10% to 17,000 (currently 15,475 are known)

7.4 At least 880 carers breaks jointly funded and accessed via GPs (currently 880)

C. Priorities for Health Improvement

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

This priority aims to add years to life and life to years – something we all aspire to. The biggest killers are heart disease, stroke and cancers. Some of the contributing factors to these diseases are beyond the influence of the individual or of health services but we can encourage healthier lifestyles and prevent disease through early detection and screening.

A gap in life expectancy still remains within Oxfordshire, with women likely to live longer than men and those in more deprived areas likely to die sooner and be ill or disabled for longer before death.

Promoting healthy lifestyles and access to screening programmes is a cost effective way of reducing the risk of chronic disease and premature death

The following priorities for action will continue to be the priorities in the year ahead:

- To reduce levels of smoking in the county by encouraging more people to quit as smoking remains a major cause of heart disease and cancer.
- To boost our cancer screening programmes so that more people are protected, focusing on the bowel cancer screening programme.
- To promote the 'Health Checks' programme which offer adults a full health 'MOT' and looks at many lifestyle factors such as obesity, exercise, smoking, blood cholesterol levels ,diabetes, blood pressure and alcohol consumption.
- Reversing the rise in the consumption of alcohol is another priority of the Health and Wellbeing Board. It is being taken forward by the Oxfordshire Community Safety Partnership and progress will be monitored by the Health Improvement Board.
- Adding measures of success for those in drugs or alcohol treatment services with the aim of improving recovery rates.

In addition to this, our work must be even more focused on those who are most at risk. The Joint Strategic Needs Assessment shows that there are differences between different groups of people and different places in the County, with some faring better than others both in terms of their life expectancy and in their chances of living healthy lives into old age. Outcomes will be set to target the groups with worst outcomes as well as the overall average.

A programme of public awareness campaigns will support this work by raising awareness of prevention and early intervention services.

Where are we now?

- Bowel screening kits are being sent out to 60-74 year olds but a large proportion of the target group are still not returning them for analysis.
- Uptake of invitations to attend NHS Health Checks improved during the year but did not meet the aspirational target of 65% and there was considerable variation in different parts of the county.
- Smoking quit rates in the county remained largely on target throughout the year. There has been some concern over quit rates during pregnancy.
- Discussion on the rates of recovery from drugs and alcohol dependency has led to the decision that the Health Improvement Board should see regular reports on progress in improving abstinence based recovery rates.

Outcomes for 2013-14

8.1 At least 60% of those sent bowel screening packs will complete and return them (ages 60-74 years) and targeted promotion of uptake will take place based on an equity audit conducted in 2013-14 to ensure all population groups are responding. ***Responsible Organisation: NHS England***

8.2 Of people aged 40-74 who are eligible for health checks once every 5 years, at least 15% are invited to attend during the year. No CCG locality should record less than 15% and all should aspire to 20%. ***Responsible Organisation: Oxfordshire County Council***

8.3 At least 66% of those invited for NHS Health Checks will attend (ages 40-74) and no CCG locality should record less than 50% with all aspiring to 66%. ***Responsible Organisation: Oxfordshire County Council***

8.4 At least 3800 people will quit smoking for at least 4 weeks. Report the baseline and rate for women smoking in pregnancy in Oxfordshire. ***Responsible Organisation: Oxfordshire County Council***

8.5 The 2014-15 target for opiate users should be set at 8.6% successfully leaving treatment (baseline 6.5%) ***Responsible Organisation: Oxfordshire County Council***

8.6 The 2014-15 target for non-opiate users should be set at 38.2%% successfully leaving treatment (baseline 15.5%). ***Responsible Organisation: Oxfordshire County Council***

Priority 9: <u>Preventing chronic disease through tackling obesity</u>

After smoking, obesity is the biggest underlying cause of ill health. It can lead to high blood pressure, heart disease, stroke, diabetes, cancer and early death. It also increases immobility and makes any other disability more severe than it would otherwise be.

Surveillance of these issues in the last year show that

- Rates of obesity in the county continue to rise. Data from surveys show a cause for concern.

- The percentage of people diagnosed with diabetes by their GP continues to rise across the county.
- The rates for breastfeeding initiation soon after birth and continuation to at least 6-8 weeks are good in Oxfordshire. These higher rates need to be maintained.
- Measurement of children shows the numbers who are deemed to be overweight or obese at both Reception Class and Year 6 are generally lower than England rates, but show over 15% obesity at year 6. These are year on year snap shot measures so trends cannot be identified.

To tackle obesity we propose to keep our focus in the following areas:

Promoting breastfeeding
Breastfeeding gives the best start to life and has been proven to lead to fewer overweight children and adults. Increasing the number of breastfed babies is still the foundation of an obesity strategy for the County. The national figure for breastfeeding prevalence at 6-8 weeks is 47% but in Oxfordshire we want to keep the stretching target of 63% and will only achieve this if we focus on the areas where rates are low.

Halting the increase in childhood obesity
Children in Reception class and Year 6 are weighed and measured every year and results show that around 8% of reception year and 15% of Year 6 children are obese. This feeds through into ever increasing levels of obesity in young adults. Making parents aware of problems early helps them to take action if they choose to. Healthy eating initiatives are part of the approach. Levels of obesity are also linked to social deprivation, with more deprived parts of the County showing higher rates of obesity, so some targeting of effort is called for here too.

Promoting physical activity in adults
Physical activity is an important component of maintaining a healthy weight for all ages and there is local encouragement here, with Oxfordshire still doing well according to the 'Active People' survey. The survey showed that 27% of the population participate in regular activity each week. Maintaining this position will be critical to good health in the County. Regular participation in physical activity will also have an impact on mental wellbeing. For the years ahead we will be encouraging those who are inactive to start to move more.

Where are we now?
- There was an improvement in obesity rates for children in year 6 but it remains above 15% across the county. There are some variations in different parts of the county.
- Over 61% of adults do at least 150 minutes of physical activity a week but over 20% of our population do less than half an hour a week.
- In some parts of the county over 84% of babies are still breastfed at 6-8 weeks and in other areas the rate is about 45%. The overall rate is increasing but the range is very wide.

Outcomes for 2013-14
9.1 Ensure that the obesity level in Year 6 children is held at no more than 15% (in 2013 this was 15.2%) No district population should record more than 19% ***Responsible Organisation: Oxfordshire County Council***

9.2 Change the physical activity indicator to reflect the number of people who are NOT physically active and set an outcome to reduce this rate. The latest Active People Survey reported that 116,943 aged 16 or older are termed sedentary (doing less than 30 minutes of activity per week). This is a rate of 22.2% against 28.5% nationally. Oxfordshire Sports Partnership has a target of 38000 People no longer inactive by 2017 - moving 1% of the population from zero to doing something per week. ***Responsible Organisation: District Councils through Oxfordshire Sports Partnership***

9.3 63% of babies are breastfed at 6-8 weeks of age (currently 60.4%) and no individual health visitor locality should have a rate of less than 50% ***Responsible Organisation: NHS England and Oxfordshire Clinical Commissioning Group***

Priority 10: <u>Tackling the broader determinants of health through better housing and preventing homelessness</u>

Housing and health are intimately connected and inextricably linked. Having a home, living in good housing conditions and in a good neighbourhood with the right kind of support, are vital ingredients to health and well-being.

There are several ways in which housing issues impact on health, including the following:

- 'Fuel poverty' affects people of all ages and in all types of housing. Having a poorly heated home shows itself in greater incidence of respiratory disease, allergies, asthma and risk of hypothermia. Excess winter deaths are directly related to poor energy efficiency in houses
- Homeless people die earlier and suffer worse health than people with a stable home. The threat and experience of homelessness also has an impact on mental wellbeing.
- Safe, secure housing contributes to improving health outcomes. Some vulnerable people need support to maintain their tenancies and live ordinary lives as fully participating members of the wider community. This is an essential ingredient for preventing ill health and homelessness.

These housing issues all have to be tackled in partnership.

Surveillance and sharing of good practice over the last few years through the Health Improvement Board has already seen a higher profile for this area of work. Concerns remain including

- Changes to the welfare benefit system have potential to put more households at risk of homelessness
- New ways of working to provide Housing Related Support will need time to develop
- Fuel poverty is still a risk for a large number of households. New systems for improving energy efficiency of homes have been introduced and need to be established.
- Fuel Poverty work is not funded sustainably.

Where are we now?

- District councils have reported similar success rates as last year in preventing homelessness. This reflects more activity as changes in the welfare system have been introduced.
- The number of households in temporary accommodation has remained at similar levels to last year.
- A large proportion of people who had received housing related support services were able to leave the services and live independently.
- A new national indicator for fuel poverty has been introduced and there is more clarity on the new arrangements for improving energy efficiency of homes.

Outcomes for 2013-14

10.1 The number of households in temporary accommodation on 31 March 2015 should be no greater than the level reported in March 2014 (baseline 197 households in Oxfordshire in 2013-14) ***Responsible Organisation: District Councils***

10.2 At least 75% of people receiving housing related support will depart services to take up independent living (baseline 83.9%). ***Responsible Organisation: Oxfordshire County Council***

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 81% in 2013- 2014 when there were 2837 households known to services). This can now be reported 6 monthly. ***Responsible Organisation: District Councils***

10.4 Establish a baseline of the number of households in Oxfordshire who have received significant increases in the energy efficiency of their homes or their ability to afford adequate heating, as a result of the activity of the Affordable Warmth Network and their partners. It is hoped that an aspirational baseline target of 550 households will be reached. ***Responsible Organisation: Affordable Warmth Network.***

10.5 Ensure that the number of people estimated to be sleeping rough in Oxfordshire does not exceed the baseline figure from 2013-14 (baseline to be confirmed) ***Responsible Organisation: District Councils***

Priority 11: **Preventing infectious disease through immunisation**

Immunisation is the most cost-effective medical public health intervention. Levels of immunisation for childhood diseases in Oxfordshire continue to improve but it is imperative that this is maintained. Constant vigilance is needed to make sure that individual children have access to immunisation. This means working closely with GPs, community nurses and individual families.

It is important that immunisation rates remain high throughout the population to maintain "herd immunity". Responsibility for commissioning immunisation services has been taken on by NHS England. This is done locally through the Thames Valley Area Team. High levels of coverage need to be maintained through this transition to new organisations within the NHS in order to continue to achieve the goal of protection for the population.

New immunisations were introduced last year. From July 2013, a rotavirus vaccination was offered at 2 months and at 3 months, flu immunisation is being given to children, (starting with 2-3 year olds and adding more ages each year), and Shingles vaccinations are offered to people aged 70 and 79.

The Oxfordshire Joint Strategic Needs Assessment shows high levels of coverage but some targets are still not being met and there are early signs that our high rates have begun to slip a little. The leadership for these services has changed profoundly during the last year and maintaining our current position will be a real challenge.

We are proposing priorities for improving immunisation levels across the board, focussing on childhood immunisation, immunisation of teenage girls to protect against cervical cancer and flu vaccinations in the elderly and vulnerable.

Where are we now?

- High coverage rates for most childhood immunisations were achieved across the county. This included the number of children receiving their first dose of MMR vaccine which remained above the 95% target.
- Rates of flu immunisations for people aged under 65 who are at risk of illness improved last year as a result of focussed effort by several organisations.
- It remains important to keep these indicators under surveillance and for the Public Health Protection Forum to ensure that good performance in Oxfordshire is continued.

Outcomes for 2013-14

11.1 At least 95% children receive dose 1 of MMR (measles, mumps, rubella) vaccination by age 2 (currently 95.8%) and no CCG locality should perform below 94% ***Responsible Organisation: NHS England***

11.2 At least 95% children receive dose 2 of MMR (measles, mumps, rubella) vaccination by age 2 (currently 93.7%) and no CCG locality should perform below 94% ***Responsible Organisation: NHS England***

11.3 – At least 60% of people aged under 65 in “risk groups” receive flu vaccination (currently 55%) ***Responsible Organisation: NHS England***

11.4 HPV targets -a high proportion of young women to receive both doses of HPV vaccination. Target to be advised by Public Health Protection Forum ***Responsible Organisation: NHS England***

Annex 1: Summary of Priorities for the Oxfordshire Health and Wellbeing Strategy

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

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

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

Annex 2: Glossary of Key Terms

Terms

Carer	Someone of any age who looks after a relative, partner, friend or neighbour who has an illness, disability, frailty, or addiction. The help they provide is not paid for as part of their employment.
Child Poverty	Children are said to be living in relative income poverty if their household's income is less than 60 per cent of the median national income.
Child Protection Plan	The plan details how a child will be protected and their health and development promoted.
Commissioning	The process by which the health and social care needs of local people are identified, priorities determined and appropriate services purchased.
Delayed Transfer of Care	The national definition of a delayed transfer of care is that it occurs when a patient is medically fit for transfer from a hospital bed, but is still occupying a hospital bed.
Director of Public Health Annual Report	http://www.oxfordshirepct.nhs.uk/about-us/publications/public-health-annual-report.aspx
Extra Care Housing	A self-contained housing option for older people that has care support on site 24 hours a day.
Fuel Poverty	Households are considered by the Government to be in 'fuel poverty' if they would have to spend more than 10% of their household income on fuel to maintain an adequate level of warmth.
Healthwatch Oxfordshire	Healthwatch is the independent 'Consumer Champion' for health and social care for people of all ages
Joint Health and Wellbeing Strategy	The strategy is the way of addressing the needs identified in the Joint Strategic Needs Assessment and to set out agreed priorities for action.
Joint Strategic Needs Assessment (JSNA)	A tool to identify the health and wellbeing needs and inequalities of the local population to create a shared evidence base for planning.
Not in Education, Employment or Training (NEET)	Young people aged 16 to 18 who are not in education, employment or training are referred to as NEETs.

Oxfordshire Clinical Commissioning Group	The Oxfordshire Clinical Commissioning Group is the new organisation in Oxfordshire that has the responsibility to plan and buy (commission) health care services for the people in the County. It is currently in shadow form until it takes over from Oxfordshire Primary Care Trust in April 2013.
Oxfordshire's Safeguarding Children Board	Representatives from the main statutory agencies who ensure there are suitable robust arrangements for protecting children in Oxfordshire.
Pooled budget	A mechanism by which the partners to the agreement bring money to form a discrete 'fund'. The purpose and scope of the fund is agreed at the outset and then used to pay for the services and activities for the relevant client group.
Quality Assurance Audit	A process that helps to ensure an organisation's systems are in place and are being followed.
Reablement	A service for people to learn or relearn the skills necessary for daily living.
Secondary Mental Health Service	Services for adults with more severe mental health problems and needs requiring the specialist skills and facilities of mental health services.
Section 75 agreement	An agreement made under section 75 of National Health Services Act 2006 between a local authority and PCT(s), NHS trusts or NHS foundation trusts. This can include arrangements for pooling resources and delegating certain functions to the other partners if it would lead to an improvement in the way those functions are exercised.
Thriving Families Programme	A national programme which aims to turn around the lives of 'Troubled' families by 2015.
Transition	This is the process through which a person with special needs transfers from children's services to adults services.

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Comments from Health Overview and Scrutiny Committee in relation to proposed indicators in the Health and Wellbeing Strategy

Children and Young People

Priority 1: All children have a healthy start in life and stay healthy into adulthood

- There should be a measure of access to Children's Mental Health services, such as availability of beds or waiting times

Priority 2: Narrowing the gap for our most disadvantaged and vulnerable groups

- There should be evaluation of how interventions resulting from the Pupil Premium are picked up across the county and their effectiveness.
- There should be measures relating to mental illness, drugs and alcohol use by children and young people

Priority 3: Keeping all children and young people safe

- **There should be tracking of the impact of the proposed changes to housing related support on domestic abuse services / incidents**

Priority 4: Raising achievement for all children and young people

- There should be a focus on young people achieving their potential as well as simply achieving national targets
- There should be a reference to the support of gifted and talented students

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

- There should be an indicator to track changes to complex needs services and impact on patients / service users
- Include in 'possible new indicator on mental health delayed discharge' measures to track the homeless and previous hostel residents
- As well as delays in mental health discharge, there should also be measures of availability of mental health beds and waiting times

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

- It should be made clearer that packages of care refer to social care rather than health

- Information should be broken down where possible to show where in the county people are being support to stay at home

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

- It is important to ensure alignment between the Joint Health and Wellbeing Strategy and the Clinical Commissioning Group strategic plans
- That key NHS performance targets for key waiting times such as 4 hour, 18 week, cancer treatment and ambulance times should be included

Health Improvement

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

- There should be a focus on smoking in school / amongst school age children

Priority 9: Preventing chronic disease through tackling obesity

- No comments

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

- No comments

Priority 11: Preventing infectious disease through immunisation

- No comments

Oxfordshire Health and Wellbeing Board
17 July 2014

Review of Adult Learning Disability Health and Social Care Services

Purpose

1. The Health and Wellbeing Board is asked to note the background and reasons for proposing to review learning disability services in Oxfordshire and agree the approach being taken by Oxfordshire County Council and Oxfordshire Clinical Commissioning Group. The majority of learning disability health and social care services in Oxfordshire are currently provided by Southern Health NHS Foundation Trust (Southern Health).

Background

2. The Director for Social & Community Services and the Chief Executive of the Clinical Commissioning Group would like the board to be aware of the overall strategy for adults with a learning disability, key issues and the approach being taken to review services.

Current Situation

The Strategy

3. Oxfordshire has had a learning disability joint commissioning strategy for adults since 1995. Oxfordshire County Council and Oxfordshire Primary Care Trust (as it was then) established a pooled budget with the Council taking on lead commissioning for almost all learning disability services in April 2006.

4. The learning disability joint commissioning strategy for adults is the Big Plan. This plan was produced in partnership with service users and families. The seven key themes in the Big Plan are to support people
    - to have more choice and control over their lives
    - so that families can carry on living together
    - to have their own home when the time is right
    - to have better health
    - to work, be independent and have active lives and full citizenship
    - to be safe from harm
    - to make best use of resources and increase value for money

5. The Oxfordshire strategy has successfully supported increasingly more adults with a learning disability to live in their own home in the community. Oxfordshire has the highest proportion of adults living in supported living per head of population in the South East (*Health & Social Care Information Centre 2013*). Over the last 2 years, the number of people open to the learning disability team has increased by 16%. The proportion of people who are supported in their own home as opposed to

residential care has increased from 72% to 81% in the same 2 years. This has been the result of a consistent strategy over the last 20 years.

	Mar-12	Mar-13	Mar-14	% increase 12/13	% increase 13/14	% increase over 2 years
Adults open to Learning Disability team	1792	1877	2078	4.74%	10.71%	15.96%
Living at home	1298	1437	1673	10.71%	16.42%	28.89%
% at home	72.43%	76.56%	80.51%	4.13%	5.16%	8.08%

Source: DH information centre: 2012-2014 RAP returns

6. A more recent key driver for change is the Winterbourne Concordat (DH 2012). The overall intention of the Winterbourne Concordat is to support patients towards discharge and to ensure that every local area is changing social and health care services and systems to support people with learning disabilities and challenging behaviour to live well in the community thereby reducing the need for inpatient admission. We are developing the Oxfordshire Joint Winterbourne Improvement Plan with the Clinical Commissioning Group. This is a national requirement and the plan will address the issue of supporting people with behaviour that challenges to live well.

Recent Issues

7. On 1st January 2011, the Council entered into a contract with Ridgeway Partnership NHS Trust for the provision of specialist health services and some social care services for adults with learning disabilities. In March 2011, Ridgeway Partnership NHS Trust Board and NHS South Central agreed that an application for NHS foundation trust was essential but unlikely to be successful if Ridgeway remained a standalone Trust.

8. In November 2012, following a comprehensive selection process led by the South Central Strategic Health Authority, the health and social care services for adults with a learning disability delivered by Ridgeway Partnership NHS Trust were transferred by statutory transfer to Southern Health and the Ridgeway Partnership NHS Trust ceased to exist. The current contract with Southern Health runs to the end of 2015.

9. Local confidence in services provided by Southern Health has been impacted upon by the death of Connor Sparrowhawk, a young man with a learning disability who was a patient in the Assessment and Treatment Unit at Slade House in Oxford at the time of his death in July 2013. An independent report (commissioned by Southern Health) into Connor's death concluded that his death was "preventable". An independent investigation into the death of Connor Sparrowhawk is currently being commissioned by the NHS England Thames Valley Local Area Team who are acting in conjunction with the Oxfordshire Safeguarding Adults Board.

10. A Care Quality Commission report based on an unannounced visit to Slade House in September 2013 issued six warning notices requiring Southern Health to make urgent improvements at the Assessment and Treatment Unit (STATT). Slade House

in Oxford includes two units, the Assessment and Treatment (STATT) and John Sharich House. The Assessment and Treatment unit is now closed and John Sharich House is closed to new admissions. The two remaining patients at John Sharich House, both from outside Oxfordshire, are due to be discharged by the end of July 2014.

11. In January 2014 NHS England, following consultation with Clinical Commissioning Groups and the County Council, called a Risk Summit due to ongoing quality and safety concerns of Southern Health services. An 'Oversight Assurance Group' was established by NHS England to provide ongoing monitoring and assurance regarding actions identified in the risk summit meetings and the Southern Health quality improvement plans.

12. In April 2014 Monitor, the regulator of independent NHS Foundation Trusts, announced that they were taking enforcement action against Southern Health.

13. Care Quality Commission inspections of John Sharich House in Oxford since the initial inspection in September 2013 have seen improvements and they have now lifted all warning notices for this service.

14. The County Council and the Clinical Commissioning Group did a joint unannounced visit of John Sharich House in May 2014. The service was judged to have improved in quality. There was evidence of improved knowledge and increased staff interactions with greater focus on raising standards within the service. However there are further improvements to be achieved on access to information about service users needs. The concerns about Southern Health amongst relatives and families are ongoing.

Current Services

15. Oxfordshire County Council commission learning disability services from Southern Health jointly with Oxfordshire Clinical Commissioning group (previously the Primary Care Trust). The services in Oxfordshire we are reviewing are:

- **Day support, respite and family support** that enables people to continue to live at home.

- **Community learning disability teams** are joint health and social care teams that work together with service users and families to promote good mental and physical health. This includes psychology, physiotherapy, occupational therapy, social work, nursing, psychiatry and speech therapy.

- **Assessment and treatment in hospital** for people who become unwell with a mental illness or for people with behaviours that challenge

- **A specialist residential care service** for people with learning disabilities who need support to move from a secure hospital environment to the community. This is called 'step down'.

- Support to people living at home who might need some extra support to stay safe. This is called **Assertive Outreach**.

16. In a separate process the Council is reviewing 'supported living' services currently provided by TQtwentyone (Southern Health's social care division) for people living in their own home. This is being undertaken as part of routine contract monitoring.

17. Southern Health (TQtwentyone) also runs a residential care home in Bicester called Piggy Lane. The Council does not commission this service but does purchase places on a case by case basis and as with all providers of services maintains a quality monitoring oversight. The Care Quality Commission have issued critical reports about this home although the latest reports shows significant improvements.

Key Issues

18. The review is being proposed in response to the following issues:

- The current contract covering the Southern Health specialist health services is due to be reviewed as it will formally end in December 2015. This includes assessment and treatment, community learning disability teams, specialist hospital 'step down' and assertive outreach services.

- We are particularly interested in looking at what is needed for adults with a learning disability and challenging behaviour to live well in the community. We are developing the Oxfordshire Joint Winterbourne Improvement Plan with the Clinical Commissioning Group, service users and families focusing on how we can support people better at this stage. We expect this plan to drive improvements in services for people with behaviours that challenge. This has been requested by the national Joint Winterbourne Improvement Programme and is being discussed at the board meeting today.

- Social care services are already being reviewed through the renewal of the Oxfordshire Framework Agreement which is due to be in place early in 2015. This Framework Agreement is an 'umbrella agreement' that sets out the terms relating to price, quality and quantity under which individual contracts (call-offs) can be made throughout the period of the agreement.

- Following concerns raised in recent regulator inspection reports of Southern Health services and an investigation report commissioned by Southern Health, we want to make sure that people with a learning disability are offered the best possible support.

Approach to reviewing services

19. The approach we propose to follow to review the services commissioned from Southern Health is summarised below. When looking at each service we want to work very closely with service users and their families to ensure that we are able to offer the best possible support.

- **Day support, respite and family support** - we recognise how essential it is for families to have good quality support. We therefore propose to enhance the capacity and expertise in these services so they can support people with more complex needs and prevent people needing a hospital admission.

- **Community learning disability teams** - we are currently developing an intensive support team as part of the community team. This team will provide assessment and treatment for people with behaviours that challenge in the community rather than in hospital and support families in a crisis. This would then prevent the need for most hospital assessment and treatment admissions. We also propose to review the wider learning disability integrated community team model alongside national best practice.

- **Assessment and treatment in hospital -** by introducing the intensive support team described above we anticipate having less need for inpatient services. We are working with NHS England Local Area Team to develop a high quality model of inpatient hospital support for people with mental health needs for the Thames Valley area. It is proposed that this would be commissioned by a Thames Valley Clinical Commissioning Group collaboration. This may mean that this type of service might not be available within Oxfordshire but will be within the Thames Valley area. Families we have spoken to say their priority is good quality, safe services.

- **A specialist residential care service (step down)** - this service is not able to move people to their own home in the community fast enough. We propose to examine the reasons for this and then identify community models of support that will enable this to happen.

- **Assertive Outreach** - we propose to review this service and explore national and local best practice.

- **Supported Living (TQtwentyone)** - supported living in Oxfordshire is delivered by providers that have gone through a rigorous selection process for acceptance onto the Oxfordshire County Council Learning Disabilities Framework. Supported Living operates through call-off contracts with providers on the Learning Disabilities Framework. The current framework agreement expires at the end of January 2015. TQtwentyone are part of this procurement process and their call off contracts expire at the end of December 2015. To date, the Care Quality Commission has judged Supported Living services provided by TQtwentyone to be compliant.

20. In addition to the above, we know from the ongoing conversations we have with people who use our services, their families and with advocacy groups there are other areas that we need to review. This includes

- how service providers implement the mental capacity act and the deprivation of liberty safeguards;
- the transition of young people to adult services, particularly mental health services;
- information, advice and guidance that enables people to make informed choices;
- how we can increase the opportunities for service users and families to support other service users and families and to be more involved in monitoring our services. This could be through peer to peer networks and through developing service user and family models of 'experts by experience';

- increase the awareness and capacity for health checks; this is for both physical checks as well as mental health checks.

21. We will consider the recommendations above as part of the work planned with the Family Support Network and service users (through My Life My Choice) over the summer to ensure we get the best possible arrangements in place.

22. We would like to assure the board that the support that people currently receive will continue whilst the review is completed. Over the next eighteen months we will examine the current services and gather feedback from people using services, families, staff and stakeholders. We will also examine national best practice to ensure that learning disability services offer local people the best possible support.

Budgetary implications

23. We will dedicate project management expertise to delivering this significant change.

24. A joint communications plan is being developed with the Clinical Commissioning Group and Southern Health to be able to communicate with all stakeholders.

25. An increase in the quality monitoring of services by the County Council is already in place to ensure the quality of the services provided throughout the review period.

26. To deliver this change the commissioners need to work closely with service users and family carers through the experts by experience model of working.

27. The commitment to increased quality controls, working in partnership with experts by experience and an increased capacity to ensure effective communication is estimated to be a pressure of £110k.

28. The review of services will identify preferred models of support which may have further budgetary implications. This will be agreed through the usual governance arrangements.

Equalities implications

29. The approach to reviewing Southern Health services will include all adults with a learning disability who are eligible for services from the County Council and for specialist health services from the NHS. The approach is intended to improve services to adults with a learning disability and create greater opportunities for people to live in their own homes in the community.

Risk Management

30. A risk workshop for commissioners has been completed to capture all possible risks and potential outcomes from the review. The work that will follow is a mitigation plan to ensure any risks are minimised.

31. There is a potential risk to staff morale during the period of the review. The review may create a period of uncertainty for staff which in turn could impact on staff

recruitment and retention and therefore potentially on the quality of services. Mitigation plans are being developed to ensure all risks are minimised.

Communications

32. The communication leads in the County Council, Clinical Commissioning Group and Southern Health NHS Foundation Trust are developing a communication plan that will include all stakeholders.

33. Adults with a learning disability who currently use Southern Health supported living, day and respite services and their families have received a letter informing them of the intention to review services in Oxfordshire. This letter has also been sent to service users of step down and assertive outreach and to families of people whose relative is receiving assessment and treatment in hospital.

Report by

David Smith,
Chief Executive, Oxfordshire Clinical Commissioning Group

John Jackson,
Director of Social & Community Services, Oxfordshire County Council

17th July 2014

Contact:
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Oxford University Hospitals NHS Trust

Quality report

Headley Way
Headington
Oxford OX3 9DU

Tel: 01865 741166
www.ouh.nhs.uk

Date of inspection visit:
25-26 February 2014 and
2-3 March 2014

Date of publication:
May 2014

This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for acute services at this trust	Good	
Are acute services at this trust safe?	Good	
Are acute services at this trust effective?	Good	
Are acute services at this trust caring?	Good	
Are acute services at this trust responsive?	Good	
Are acute services at this trust well-led?	Good	

Summary of findings

Contents

Overall summary

Oxford University Hospitals NHS Trust is one of the largest acute teaching trusts in the UK and has four hospitals. The John Radcliffe Hospital, the Churchill Hospital, and the Nuffield Orthopaedic Centre are situated in Oxford and serve a population of around 655,000. The Horton General Hospital in Banbury serves a population of around 150,000 people in north Oxfordshire, south Northamptonshire and south east Warwickshire. The trust has around 1465 beds, 832 of which are at the John Radcliffe. The trust has around 186,000 patients who stay in hospital and it arranges around 835,000 outpatient appointments every year. The hospitals in the trust are busy with the John Radcliffe being the busiest. The trust's bed occupancy from July to September 2013 has been 92%, higher than the England average of 85.2%. The recommended occupancy rate is 85%, beyond that the pressure that a hospital is under can start to affect the quality of care given and the orderly running of the hospital.

The trust is registered to provide services under the regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Family planning
- Maternity and midwifery services
- Nursing care
- Personal care
- Surgical procedures
- Termination of pregnancies
- Treatment of disease, disorder or injury

Staffing
The trust employs around 11,000 staff. It has difficulties in recruiting and retaining sufficient staff, particularly nursing staff and healthcare assistants, in all four hospitals. The high cost of living in Oxford coupled with the difficulty and cost of parking is felt to be an issue. The trust has an ongoing recruitment campaign and is exploring options to help ease the parking problems. The trust employs agency and bank staff to make up the shortfalls and permanent staff spoke positively about the skills of their temporary colleagues. At the John Radcliffe hospital the vacancy rates were particularly high in the surgical wards and theatres, 19% in nursing and medical grades in January 2014. Staff described working long days and overtime to help address the shortfalls. However staff shortages have led to the cancellation of operations. At the Horton hospital staff felt that people were deterred from applying for posts because of perceived uncertainties about the future of services there however the low turnover of staff made it the most stable of the four hospitals for staffing. Staff turnover at the trust has run at or slightly above 11% over the last two years. The trust has a clear workforce plan and has set a target to reach 10% turnover. Targeted actions at problem areas for turnover have delivered significant improvements. Staffing levels have been increased on medical wards following an audit and assessment of patients' needs.

Cleanliness and infection control
All four hospitals were clean and we observed good infection control practices among staff. Staff were wearing appropriate personal protective equipment when delivering care to patients and they cleaned their hands between patients. There were suitable hand-washing facilities in the hospitals and a good provision of hand gels. We saw staff using the gels and asking patients to do the same. Staff observed the hospital's policy on being bare below the elbow. The number of methicillin resistant *Staphylococcus Aureus* (MSRA) bacteraemia infections and *Clostridium difficile* infections were within an acceptable range for a trust of this size. Each reported case had been reviewed in detail. The trust takes action to access its own performance with its policies and practices both for cleaning and infection control.

The five questions we ask about trusts and what we found

We always ask the following five questions of services.

Are services safe?

Good

We found that services at the trust were safe however some improvements were required. The trust had a good track record on safety. Performance against a range of safety measures was monitored and reported monthly. The trust benchmarks itself against other organisations and takes account of national safety performance information. This included monitoring of pressure ulcers, falls, venous thromboembolism and patients with catheter related urinary tract infections. Overall the trust's infection rates lie within a statistically acceptable range; falls rates have been consecutively lower than the England average; and, although rates of new venous thromboembolism were higher than the national average for some of 2013, latterly this has reduced. Actions were being taken across the trust to minimise the occurrence of these key areas. The trust had a good system in place to enable it to change staffing levels on a ward quickly in response to the changing needs of patients.

There were systems in place to report and learn from incidents. The quality and timeliness of investigations into incidents was monitored. We saw that changes had been made to policies and procedures in response to the findings from investigations. There were arrangements in place to share the learning from incidents. We saw that the learning from incidents had been widely shared however we also saw that this had not always happened between the four hospitals. Staff were supported to raise concerns and were encouraged to speak up. Most staff told us that they felt able to do this, but some surgical senior clinicians did not feel able to.

People were protected from abuse and staff were trained to deal with suspicions of abuse. Staff were able to describe how they would recognise the signs of potential abuse and how they would report this.

Are services effective?

Good

We found that services at the trust were effective. The care and treatment given achieved good outcomes for people and followed current best practice. The trust's links with Oxford University meant that in some areas the trust had been involved in developing the accepted best practice guidelines. The trust took action to check that care and treatment was being delivered appropriately within the guidelines and this was reported across the trust. Feedback from patients contributed to the overall assessments of effectiveness. The trust assessed its effectiveness against known national standards and benchmarked performance against other similar organisations.

The trust had taken action to provide a comprehensive programme of mandatory and specialist training and development for staff at all levels and in all services. Staff spoke positively about the training, support, and supervision that they received. The trust generally had the facilities and equipment needed to deliver services although there are areas of the estate that need updating. Multidisciplinary working is well established and staff are proud of the integrated approach to care. The trust worked positively with local partners although the long standing issues with delayed transfers of care remained an issue that impacted on the running of services and the experiences of patients.

Are services caring?

Good

We found that services at the trust were caring. The trust's mission statement is "delivering compassionate excellence". Across the trust at all hospitals and within all services we observed patients being treated with dignity, respect, and compassion by all staff. The feedback from patients and carers, both at the inspections, listening events and through comment cards was overwhelmingly positive. The caring

provided by staff in the intensive and critical care services at the John Radcliffe, Horton, and Churchill hospitals was considered to be good. There were some issues to be addressed at the A&E department at the John Radcliffe hospital, caused in part by the challenges of the environment they are working in. In other areas where patients and families had raised concerns those concerns were known and understood by staff and were being addressed, for example by increasing the number of staff working on a ward to ensure that there was sufficient time available to treat patients in a kind and compassionate way.

Patients, carers and relatives were involved in plans and decisions about care. Relatives and carers were encouraged to provide support, for example by supporting their relative at meal times if they wished. Training was provided to family members to support care following discharge as appropriate. People were positive about the support they had received and the difference that this had made to them.

Are services responsive to people's needs?

Good

We found that services provided by the trust were responsive to people's needs however some improvements were needed at the John Radcliffe hospital in A&E, surgery, and outpatients services. There are issues with waiting times in A&E, there is a lack of capacity in theatres and targets for referral to treatment times not being met in outpatient departments. The trust was designing and organising services to meet people's needs. The trust was aware of the areas that needed addressing, risks were captured and reported, and plans were in place. The trust engaged with commissioners and other providers of services but there were long standing problems, dating back a number of years, around the availability of onward care and support for people leaving hospital. The trust had taken some innovative steps, such as the providing personal care to patients in their homes when they leave hospital and there is engagement at matron level with social care providers in the area to improve communication and pathways.

The trust has appropriate processes in place to meet the needs of patients who are vulnerable and who may lack capacity. Most patients are able to access services in a timely way although the lack of emergency theatre capacity has meant that some planned operations have been cancelled. The trust has a dedicated discharge team who support people when they are ready to leave hospital. We observed dedicated and holistic support being given to elderly people who were ready to go home. The trust has improved its arrangements for handling and learning from complaints. Some people told us that they found it difficult to make complaints. Some organisations that support people to make complaints told us that the trust is open and honest in their dealings with complainants and that they accept responsibility when things have gone wrong. However, the trust can be slow to arrange meetings for complainants which can delay the resolution of the issue for the patient concerned and delay the learning and improvement for the trust.

Are services well-led?

Good

We found that all services at every hospital and the trust overall were well led. The trust had a clear vision that was focused on quality and safety and improving patient outcomes and care. The trust were aware of the risks and issues within services, hospitals and across the organisation. The trust was innovative in seeking solutions to long standing problems and targeted efforts in the areas most likely to make a difference to patients and staff. The trust identified and reported risk in a coherent way and planned to mitigate and remove risks where possible. The integrated clinical management structure worked well across the four hospitals with clear lines of accountability. The staff survey and human resource indicators gave a picture of a high performing and engaged staff group who were proud of the services that they deliver and of their colleagues. The trust took patient and staff feedback seriously and considered that information alongside other performance data. The trust had systems to focus on learning and improvement and the Listening into Action project gave staff a vehicle to find and implement solutions.

What people who use the trust's services say

The people that we met at the two listening events and the patients and carers that we spoke to during our inspections of the hospitals spoke highly about the services they had received and about the staff who worked there. While concerns were raised about the future of some services and there were concerns about waiting times, cancelled operations and the way that some staff have spoken to people the overwhelming majority of comments and information we received were very positive.

The NHS Choices website which scores hospitals out of five stars shows the trust is attaining an overall score of 4.5. The Adult Inpatient Survey 2012 (the last available) shows that the trust has performed within expectations compared to other trusts, meaning that patients who completed the survey have not rated it as significantly better or worse than other trusts. The trust is performing above the England average for the Friends and Family Test on both the inpatient and accident and emergency tests, this test measures whether staff recommend their hospital as a place to receive treatment. The trust performed well compared to other trusts in the Cancer Patient Experience Survey in 2012/13 with only two areas scoring poorly; these were around ease of making contact and being offered a written assessment and care plan.

Areas for improvement

Action the trust MUST take to improve

- The trust needs to plan and deliver care safely and effectively to people requiring emergency, surgical and outpatient care, to meet their needs and to ensure their welfare and safety.
- The trust needs to ensure that it has suitable numbers of qualified skilled and experienced staff to safely meet people's needs at all times.
- The trust needs to plan and deliver care to people requiring emergency care in a way that safeguards their privacy and dignity.
- The trust needs to ensure that staff receive suitable induction to each area that they work within the trust.
- The trust needs to ensure that midwives receive appropriate supervision and newly qualified midwives are appropriately supported.

Good practice

- The system the trust used to identify and manage staffing levels was effective and responsive to meet the needs of the hospitals.
- There were good care pathways for patients attending the A&E department following a stroke.
- Services were innovative and professional.
- There was a strong sense of improving the outcomes for frail elderly patients and those with dementia on the medical wards. The psychological medicine service was supporting staff to understand the care and support needs of these patients. Wards on level 7 were being redesigned to make it more accessible for patients with dementia.
- Caring compassionate staff throughout the four hospitals.
- Managers had a strong understanding of the risks in service and improvements required. Incident reporting and monitoring was well managed and the learning from incidents was evident. There was a strong commitment, supported by action plans, to improve the service.
- Staff worked well between teams. The value of an effective multidisciplinary approach, in improving outcomes for patients, was understood and actively encouraged.
- It was evident that significant efforts had been being made to improve the effective discharge of patients within medical areas. The hospital was working closely with commissioners, social services,

and providers to improve the transfer of patients to community services.

- Two gerontologists worked in trauma wards to provide medical input and an integrated approach to trauma patients who were older people with co-existing illnesses.
- The nurse consultant in trauma care. This was the first such appointment in the UK and enabled the facilitation and coordination of shared care for complex trauma patients.
- The acknowledgement of excellence of junior medical staff within the trauma directorate by leaders.
- The trauma service in general was praised by patients and staff. It was well-led with well-supported staff and happy patients.
- There was good learning from incidents within critical care which translated into training and safer practice.
- The approach to caring for adolescents, within an environment designed to meet their needs and a clear team approach.
- Involvement of young people in developing art work which was made in to posters to promote the values that are important to the young people themselves.
- Patients within maternity expressed a high degree of satisfaction about the care they were receiving and the staff who supported them.
- Patients had the expertise of specialist midwives such as diabetes, breast feeding to ensure they received appropriate care and treatment.
- Patients received care in a compassionate way which included a designated bereavement suite and pastoral care in the maternity unit.
- There was good multidisciplinary team working for the benefits of mothers and their babies
- There were processes in place throughout the hospitals which took into account patients' diversity. These included interpretation service and information provided in different formats according to the patients' needs.
- The trust internal peer review process, in which over 100 clinical areas had been reviewed in a three month period across the trust.

Oxford University Hospitals NHS Trust

Good

Detailed findings

Hospitals we looked at
Churchill Hospital, Oxford
Horton Hospital, Banbury
John Radcliffe Hospital, Oxford
Nuffield Orthopaedic Centre, Oxford

Our inspection team

Our inspection team was led by:

Chair: Dr Chris Gordon, Consultant Physician, Medicine and Elderly Care, Hampshire Hospitals Foundation Trust; Programme Director NHS Leadership Academy

Team Leader: Mary Cridge, Head of Hospital Inspections, Care Quality Commission

The team of 51.included CQC inspectors, managers and analysts, consultants and doctors specialising in emergency medicine, obstetrics and gynaecology, oncology, diabetes care, cardiology and paediatrics. It also included junior doctors, a matron, nurses specialising in care for the elderly, end of life care, children's care, theatre management, cancer, and haematology and two midwives, together with patient and public representatives and experts by experience. Our team included senior NHS managers, including two medical directors, a deputy chief executive, and a clinical director in surgery and critical care.

Background to Oxford University Hospitals NHS Trust

Oxford University Hospitals Trust is one of the largest acute teaching trusts in the UK and has four hospitals. The John Radcliffe Hospital, the Churchill Hospital, and the Nuffield Orthopaedic Centre are situated in Oxford and serve a population of around 655,000. The Horton General Hospital in Banbury serves a population of around 150,000 people in north Oxfordshire, south Northamptonshire and south east Warwickshire. The trust has around 1,465 beds, 832 of which are at the John Radcliffe. The trust has around 186,000 patients who stay in hospital and it arranges around 835,000 outpatient appointments every year.

The trust has teaching hospital status as part of Oxford University. The trust employs around 11,000 staff and had an annual turnover in 2012/13 of £822 million. The trust provides acute medical and surgical services, trauma, and intensive care and it offers both specialist and general clinical services. The trust leads regional networks for trauma, secular surgery, cancer, neonatal intensive care , primary coronary intervention, and stroke.

Why we carried out this inspection

We inspected this hospital as part of our in-depth hospital inspection programme. We chose this hospital because they represented the variation in hospital care according to our new intelligent monitoring model. This looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations. Using this model, Oxford University Hospitals

Trust was considered to be a medium risk trust and an aspirant foundation trust.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team always inspects the following core services at each inspection:

- Accident and emergency
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Maternity and family planning
- Children's care
- End of life care
- Outpatients.

Before visiting, we reviewed a range of information we hold about the hospital and asked other organisations to share what they knew about the hospital. We carried out an announced visit on 25 and 26 February 2014.

During our visit we held focus groups with a range of staff in the hospital including nurses below the role of matron, matrons, allied health professionals, junior doctors, student nurses, consultants and administration staff. Staff were invited to attend drop-in sessions. We talked with patients and staff from all areas at all four hospitals including the wards, theatres, outpatient departments and the A&E departments. We observed how people were being cared for and talked with carers and/or family members. We reviewed personal care or treatment records of patients. We held two listening events in Banbury and Oxford where patients and members of the public shared their views and experiences of the location.

An unannounced visit was carried out on 2 and 3 March 2014.

Are services safe?

Good

Summary of findings

We found that services at the trust were safe however some improvements were required. The trust had a good track record on safety. Performance against a range of safety measures was monitored and reported monthly. The trust benchmarks itself against other organisations and takes account of national safety performance information. This included monitoring of pressure ulcers, falls, venous thromboembolism and patients with catheter related urinary tract infections. Actions were being taken across the trust to minimise the occurrence of these key areas. The trust had a good system in place to enable it to change staffing levels on a ward quickly in response to the changing needs of patients.

There were systems in place to report and learn from incidents. The quality and timeliness of investigations into incidents was monitored. We saw that changes had been made to policies and procedures in response to the findings from investigations. There were arrangements in place to share the learning from incidents. We saw that the learning from incidents had been widely shared however we also saw that this had not always happened between the four hospitals. Staff were supported to raise concerns and were encouraged to speak up. Staff told us that they felt able to do this.

People were protected from abuse and staff were trained to deal with suspicions of abuse. Staff were able to describe how they would recognise the signs of potential abuse and how they would report this.

Our findings

Safety and performance

Overall, the trust had a good track record on safety although some improvements are required in maternity and surgery at the John Radcliffe hospital. Staffing levels in maternity, operating theatres and on surgical wards were not always sufficient to meet people's needs. The trust has recognised these issues and has plans in place to recruit additional staff and reduce turnover. Some areas at the Churchill Hospital and Nuffield Orthopaedic Centre looked old and worn and presented a potential risk to safety. These risks had been identified and are on the relevant risk registers.

The trust has effective arrangements in place for reporting patient and staff safety incidents and allegations of abuse and these are in line with national guidance. There are clear accountabilities for incident reporting. There was some variation in the robustness of these arrangements between the four hospitals and between services within individual hospitals.

People were protected from abuse and staff were trained to deal with suspicions of abuse. Training records showed that staff at all levels were trained in safeguarding vulnerable adults and this topic was included on induction training for all new staff. Staff were able to describe how they would recognise the signs of potential abuse and how they would report this. Staff were aware of their duty to raise a safeguarding alert of they were concerned about the safety of a patient or somebody accompanying them.

Learning and improvement

Overall the trust had a good approach to incident reporting and was committed to capturing and sharing the learning from incidents and complaints. Staff received training in health and safety and incident reporting. The learning from incidents and complaints related to safety was variable. In some areas there was clear learning which had been shared and disseminated to staff. We saw some good examples, for instance, the A&E unit at the John Radcliffe hospital reported a higher number of incidents compared to trusts of a similar size. We saw that incidents had been analysed and action had been taken. In the medical wards at the same hospital we saw that the lessons following the investigation of a fall that had led to harm was shared with staff at ward meetings. However, in others it was not clear that learning from or awareness of incidents had occurred. This included learning from never events in operating theatres with some staff

working in surgery at the John Radcliffe hospitals being unaware of the never events in surgery at the Churchill hospital.

Systems, processes and practices
The trust had effective systems, processed and practices in place in a range of areas that were key to patient safety. These included effective systems for cleanliness and infection control. The layout of departments was safe with clear routes through and between wards and departments. There were clear processes for the storage of medicines, equipment, and consumables.
The trust monitored the investigation of incidents at a monthly quality meeting to help ensure that these were completed promptly and to a good standard and that the learning from them was shared.

Monitoring safety and responding to risk
Safety is monitored throughout the four hospitals through a programme of regular reviews and risk based audits. Areas monitored included pressure ulcers, falls, venous thromboembolism, and patients with catheter related urinary tract infections. Actions were being taken across the trust in all relevant service areas to improve safety. The trust used the "safety thermometers" as part of their measurement. Action had been taken in response to fluctuations in trust performance against this. Each of the five clinical divisions produces a monthly safety report. Wards displayed their information about individual performance.
Staff were supported to raise concerns and were encouraged to speak up. Staff told us that they felt able to do this.

Staff spoke highly of the system for responding to the need for an increase in staffing when the needs of patients in a particular ward changed. Green, amber, and red staffing levels had been set for each ward. The model was used to identify risks and changing needs and enable staff to be redeployed and for extra staff to be brought in if needed. This system worked in real time and made the changes needed quickly.
Staff across the trust demonstrated an awareness of the Mental Capacity Act 2005 and we saw examples of applications that had been made in line with the deprivation of liberty safeguards.

Anticipation and planning
Although the trust did not have any explicit headline references to safety in its strategic objectives for 2013/14 it is implied under the umbrella aim of "delivering compassionate excellence". The monitoring and reporting arrangements that sit underneath the objectives included safety as a component of quality. The trust benchmarked itself against other trusts in assessing performance. Plans are risk assessed and the impact on patient safety is monitored. The monitoring arrangements were at set at divisional level rather than by individual hospital. It was not clear how long issues specific to a hospital would take to emerge through this route.

The trust had plans in place to respond to major incidents and emergencies. The A&E departments worked as part of a network with other trusts and had detailed plans for transferring and redirecting patients in the event of a major emergency.

Are services effective? (for example, treatment is effective)

Good

Summary of findings

We found that services at the trust were effective. The care and treatment given achieved good outcomes for people and followed current best practice. The trust's links with Oxford University meant that in some areas the trust had been involved in developing the accepted best practice guidelines. The trust took action to check that care and treatment was being delivered appropriately within the guidelines and this was reported across the trust. Feedback from patients contributed to the overall assessments of effectiveness. The trust assessed its effectiveness against known national standards and benchmarked performance against other similar organisations.

The trust had taken action to provide a comprehensive programme of mandatory and specialist training and development for staff at all levels and in all services. Staff spoke positively about the training, support, and supervision that they received. The trust generally had the facilities and equipment needed to deliver services although there are areas of the estate that need updating. Multidisciplinary working is well established and staff are proud of the integrated approach to care. The trust worked positively with local partners although the long standing issues with delayed transfers of care remained an issue that impacted on the running of services and the experiences of patients.

Our findings

Using evidence-based guidance

The trust systematically identified relevant legislation and current and new best practice. This was achieved through the trust's audit, governance, and clinical review committees. Pathways of care had been developed in line with latest guidance from the National Institute for Health and Care Excellence (NICE).

The trust monitored practice to ensure that care and treatment was delivered in line with the practices agreed for the trust. This was monitored within the clinical divisions by designated leads and reported on a trust wide basis through the governance systems. Some pathways of care were under active review, for example an integrated care pathway for patients with diabetes was being formalised.

The trust has taken part in research in conjunction with Oxford University that has led to the development of best practice guidelines that have been adopted nationally and internationally, for example, around the increased risk of mini strokes in the aftermath of a stroke.

Patients were provided with information and support to make choices about their care and treatment. Staff demonstrated an awareness of the processes in place when a patient was considered to lack capacity to consent. There was evidence in services across the trust that these processes had been appropriately followed.

Performance, monitoring and improvement of outcomes

The outcomes for patients receiving treatment at the trust were good and compared well with similar organisations. This was determined through participation in national clinical audits and through independent audits commissioned by the trust. Performance against an agreed set of patient outcomes was monitored on a monthly basis. Shortfalls in performance were identified and improvement plans put in place and monitored. The risks to patients identified through the NHS Safety Thermometer process were being managed. Mortality rates are within expected levels.

Patients were included in the process of evaluating the effectiveness of their treatment. Patients asked to report on the outcomes of their surgery showed they had achieved good outcomes. Comment cards from patients and other feedback described the improvements they had experienced in the control of pain and the improvements such as mobility and quality of life.

Staff, equipment and facilities

The trust had a programme of mandatory training for staff. Specialist training was provided appropriate to the roles performed by staff at different levels. The trust provided skills and language classes for staff who

had trained abroad. The trust had an academy for care support workers that provided support from practice development nurses. Student nurses praised the support and development that they received. There were develop and leadership programmes available. Refresher training was available to ensure practice remained up to date. The trust had developed training in response to identified needs, for example a dementia training programme for doctors, medical students, nurses, and ward staff had been developed in response to the findings of a national audit.
The trust generally had the appropriate equipment and facilities to support safe and effective care across the range of its services. There were some significant exceptions to this relating to the condition of the main theatres at the John Radcliffe hospital. These risks are reflected in the trust's risk registers. The experience of surgeons in obtaining specialist equipment was mixed. The spinal team said their requests for equipment had not been met while other specialist teams said they had everything that they needed. The trust were aware of the concerns and plans were in place to refurbish the theatres at the hospital. Equipment was maintained as needed. Some parts of the estate, particularly at the Churchill hospital, are in need of updating and refurbishment and these issues are appropriately captured on risk registers and plans.

Multidisciplinary working and support
Multidisciplinary working was well established within and across different services and hospitals. Treatment and care plans reflected the multidisciplinary approach. Staff were proud of the integrated approach to caring for people with complex needs. End of life care was integrated within the hospitals and with community services. Patients and staff were very positive about this service. The trust worked positively with local care and transport providers in the best interests of patients. The long standing problem with delayed discharges in Oxfordshire remained an issue and impacted on the wellbeing and experience of patients. The trust had sought solutions, for example, by supporting patients on their return home through the provision of personal care and working with local social care providers to improve communication and discharge arrangements.

Are services caring?

Good 

Summary of findings

We found that services at the trust were caring. The trust's mission statement is "delivering compassionate excellence". Across the trust at all hospitals and within all services we observed patients being treated with dignity, respect, and compassion by all staff. The feedback from patients and carers, both at the inspections, listening events and through comment cards was overwhelmingly positive. The caring provided by staff in the intensive and critical care services at the John Radcliffe, Horton, and Churchill hospitals was considered good. There were some issues to be addressed at the A&E department at the John Radcliffe hospital, caused in part by the challenges of the environment they are working in. In other areas where patients and families had raised concerns those concerns were known and understood by staff and were being addressed, for example, by increasing the number of staff working on a ward to ensure that there was sufficient time available to treat patients in a kind and compassionate way.
Patients, carers and relatives were involved in plans and decisions about care. Relatives and carers were encouraged to provide support, for example, by supporting their relative at meal times if they wished. Training was provided to family members to support care following discharge as appropriate. People were positive about the support they had received and the difference that this had made to them.

Our findings

Compassion, dignity and empathy
We observed, and people told us, that they were treated with compassion, dignity and empathy. In each service at all four hospitals people described the way in which staff had been kind to them and had taken the time to make them feel safe and supported.
Some people told us they were concerned about the way their elderly relatives had been treated, that they were not always helped in a timely way, and that some staff were not patient with them. Staff at all levels in that service were aware of the concerns that had been raised and additional staff had been provided. Staff understood that disrespectful behaviour would not be tolerated. We observed kindness and consideration on the part of staff across all the services.
The exception to this overall positive picture was the A&E department at the John Radcliffe hospital. The staff there were observed to be caring in many ways and had been motivated to improve the way that the service was designed and delivered for patients. However, at busy times some patients did not feel safe or comfortable. The physical environment contributed to the challenges of delivering care in a dignified way. The Atrium was in effect a corridor, vulnerable to extremes of heat and cold, separated from the main entrance by a screen and overlooked by office windows from above. Patients who have been admitted waited here for a bed to become available. Some patients were not assessed in a way that respected privacy or confidentiality, conversations could be overheard, and doors were not closed.

Involvement in care and decision making
The trust was able to demonstrate that patients are considered partners in their own care. This was apparent in the plans and assessments that preceded decisions and in the assessments made of the effectiveness of the care and treatment given. Patients and relatives told us that they had felt as involved as they could be in decisions. Conversations included discussions of the pros and cons of treatment options and the provision of verbal and written information to help people make choices. Patients were able to refer themselves to the specialist palliative care team and to speak to a member of staff when they wished. Relatives and carers were given the opportunity to be involved in patient care. The trust welcomed carers to support patients with their meals and we observed this taking place. We saw examples of relatives who had been provided with training to enable them to provide support and care once the patient had been discharged.

Trust and communication
Patients and their relatives described staff as kind and caring in the way that they communicated with them and this included housekeeping and cleaning staff. Nurses who worked as part of the palliative care teams completed a course in advanced communication skills. Parents of sick children and babies described how

staff took the time they needed to support them and what a difference that had made to their ability to cope. The trust website provides online support and guidance and provides links to relevant sources of further information and a variety of relevant written information is provided.

Emotional support
Patients were supported by trained staff to cope emotionally with their care and treatment during their stay in hospital. People told us about the good support that had been provided by the chaplaincy team. Patients were encouraged to stay in contact with family and friends. Visiting times were flexible, the relatives of elderly patients were welcome to stay for longer periods, and we observed staff supporting patients to make telephone calls. In areas with single rooms communal areas had been provided to enable patients to have some social contact. Additional and targeted support was given to patients and their families when a diagnosis of dementia was given. Psychiatrists were providing ward staff with guidance on how to meet the emotional needs of patients with dementia. People who spoke to us in every service at all four hospitals wanted to tell us about the support they had received and the difference that this had made to them.

Are services responsive to people's needs?
(for example, to feedback?)

Good

Summary of findings

We found that services provided by the trust were responsive to people's needs however some improvements were needed at the John Radcliffe hospital in A&E, surgery, and outpatients services. There are issues with waiting times in A&E, there is a lack of capacity in theatres and targets for referral to treatment times not being met in outpatient departments. The trust was designing and organising services to meet people's needs. The trust was aware of the areas that needed addressing, risks were captured and reported, and plans were in place. The trust engaged with commissioners and other providers of services but there were long standing problems, dating back a number of years, around the availability of onward care and support for people leaving hospital. The trust had taken some innovative steps, such as the providing personal care to patients in their homes when they leave hospital and there is engagement at matron level with social care providers in the area to improve communication and pathways. The trust has appropriate processes in place to meet the needs of patients who are vulnerable and who may lack capacity. Most patients are able to access services in a timely way although the lack of emergency theatre capacity has meant that some planned operations have been cancelled. The trust has a dedicated discharge team who support people when they are ready to leave hospital. We observed dedicated and holistic support being given to elderly people who were ready to go home. The trust has improved its arrangements for handling and learning from complaints. Some people told us that they found it difficult to make complaints. Some organisations that support people to make complaints told us that the trust is open and honest in their dealings with complainants and that they accept responsibility when things have gone wrong. However the trust can be slow to arrange meetings for complainants which can delay the resolution of the issue for the patient concerned and delay the learning and improvement for the trust.

Our findings

Meeting people's needs
The trust worked with stakeholders to assess the needs of the local community and to plan and design services to meet those needs. Commissioners commented that there is an open dialogue with the trust that involves both clinicians and managers. Co-ordinated pathways of care had been discussed and agreed with partners. Services and related support was planned to meet the needs of different groups of people using services. This support included arrangements for the visually impaired, hearing loops, translation services, and support for people with a learning disability. Equality impact assessments were undertaken There were some challenges, particularly at the John Radcliffe hospital, because bed occupancy ran at about 92%. This meant that patients admitted from A&E sometimes had to wait for a bed to become available and patients were delayed leaving critical care for the same reason.

Vulnerable patients and capacity
The trust had a process in place to decide if a patient had the capacity to consent to care and treatment and where a patient lacked that capacity staff followed a process to make sure the patient's best interests were assessed and recorded. Staff had received training in the safeguarding of vulnerable adults and demonstrated a good understanding of the Mental Capacity Act 2005 and the deprivation of liberty safeguards. The responsibility for applications rested with ward sisters who were supported by the psychological medicine service for complex applications. Patients with fluctuating capacity were supported to manage their confusion.

Access to services
The trust performance on access and waiting times was variable with the most pressure experienced at the John Radcliffe Hospital. A&E targets had been missed and targets for referral to treatment times had not been met in outpatient departments. The trust had anticipated a higher demand for medical beds in the

winter months and escalation plans were in place. The trust had a major project underway to reprofile outpatient clinics to improve access and this was on target but has not yet delivered the improvements needed.

Leaving hospital
The trust had processes in place for the planning of discharges and transfers of care that met patients' needs. There were long standing issues within the health economy which means that every month there were delayed transfers of care. These delays contributed to pressures throughout the hospitals. The trust had been innovative in seeking solutions and this included the provision of personal care in people's homes and engagement at matron level with social care providers. We observed a holistic approach to planning for leaving hospital. Extra care and preparations were provided for elderly people who lived on their own to return home.

Learning from experiences, concerns and complaints
The trust has arrangements in place to capture and learn from patient feedback, concerns and complaints. During 2012/2013 the top three themes from the 860 formal complaints received related to delays and difficulties making appointments, poor and uncoordinated discharge and staff attitude, behaviour and communication. The trust board received a report on the themes from complaints and feedback and divisional and trust wide learning and actions were identified. The trust had work in progress to address the issues raised. The outpatient reprofiling project, the discharge oversight group and the implementation of the patient experience strategy were all in response to issues that had been identified through monitoring and feedback. The commitment shown by management and staff to improve the effectiveness of complaint handling was impressive. Organisations that supported people to make complaints considered that the trust performed well in comparison to other organisations that they dealt with.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

Good

Summary of findings

We found that all services at every hospital and the trust overall were well-led. The trust had a clear vision that was focused on quality and safety and improving patient outcomes and care. The trust were aware of the risks and issues within services, hospitals and across the organisation. The trust was innovative in seeking solutions to long standing problems and targeted efforts in the areas most likely to make a difference to patients and staff. The trust identified and reported risk in a coherent way and planned to mitigate and remove risks where possible. The integrated clinical management structure worked well across the four hospitals with clear lines of accountability. The staff survey and human resource indicators gave a picture of a high performing and engaged staff group who were proud of the services that they deliver and of their colleagues. The trust took patient and staff feedback seriously and considered that information alongside other performance data. The trust had systems to focus on learning and improvement and the Listening into Action project gave staff a vehicle to find and implement solutions.

Our findings

Vision, strategy and risks

The trust had a clear vision, captured in the phrase "delivering compassionate excellence". This was underpinned by a set of strategic objectives that in turn influenced the detailed objectives within divisions and services. Risks were identified and captured and this was a significant exercise given the size of the trust and the range of services. There is a clear connection between the concerns raised by patients and staff and the trust risks and related plans. The trust had launched a five year vision in 2012 which aimed to deliver continuous quality improvement. The focus on 2013/14 was patient safety, patient experience, and clinical effectiveness.

Governance arrangements

The trust had an integrated clinical management structure with a single point of accountability for services across all four hospitals. The trust is organised into five clinical divisions, 17 clinical directorates and 74 clinical service units. There were clear reporting lines. The members of the board and executive team that we met were clear about their roles and responsibilities and the extent of their authority. The divisional structures had enabled a consistent approach to be taken across the different hospitals and reinforced the intention to take a whole trust approach. Some staff felt that this approach made them feel that there was no one in overall charge at the individual hospitals. The trust did not have performance information readily available at hospital level and this raised a question about the ability of the governance and reporting arrangements to pinpoint areas of concern. The governance arrangements had brought a sense of cohesiveness to a large and dispersed organisation.

Leadership and culture

The leadership strategy is one that focuses on excellence and high performance. This was articulated in discussions with executive and non-executive members of the board. The trust was found to be performing better than expected for the majority of the 28 NHS 2013 Staff survey indicators. Staff are motivated and satisfied with their jobs and experience proportionally less bullying and harassment compared to the England average. With the exception of the midwifery staff group sickness absence rates between April 2011 and September 2013 were consistently below the England average. The trust's ratio of nurses to bed days is above the England average.

The trust had a strong medical culture. Medical staff were proud of the trust and of the association with Oxford University. Medical staff talked positively about the quality of their colleagues at all levels and about their pride in the outcomes for patients. There were some pockets of significant discontent among the consultant body. These consultants talked about their frustration when they raised issues that were not

dealt with in a timely way although they remained proud of the work that they were doing. There was also a sense of some disconnection between the John Radcliffe hospital and the other hospitals and between the hospitals based in Oxford and the Horton General hospital in north Oxfordshire. Perceptions about the future of services at the Horton were impacting on the way that staff there felt about the leadership of the trust.

Patient experiences, staff involvement and engagement
The trust recognised the importance of patient and public views. Patient and staff feedback was a standing agenda item and monthly governance and board meetings. This feedback was considered alongside other performance information. Staff felt involved and informed about patient experiences. The clinical governance committee received reports on the concerns raised by whistleblowers. Action plans were in place at ward and service level to improve practice and patient experience. Positive feedback was shared with staff and displayed in ward areas. The trust's Listening into Action project empowered and encouraged staff to find innovative solutions to the issues they had identified.

Learning, improvement, innovation and sustainability
The trust had systems in place to enable learning and improve performance. Risk reporting systems were reviewed and an improved integrated risk reporting system was in development. Staff teams in different services were able to take time out for focused and in-depth reviews of performance and pathways. Board away days were focused on improvement and sustainability. Staff felt encouraged to continue with their learning and development.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury Surgical procedures	The provider had failed at times to plan and deliver care to patients needing emergency care, surgical care and outpatient care to meet their needs and ensure their welfare and safety. This is a breach of Regulation 9(1)(b)(i) and (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The accident and emergency department were regularly missing waiting-time targets due to the lack of available beds to discharge people effectively. The outpatient department was failing to provide an effective booking service, failing to meet national standards for timely referral to treatment and failing to provide suitable information. In some surgical specialties waiting times for surgery were too long and operations were cancelled too often. There was not suitable attention paid to the identification, assessment and planning of care needs for vulnerable people, particularly those with dementia in surgery and A&E.

Regulated activity	Regulation
Treatment of disease, disorder or injury Surgical procedures Family planning Maternity and midwifery services Termination of pregnancies	The provider had failed to consistently safeguard the health, safety and welfare of patients because they did not ensure that that at all times there were sufficient numbers of suitably qualified, skilled and experienced staff employed. This is a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. There were not sufficient numbers of suitably qualified, skilled and experienced staff employed in the maternity department and on surgical wards and in operating theatres.

Regulated activity	Regulation
Treatment of disease, disorder or injury	The provider had failed at times to deliver care to patients that ensured their privacy, dignity and human rights were respected. This is a breach of Regulation 17(1)(a) and (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The use of the accident and emergency triage room, the atrium area, and layout of the reception did not give patients privacy and dignity

Regulated activity	Regulation
Treatment of disease, disorder or injury.	The provider had failed at times to take proper steps to ensure that patients were protected against the risks of receiving unsafe or inappropriate care or treatment arising from a lack of proper information about them, by means of the maintenance of an accurate record in respect of each patient, including appropriate information and documents in relation to that care and treatment. Regulation 20 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 There was no suitable information within care records to inform staff about the individual care patients needed. This was particularly in relation to the needs for vulnerable people, particularly those with dementia and patients requiring complex wound management. Records did not contain all the required information to ensure care was delivered safely to meet the patient's needs. Risk assessments, monitoring records and care plans were not all fully completed and were not explicit in how risks were to be managed and care was to be provided. This placed patients at risk of not receiving the care they needed.

Regulated activity	Regulation
Treatment of disease, disorder or injury Maternity and midwifery services	The provider did not have suitable arrangements in place in order to ensure that all staff were appropriately supported in relation to their responsibilities to enable them to deliver care and treatment to service users to an appropriate standard through receiving appropriate training, professional development and supervision. This is a breach of Regulation 23(1)(a) the Health and Social Care Act 2008 (Regulated Activities)

	Regulations 2010. Some of the new nursing staff coming to work at the hospital did not have sufficient induction into the A&E department. Newly qualified midwives did not always receive adequate preceptorship. Not all nurses qualified overseas working in A&E and newly qualified midwives were appropriately supervised to ensure they were competent and trained to deliver all care and treatment procedures to the appropriate standard.

Oxfordshire County Council Inspection of services for children in need of help and protection, children looked after, care leavers and the Review of the effectiveness of the local safeguarding children board.

Contact Officer:

Lucy Butler
Deputy Director Children's Social Care and Youth Offending Service

Purpose:

Members are asked to note the outcome of the recent Inspection. A short presentation of findings will be given by Lucy Butler.

Background:

During May this year Ofsted carried out an inspection of children's services in Oxfordshire. This Inspection has been thorough and wide-ranging, looking at around 180 different cases across all areas of work. Inspectors met with 27 young people, 11 parents and 2 carers. In addition, they have observed dozens of practice meetings and met with a very significant number of partner organisations.

The final judgement from Ofsted was published on 30th June. The outcome of our 4 week inspection is that Children's Services have been judged as Good in all six categories.

These include:

- Children who need help and protection
- Looked After Children
- Adoption
- Experiences and progress of Care Leavers
- Leadership, Management and Governance
- The Local Children's Safeguarding Board

The full report is attached but in summary inspectors said that we had significant strengths in that;

- Our children and young people are safe and protected.
- Social workers are compassionate and really care about the children and young people they work with.
- Achievements of children and young people are celebrated and social workers are really proud of those achievements.
- Staff are enthusiastic and knowledgeable, really know the children and young people they work with and speak about them with warmth.
- The voice of the child comes through in everything we do and we learn and develop our practice to take into account what we hear. We talk to our children and young people and really listen to them.

- Social Care and Early Intervention services are working well together.
- Parents feel really supported by step down arrangements - they are pleased with the support they have from Early Intervention when stepping down from statutory services.
- Thresholds are well used and responses are timely and proportionate.
- There is good management oversight and commitment and staff feel supported by their managers.
- Children and young people benefit from a stable, reliable workforce.
- We use creative and innovative approaches to our work.

There are, however, areas that the Inspectors have said need further development, including that;

- Parents need to be given more time to read and question reports prepared for Child Protection Conferences.
- There needs to be a greater range of available placements for young people who are looked after by the Authority.
- The educational outcomes for our looked after children needs to improve.
- Some of our governance arrangements need to improve.

Submission of the post inspection Action Plan to address the areas for improvement is Monday 6th October 2014.

Oxfordshire Health and Wellbeing Board
17 July 2014

The Winterbourne Improvement Plan - Improving lives for people with learning disabilities, autism and challenging behaviour

Purpose / Recommendation

This paper summarises the actions to be taken in Oxfordshire to support the delivery of *Transforming Care* and the national *Winterbourne Concordat* (DH, 2012) and improve lives for people of all ages with learning disabilities, autism and challenging behaviour.

The Health and Wellbeing Board is asked to note the strategic intentions of the Winterbourne Improvement Plan for Oxfordshire and monitor delivery of the action plan

Background

Effective health and social care support for people with learning disabilities and autism who experience periods of mental ill-health and challenging behaviour is critical both in ensuring a good quality of life for people and their families and in making best use of resources. The national Winterbourne Concordat makes clear the expectation that this group of vulnerable people should be enabled to live well in the community and not be subject to prolonged and unnecessary periods of inpatient care simply because of a lack of sufficient resource to meet their needs.

In order to support the delivery of the Winterbourne Concordat and to improve lives for people with learning disabilities and challenging behaviour, Oxfordshire County Council and Oxfordshire Clinical Commissioning Group have already delivered on a series of requirements.

- The Council established and maintains a register of people who are receiving assessment and treatment in hospital and is actively working to prevent admissions and support discharge.
- The Council supported the completion of person centred reviews for all patients who were in assessment and treatment hospital services in March 2013 and enabled all patients who were ready for discharge, to move to community placements by 1st June 2014.
    - 12 of the 14 patients identified in March 2013 have now been discharged. Of the remaining two patients, one is subject to Ministry of Justice restrictions and is not presently ready for discharge. The second patient is appropriately placed and the Learning Disability Team are actively working to support discharge planning with assistance from the national Transforming Care Team.
    - Currently, six Oxfordshire patients are in assessment and treatment hospital services commissioned by the Council.

The Winterbourne Improvement Plan is a national requirement for all areas. The overall intention of the Winterbourne Concordat is not only to support patients towards discharge but to ensure that every local area is changing social and health care services and systems to support people with learning disabilities and challenging behaviour to live well in the community thereby reducing the need for inpatient admission.

The Oxfordshire improvement plan has been developed with input from people with learning disabilities and family members working with service providers, the Council and Oxfordshire

Clinical Commissioning Group. This plan contributes to the delivery of the overall Oxfordshire strategy for people with learning disabilities; promoting independence, rights, choice and control with a major emphasis on supported living, meaningful activities, prevention of inpatient admission and timely discharge to the community. The improvement plan covers people of all ages and is closely aligned with other Council activities such as the SEND (Special Educational Needs & Disabilities) Reforms Program for young people. The improvement plan should be seen not only as a plan for action but a living document which will be reviewed and developed over time.

Strategic Intentions

Priority 1
To improve the transition arrangements for young people with learning disabilities, autism and challenging behaviour so that as young people reach adulthood, they and their families feel supported and informed.

Actions for 2014/2015
1. Develop a shared register across children and adults services which identifies young people and adults who have learning disabilities, autism and behaviours which challenge, and who are particularly at risk of being placed in residential services out of Oxfordshire or admitted to specialist inpatient services.
2. Finalise and implement transition protocols between Oxford Health NHS Foundation Trust and Southern Health NHS Foundation Trust.
3. Implement the Education, Health and Care Planning process (SEND Reforms) across Oxfordshire to support co-ordinated, person centred planning with young people with learning disabilities, autism and challenging behaviour.
4. Establish transition workshops for young people and their families run by people with learning disabilities and their families.

Priority 2
To extend the availability of local educational support so that young people with learning disabilities, autism and challenging behaviour can receive schooling in Oxfordshire.

Actions for 2014/2015
1. Support the opening of a new academy for children and young people with learning disabilities, autism and challenging behaviour, thereby reducing the need for out of area placements.
2. Extend the availability of personal budgets for children, young people and families (SEND Reforms) so that families have more flexibility to purchase support to meet the educational, health and social care needs or their child or young person.

Priority 3
To improve specialist health support and establish an effective care pathway for people with learning disabilities, autism and challenging behaviour.

Actions for 2014/2015
1. Develop an Intensive Support Service for adults with learning disabilities. This will enable people to receive health assessment and treatment in their own home or family home and reduce the need for inpatient hospital admission.
2. Complete the nationally promoted Green Light Toolkit which will identify improvements that can be made within generic mental health services to enable effective, crisis support to be provided to people with learning disabilities with mental health needs.

3. Work alongside NHS England, the Thames Valley Area Team and other commissioners to understand current and future demographic needs across the region and develop a regional framework of quality assured health care providers.
4. Review the assertive outreach model of support and explore ways of delivering support to people with learning disabilities, mental health needs and substance use issues who have lower support needs but may at times engage in behaviours which put themselves or others at significant risk. This review will look at potential for work with services supporting people who do not have learning disabilities as well as consider people with learning disabilities who are supported by social care providers.
5. Review the Step-Down provision to ensure that the sufficient services exist to support people in low and medium secure settings to return to community living.
6. Ensure that locally driven person centred reviews are completed out for all Oxfordshire patients in low and medium secure forensic settings (which commissioned by Specialised Commissioning) and future discharge plans are in place.

Priority 4
To increase the availability of specialist supported living so that more people with learning disabilities, autism and challenging behaviour can live in their own home in Oxfordshire.

Actions for 2014/2015
1. Work in partnership with Cherwell District Council to develop 12 specialist supported living flats for people with learning disabilities and autism. The initial 6 placements will be available from 2016.
2. Increase the overall number of specialist supported living placements which are available by supporting people using direct payments.
3. Initiate a project which will identify a support and housing provider to assess and plan with people with learning disabilities, autism and challenging behaviours, who are living in registered residential care services outside of Oxfordshire and want to return to the County, and develop person centred solutions which will support them to come back to Oxfordshire.

Priority 5
To increase the involvement of people with learning disabilities and their families and to improve the quality of information about the needs of people with learning disabilities, autism and challenging behaviour which in turn will support good planning and development of health and social care services.

Actions for 2014/2015
1. Extend the role of ‘experts by experience’ in the reviewing of services.
2. Work with the Oxfordshire Family Support Network and the Department of Health to pilot the 'peer to peer' support model for families who are supporting a relative with learning disabilities, autism and challenging behaviour. This is a model where people using services and families mentor other people using services and their families.
3. Embed processes which support people with learning disabilities and their families to choose their own support provider as part of a Council-led procurement process.
4. Enhance the role of the all age Learning Disability Partnership Board in monitoring the delivery of action plans, including the Winterbourne Improvement Plan and the Next Big Plan (the Commissioning Strategy)
5. Promote the involvement of people with learning disabilities and families in decision making within the Council such as the selection of CQUIN targets for Southern Health and the Project Board to deliver the Intensive Support Team.
6. Ensure that information about the needs of people with learning disabilities, autism and challenging behaviour is systematically collected as part of the Joint Strategic Needs Assessment (JSNA)

7. Review and agree key performance indicators and benchmarks which can be used to measure the success of action plans for improvement and inform next steps.
8. Extend the reach and depth of Mental Capacity Act training across the social and health care workforce and families, particularly of young people in transition.

Priority 6
To enhance the support which is available to people with learning disabilities, autism and challenging behaviour who are living at home with families.

Actions for 2014/2015
1. To finalise the respite review in adult services and deliver the action plan to ensure the availability of respite care and short breaks for families supporting people with learning disabilities, autism and challenging behaviour. This may require the development of a business case for intensive respite for people with more complex needs.
2. To improve the availability of information and support for children, young people and their families through extension of the Local Offer and Education, Health and Care Plans.

Priority 7
To extend the range of good quality social and health care provision within Oxfordshire.

Actions for 2014/2015
1. Establish a new procurement framework for adults with learning disabilities, extending the number of providers who have proved their competence in providing good quality, person centred flexible care and their ability to '*stick'* with people with behaviours which challenge.
2. Promote the use of Positive Behaviour Support in Oxfordshire through partnership working with providers, procurement processes, quality and contract management.
3. Encourage and support providers of learning disability services in Oxfordshire to sign up to the *Driving up Quality Code*, to review their own performance and develop plans for further improvement.
4. Develop a business case and pilot the use of Individual Service Funds and co-operative working between providers as a means of supporting the delivery of person centred support for people with learning disabilities, autism and challenging behaviour.
5. Where applicable, ensure that providers of health and social care services achieve actions within their Quality Improvement Plans.

Key Issues

It is anticipated that the Winterbourne Improvement Plan will have a significant role to play in driving change across social and health care sector for both adults and children with learning disabilities, autism and challenging behaviour. This is an area of national priority and attention.

Improved health and social care support for this vulnerable group will not only improve quality of life but will also impact positively on the efficiency and effectiveness of the sector.

Budgetary implications

It is broadly anticipated that the overall plan will be delivered within current resources. The budgetary implications for each action within the Winterbourne Improvement Plan have been or will be individually determined and agreed through usual governance arrangements.

Equalities implications

The Winterbourne Improvement Plan is aimed at improving health and social care for people with learning disabilities, autism and challenging behaviour. This group of individuals have otherwise been significantly disadvantaged in the health and social care sector. This plan aims to address this disadvantage and inequality.

A social and communities impact assessment will be completed.

Risk Management

The risks associated with each action within the Winterbourne Improvement Plan have been or will be individually determined.

A risk register for the overall plan will be developed.

Communications

The Winterbourne Improvement Plan has been developed in partnership with people who use services, families and service providers with the Council and Clinical Commissioning. This plan is supported by the Learning Disability Partnership Board.

A communication plan will be developed with all stakeholders.

Key Dates

The actions within the Winterbourne Improvement Plan will be delivered to individual timescales.

It is recommended that delivery of the plan is formally reviewed by the Health and Wellbeing Board every six to twelve months.

David Smith
Chief Executive, Oxfordshire Clinical Commissioning Group

John Jackson
Director for Social & Community Services, Oxfordshire County Council

July 2014

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Healthwatch Oxfordshire

Update for the Health and Wellbeing Board – 17th July 2014

1 Delivery of Healthwatch Oxfordshire

1.1 The original grant for the delivery of Healthwatch Oxfordshire (HWO) was awarded to Oxfordshire Rural Community Council (ORCC) until 31st March 2014. Following the subsequent tender process the grant for the next two years was awarded to a Community Interest Company called EASI Healthwatch CIC which was specifically created to act as a vehicle for the delivery of HWO. EASI Healthwatch CIC took over responsibility for the delivery of the service from 1st April 2014 with arrangements made to complete the transition of the service from ORCC to the CIC. All members of the Board of Healthwatch Oxfordshire were appointed as Directors of the CIC.

1.2 The first chairman was Larry Sanders. He has recently retired from the chair, having given HWO an excellent start. In his place the HWO board has appointed Jean Nunn-Price as Chairman and Dermot Roaf as Vice Chair for the next few months.

2 Chief Executive

2.1 David Roulston was appointed as an interim Chief Executive in November 2013 pending the recruitment of a permanent successor and stood down on 27th June 2014. The Board has appointed Rachel Coney, currently Assistant Director of the CCG, as Chief Executive from 21 July 2014

3 Project Fund

3.1 A project fund of £30,000 was established by Healthwatch Oxfordshire to support project work and research into different areas affecting people in respect of health and social care. 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.

3.2 The Project Fund is overseen by a sub-committee of the HWO Board and projects funded in the last financial year included:

3.3 Research in partnership with the Patients Association into people in Oxfordshire's experience of access to GPs.

3.4 Research by Oxfordshire Family Support Network into the health service experiences of people with learning disabilities and their families.

3.5 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

3.6 Research by Oxford Mental Health Forum into young people's perception of the information available to them about mental health support services.

3.7 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.

3.8 A project with Sign Lingual to explore the underlying communication issues affecting deaf people in accessing health and social care services.

3.9 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.

3.10 Partial funding support for a Quality of Life survey to be undertaken by Oxford City Council's neighbourhood team.

3.11 The reports arising from the above projects are at different stages of completion. The first reports published arise from the projects conducted by Oxfordshire Family Support Network, Oxford Mental Health Forum and My Life My Choice. Some of the findings and details arising from these reports are highlighted later in this report for consideration by members of the committee.

4 Research into the Healthcare Experiences of students of Oxford University

4.1 As Board members will recall HWO commissioned a project last year to collect intelligence about Oxford University Students' experience of and impact on local publicly funded Health Services.

4.2 This involved a survey of 317 Oxford University students in November 2013 with a report subsequently compiled in February 2014 which was shared with Oxford University Student Welfare and Support Services Director, Oxford University Hospitals NHS Trust (OUHT) and Oxfordshire Clinical Commissioning Group (OCCG).

4.3 There were 4 main findings from the report:

4.3.1 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 had used A and E services.

4.3.2 Problems of access for international 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.

4.3.3 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 undertaken concerning the different types of mental healthcare provision and how improvements could be made.

4.3.4 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 this were raised in many of the personal comments made by respondents.

4.4 OCCG have conducted a further analysis of student data following receipt of the report and this correlates with the findings concerning the demands placed on the A and E service

4.5 A follow up study has been undertaken in conjunction with the Student Consultancy as a more qualitative analysis looking in greater depth at students' experiences of A and E and mental health services. This report is at the stage of being finalised and will be issued for comment shortly.

5 Research focus area 1 – Oxfordshire Family Support Network

5.1 The purpose of this project and associated report was to contribute to the debate about how extremely vulnerable people with learning disabilities, autistic spectrum disorder and mental health needs or challenging behaviours can be better supported and safeguarded by providing information, advice and support to their families. In order to compile the report three focus group meetings were held with local families (one of which was held with Bill Mumford, the Director of the National Winterboune View Joint Improvement Programme) and a series of focussed interviews were undertaken.

5.2 There are a range of findings with regard to the commissioning of the services provided for this group and understanding the needs of the families and young people using these services. The full detail of recommendations arising from the report can be found in appendix 1 to this report.

5.3 The report highlights the failures in respect of the current system and calls on local commissioners to work with families and services users to create services which meet their needs by working with them as 'experts by experience'. Particular areas which require more detailed consideration include the following:

5.3.1 The problems associated with the transition between children and adult services.
5.3.2 The frequent failures to provide information and support to enable families to make informed choices about which services to use.
5.3.3 A proposal to undertake scoping work on developing a peer-to-peer network of support and advocacy for families with the suggestion that Oxfordshire could be a potential pilot area to test out a peer advocacy and support model.
5.3.4 The importance of services and commissioners working with families to seek solutions rather than perceiving families as part of the problem.

5.4 HWO will wish to see progress in changing the methods of commissioning in response to the findings outlined in this report and the report has highlighted a range of issues that require further scrutiny.

6 Research Focus Area 2 – Oxford Mental Health Forum

6.1 The report associated with this project arises from an extensive online survey to find out about the information and support available on mental health for young people in Oxfordshire. The survey collected a total of 406 responses from a range of sources which included schools, young people (aged 16-25), professionals and parents/carers.

6.2 The executive summary and recommendations from the report can be found in appendix 2 to this report. Particular areas addressed in the report include the following:

6.2.1 There are many information gaps for young people about mental health issues and it is important that this is addressed through a focus on early intervention and increasing mental health awareness and understanding amongst young people, their parents/carers and the staff who support them.
6.2.2 Many of the people surveyed highlighted problems with long waiting times to access mental health services.
6.2.3 Young people need practical help and support in addressing mental health related problems.
6.2.4 A very high proportion of the parents/carers who took part in the survey had concerns about their child's mental health and they experienced difficulties in gaining access to the information and guidance and support they needed.

6.3 HWO has received confirmation from OCCG that they are starting work this year to review the way that services for children and young people are commissioned and that the report will help inform this approach. Oxford Health has also provided a detailed response to the report highlighting actions which are being taken on a

range of fronts to address some of the matters covered in the report which include the following:

6.3.1 They have been awarded the contract to provide school health nursing from April 2014 and the model to be adopted will mean that from September 2014 there will be a School Health Nurse (SHN) in every state school in Oxfordshire.

6.3.2 The SHN will have an integral role in ensuring that a health plan is developed in each school to include the mental health and wellbeing of students.

6.3.3 A pilot project initially involving three schools is about to be run to put the Primary Child and Adolescent Mental Health Services (PCAMHS) into secondary schools on a weekly basis. This will enable schools to book young people into sessions as well as staff being able to discuss any concerns they may have about mental health of pupils. A move is also underway to enable 16 and 17 year olds to self-refer to the service this year in addition to the arrangements for GPs, schools, children's centres and youth workers to refer people to the service.

6.3.4 Emergency and urgent referrals are being seen within the respective targets of 24 hours and 7 days but there is an acknowledgement of an increase in waiting times for routine referrals to the service.

6.4 The report mirrors evidence found elsewhere of an increase in demand for services and increased waiting times.

7 Research Focus Area 3 – My Life My Choice

7.1 The report arising from this project was compiled based on the results arising from facilitated discussions with eleven self-advocacy groups across Oxfordshire.

7.2 The recommendations arising from the report can be found at appendix 3 of this report. Particular areas addressed in the report include the following:

7.2.1 People with learning disabilities suffer notable health inequalities when compared with the population as a whole. A recent inquiry into the premature deaths of people with learning disabilities found that three times as many people with learning disabilities die before the age of 50 compared to the general population.

7.2.2 Annual health checks represents a significant opportunity to address this inequality however in Oxfordshire only 45% of those eligible had a health check in 2012/13 compared to the national average of 53%. The target set by Oxfordshire's Joint Health and Wellbeing Strategy was 50% for 2012/13 and 60% for 2013/14 but the report raises concerns about whether this target will be met.

7.2.3 There is a general lack of knowledge about learning disability amongst those working in healthcare services. This needs to be addressed and people with a learning disability given respect as 'active protagonists in their own healthcare'.

7.3 The report also adds to the body of evidence that is being compiled in relation to access to GPs by people in Oxfordshire.

8 Initial Priorities Set by Healthwatch Oxfordshire

8.1 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

8.2 In order to explore the issue of GP access a survey was conducted throughout Oxfordshire and over 830 responses received back. The report arising from this report is being finalised and is due for publication at the time of compiling this report.

8.3 HWO is in discussion with a range of different parties about the establishment of representative groups for relatives in care homes with a view to compiling a subsequent best practice guide to promulgate the establishment of such groups more widely in care homes.

8.4 HWO welcomed the additional £800k which has been found to do away with 15 minute visits for personal care. HWO has been in correspondence with the County Council regarding the implementation of this new approach and will be designing a study for later in the year to look at the impact of the change in policy. Among the points arising from this correspondence are the following points:

8.4.1 An instruction has been issued to County Council staff asking them to stop commissioning 15 minute home care visits for undertaking certain personal care tasks.

8.4.2 A recent analysis of their records has indicated that about 770 people a receiving a 15 minute visit of some form. A review is being undertaken to establish how many of these visits involve some form of personal care.

8.4.3 The County Council will be writing to all clients who receive a 15 minute visit to book a review with them.

8.5 HWO will be holding a whistleblowing conference in October/November 2014. As mentioned previously the reason for HWO setting this priority was to seek reassurance that whistleblowers in health and social care services in Oxfordshire are being actively listened to and their concerns are acted upon. 4 high profile whistleblowers will be speaking at the conference including Helene Donnelly who is a former A and E nurse who was called to give evidence at the Francis Enquiry. HWO hopes that the conference will attract a wide range of attendees and support its objective for delegates to increase the awareness of whistleblowing and seek to put in place actions which will enable staff to speak out safely.

9 Engagement with the voluntary sector

9.1 HWO is arranging a conference to bring together representatives from the voluntary sector to consider the range of issues faced in the commissioning and

delivery of health and social care locally and to help it shape its future priorities in respect of areas requiring attention in respect of the commissioning and delivery of health and social care.

10 Care.data

10.1 HWO contacted Healthwatch England earlier in the year 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 and 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.

10.2 HWO has issued a preliminary position statement highlighting particular concerns it has about the programme together with suggested actions which could be taken in response. We have also arranged a public debate in Oxford on 10th September on the subject of care.data to enable the public to become better informed about the programme and raise issues of concern for clarification. The debate will be attended by representatives from Medconfidential and NHS England and Dame Fiona Caldicott has agreed to chair the discussion.

11 Additional matters for consideration

11.1 HWO has received expressions of concern about the status and future use of community hospitals. These include the ongoing debate regarding the status of the Horton General and the recent decision to close 10 community beds at Didcot Community Hospital. This issue has been raised in the context of the use of community hospitals to address issues like delayed discharges, the impact of Winter pressure and the desire to deliver care 'closer to home' as envisaged in OCCG's future strategy. The Health Overview and Scrutiny Committee is due to consider community hospitals at its meeting on 18th September and HWO has encouraged the committee to include such considerations as part of its scrutiny.

11.2 Finally it has come to the attention of HWO that the current policy in Oxford is that people sleeping rough in the city who are admitted to hospital are not being prioritised for hostel beds upon discharge. We understand that this is based on a priority being placed on reducing the number of rough sleepers on the streets in Oxford but are concerned (amongst other considerations) this could displace people who were in hostel accommodation prior to being admitted to hospital and leaves them at risk of a return to the streets following discharge from hospital. This is of concern with regard to the future health needs of those affected but also in the light of emerging evidence contributing to Healthwatch England's Special Inquiry looking at the subject of unsafe discharges from hospitals and care homes.

11.3 HWO recognise the complexities and interplay of homelessness, delayed discharges and the severe lack of accommodation within the city however we feel that this issue should be the subject of further scrutiny given the potential issues raised in respect of increased risk and the challenges raised for healthcare staff in discharging people safely from their care.

Appendix 1 – recommendations arising from the report compiled by Oxfordshire Family Support Network

Recommendations for Healthwatch Oxfordshire

1. Healthwatch uses its powers to verify the quality and safety of local provision on behalf of some of the most vulnerable Oxfordshire people with learning disabilities, mental health needs and challenging behaviours

2. Heathwatch continues to hold Oxfordshire County Council (OCC) and Southern Health accountable for the commissioned services and keep the local Winterbourne Concordat on track

3. We recommend that Healthwatch particularly monitors what is happening to young people under the age of 25 - and especially those who are under 18 years of age

4. Careful monitoring of the use of physical restraint

5. Healthwatch uses its role to monitor health inequalities for people with learning disabilities, mental health needs and challenging behaviours who may also have a dual diagnosis of autism

6. Ensures families are signposted to advocacy support

Recommendations for Oxfordshire County Council

a) Commissioning

1. Oxfordshire County Council must commission services for people with learning disabilities, mental health needs and challenging behaviours that are safe and of good quality - indeed that Oxfordshire can be proud of. The global principles of open contracting should be employed.

2. OCC must ensure that commissioners have a close working relationship with providers that enable them to be sure of how the providers are performing. The key performance indicators need to be robust, meaningful and with a focus on providing personalised approaches with positive outcomes for people using these services

3. OCC should work with families and people with learning disabilities to define what the characteristics of good services should be like and to identify innovative approaches and locate gaps in commissioning so that people are not held in secure units simply because there is no opportunity to move on

4. Work with experts by experience with learning disabilities and family carers to monitor quality and develop good training for staff

5. Crucially, OCC should not allow providers to continue providing services on the basis that they are “too big to fail” as it is simply too risky for vulnerable people with learning disabilities

6. The recent experiences of failing services demands greater local accountability from service providers in the future

b) Understanding the needs of young people

1. Work closely with NHS England and Oxfordshire Clinical Commissioning Group to identify what is happening to young people and where they are so that no young person goes out of county without close monitoring and regular follow up

2. Ensure that Southern Health has a transition policy in place as a matter of urgency

3. Use health checks at 14 as a minimum to aid earlier identification of young people with mental health needs and behaviours that challenge

4. Develop a menu of local provision that is suitable for these young people, including respite care and residential treatment facilities. This requires highly skilled staff that can use a range of interventions, including Positive Behavioural Support and also community-based facilities that enable young people to develop skills, meaningful activities and that support families effectively

c) Using the SEND Reforms to drive change

1. Improve the Local Offer under the Special Educational Needs and Disability (SEND) Reforms so that young people with learning disabilities and autism and their families are supported well through transition to adult services when they have mental health needs and challenging behaviours

2. Use the Single Assessment Education Health and Care plans to capture the needs of vulnerable young people with particularly complex needs and put action plans in place to support them at the earliest possible stage

3. Ensure that the Local Offer of information gives clear information about the appropriate use of the Mental Capacity Act and Best Interests meeting and that families are informed about the planned reforms to Deprivation of Liberty Safeguarding

Recommendations for Oxfordshire Clinical Commissioning Group (OCCG)

1. OCCG explores with partners the need for an in-patient facility for under 25s and works with families and people with learning disabilities to commission innovative support

2. Works with experts by experience to improve training in the awareness of the needs of people with learning disabilities, challenging behaviours and mental health needs

3. OCCG ensures better training in learning disability and mental health for GPs and in the Mental Capacity Act

4. To similarly provide better training in the appropriate use of the Mental Capacity Act for nurses and other clinical staff

5. Ensure that there is a clear understanding of person-centred approaches and that these are embedded in clinical practice across Oxfordshire

6. Commission for person-centred, quality support that leads to better outcomes including development of a specialist transition nurse role

7. Development of enhanced models of crisis care support

Recommendations for NHS England

1. Ensure the commissioning of high quality services that are designed and commissioned with the involvement of people with learning disabilities and their families using the global contracting principles referred to in the full recommendations

2. NHS England to work with Local Authorities and local Clinical Commissioning Groups to ensure that the local community know who are supported in secure units, where they are and their ages. We want to see unstinting efforts made to provide effective treatment and support that is subject to close local scrutiny by Healthwatch, CQC and local safeguarding services. We recommend that person-centred services are developed in local communities using highly skilled staff as part of the menu of support

3. Ensure better information transfer between in-patient and community-based health and social care services including integrated IT systems. A particular weakness was identified when information needs to be transferred between private hospitals and NHS facilities.

Appendix 2 – Executive Summary and Recommendations Arising from Report Compiled by Oxford Mental Health Forum

Executive summary

An extensive online survey was carried out to find out more about the information and support available on mental health for young people in Oxfordshire. The survey collected responses from schools, young people (aged 16-25), professionals, and parents/carers. There were 406 responses to the survey in total, which included feedback from 15 schools, over 300 young people, 44 professionals and 21 parents/carers. The following commentary provides the findings from the research, along with key recommendations for each group.

Overall core recommendations:

For secondary school head teachers and mental health providers:

▫ Provide a greater focus on early intervention and increased mental health awareness and understanding.

In particular:

- Introduce regular talks on mental health in schools;

- Increase the training and resources to better equip and support staff in schools.

Actions: Oxford Mental Health Forum and Healthwatch Oxfordshire to contact head teachers and local mental health providers to work collaboratively to roll-out mental health talks from local mental health support groups/providers (such as the Samaritans, Oxfordshire Mind, Oxford Health NHS FT) in all secondary schools in Oxfordshire and help to identify and address training and resource gaps to better equip and support staff in schools.

For local commissioners and service providers:

▫ Reduce waiting times and improve access to mental health services.

Actions: Healthwatch Oxfordshire to work with the Oxfordshire Clinical Commissioning group, CAMHS (Oxford Health NHS FT), TalkingSpace (Oxfordshire Mind and Oxford Health NHS FT), and GPs to tackle the long waiting times for accessing mental health services, including establishing ways of increasing efficiency of referral processes/systems.

For secondary schools, commissioners, and service providers:

▫ Provide more practical help and support for young people suffering from mental health problems/difficulties.

Actions: Schools and local mental health providers to ensure young people are provided with both spoken and printed material containing practical guidance on looking after mental wellbeing and information on how to go about gaining help when suffering a mental health problem. In addition, local commissioners to focus on providing more practical-based therapy options including CBT and Mindfulness, and to ensure that sufficient support is available to meet demand.

For mental health providers:

▫ Improve/consolidate the resources available for professionals for increased accessibility.

Actions: Increase awareness and accessibility of Oxfordshire Mind's: The Mind Guide to mental health services in Oxfordshire: a comprehensive guide to mental health services in the county. Oxford Mental Health Forum and Healthwatch to help promote the guide and work with increasing signposting of other resources aimed at professionals, including the newly launched MindEd e-learning portal supported by the Department of Health, via local providers including Oxford Health NHS FT and Oxfordshire County Council.

For secondary schools, GP services, and mental health providers:

▫ Ensure that there is sufficient support available for parents/carers.

Actions: Stakeholders and providers to help promote parent/carer groups such as the Oxfordshire Rethink Carers service, Oxford Health CAMHS parent group, and parent/carer support groups in schools, along with resources such as printed materials aimed at providing help and support to parents/carers. GPs to try and help identify if parents/carers need support themselves when seeking help for their child for mental health related problems.

Secondary schools

Key findings:

▫ Overall, schools feel that they do not have enough resources to be able to provide appropriate information and support to young people on mental health;

▫ The main barriers/difficulties identified were: not having enough resources to be able to provide the help and support needed; and a lack of training.

Recommendations:

▫ Organise more talks for students in schools from mental health providers, such as Oxford Health NHS FT, Oxfordshire Mind, or the Samaritans.

This was identified as a popular form of information and support that young people said they would have found helpful looking back to their first years at school. It was also identified as the top form of support that parents/carers felt their child would have benefitted from. Only three of the fifteen schools who took part in the survey said they provided this form of support.

▫ Provide more training on mental health to equip and support staff in schools: Identify training and resource gaps in schools and develop a programme of training to be delivered to address the gaps identified.

There have been recent reports in the national media calling for mental health to be included on the timetable in schools1. One of the key findings identified from this survey is the lack of resources and training available, which is fundamental in being able to facilitate improved integration of mental health information and support in schools.

▫ All schools should have counselling available.

Given the increasing levels of mental health issues reported, the increase in resources needed for schools, and that one-to-one support is the most popular form of support identified by young people as the type of support they would find most helpful; it is vital that all schools have access to counselling services available.

Young people

Key findings:

▫ 16% of the 324 young people who took part in the survey had not previously received or been given any information on mental health, or were unsure whether they had.

▫ Approximately half of those surveyed who had previously received information on mental health, found the information they received helpful (53%). The top sources were: online, school, mental health specialist, GPs. A greater percentage of males gained information online; a greater percentage of females than males gained information from their GP.

▫ 60% received all of the information that they needed (a slightly greater percentage of females than males).

▫ For those who had previously received help and support for a mental health problem, less than half (49%) found the information and support they received entirely helpful. The most common problems reported included the length of time for obtaining the help and support needed, and a lack of practical help and advice.

▫ When asked what forms of information and support young people would have found most helpful looking back to their first years at secondary school: One-to-one support with a professional was the most popular, followed by online material, a school visit from a mental health support group such as Oxfordshire Mind or the Samaritans, and printed material. A large proportion of respondents to this question, nearly half (46%), felt that they would not have found a mobile/tablet app helpful.

Recommendations:

The priorities for addressing young people's needs are:

▫ Reduce waiting times/increase ease of access to mental health services and ensure continuity of care.

▫ Provide more practical advice and support in helping to address mental health related problems.

▫ Focus on early intervention and increased mental health awareness and understanding, including offering wider support aimed at prevention and looking after mental wellbeing.

▫ Ensure sufficient mental health support is available both within and outside of school.

▫ Ensure there is a range of forms of information and support available for young people on mental health to address different needs, in particular, one-to-one support, online material, talks in schools and printed material.

Professionals

Key findings:

▫ The most common mental health problems/concerns encountered by professionals were young people who were feeling unhappy/depressed, worried/anxious, and problems related to self-harm or thoughts of self-harm (95% of professionals had encountered these problems). Young people who had been affected by bullying, feeling very stressed, feeling very angry, and relationship difficulties also ranked very highly.

▫ Over 75% of professionals who took part in the survey had encountered some form of difficulties or barriers in being able to provide mental health information or guidance and support needed to young people.

Recommendations:

▫ Reduce waiting times for referral for accessing mental health services, along with increasing ease of access.

The most common difficulties/barrier encountered by professionals was the difficulty in accessing other services if a referral was needed and a delay in being able to provide a referral if a referral to another service was needed (70% of respondents highlighted these two issues as the main difficulties/barriers).

▫ Improve the resources available, including increasing accessibility and availability.

Only 25% of the professionals surveyed felt that overall they had enough resources available to be able to provide appropriate information and support on mental health to young people. Several professionals suggested there should be more or improved material available on local services, mental health conditions, and information on medications.

Parents/carers

Key findings:

▫ 70% of parents/carers that took part in the survey specified that they currently had worries or concerns about their child's mental health. Only 33% felt able to give their child advice and support themselves, without additional help and support.

▫ From those who had been able to seek help, less than half found the information or guidance and support obtained helpful (40%). Over 90% had experienced difficulties in gaining access to the information or guidance and support needed.

Recommendations:

▫ Improve waiting times/ease of access to services.

The most common difficulty experienced by parents/carers in obtaining help and support for their child was the time it took to be able to gain access to the help and support.

▫ Ensure support is available to parents/carers themselves.

Several responses from parents/carers highlighted the wider impact mental health problems can cause, not least for the young sufferer, but the family as a whole, and the frustrations and difficulties parents/carers can experience when trying to obtain help and support.

Appendix 3 – recommendations arising from report compiled by My Life My Choice

With just over half those questioned being satisfied with the service provided by their GP's, there is room for improvement. User-led training in working with PWLD would be one way to ameliorate this situation.

▫ 68% of those questioned said that they have received an annual health check. This is a far higher figure than NHS statistics for 2012/13 (see page 36) and should be treated with caution. It is not known when respondents had their last health checks and many respondents have difficulty in differentiating between a health check & a regular GP visit.

Further and continuing MLMC involvement in partnerships with Health Care professionals, and much greater priority given to health checks by Health Care professionals would be highly desirable (see message from Health Champion page 36).

▫ The appointments system is fraught with difficulty. User-led training for administrative staff could help them improve on this & would potentially encourage PWLD to book appointments on their own behalf.

▫ Much work has taken place with regards to 'reasonable adjustments' and the Report found favourably in this respect. However, more could be done in respect of developing accessible (Easy Read) printed information and instructions for medication.

▫ On the whole there is some very good practice around PWLD feeling 'heard' by their GP's and the family carer/support worker being involved in the process. There is still some room for improvement around communication and inclusion of the person with the LD in these discussions. This, coupled with the fact that around half of our Group Members feeling that their GP's could know more about Learning Disabilities would also indicate that user-led training would be highly desirable.

OXFORDSHIRE HEALTH & WELLBEING BOARD
17 JULY 2014

Proposal to dissolve the Adult Health and Social Care Board

1. Key functions of the Health and Wellbeing Board include promoting local accountability and democratic legitimacy, encouraging the integration of services and ensuring the effective use of resources through partnership working. This includes overseeing the joint commissioning arrangements for health and social care services.

2. The Oxfordshire Adult Health and Social Care Board exists to support the Oxfordshire Health and Wellbeing Board in this purpose. In particular it reports on the delivery of agreed performance targets for NHS and social care services in Oxfordshire and is responsible for holding the Joint Management Groups to account for the delivery of joint commissioning strategies and pooled budgets.

3. However, it has become apparent that the Adult Health and Social Care Board is not adding any value in helping the Health and Wellbeing Board fulfil these functions. This is why two out of the last four meetings have been cancelled, as there was insufficient business that the Adult Health and Social Care Board needed to discuss. In addition, the items discussed at the other two meetings were repeats of discussions that had already taken place in other meetings, most notably the Older People Joint Management Group.

4. It is proposed that the Adult Health and Social Care Board ceases to exist and its responsibilities are passed to the Joint Management Groups that are responsible for overseeing the joint commissioning arrangements and pooled budgets between the NHS and Social Care. There are Joint Management Groups for all four recognised client groups (older people, learning disability, physical disability and mental health), and membership includes representatives from Oxfordshire County Council, Oxfordshire Clinical Commissioning Group, service users and carers. All members of the Adult Health and Social Care Board are already represented on the Older People Joint Management Group and District Council representation will be welcomed and actively sought on all Joint Management Groups.

5. Significant changes were made to the Older People Joint Management Group last year, including meeting in public to increase accountability. The Older People Joint Management Group already has a cross-cutting responsibility for areas such as equipment and carers, and will be responsible for overseeing implementation of the Better Care Fund from April 2015 that will have benefits across all client groups. It is therefore duplication to have another board for this purpose, particularly as the Joint Management Groups have decision-making authority that the Adult Health and Social Care Board does not.

6. It is proposed that the Joint Management Groups should be directly accountable to the Health and Wellbeing Board, and continue to be responsible for the delivery of performance targets for NHS and social care services as they are now. Indeed, they have taken the lead for setting the proposed adult health and social care indicators and targets for 2014/15 that have been proposed to this meeting of the Health and Wellbeing Board.

7. Cllr Judith Heathcoat, the Cabinet Member for Adult Social Care, is the Chairman of the Adult Health and Social Care Board and the Older People Joint Management Group. Dr Joe McManners, Clinical Chair of the Clinical Commissioning Group, is currently the Vice Chairman of both. The proposed dissolution of the Adult Health and Social Care Board would therefore not require any changes to the membership of the Health and Wellbeing Board.

8. The Oxfordshire Joint Health Overview and Scrutiny Committee (OHOSC) is the joint committee responsible for scrutinising health services and the Health and Wellbeing Board, and the County Council's Performance Scrutiny Committee is responsible for overseeing adult social care services. OHOSC already has the power to hold the Joint Management Groups to account for the delivery of joint commissioning strategies and pooled budgets, and this will continue to be used as appropriate.

9. As a result of the Care Act, safeguarding adults is the responsibility in law of the Adult Safeguarding Board. A protocol between the Health and Wellbeing Board and the Adults and Children's Safeguarding Boards to formalise and strengthen the relationships between them is considered elsewhere on this agenda. The dissolution of the Adult Health and Social Care Board is likely to facilitate a stronger link directly to the Joint Management Groups that are directly responsible for commissioning services.

RECOMMENDATIONS

The Health and Wellbeing Board is RECOMMENDED to agree:

(a) to dissolve the Adult Health and Social Care Board;

(b) that the Joint Management Groups will report directly to the Health and Wellbeing Board in future, including responsibility for the appropriate measures for adults in the Joint Health and Wellbeing Strategy; and

(c) that the Oxfordshire Joint Health Overview and Scrutiny Committee should continue to hold the Joint Management Groups to account for the delivery of joint commissioning strategies and pooled budgets.

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Director for Social & Community Services

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July 2014

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PROTOCOL IN SUPPORT OF THE RELATIONSHIP BETWEEN THE OXFORDSHIRE HEALTH AND WELLBEING BOARD, THE OXFORDSHIRE SAFEGUARDING CHILDREN BOARD (OSCB) ANDTHE OXFORDSHIRE SAFEGUARDING ADULTS BOARD (OSAB)

Background

1. This paper sets out a proposed framework and protocol within which to secure effective joint-working between the Health and Wellbeing Board, Oxfordshire Safeguarding Children Board and Oxfordshire Safeguarding Adults Board. It also refers to the relationship between the safeguarding boards and other partnership forums in Oxfordshire.

2. This protocol sets out the distinct roles and responsibilities of the Boards, the inter-relationships between them in terms of safeguarding and well-being and the means by which we will secure effective co-ordination and coherence between the Boards.

3. Whilst currently there is no statutory requirement to secure a formal relationship between the Health and Wellbeing Board and the safeguarding boards there are clear benefits to doing so and there is guidance steering in this direction that may become a requirement. The annual reports of both safeguarding Boards are already reported to the Health and Wellbeing Board.

Oxfordshire Health and Well-Being Board

4. The Oxfordshire Health and Wellbeing Board is the principal structure in Oxfordshire with responsibility for promoting the health and wellbeing of the people of the county. It is a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities.

5. Board members are expected to collaborate to understand their local community's needs, agree priorities and encourage commissioners to work in a more joined up way. As a result, patients and the public should experience more joined-up services from the NHS and local councils in the future.

6. The Health and Wellbeing Board has strategic influence over commissioning decisions across health, public health and social care through the development of the Joint Health and Wellbeing Strategy. This is based on a shared understanding of the health and wellbeing needs of the community through the Joint Strategic Needs Assessment (JSNA), developed by involving all key stakeholders. This will include recommendations for joint commissioning and integrating services across health and care.

7. The Health and Wellbeing Board strengthens democratic legitimacy by involving democratically elected representatives and patient representatives in commissioning decisions alongside commissioners across health and social

care. The Board also provides a forum for challenge, discussion, and the involvement of local people.

8. Through undertaking the JSNA and agreeing strategic priorities, the Board will drive local commissioning of health care, social care and public health and create a more effective and responsive local health and care system. Other services that impact on health and wellbeing such as housing and education provision will also be addressed.

Oxfordshire Safeguarding Children Board (OSCB)

9. The key objectives of the OSCB as set out in 'Working Together to Safeguard Children 2013' are:

    - To co-ordinate local work to safeguard and promote the well-being of children;
    - To ensure the effectiveness of that work

10. Safeguarding and promoting the welfare of children is defined as:

    - Protecting children from maltreatment
    - Preventing impairment of children's health or development
    - Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care
    - Taking action to enable all children to have the best outcomes

11. A key objective in undertaking these roles is to enable children to have optimum life chances and enter adulthood successfully.

12. The role of OSCB is to scrutinise and challenge the work of agencies both individually and collectively. The OSCB is not operationally responsible for managers and staff in constituent agencies.

Oxfordshire Safeguarding Adults Boards (OSAB)

13. Safeguarding Adult Boards are now statutory bodies following the implementation of the Care Act 2014. The OSCB is already well established and has operated within the framework promoted by 'No Secrets' which was published by the Department for Health and the Home Office in March 2000 and by 'Safeguarding Adults' which was published by the then Association of Directors of Social Services in October 2005.

14. The focus of the work of Safeguarding Adults Boards is 'vulnerable' adults. The forms of abuse which the Board aims to prevent and address are: physical abuse, sexual abuse, psychological abuse, financial or material abuse, neglect or acts of omission, discriminatory abuse.

15. The role of the OSAB is to ensure effective safeguarding arrangements are in place in both the commissioning and provision of services to vulnerable adults

by individual agencies and to ensure the effective interagency working in this respect.

16. The OSAB has identified agreed objectives and priorities for its work which include clear policy, procedural and practice arrangements, mechanisms to secure coordination of activities between agencies, the provision of training and workforce development in support of safeguarding and quality assurance and performance management arrangements to test the effectiveness of safeguarding and the impact of the Board.

The need for effective communication and engagement between the Boards

17. Safeguarding is everyone's business. As such, all key strategic plans whether they be formulated by individual agencies or by partnership forums should include safeguarding as a cross-cutting theme to ensure that existing strategies and service delivery as well as emerging plans for change and improvement include effective safeguarding arrangements that ensure that all people of Leicestershire are safe and their well-being is protected. The two safeguarding boards have a responsibility to scrutinise and challenge these arrangements.

18. The Health and Wellbeing Strategy is a key commissioning strategy for the delivery of services to children and adults across Oxfordshire and so it is important that in drawing up, delivering and evaluating the strategy there is effective interchange between the Oxfordshire Health and Wellbeing Board and the two safeguarding boards.

19. Specifically there need to be formal interfaces between the Health and Wellbeing Board and the safeguarding board at key points including:

    - The needs analyses that drive the formulation of the annual Health and Wellbeing Strategy and the Safeguarding Boards' Business Plans. This needs to be reciprocal in nature ensuring both that safeguarding boards' needs analyses are fed into the JSNA and that the outcomes of the JSNA are fed back into safeguarding boards' planning;
    - Ensuring each Board is regularly updated on progress made in the implementation of the Health and Well Being Strategy and the individual Board Business Plans, and raising significant emerging issues, in a context of mutual scrutiny and challenge;
    - Annually reporting evaluations of performance on Plans to provide the opportunity for reciprocal scrutiny and challenge and to enable Boards to feed any improvement and development needs into the planning process for future years' strategies and plans.

20. The opportunities presented by a formal working relationship between the Boards can therefore be summarised as follows:

    - Securing an integrated approach to the JSNA, ensuring comprehensive safeguarding data analysis in the JSNA, in line with Working Together guidance

- Aligning the work of the OSCB business plan and OSAB Strategic Plan with the Health and Wellbeing Strategy and related priority setting.
- Ensuring safeguarding is ‘’everyone’s business’’, reflected in the public health agenda and related determinant of health policies and strategies.
- Evaluating the impact of the Health and Wellbeing Strategy on safeguarding outcomes, and of safeguarding on wider determinants of health outcomes
- Identifying a coordinated approach to performance management, transformational change and commissioning
- Cross-board scrutiny and challenge and ‘’holding to account’’: the Wellbeing Board for embedding safeguarding, and the Safeguarding Boards for overall performance and contribution to the Health and Wellbeing Strategy.

Arrangements to secure coordination between the Boards.

21. In order to secure the opportunities identified above it is proposed that the following arrangements would be put in place to ensure effective co-ordination and coherence in the work of the three Boards. The role of the OSCB and OSAB in relation to the Health and Wellbeing Board would be one of equal partners underpinned by this protocol.

    - Between September and November each year the Independent Chairs of the two Safeguarding Boards to present to the Oxfordshire Health and Well-Being Board their Annual Reports outlining performance against Business Plan objectives in the previous financial year. This to be supplemented by a position statement on the Boards’ performance in the current financial year. This would provide the opportunity for the Health and Well-Being Board to scrutinise and challenge the performance of the Boards, to draw across data to be included in the JSNA and to reflect on key issues that may need to be incorporated in the refresh of the Oxfordshire Health and Well-Being Strategy.

    - By March, the Oxfordshire Health and Well-Being Board to present to the safeguarding boards the refreshed JSNA that will form the basis of updated priorities and plans.

    - By June, the Health and Wellbeing Board to present the proposed priorities and objectives for the refreshed Health and Wellbeing Strategy to enable the safeguarding boards to scrutinise and challenge performance of the Health and Wellbeing Board and to ensure that their refreshed Business Plans appropriately reflect relevant priorities set in the refreshed Health and Wellbeing Strategy.

    - In July the Boards will share their refreshed Plans for the financial year to ensure co-ordination and coherence.

Relationships between the Safeguarding Boards and other partnership forums

22. In the context of our aim to ensure that 'Safeguarding is Everyone's Business' it is intended that there should be effective co-ordination and coherence in relation to safeguarding and well-being between the two safeguarding boards and the key strategic partnership forums in the county, including the Oxfordshire Safer Communities Partnership and those reporting to the Health and Wellbeing Board. This could be achieved in two ways:

    - Formally sharing annual plans during the formulation stages to enable co-ordination and coherence where there are business overlaps – for example domestic violence features as a priority for both safeguarding boards, the Health and Wellbeing Board and the Safer Communities Partnership. The purpose of this sharing will be to secure clarity of roles, responsibilities and purpose, to avoid duplication and to prevent gaps.

    - Where appropriate, to ensure that there is cross-Board representation to secure on-going communication. This already exists for some groups (for example, there are members of the Oxfordshire Children and Young People's Partnership Board on both safeguarding boards) but this needs to be formalised across all relevant groups.

23. At present there is a formal protocol between the OSCB and the Children and Young People Partnership Board (CYPPB). However, the relationship between the two Boards could be further strengthened and was identified as an area of possible improvement in the recent Ofsted inspection of services for children in need of help and protection, children looked after, care leavers and the Review of the effectiveness of the local safeguarding children board.

24. There is work underway to review and improve the Children's Trust (CYPPB), including the relationship with the OSCB. As part of this, the existing protocol will also be reviewed and updated as appropriate.

25. More formal protocols between OSAB and the Adult Health and Social Care Board, and Joint Management Groups overseeing the delivery of commissioning strategies and pooled budgets will also be proposed and developed as appropriate.

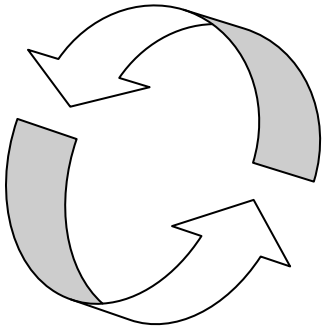
26. Similarly the relationship between the Oxfordshire Safer Communities Partnership, Health and Wellbeing Board and the two safeguarding boards will be reviewed and formal protocols developed as appropriate.

27. The role of Oxfordshire County Council Scrutiny Committees in scrutinising the performance of safeguarding boards and being consulted on policy changes and related service design and commissioning intentions will remain unchanged.

28. The diagram below summarises the relationships set out in this protocol.

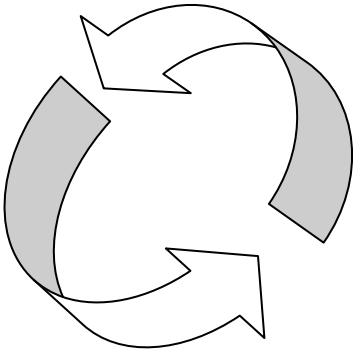
OXFORDSHIRE HEALTH AND WELLBEING BOARD

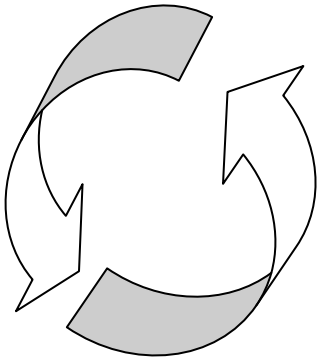
Strategic vision, direction, objectives and outcome setting and oversight.



OXFORDSHIRE CHILDREN AND YOUNG PEOPLE PARTNERSHIP BOARD, SAFER COMMUNITIES PARTNERSHIP BOARD AND OTHER PARTNERSHIP FORUMS

Delivery of strategic objectives, localised monitoring of outcomes.





RECOMMENDATION

29. **The Health and Wellbeing Board is recommended to agree the principles and further work required as set out in this paper to formalise and improve the relationships between the Health and Wellbeing Board and two safeguarding Boards, and to delegate responsibility to the Director for Children's Services and the Director for Social and Community Services to work with the respective Chairs of the Safeguarding Boards to take this forward.**

Oxfordshire Health and Wellbeing Board, 17 July 2014

Pharmaceutical Needs Assessment – a report on progress

Introduction

1. As reported in March 2014 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 1 April 2015.

2. A steering group has been established to oversee this work, comprising partner organisations of the Health and Wellbeing Board along with representatives of the Local Pharmaceutical Committee and Local Medical Committee. A management group led by Public Health is making sure all operational details are on track.

3. A procurement exercise was carried out through open tender. A contractor (Primary Care Commissioning) has been appointed jointly with Buckinghamshire County Council. The contractor will undertake the work to produce needs assessments for each county. The joint contract is more cost effective for both counties than working separately.

4. The work includes the following elements

    - A community pharmacy questionnaire (using a national template)
    - Data analysis to identify population need for pharmacy services.
    - Production of a draft PNA document for consultation
    - A wide ranging public consultation with key local stakeholders for a minimum of 60 days
    - Collation of the consultation responses into a report
    - Production of a final PNA report.
    - Recommendations for how the PNA will be maintained and updated in the future
    - A map of premises at which pharmaceutical services are provided in the county, as well as further maps covering current commissioned services in pharmacies, access and relevant demography
    - A template for supplementary statements after publication

5. The work is on track and regular management meetings are taking place.

6. Work is currently underway to analyse local data and consult the public on the use of existing pharmacies. This will result in a draft Pharmaceutical Needs Assessment by September. It is a statutory requirement that this draft is subject to public consultation for at least 60 days. All partners will be consulted, along with a range of other stakeholders.

7. This statutory consultation period is scheduled for October – December 2014 and the draft document has to be approved by the Board before consultation. As the Health and Wellbeing Board will not meet again until November, it is suggested that authority could be delegated to the Director of Public Health, following consultation with the Chairman and Vice - Chairman of this Board, to approve the draft document so that it could be released for consultation. Delaying the consultation until after the November Board meeting will leave too little time to carry out the consultation before the report is due in March 2015.

RECOMMENDATION

8. **The Health and Wellbeing Board is RECOMMENDED to note progress with this work and to delegate the authority to approve the draft PNA document for consultation to the Director of Public Health, following consultation with the Chairman and Vice - Chairman of this Board.**

Dr Jonathan McWilliam
Director of Public Health

Background papers: None

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

July 2014

Communications received by the Chairman February - June 2014
Report to the Health and Wellbeing Board, July 2014

The Chairman of Health and Wellbeing Board receives correspondence from a range of partners and stakeholders. The Board agreed a process by which this correspondence can be directed to the most appropriate individual, organisation or group for action. The table below summarises activity from February to June 2014.

Date received	Communication topic	Action taken
26.2.14	What are you doing to prevent another Winterbourne View?	Reply sent outlining the lead role of the Council in implementing the actions outlined in the Winterborne View Concordat and Action Plan.
3.3.14	Letter from the Dementia Action Alliance about the Carers' Call to Action	Letter forwarded to the lead officer in Social and Community Services for action. Dementia is recognised within the Joint HWB Strategy and Better Care Fund plans, and there is extensive work on carer support.
12.3.14	Invitation to attend the Local Dental Committee meeting to give information about H&WB	Jackie Wilderspin attended the meeting and gave a presentation on the work of the H&WB
24.3.14	Information on application for merging 2 GP practices	No response necessary
25.3.14	Information about the Halve It campaign - the benefits of early diagnosis of HIV	A response was sent from Public Health inviting future contact on this topic.
26.3.14	Proposals for how to share information about the Oxford University Hospitals Annual Quality Account.	An outline paper was presented at the Health Overview and Scrutiny Committee as this fitted with the timescales of the OUHT
15.4.14	National Audit Office invitation to participate in a value for money study for Parliament about national progress with health and wellbeing boards' planning for the Better Care Fund	A response was sent from Adult Health and Social Care Directorate.
16.4.14	Treatment for fibroids at the Oxford University Hospitals Trust	A full response was sent from the Clinical Commissioning Group and the response from the Chairman acknowledged this.
27.4.14	Environmental issues and the impact on health related to transport issues	The issue was noted and a response sent.
7.5.14	Health and Wellbeing for Young People – a lesson plan and outline of service available from the correspondent	The email was acknowledged and passed to relevant officers.

13.5.14	Taking action on lethal discrimination – premature mortality rates for people with mental health issues (6 emails received)	The emails were all responded to with an outline of the current work of the H&WB relevant to this issue.
9.6.14	Southern Gas Network Help to Heat Scheme - information on help for vulnerable people at risk of fuel poverty.	The letter was acknowledged and information passed to relevant officers in the Affordable Warmth Network for action.
11.6.14	Letter from Andrew Smith MP on proposed staff changes at the CCG	A response was sent and the Chairman of the Health Overview and Scrutiny Committee was notified.
17.6.14	Spread the Word on Breast Cancer Campaign	Public Health were notified of the campaign and have highlighted the messages as appropriate.

Any questions on this report can be directed to jackie.wilderspin@oxfordshire.gov.uk