Notice of Meeting Public Document Pack

Oxfordshire Joint Health Overview & Scrutiny Committee

Thursday, 1 May 2014 at 10.00 am
County Hall

Membership

Chairman - Councillor Lawrie Stratford
Deputy Chairman - District Councillor Alison Thomson

Councillors:	Kevin Bulmer	Mark Lygo	Alison Rooke
	Pete Handley	Laura Price	Les Sibley
District Councillors:	Martin Barrett	Susanna Pressel	
	Christopher Hood	Rose Stratford	
Co-optees:	Moira Logie	Dr Keith Ruddle	Mrs A. Wilkinson

Notes: ***Date of next meeting:*** *3 July 2014*

What does this Committee review or scrutinise?

- Any matter relating to the planning, provision and operation of health services in the area of its local authorities.
- Health issues, systems or economics, not just services provided, commissioned or managed by the NHS.

How can I have my say?

We welcome the views of the community on any issues in relation to the responsibilities of this Committee. Members of the public may ask to speak on any item on the agenda or may suggest matters which they would like the Committee to look at. **Requests to speak must be submitted to the Committee Officer below no later than 9 am on the working day before the date of the meeting.**

For more information about this Committee please contact:

Chairman	-	Councillor Lawrie Stratford E.Mail: lawrie.stratford@oxfordshire.gov.uk
Policy & Performance Manager	-	*Ben Threadgold Tel: (01865) 328219* *ben.threadgold@oxfordshire.gov.uk*
Committee Officer	-	*Julie Dean Tel: (01865) 815322* *julie.dean@oxfordshire.gov.uk*

Peter G. Clark.

Peter G. Clark
County Solicitor

April 2014

About the Oxfordshire Joint Health Overview & Scrutiny Committee

The Joint Committee is made up of 15 members. Twelve of them are Councillors, seven from Oxfordshire County Council, and one from each of the District Councils – Cherwell, West Oxfordshire, Oxford City, Vale of White Horse, and South Oxfordshire. Three people can be co-opted to the Joint Committee to bring a community perspective. It is administered by the County Council. Unlike other local authority Scrutiny Committees, the work of the Health Scrutiny Committee involves looking 'outwards' and across agencies. Its focus is on health, and while its main interest is likely to be the NHS, it may also look at services provided by local councils which have an impact on health.

About Health Scrutiny

Health Scrutiny is about:

- Providing a challenge to the NHS and other organisations that provide health care
- Examining how well the NHS and other relevant organisations are performing
- Influencing the Cabinet on decisions that affect local people
- Representing the community in NHS decision making, including responding to formal consultations on NHS service changes
- Helping the NHS to develop arrangements for providing health care in Oxfordshire
- Promoting joined up working across organisations
- Looking at the bigger picture of health care, including the promotion of good health
- Ensuring that health care is provided to those who need it the most

Health Scrutiny is NOT about:

- Making day to day service decisions
- Investigating individual complaints.

What does this Committee do?

The Committee meets up to 4 times a year or more. It develops a work programme, which lists the issues it plans to investigate. These investigations can include whole committee investigations undertaken during the meeting, or reviews by a panel of members doing research and talking to lots of people outside of the meeting. Once an investigation is completed the Committee provides its advice to the relevant part of the Oxfordshire (or wider) NHS system and/or to the Cabinet, the full Councils or scrutiny committees of the relevant local authorities. Meetings are open to the public and all reports are available to the public unless exempt or confidential, when the items would be considered in closed session.

If you have any special requirements (such as a large print version of these papers or special access facilities) please contact the officer named on the front page, giving as much notice as possible before the meeting

A hearing loop is available at County Hall.

AGENDA

1. Apologies for Absence and Temporary Appointments

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

3. Minutes

To approve the minutes of the meeting held on 27 February 2014 (**JHO3**) and to receive information arising from them.

4. Speaking to or Petitioning the Committee

5. Oxfordshire Healthwatch

10:15

Larry Sanders, Chairman of Healthwatch and David Roulston, Interim Chief Executive, will attend to present an update on their current work (**JHO5**).

6. Priorities for next Director of Public Health Annual Report

10:35

The Director of Public Health, Dr Jonathan McWilliam, will give an oral report on the priorities for his next Public Health Annual Report.

7. Oxfordshire Health & Wellbeing Strategy 2014 - 2015 (JHWBS)

11:00

The Director of Public Health , Dr Jonathan McWilliam, will present a report **(JHO7)** updating the Committee on the process for refreshing the Oxfordshire Health & Wellbeing Strategy. The report also sets out the proposed newly updated indicators and measures to be included in the revised draft Strategy which is due to be submitted to the Health & Wellbeing Board on 17 July 2014 for approval.

The Committee is RECOMMENDED to:

(a) ***consider and comment on the process which has been put in place to refresh the priorities in the JHWBS; and to note that a report will be submitted to the 3 July 2014 meeting which will include the draft JHWBS to be presented to the Health and Wellbeing Board on 17 July 2014; and***

(b) ***comment on the current priorities as set out in Appendix 2 of the report together with the indicators currently used to measure progress / demonstrate improvement: and to note that any suggestions and comments for changing and developing the current list of priorities and indicators will be noted as part of the revision process.***

8. Oxfordshire Clinical Commissioning Group (OCCG) Strategy 2014-19 and Implementation Plan for 2014/15 - 2015-16

11:25

Ian Wilson, Interim Chief Executive, Oxfordshire Clinical Commissioning Group (OCCG), will give a presentation on Oxfordshire's CCG strategic and operational Plan. A link to the Plan appears below:

http://www.oxfordshireccg.nhs.uk/wp-content/uploads/2014/04/OCCG-5-2014-2019-strategy-and-2014-2016-plan.pdf

For ease of reference, a copy of the 'Plan on a Page' is attached at **JHO8.**

The regular update from the OCCG is also attached at **JHO8**.

9. Better Care Fund

11:50

Ian Wilson, Interim Chief Executive , Oxfordshire Clinical Commissioning Group, and John Jackson, Director for Social & Community Services, Oxfordshire County Council, will present plans for the Better Care Fund (**JHO9**).

10. Oxford University Hospitals NHS Trust (OUH) Draft Quality Account 2013/14

12:15

Dr Ian Reckless, Assistant Medical Director of OUH will present the Trust's Quality Account for 2013/14 (**JHO10**).

11. Pre-consultation on proposed changes to Non-Emergency Patient Transport Services

12:35

A representative from the OCCG will present the proposed changes to the eligibility criteria for Patient Transport Services and will outline the approach to consultation and engagement (**JHO11)**. The views of the Committee are requested.

12. Chairman's Report and Forward Plan

12:40

The Chairman will give an oral update on meetings he has attended since the last meeting.

A list of proposed items for the Forward Plan is attached at **JHO12.**

13. Dates of Future Meetings 2014/15

13:00

Please note that the Joint Committee will meet on the following dates during the 2014/15 municipal year:

- 3 July 2014
- 18 September 2014
- 20 November 2014
- 5 February 2015

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.

OXFORDSHIRE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 27 February 2014 commencing at 10.00 am and finishing at 1.00 pm

Present:

Voting Members:	Councillor Lawrie Stratford – in the Chair
	District Councillor Alison Thomson (Deputy Chairman) Councillor Kevin Bulmer Councillor Mark Lygo Councillor Laura Price Councillor Alison Rooke Councillor Les Sibley District Councillor Martin Barrett District Councillor Dr Christopher Hood Councillor Susanna Pressel District Councillor Rose Stratford Councillor Neil Owen (In place of Councillor Pete Handley)
Co-opted Members:	Dr Harry Dickinson, Dr Keith Ruddle and Mrs Anne Wilkinson
Officers:	
Whole of meeting	Claire Phillips (Chief Executive's Office); Director of Public Health
Part of meeting	J. Dean and S. Whitehead (Chief Executive's Office)

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

1/14 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 1)

Councillor Neil Owen substituted for Councillor Pete Handley.

2/14 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 2)

There were no declarations of interest submitted.

3/14 MINUTES
(Agenda No. 3)

The Minutes of the meeting held on 5 December 2013 were approved and signed as a correct record subject to the references to 'Mr Stephens' in Minute 130/13 being corrected to 'Mr Stevens'.

4/14 SPEAKING TO OR PETITIONING THE COMMITTEE
(Agenda No. 4)

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

- Keith Strangwood, Chair, Keep the Horton General Group (Agenda Item 5)
- Jenny Jones, a member of the public (Agenda Item 5)
- Patricia Astle, a member of the public (Agenda Item 6)

Patricia Astle urged the Committee to scrutinise the OCCG plans to progress a new form of contracting termed Outcomes Based Commissioning as set out at Agenda Item 6. She believed the plans to be untried and untested leaving successful delivery in doubt.

Mr Strangwood asked the following questions of Andrew Stevens as a source of clarification in relation to Minute 130/13 of the last meeting:

- Did an independent review of the Emergency General Surgery (EGS) service take place by the Royal College of Surgeons?
- Did a series of workshops take place during the second half of 2013 and why were the public not aware of it?
- Why had a full consultation on the proposals not been carried out in a similar vein to that which took place in 2006 following the proposal to alter the maternity and paediatrics services at the Horton Hospital? He added that it was only during this consultation that all aspects, facts and consequences of the proposed service removal became clear. A Banbury public meeting to take place 12 months after the EGS service had been removed was promised at the last meeting of this Committee.

Mr Strangwood added that despite promises made at the last meeting from Dr Stephen Richards, a full year's data had not been made available at this meeting for consideration, nor had 2 public meetings taken place. In his view, the public meeting, which was held at a country golf club during adverse weather conditions, was not adequate for its purpose and therefore did not constitute a full consultation. He urged the Committee to obtain an assurance from the Oxfordshire Clinical Commissioning Group (OCCG) that a full consultation would take place and if this was not given, to carry out a referral to the Secretary of State for Health on the grounds that consultation was inadequate.

Jenny Jones urged the Committee to request that a full consultation be carried out in order that all issues could be highlighted. It was her view that the service was not equitable across the county giving the example that Henley–on–Thames was situated

less than 11 miles from the Royal Berkshire Hospital and that the OCCG had stated that 50% of the SE Locality Group referred their patients to this hospital. She also pointed out that her own village, Claydon, was situated at the most northern point of the county which was less than 20 miles from Warwick Hospital. In light of this, she added her personal discomfort about the service offered by the South Central Ambulance Service.

5/14 STRATEGY FOR SERVICES AT THE HORTON HOSPITAL, BANBURY INCLUDING EMERGENCY ABDOMINAL SURGERY
(Agenda No. 5)

At its last meeting, the Committee had responded to a number of concerns voiced by the Keep the Horton General Group regarding their perceived lack of adequate consultation on changes which had been made to the emergency abdominal surgery service at the Horton Hospital, Banbury. This had been temporarily suspended in 2013 for clinical reasons that the Oxford University Hospitals NHS Trust (OUHT) had been unable to foresee (Minute 130/13).

The Committee had before them two reports from the OCCG and the OUHT (JHO5) on the public meeting held in February to discuss their plans and strategy for services for local people served by the Horton Hospital.

Members were asked to consider if the Trust Board's rationale for its suspension of the emergency abdominal surgery was to their satisfaction and if not, whether the consultation was adequate in terms of content or time allowed; or whether the proposals would not be in the interests of the local health service; or, whether the reasons given for the suspension of the service because of an immediate risk to safety or welfare of patients or staff was adequate.

The interim Chief Executive of the OCCG, Ian Wilson, introduced his report explaining that the OCCG had put the same questions as the Committee had to the OUHT about their plans for public consultation, and had been satisfied with the responses given. The OCCG believed that the Horton Hospital had a good future ahead of it for the new provision of other general/specialist services and that the view that services at the Horton were being downgraded was ill-founded. He added that he believed the public meeting was both substantive and exhaustive of the issues brought to it; and could be viewed on the OCCG website. He expressed his satisfaction also that the patient survey of GP practices in the locality and a conversation he had had with the Keep the Horton General Group had taken into account all the salient points. However, he stated that important lessons and examples of good practice needed to be learned by everybody from this, particularly in light of an apparent history of mistrust for the NHS inherent within the local community of Banbury and its environs. He added that the OCCG was of the view that it was good practice to start public engagement early if there were changes that needed to be made. He apologised on behalf of the OCCG for any shortcomings in communication and informed the Committee of the OCCG's intention to draw up mutual plans with all bodies, including the district council, to ensure that there is proper engagement with stakeholders in the north of the County in the future.

Mr Wilson stated that GPs within the locality had taken substantial clinical advice on the situation, and various feedback had concluded that the case for suspension of the service, and its eventual permanent closure was compelling on safety grounds. GPs had then engaged with colleagues to address some modification and extension to services provided by the surgical clinic to enable more minor surgery to take place at the hospital. He added that the survey of patients referred to in pages 4/5 of the report indicated that there was not a strong difference of opinion between those patients in the control group and the group of patients who were transported to the JR Hospital. However, efforts were being made by the OUHT to minimise the number of patients being transported to the John Radcliffe Hospital.

Andrew Stevens reiterated Ian Wilson's point that the Horton Hospital had a very positive and vibrant future with the expansion of the chemotherapy and renal dialysis services, together with future plans. However, it had been necessary for some services to change, such as those for cardiac patients. Mr Stevens added that the Royal College of Surgeons had agreed with the Trust's decision in relation to the suspension of one of the emergency procedures on the grounds that there were no specialist consultants trained in that particular procedure. Moreover, initial work with the GPs had resulted in an inability to identify other options which could be presented to the public.

He accepted that public consultation in the earlier stages of the changes could have been better but that the unavailability of five members of staff on the rota had been unforeseeable. However, the Trust had sought assistance from the Community Partnership Network (CPN) in their networking with the public and had attended meetings with the Keep The Horton General group, together with attendance at a series of other events. Mr Stevens also pointed out that the Trust was committed to continual engagement with the public and had endeavoured to improve its engagement with the public over the last few years and to find acceptable solutions to problems . For example, it had found an innovative solution to the provision of Obstetric services and as a result had been able to keep the service at the Horton Hospital. In addition it had taken feedback from the CPN, GPs and others to improve patient care with regard to Pharmacy services. A specially designed out-patient facility was a project about to be embarked upon and the Trust were looking to expand the number of elective operations listed per annum from 200 to 350.

Sir Jonathan Michael, Chief Executive, Oxford University Hospitals NHS Trust, stated that it was the opinion of the Board that from a quality of patient care perspective, the temporary suspension of the service should be made permanent.

Members of the Committee then commented on the reports and put a series of questions to the Panel. There was a general appreciation for the improvements to be made to services offered at the Horton Hospital and for the apology made by Mr Wilson for the manner in which consultation with the public had been handled. Concern was expressed, for the reasons of transparency, that the public consultation had not begun sooner. Mr Stevens was asked about the time span between the first, second and third surgeon leaving and what actions had been taken to replace them in that time. He responded that they had left their employment during a period of 4 to 6 weeks, adding that the Trust had been able to sustain the service over a short period, but for health reasons, this had proved unsustainable for the remaining

individuals who were working long hours. He added that there were no longer any general surgeons, all were trained in their specialities.

Councillor Thomson made reference to the point made by addressee Jenny Jones regarding the closer geographical situation of out of county hospitals and that the Ambulance Service should not override patient choice. Mr Stevens agreed that administrative boundaries should not get in the way of patient choice.

Mr Wilson was asked if, in his opinion, there were any reasons why the Committee should not ask for a full consultation to be carried out. He responded that if the Committee felt it was likely that the Trust and the OCCG could achieve a safe and affordable system for dealing with emergency assessment of abdominal surgery and if there were any new facts to be adduced for a full, and expensive, consultation, then the Committee should go ahead and request one. Sir Jonathan Michael commented that a detailed discussion of the clinical evidence for the decision made to temporarily suspend the service for patient safety reasons, had taken place at the public meeting. He advised that his Clinical Director of Surgery would be happy to attend a future meeting with the evidence, if required. Members were advised that the clinicians evidence was also available on Youtube.

Mr Stevens was asked for assurance that there would be no delays for patients going to Oxford if the Committee was to agree to no further consultation on the change. He responded that if the 3 or 4 patients a day it applied to were acutely ill, they would be seen immediately. In response to a question regarding the means of travel for these patients, Mr Stevens stated that it would depend on the clinical needs of the patient. He added that the OUHT had agreed some protocols with the South Central Ambulance Trust to address any need. Mr Wilson added that the highlighted issues from the patient survey would be taken on board.

Members of the Committee then considered their views having heard from all the stakeholders concerned with the proposals and

RESOLVED (nem con) to:

(a) support the proposal by the OUHT and the OCCG that the suspension of the emergency abdominal surgery performed at the Horton General Hospital be made permanent on the grounds of better patient outcomes and patient safety;

(b) support the CCG's call to encourage the OUHT to continue their further efforts to ensure that the number of patients needing to be transferred from the Horton General Hospital to the John Radcliffe Hospital site in Oxford for surgical assessment is minimised; and to welcome the OCCG monitoring of the situation;

(c) advise the OUHT that they should begin their dialogue with the Committee on how they intend to consult with the public on proposals at a much earlier stage in the future; and

(d) to welcome the proposal that the OCCG and OUHT should work in collaboration with the other stakeholders represented on the Community Partnership Network to draw up plans for securing the wider engagement of the local population in health and social care planning.

6/14 OXFORDSHIRE CLINICAL COMMISSIONING GROUP (OCCG) STRATEGIC PLAN

(Agenda No. 6)

Ian Wilson, Interim Chief Executive and Dr Joe McManners, OCCG attended the meeting to present their OCCG update (JHO6).

During the presentation Mr Wilson referred to the OCCG's revised constitution at which he paid tribute to Dr Stephen Richards, the former Chief Executive of OCCG, for the considerable support he had given to him in his new role as interim Chief Executive. Members of the Committee took this opportunity to thank Dr Richards in appreciation for his contribution to the work of the Committee and wished him well for the future.

Mr Wilson made reference to a modified version of Outcomes Based Commissioning which the OCCG Governing Body had decided to take forward at their January 2014 meeting, as set out at paragraphs 2 and 3, of the report, which had taken the best elements forward using a collaborative approach, following consultation. The Committee received an assurance that the public would be able to see evidence of the new modified model in action in the OCCG Board papers online. In relation to mental health commissioning, Mr Wilson also reassured Members that because data would be collected in an assiduous manner, any problems would be picked up early which would in turn lead to better outcomes for patients and a better quality of service. The intention was to monitor this very closely.

Reference was also made to feedback received from the recent series 'A Call to Action' public meetings which were held around the county from November 2013 to January 2014 with the aim of understanding what people wanted from their NHS service. Since then, the OCCG had agreed six objectives for its 5 year Strategic Plan and 2 year Operational Plan (to be presented to NHS England in February) which had been revised in light of the public feedback. In response to a question, Mr Wilson confirmed that the OCCG had modified their objectives in response to public consultation, adding that once the objectives were put into practice, they would cease to feel like 'motherhood and apple pie'.

In response to questions raised by Members of the Committee, Dr McManners confirmed that data on the ethnicity of patients was being collected by GPs. This was linked to the requirements of the Joint Strategic Needs Assessment (JSNA) to seek out where the inequalities were in the County and closer links between Health and Public Health teams were being forged. The Director of Public Health commented that the various responsibilities of Health and Public Health to contribute to the Joint Health & Wellbeing Strategy and the JSNA ensured that a close eye was kept on areas of health inequalities within the County. With regard to the issue of longer waiting times for patients in general practice, Dr McManners referred to the considerable emphasis being placed on preventative care which it was envisaged

would serve to combat this problem. He added that there had been a large increase in people wanting appointments and considerable variability in how practices were responding. The Locality Teams were gleaning information on where the problems lay and thought was being given to ways of improving patient care, given the limited resources.

Mr Wilson and Dr McManners were thanked for the update.

7/14 EMERGENCY SERVICES IN OXFORDSHIRE

(Agenda No. 7)

The Committee had previously raised various issues relating to the performance of Accident & Emergency, ambulance response times, community responders and services aimed at diverting pressure away from Accident & Emergency Departments and had expressed a wish to perform a scrutiny exercise on the services in question.

The following representatives attended the meeting in order to respond to questions:

- Ian Wilson CBE and Dr Joe McManners, OCCG
- Sir Jonathan Michael, Paul Brennan and Andrew Stevens, OUHT
- Yvonne Taylor and Anne Brierley – Oxford Health NHS FT(OH)
- Steve West – South Central Ambulance Service NHS FT (SCAS)
- Martin Bullock – London Ambulance Service

The Committee had before them an Urgent Care Briefing, which had been produced on behalf of NHS Partners in Oxfordshire (JHO7), giving performance figures for Accident & Emergency, the Ambulance Services, Emergency Multidisciplinary Units, NHS 111, the Out of Hour service and Minor Injuries/First Aid Units.

Steve West and Martin Bullock, Community Defibrillation Officer for the London Ambulance Service were invited up to the table. Martin Bullock described his role in supplying a defibrillator, and giving training in its use, to 54 towns and parishes across West Oxfordshire district as a result of an anonymous donation and District Council funding, following concerns about falling ambulance response times. West Oxfordshire was the first rural district in the country to receive this level of coverage.

The Committee asked for clarification on the reasons for the falling ambulance response times across the county and asked for a table to be produced over a period of time to illustrate the exact size of the problem. Mr West responded that the bad winter of 2013/14 had created pressures at various points, a significant one being at the JR Hospital itself. SCAS were very grateful for the support given to them from the OUHT who had responded by designing the rapid nurse assessment system which is now in place on admission at the JR . This had helped enormously, though it had not completely eradicated the problem. The Committee asked that further data be presented in relation to this initiative.

In response to questions from the Committee clarification was given that there was no policy directing paramedic clinicians as to which hospital was appropriate for particular conditions which patients were presenting with. The Chairman asked that officers review the evidence on this matter. There was some discussion of the

resources being invested and a query on what plan there was if matters did not improve. The Committee was assured that there was vigorous monitoring of the position and there was a recognition of the need to keep a focus on local areas. There was reference to the co-responding pilot with the Fire Service. There was a recognition that as demand continued to grow there was a need to look at doing things differently making use of the NHS Pathway.

There was some discussion of the Witney Emergency Multi-disciplinary Unit (EMU). Although it was recognised that it was early days, signs were good that it was following the expected pattern as achieved at Abingdon. The EMU function could be rolled out further but there would be no new building connected with any expansion of the programme.

The Committee discussed the 111 Service and some concern was expressed over patient waiting times. The importance of getting the service right in order to reduce numbers attending A&E was recognised. Steve West referred to the Call Answering Standards that saw 95% of calls answered in 60 seconds.

The Committee raised the issue of waiting times at the A&E Units and heard the steps that were being taken in the face of increasing numbers.

The Chairman thanked those attending and it was **AGREED** that they would be invited back to discuss the further statistics requested and EMU's in due course.

8/14 PUBLIC HEALTH UPDATE

(Agenda No. 8)

Jackie Wilderspin, Public Health Specialist explained the priorities of the 2014 Joint Strategic Needs Assessment (JSNA), a draft of which was to be considered at the Oxfordshire Health & Wellbeing Board on 13 March 2014. Councillor Hibbert Biles attended for this item.

Jackie Wilderspin undertook to circulate a copy of the JSNA to Committee members when it was available. The Chairman agreed it would be appropriate to receive what was being considered at the Health & Wellbeing Board and at a future meeting to review the priorities and to look at monitoring. Jackie Wilderspin confirmed that early input from members of the Committee would be most helpful.

In response to a question about monitoring Jackie Wilderspin stated that it was the intention to make as much data as possible available for use by all. The Health & Wellbeing Board would be monitoring progress.

A Member highlighted the role Government policies played in promoting better health (such as minimum pricing for alcohol) and queried what could be done to raise such issues with them. The Chairman felt that the data would be interesting and the Committee should focus on areas where it was possible to have a direct influence. He believed that the District Council's themselves might well welcome the challenge and support from the Committee. Responding to requests for detailed information on a number of matters, the Chairman noted that the level of detail would be with the data when received.

9/14 CHAIRMAN'S UPDATE

(Agenda No. 9)

The Chairman gave a verbal update on meetings he had attended since the last formal meeting of the Committee. Members also had the opportunity to discuss the Forward Plan (JHO9).

The Chairman indicated that it could be the last meeting for some of the Co-opted members and thanked them for their support and contribution to the work of the Committee. Dr Harry Dickinson replied that he had enjoyed his time on the Committee which he had found to be effective and well chaired. He also paid tribute to the officers and former officers who supported the Committee and in particular, Roger Edwards, Claire Phillips and Julie Dean.

The Chairman advised the Committee on the process to recruit co-opted members.

He noted that it would be Claire's last meeting for some time as she was going on maternity leave and her role would be covered by Ben Threadgold who already supported the Health & Wellbeing Board. The Committee gave Claire their best wishes.

..... in the Chair

Date of signing .....

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Healthwatch Oxfordshire Update for HOSC

1 Future operation of Healthwatch Oxfordshire

1.1 The current grant for the delivery of Healthwatch Oxfordshire (HWO) was awarded to Oxfordshire Rural Community Council (ORCC) until 31st March 2014. Following a subsequent tender process the operation of HWO will be taken over by a Community Interest Company which was specifically created to act as a vehicle for the delivery of HWO. The Community Interest Company (CIC) will take over responsibility for the delivery of the service from 1st April 2014. Arrangements are underway to complete the transition of the service from ORCC to the CIC.

1.2 A CIC is a new type of company designed for social enterprises that want to use their profits and assets for the public good. CICs are intended to be easy to set up, with all the flexibility and certainty of the company form, but with some special features to ensure they are working for the benefit of the community

2. Board

2.1 10 people from a range of backgrounds have now been appointed to act as the Board for Healthwatch Oxfordshire. A gap has been identified in the skills available to the Board and a recruitment process for an additional Board member with recent and relevant financial experience is underway. The current Board will all be transferring to the new CIC as Board members.

3 Director

3.1 David Roulston was appointed as an interim Director in November 2013. The process of appointing his successor is underway with a view to appointing a permanent replacement early in the next financial year.

4 Project Fund

4.1 A project fund was established to support project work and research into different areas affecting people in respect of health and social care. HWO launched the Project Fund in September 2013. The purpose of the fund is to enable HWO to better understand the experiences and needs of people in Oxfordshire and to identify good practice and areas for improvement in local Health and Social Care services. The Healthwatch staff team have been actively supporting the development of applications and proposals from frontline projects, including from 'seldom heard' groups.

4.2 The Project Fund is overseen by a sub-committee of the Healthwatch Board and projects funded include:

4.3 Research in partnership with the Patients Association into people in Oxfordshire's experience of access to GPs (further detail below).

4.4 Research by Oxfordshire Family Support Network into the health service experiences of people with learning disabilities and their families.

4.5 Research by Oxford Asian Women's Project into the health and social care experiences of Asian women in Oxford with a particular focus on primary care, mental health and domiciliary care

4.6 Research by Oxford Mental Health Forum into young people's perception of the information available to them about mental health support services.

4.7 Research by Community Glue to provide information and gather perspectives from a range of organisations about the introduction of Personal Health Budgets based on the personal experience of service users and carers, projects in other parts of the country and evaluations.
4.8 A project with Sign Lingual to explore the underlying communication issues affecting deaf people in accessing health and social care services leading to the production of a video describing their experiences.
4.9 A project by My Life, My Choice to explore the experiences of people with learning disabilities of their healthcare treatment at their local GP surgery.
4.10 Partial funding support for a Quality of Life survey to be undertaken by Oxford City Council's neighbourhood team.

5 Research into the Healthcare Experiences of students of Oxford University

5.1 In October 2013 Healthwatch offered an opportunity to a team of 4 students to work on a project which would collect intelligence about Oxford University Student's experience of and impact on local publicly funded Health Services.

5.2 The Student Consultancy team conducted a survey of 317 Oxford University students in November 2013, attempting to gain an insight into varying student experience and perceptions of the quality and ease of access of the different public health services they used.

5.3 A subsequent report has been compiled and the results shared with Oxford University Hospitals NHS Trust and Oxfordshire Clinical Commissioning Group for attention.

5.4 There were 4 main findings from the report:

5.5 High usage of A and E services –a surprisingly high number of students surveyed (13.88%) claimed to have used A&E services whilst at Oxford. Of particular concern was that over 20% of males surveyed has used A and E services.

5.6 Problems of access for UK students: In comparison with UK students problems with knowing how to access public services was far more prevalent amongst international students. More than half of the international students surveyed had no idea how to access listed health services (such as GPs and the 111 service) and the numbers of international students using services was lower. This provided a strong suggestion that information about local health services for international students is inadequate and accordingly they do not know how to properly use services.

5.7 Mental health services: From a comparison of students perceptions of quality and access to the services they used mental health services came out lower than their perception of other health services. It also came out as more polarised with many responses extremely positive but also many negative responses. The research recognised that further research needs to be collected concerning the different types of mental healthcare provision and how improvements could be made.

5.8 Centralisation: each college at Oxford provides certain health services such as a privately employed nurse and NHS GPs present once or twice a week. However the system is decentralised with no college mandated to do anything and little or no centralised authority or provision for student healthcare. This came up both in the analysis of current services and issues surrounding were raised in many of the personal comments made by respondents.

5.9 A follow up study to examine some of these issues in greater depth is currently being designed in conjunction with the Student Consultancy.

6 Initial Priorities Set by Healthwatch Oxfordshire

6.1 The following four initial priorities for attention were set by the Board of HWO:
• Access to GPs
• Setting up representative groups for relatives in care homes
• 15 minute visits in domiciliary care
• Whistleblowing

6.2 In order to explore the issue of GP access a questionnaire was designed in conjunction with the Patients Association to build on an earlier report they compiled during 2013 called 'Access Denied' which found a variety of evidence of patient experiencing difficulties in accessing community based healthcare.

6.3 A survey was launched during February and is about to close at the time of compilation of this report. There has been a healthy response to the questionnaire with over 830 having been returned. The results of the survey will be analysed during March with a view to completing and subsequently issuing a report.

6.4 HWO wrote to every care home in Oxfordshire during February and has had discussions with different parties about the establishment of representative groups for relatives. We plan to establish a pilot set of such groups in 4 care homes facilitated by HWO's Engagement Officer with a view to compiling a subsequent best practice guide to promulgate the establishment of such groups more widely in care homes.

6.5 HWO welcomes the additional resources which have been found to reduce the number of 15 minute visits being commissioned by Oxfordshire County Council. We are in the process of designing a study into domiciliary care to further this priority area.

6.6 HWO is reviewing a range of literature which has been issued in respect of whistleblowing in health and social care with a view to designing how best to take this priority area forward. The ultimate objective is to seek reassurance that whistleblowers in health and social care services in Oxfordshire are being actively listened to and their concerns are acted upon.

7 Contacts made with Healthwatch

7.1 Awareness of the existence of HWO as gradually increased over the course of the year as evidenced by contacts made to the office and requests to participate in a range of activities.

7.2 Healthwatch England (the parent body for local Healthwatch organisations) is finalising a relationship database for use by local Healthwatch like HWO in capturing the range of comments about health and social care services for national compilation and to enable local Healthwatch to provide more detailed feedback to local organisations. The database is expected to 'go live' shortly and HWO will be seeking to introduce the system in the first quarter of the next financial year.

7.3 It is anticipated that this will be supplemented by the promotion of the use of a dedicated website to support the public in giving feedback about health and social

care services in Oxfordshire.

8 Future Events

8.1 An annual social care engagement event called 'Hearsay' will be being held on 14th March. This will build on previous events which have taken place since March 2010. The purpose of the day is to ask the users of services and their carers what changes the most want to see made to adult social care services and come up with suggestions about how to make these changes. A report will be compiled following the event to support commissioners and providers in responding to the points raised.

8.2 HWO plans to hold an event later in the year to enable a range of stakeholders to help shape its future priorities in respect of areas requiring attention in respect of the commissioning and delivery of health and social care.

9 Care.data

9.1 HWO contacted Healthwatch England regarding concerns which had been raised by patients and other patient groups regarding the introduction of the care.data programme. This echoed concerns which had been raised by a range of other local Healthwatch organisations. Subsequent work included participating in a mystery shopper exercise of the NHS care.data telephone helpline. Healthwatch England subsequently raised concerns about the failure to adequately inform the public about this measure. HWO has welcomed the use of Healthwatch England's statutory powers to raise such concerns and the subsequent delay of the programme to enable better engagement and information for members of the public.

10 Additional matters for attention by the Health and Wellbeing Board

10.1 HWO is concerned that there needs to be monitoring of the impact of the combined effect of changes taking place at present associated with social care cuts, health efficiency savings and other changes (for example to benefits) and would encourage the Health and Wellbeing Board to take steps to monitor the impact of the changes so that this can be used to inform future priorities.

10.2 Homeless Pathways has given a good example of how the impact of cuts could be monitored in respect of homeless services. Potential measures could include:
• Numbers of rough sleepers
• Length of stay in homelessness services
• Rate of return to homelessness services
• Referrals to floating support teams
• A&E visits by people with No Fixed Abode
• Number of days of Delayed Transfer from hospital due to lack of suitable accommodation to be discharged to
• Number of homeless people detained under S136 for their own/others' safety, because there is nowhere else for them to go
• Number of people using food banks
• Petty crime stats, e.g. anti-social behaviour, shoplifting, drinking on the streets, begging
• Methadone prescribing because there likelihood of prescribing for longer and higher doses because someone is homeless.

10.3 Recent research has highlighted that people with a learning disability and/or

mental health problems live, on average, fifteen to twenty years less than the general population of the UK. It is a priority of the local strategy that early death be prevented, particularly for those most at risk. Valuable work and targets are in place but it appears to Healthwatch that the enormity of the mortality gaps is not fully reflected in either. HWO would encourage the Health and Wellbeing Board to take steps to address the mortality gaps as reported and address the health inequalities experienced by people with a learning disability and/or mental health issues.

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JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE
1 MAY 2014

Oxfordshire Joint Health and Wellbeing Strategy 2014-15

Purpose

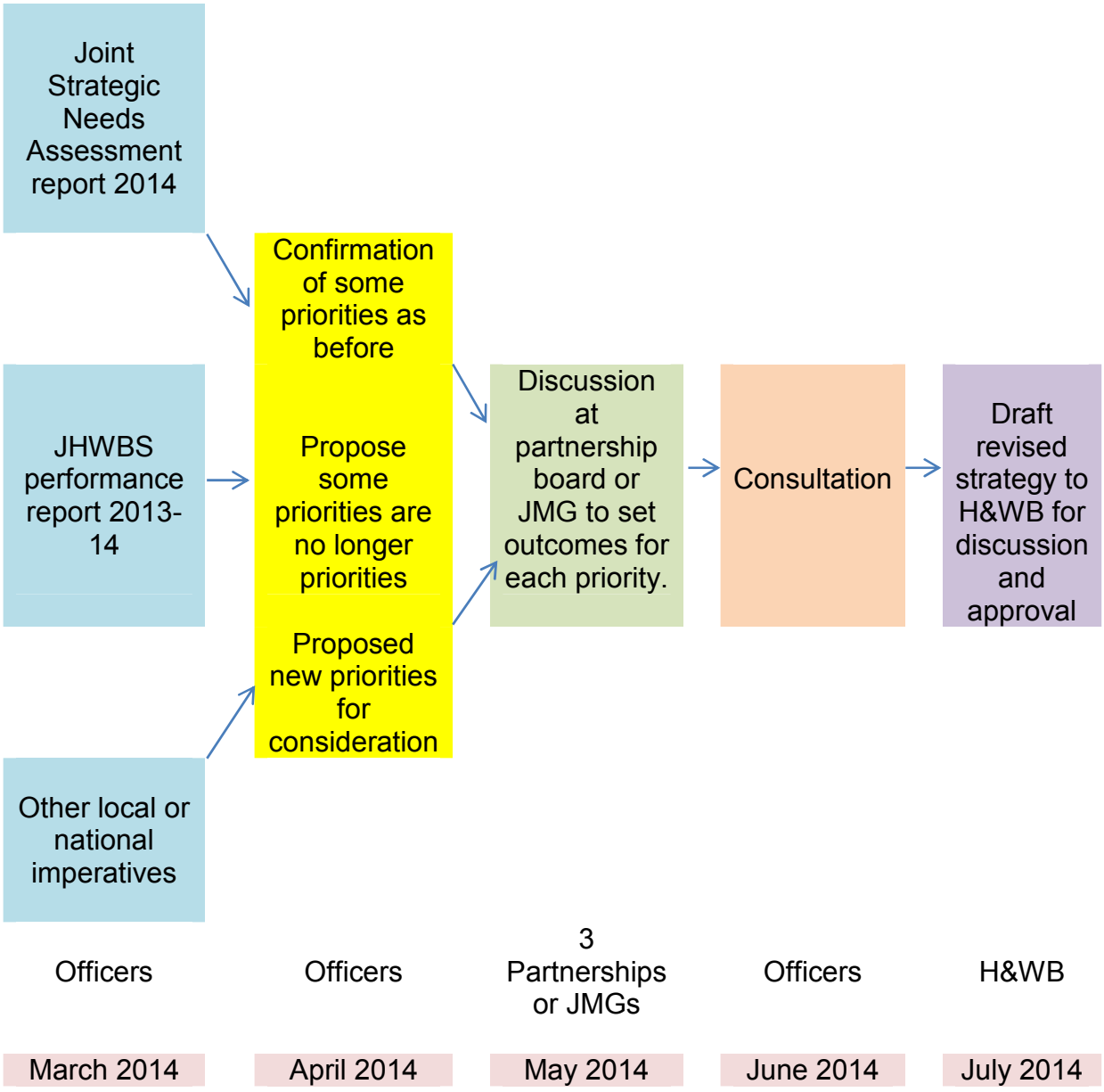
1. To update the committee on the process for refreshing the Joint Health and Wellbeing Strategy, and to consider indicators and measures for 2014/15.

Introduction

2. The Joint Health and Wellbeing Strategy for Oxfordshire is revised annually to take account of findings from the Joint Strategic Needs Assessment, performance issues and other national or local imperatives. The Strategy is a key document for all partners and sets out priorities which are agreed following consideration of the following questions:

    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?

A process for revising the Joint Health and Wellbeing Strategy (JHWBS)



Findings from the Joint Strategic Needs Assessment

3. An annual report from data collections and analysis carried out as a Joint Strategic Needs Assessment was presented to the Health and Wellbeing Board (H&WB) in March 2014. Following feedback the report is currently being amended to include additional information about mental health issues. The report can be seen in full via this link: http://insight.oxfordshire.gov.uk/cms/jsna-2014.

4. The Executive Summary is included as Appendix 1

Current Priorities and indicators in the Joint H&WB Strategy

5. The current priorities and the indicators which are used for performance management at each meeting of the Health and Wellbeing Board are set out in Appendix 2. Baselines at the beginning of 2013-14 are given for each indicator. Full details of performance on each of these indicators is not given in this paper but the report to the March Board meeting can be seen here: http://mycouncil.oxfordshire.gov.uk/documents/s24543/HWB_MAR1314R06.doc.pdf

Initial ideas for revision of the JHWBS

6. It is likely that the revised version of the JHWBS may include:
    a. Better Care Fund – indicators so that progress can be measured in implementing joint plans. There is already close alignment between the nationally set measures and the JHWBS, and we will ensure total alignment as part of the refresh. Issues raised by Healthwatch Oxfordshire as a result of their recent reviews
    b. Partnership issues that are included in the Clinical Commissioning Group 5 year Strategy
    c. Other priorities raised by members of the Partnership Boards or Joint Management Groups or through the period of consultation.

Recommendations

The Committee is RECOMMENDED to:

(a) consider and comment on the process which has been put in place to refresh the priorities in the JHWBS; and to note that a report will be submitted to the 3 July 2014 meeting which will include the draft JHWBS to be presented to the Health and Wellbeing Board on 17 July 2014; and

(b) comment on the current priorities as set out in Appendix 2 of the report together with the indicators currently used to measure progress / demonstrate improvement: and to note that any suggestions and comments for changing and developing the current list of priorities and indicators will be noted as part of the revision process.

Dr Jonathan McWilliam
Director of Public Health

Background Papers: None

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April 2014

Appendix 1
Annual report on the Oxfordshire Joint Strategic Needs Assessment

Executive Summary

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

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

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

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

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

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

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

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

Limitations of the data and areas for future development

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

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

Appendix 2
Current Priorities and Measures in the Joint Health and Wellbeing Strategy

Children and Young People

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

Outcomes for 2013-14

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.
1.2 Ensure that at least 90% of children aged 2-2.5 years old receive a Health Visitor review (currently 90%)
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
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.

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

Outcomes for 2013-14

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)
2.2 Increase the take up of free early education for 2 year-old Looked After children to 80% (currently at 8% - 2/24)
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)
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%).
2.5 Maintain the number of looked after children permanently excluded from school at zero.
2.6 Establish a baseline of all children who are persistently absent from school who are also receiving a service from any of the County Council targeted children's services (e.g. Early Intervention Hubs and Children's Social Care)
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.
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)
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: 16.8% 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)

Priority 3: **Keeping all children and young people safe**
Outcomes for 2013-14

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 assessment by the Independent Domestic Violence Advisor Service)

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 through quarterly reporting on victims and perpetrators to the Child Sexual Exploitation sub group of the Oxfordshire Safeguarding Children's Board.

3.4 Reduce the episodes/incidents of children and young people who go missing from home (from 1130 episodes involving 654 children in 2012)

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

Priority 4: **Raising achievement for all children and young people**
Outcomes for 2013-14

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)

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)

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)

4.4 61% (3840 children) of young people achieve 5 GCSEs at A*-C including English and Maths at the end of the academic year 2012/13 (currently 57.9% or 3474 children)

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)

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).

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 7% or 30 children)

4.8 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)

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)

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**

Outcomes for 2013-14

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)

5.2 Maintain the proportion of people with a long-term condition who feel supported to manage their condition at 85%.

5.3 100% patients with schizophrenia are supported to undertake a physical health assessment during 2013/14 (this is a new indicator and the baseline will be established this year)

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

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)

5.6 Reduce the number of emergency admissions for acute conditions that should not usually require hospital admission for people of all ages (baseline rate of 1012.6 per 100,000)

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 (baseline rate of 490.5 per 100,000)

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)

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.

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

Outcomes for 2013-14

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)

6.2 Reduce the average number of days that a patient is delayed for discharge from hospital (baseline and target to be confirmed following audit in summer 2013)

6.3 Reduce the number of emergency admissions to hospital for older people aged 60+ (from 25,538 in 2012/13)

6.4 Develop a model for matching capacity to demand for health and social care, to support smooth discharge from hospital, by September 2013

6.5 No more than 400 older people per year to be permanently admitted to a care home (currently 582)

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.

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 2537 clients)

6.8 60% of the expected population (4251 of 7086 people) with dementia will have a recorded diagnosis (currently 49.6% or 3516 people)

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)

6.10 3500 people will receive a reablement service (currently 2197)

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)

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).

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).

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

6.15 Produce an analysis of demand for alternative housing options for older people within Oxfordshire to inform future targets and planning by September 2013

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)

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)

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%)

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

Outcomes for 2013-14

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.

7.2 Agree an expanded and genuinely pooled budget for older people by July 2013

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)

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)

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)

7.6 Increase the number of carers known and supported by adult social care by 10% to 15,265 (currently 13,877 are known so this would represent an additional 1,388)

7.7 880 carers breaks jointly funded and accessed via GPs (currently 881)

Health Improvement

Priority 8: **Preventing early death and improving quality of life in later years**
Outcomes for 2013-14

8.1 At least 60% of those sent bowel screening packs will complete and return them (ages 60-74 years)
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)
8.3 At least 65% of those invited for NHS Health Checks will attend (ages 40-74)
8.4 At least 3800 people will quit smoking for at least 4 weeks (last year target 3676, actual 3703)

Priority 9: **Preventing chronic disease through tackling obesity**
Outcomes for 2013-14

9.1 Ensure that the obesity level in Year 6 children is held at no more than 15% (in 2012 this was 15.6%)
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)
9.3 65% of babies are breastfed at 6-8 weeks of age (currently 59.1%)

Priority 10: **Tackling the broader determinants of health through better housing and preventing homelessness**
Outcomes for 2013-14

10.1 The number of households in temporary accommodation on 31 March 2014 should be no greater than the level reported in March 2013 (baseline 216 households in Oxfordshire)
10.2 At least 75% of people receiving housing related support will depart services to take up independent living.
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%)
10.4 Fuel poverty outcome to be determined in Sept 2013

Priority 11: **Preventing infectious disease through immunisation**
Outcomes for 2013-14

11.1 At least 95% children receive dose 1 of MMR vaccination by age 2 (currently 95%)
11.2 At least 95% children receive dose 2 of MMR vaccination by age 5 (currently 92.7%)
11.3 At least 55% of people aged under 65 in “risk groups” receive flu vaccination (currently 51.6%)
11.4 At least 90% 12-13 year old girls receive all 3 doses of human papilloma virus vaccination (currently 88.1%).

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 approximately 100 (depending on time of year) 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.

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Update from Oxfordshire Clinical Commissioning Group
May 2014

1. Appointment of Chief Executive

Oxfordshire Clinical Commissioning Group (OCCG) has appointed a new Accountable Officer / Chief Executive. David Smith is currently in the same role in Kingston CCG, South London, where he was also a Director of Health and Adult Services for that London Borough. Prior to that he was the Chief Executive of NHS Kingston (Kingston PCT) from November 2006 onwards. He has worked in the NHS since 1975. David will take up his post in mid-June. Ian Wilson will continue to cover the role until he starts.

2. Appointment of Lay Member for Governance and Audit (Vice Chair) and Lay Member

The recruitment process for the Lay Vice Chair member for Governance and Audit (Vice Chair of Governing Body) and Lay Member was successful with the appointment of Roger Dickinson as the Lay Member, Lead for Governance and Vice Chair and Duncan Smith as the third Lay Member.

Roger brings with him a wide range of experience from across the public and private sectors and several industries. In addition he brings sound knowledge of good governance and its importance in providing oversight and assurance in organisations. Roger will start his role in April.

Duncan currently works as a Management Consultant. Prior to this he worked at Director level in the NHS and has experience working in local government and the private sector. Duncan will start his role on 1st May.

3. Appointment of South West Locality Clinical Director

Dr Gavin Bartholomew is stepping down from his role as South West Locality Clinical Director. Dr Julie Anderson has been appointed as the new South West Locality Clinical Director.

4. The Financial Challenge

OCCG has reported a £5.5m deficit at month eleven. This is slightly better than the month ten position. However there are continued pressures in spending on acute care (planned and unplanned), ambulance services, continuing care and nursing and care homes. OCCG is still predicting an end of year deficit position of £6.1m.

5. Strategic Plan – to be addressed with separate paper.

6. Performance including Delayed Transfers of Care

A major cause of concern across the health and social care system remains the high level of delayed transfers of care in the county. An enormous amount of joint work with OCCG partners has been undertaken in the past two months to tackle DTOC. There was a substantial dip in numbers at the beginning of March (98 week ending 2 March) but this number has increased in the past few weeks with 141 week ending 3 April.

A revised policy around 'Patient Choice, Equity and Fair Access' has been developed to tackle DTOCs. It focuses on proactively engaging with patients and carers early in admission regarding their onward care. The policy sets out a process for speaking with patients and their families where appropriate on choice issues when leaving hospital, and to provide personalised letters at each stage of the process to accompany the existing admission leaflets and discharge planning discussions with families.

Other performance issues include a failure to meet the four hour A&E target for Q1 and Q3. The Oxford University Hospitals NHS Trust (OUHT) has reported a higher acuity of presenting cases.

Overall waiting times for planned care are increasing and referral to treatment targets have not been met by the OUHT in a number of specialties. OCCG continues to work with the OUHT to ensure delivery of a collaborative plan to improve performance.

OCCG is continuing to work with the OUHT to ensure delivery of a collaborative plan to improve performance.

7. Outcomes based contracts (previously commissioning)

OCCG has been progressing a new form of contract to deliver improved outcomes for patients and greater financial stability for the health economy called outcomes based contracting (OBC). It is supported by NHS England and is being adopted by a growing number of CGGs. By adopting OBC, the success of healthcare provision will be measured by results that matter to the patient not by numbers of patients seen. Patients will have more influence over how their healthcare is delivered by helping to shape the outcomes that are included in the contracts and by making informed decisions about how their care is delivered.

Following a pause in the progression of OBC in Oxfordshire during which time an NHS Gateway Review was undertaken, phase 3 of the project has commenced and will see OBC being developed and enacted for Frail and Elderly Care and Mental Health. At this time Maternity Care will not be taken forward as part of the OBC.

8. Ensuring Quality of services

Patient safety and the quality of services are paramount in OCCGs commissioning. As part of the CCGs ongoing drive to ensure high standards of care, it visits its bigger hospitals, where possible without notice, to monitor services and performance. This is to ensure OCCG is getting the quality of service it expects for patients.

OCCG has now extended this approach for unannounced visits to all of the providers it commissions. OCCG wrote to all such providers in January and those who responded were happy to support this approach. As a result OCCG is planning visits to its smaller providers from April 2014 onwards.

OCCG is also setting up an NHS mystery shopper project. The project is currently recruiting real patients who regularly use services commissioned by OCCG (excludes primary care). There has been an overwhelming response to the request for volunteers to be mystery shoppers. The role involves the patients making notes of contacts with NHS services, which are fed back to the CCG. This will give OCCG better insight into patients experience so that it can bring about improvements.

9. Rowan Day Hospital Rehabilitation Unit

Adjustments are being made to the care provided at the Rowan Day Hospital Rehabilitation. For a long time now the day hospital function has been more centred on social care rather than acute medical care and intensive rehabilitation. With the increase in older people with complex health needs the Day Hospital will focus on providing ambulatory* care for older people to help reduce admissions to the inpatient facilities at the Horton General Hospital in Banbury or John Radcliffe Hospital in Oxford.

OCCG and OUHT are also planning to develop a new discharge lounge at the day hospital so that inpatients can be moved from bed based care to a comfortable lounge setting when they are medically fit to leave. Patients will able to vacate their inpatient bed at the beginning of the day and wait in the lounge for their medication and transport to their onward place of care be it home, a care home or community hospital. It is hoped that this will help to reduce the high number of delayed transfers of care in the County.

Local GPs are referring patients with social and rehabilitation needs to social services day care and to the County's single point of access, which provides GPs and other healthcare professionals with a quick and easy way of referring patients to community health services e.g. community therapy and community nursing. Via the single point of access packages of health and social care are put in place for patients to support them in a community setting or in their own home.

*Ambulatory care is a type of medical care that is provided to patients who do not need to be admitted to an inpatient hospital for treatment but require more acute medical care than is available in the community.

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OXFORDSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

1 MAY 2014

BETTER CARE FUND

Purpose

1. The purpose of this paper is to update the Committee on the proposed use of the Better Care Fund in Oxfordshire, and how it aligns with other key plans covering health and social care in the County. Plans were submitted to NHS England (as an integral part of the Oxfordshire Clinical Commissioning Group's Strategic and Operational Plans) on 4 April 2014 following agreement by the Health and Wellbeing Board, the County Council and Oxfordshire Clinical Commissioning Group.

Background to the Fund

2. The Better Care Fund will total approximately £37 million in Oxfordshire from 2015/16 onwards, and is not new money as it will be reallocated from within the health and social care system.

3. However, a significant proportion may be newly accessible to adult social care, and can be used to protect services where it can also be demonstrated that there are benefits to health.

4. The remainder of the Better Care Fund includes existing funding for carers breaks, reablement and capital (including Disabled Facilities Grants), and these will be protected. It also includes some elements of funding to meet the impact of changes on adult social care proposed in the Care Bill.

5. The Better Care Fund forms a key element of the Clinical Commissioning Group's planning framework, and links closely to the operational and strategic plan (also on the agenda of this meeting). The proposed plan also aligns closely to the Joint Health and Wellbeing Strategy 2012-2016, Joint Strategic Needs Assessment, Older People's Joint Commissioning Strategy 2013-2017 and the Directorate Business Strategy for Adult Social Care 2014/15-2017/18.

6. It is important to understand that the resources for the Fund have to come from existing spending on health and social care. This will be a significant challenge for the health and social care system in Oxfordshire given the current pressures it faces.

7. There is an element of the Better Care Fund for Oxfordshire that comes from other Clinical Commissioning Groups. This reflects differences in County and Clinical Commissioning Group boundaries, and includes £353,000 from Swindon Clinical Commissioning Group as Shrivenham is in their area and £424,000 from Aylesbury Vale Clinical Commissioning Group as Thame is in their area.

Discussions have been held with both Groups, and proposals in our plans have been aligned with their intentions to ensure that both areas benefit equally and are not adversely affected by falling across more than one Better Care Fund plan.

Our Approach

8. Attached as appendices are the national templates that set out the Better Care Fund plan for Oxfordshire, including narrative, financial and performance information.

9. The focus of the Better Care Fund is predominantly on meeting the needs of older people, given this is the most significant pressure facing both health and social care in Oxfordshire. However, some cross-cutting initiatives will benefit adults of all ages including people with mental health needs.

10. It is proposed that over time the Clinical Commissioning Group and the Council create a Joint Commissioning Unit, better able to target services to give the greatest impact on outcomes, produce financial efficiencies by reducing duplication and focusing on value for money for every pound spent.

11. We will also develop and implement a single assessment process reducing the need for people to be assessed more than once when transitioning between health and social care services and making the process smoother for service users.

12. It is proposed that the Council front line social work and occupational therapy teams join up with the community provision delivered by Oxford Health and further develop links with primary care including GPs. This will avoid duplication, reduce waste and bureaucracy, minimise delays in care and give people the right support at an earlier stage so they are less likely to experience worsening of their condition. This is not a new development – it reflects discussions that have been taking place over the last two years. It is also reflected in one of the targets in the current Health and Wellbeing Strategy.

13. There are a number of key performance indicators already identified as priorities in Oxfordshire that are required to meet Government guidance on the outcomes the Fund should achieve:

    - Reduce the number of older people per year permanently admitted to a care home Increase proportion of people who complete reablement who need no on-going care
    - Reduce the number of patients delayed for transfer or discharge from hospital so that Oxfordshire's performance is out of the bottom quartile
    - Reduce the number of emergency admissions to hospital for older people aged 60+
    - Achieve above the national average of people very satisfied with the care and support they receive from adult social care
    - Achieve above the national average of people satisfied with their experience of hospital care

- Achieve above the national average of people 'very satisfied' with their experience of their GP surgery
- Increase the proportion of older people with an ongoing care package supported to live at home

14. Most of these are already within the Joint Health and Wellbeing Strategy, and the target for reablement will be added when the Strategy is refreshed later this year to ensure alignment.

15. We are therefore proposing the Fund is used to invest in the following areas:
    - Information and advice
    - Equipment and assistive technology
    - Creating a more personalised approach to home support which will include removing short visits for personal care for older people
    - Integrated support for hospital admission avoidance
    - Investment in Carers Breaks jointly funded and accessed via GPs
    - Support to people with dementia
    - Reablement and rehabilitation
    - Support for people to die at home / in residential care when this is their choice

16. Further detailed work will be required throughout 2014/15 to develop these proposals fully, including quantifying the financial benefits of each. The plan will also be reviewed and updated to reflect performance in the year, and any emerging pressures and priorities. Our proposals therefore include a contingency of approximately £4.6m, equivalent to just over 1% of the total fund. It is intended that this will be used to manage risks, fund emerging priorities, and allow further investment in areas that are proving particularly effective in achieving the outcomes in the fund.

17. It is recognised that because the resources for the Fund have to come from existing spending on health and social care, this will be a significant challenge for the health and social care system in Oxfordshire given the current pressures it faces. We also recognise the need for further alignment of plans across the whole health and social care system, so we working with our key providers to consider how best to ensure:

    - 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 Better Care Fund
    - Good programme oversight of the initiatives set out in the Better Care Fund plan and in particular the role of the Whole Systems Programme Board in ensuring that, when taken as a whole with the work streams of the Older People's Programme and the Urgent Care Improvement Plan, the Better Care Fund initiatives are complementary to the remainder of the work on the urgent care pathway. There will also be alignment with the Adult Services Improvement Programme and implementation of the Care Bill.
    - Production of high quality business cases for the initiatives in the Better Care Fund so that they demonstrate 'clear benefits to the wider health and social

care sector and reduce costs in acute health care' and their subsequent monitoring and evaluation and where and how they are best signed off.

18. The work to agree the above arrangements has been scheduled to be completed in the first quarter of 2014/15.

19. Progress in implementing the Better Care Fund Plan will be monitored through the Health and Wellbeing Board, Adult Health and Social Care Partnership Board and through the performance reports presented to the Older People's Joint Management Group on a regular basis.

John Jackson
Director for Social &
Community Services
Oxfordshire County Council

Regina Shakespeare
Interim Chief Operating Officer &
Director of Commissioning &
Partnerships
Oxfordshire Clinical Commissioning
Group

April 2014

Better Care Fund planning template – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

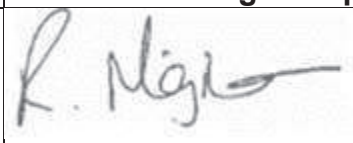
Local Authority	**Oxfordshire County Council**
Clinical Commissioning Groups	**NHS Oxfordshire Clinical Commissioning Group**
	NHS Swindon Clinical Commissioning Group
	NHS Aylesbury Vale Clinical Commissioning Group
Boundary Differences	**Thame, Shrivenham – addressed by sharing plan with relevant CCGs (Aylesbury Vale CCG and Swindon CCG respectively) for these areas and ensuring equity of delivery across the county as a whole**
Date agreed at Health and Well-Being Board:	**13 March 2014**
Date submitted:	**4 April 2014**
Minimum required value of ITF pooled budget: 2014/15	**£10,503,000.00**
2015/16	**£37,574,000.00**
Total agreed value of pooled budget: 2014/15	**£10,503,000.00**
2015/16	**£37,574,000.00**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	**NHS Oxfordshire Clinical Commissioning Group**
By	

	 Dr Joe McManners
Position	Clinical Chair
Date	3 April 2014

Signed on behalf of the Clinical Commissioning Group	**NHS Swindon Clinical Commissioning Group**
By	 Caroline Gregory
Position	Chief Finance Officer
Date	4 April 2014

Signed on behalf of the Clinical Commissioning Group	**NHS Aylesbury Vale Clinical Commissioning Group**
By	 Robert Majilton
Position	Chief Finance Officer
Date	02 March 2014

Signed on behalf of the Council and the Health and Wellbeing Board	**Oxfordshire County Council**
By	Cllr Ian Hudspeth 
Position	Leader of the Council and Chairman of Health and Wellbeing Board
Date	2014

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

Oxfordshire County Council and the Oxfordshire Clinical Commissioning Group already have well established and effective working relationships, and an ongoing commitment to further integrate services to ensure all the available funding is used to best effect, improves quality and improves outcomes for service users / patients and carers.

The Council and the Clinical Commissioning Group have worked together in establishing strong governance arrangements, including the Health and Wellbeing Board and Joint Management Groups overseeing the pooled budgets that engage commissioners, GPs, clinicians, providers and service users / carers in decision making. In addition, Oxfordshire has had an effective Urgent Care Working Group in operation since 2012 with membership from Oxfordshire Clinical Commissioning Group (OCCG) Oxfordshire County Council (OCC) Oxford University Hospitals NHS Trust (OUHT), Oxford Health and South Central Ambulance Service (SCAS)

Specifically Oxford Health have played a key role in shaping some of the proposals in this plan, as we have already been working with them as a key delivery partner for locality based integrated teams, shared care coordination and shared data

Social care providers have been involved in the development of the plan through their roles on the Older People's Partnership Board, and as part of the full and wide consultation / engagement activity to develop the Joint Older People's Commissioning Strategy that underpins the proposals for this Fund.

The plan will be shared widely with providers once agreed, as they will have a key role in shaping the proposals further and ensuring they are implemented successfully.

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

Service users are represented on the Older People's Joint Management Group and the Older People's Partnership Board, both of which have been involved in developing the proposals and will have roles in implementation.

An additional workshop was held with representatives of older people, learning and physical disability, mental health and carers to discuss and develop proposals.

There was full and wide consultation as part of developing the Joint Older People's Commissioning Strategy that sets the context for the proposals in this plan. This included online consultation, focus groups, workshops with a wide representation of older people and providers, and a reference group comprised of and chaired by older people alongside commissioners.

This plan also aligns closely to the Oxfordshire Clinical Commissioning Group 5 Year Strategic Plan, that was subject to public consultation in late 2013.

e) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Health and Wellbeing Strategy 2012-2016	https://www.oxfordshire.gov.uk/cms/sites/default/files/folders/documents/aboutyourcouncil/plansperformancepolicy/oxfordshirejointhwbstrategy.pdf
Joint Older People's Commissioning Strategy 2013-2016	http://www.sourceoxfordshire.org.uk/cms/sites/source/files/folders/documents/OlderPeoplesJointCommissioningStrategy.pdf
Adult Social Care Business Strategy 2014/15 – 2017/18	http://mycouncil.oxfordshire.gov.uk/documents/s24264/Section%203.pdf (see pages 21-39)
Section 75 for all client groups	Attached
Existing S256 Transfer Agreement	Attached

2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

The current vision for Oxfordshire through to 2018/19 is that articulated through the Oxfordshire's Joint Health and Wellbeing Strategy 2012-2016, Adult Social Care Business Strategy 2014/15-2017/18 and the Clinical Commissioning Group's five-year strategic plan:

i. More children and young people will lead healthy, safe lives and will be given the opportunity to develop the skills, confidence and opportunities they need to achieve their full potential
ii. More adults will have the support they need to live their lives as healthily, successfully, independently and safely as possible, with good timely access to health and social care services
iii. Everyone will be given the opportunity to voice their opinions and experiences to ensure that services meet their individual needs
iv. The best possible services will be provided within the resources we have, giving excellent value for the public
v. Be delivering fully integrated care, close to home, for the frail elderly and people with complex multi-morbidities.
vi. Have a primary care service that is driving development and delivery of this integrated care, and is itself offering a broader range of services at a different scale.
vii. Support choice and control in the belief that people themselves, regardless of age or ability, are best placed to determine what help they need.
viii. Routinely enable people to live well at home and to avoid admission to hospital when this is in their best interests.
ix. Be continuing to provide preventative care and to tackle health inequalities for patients and carers in both its urban and rural communities
x. Be providing health and social care that is rated amongst the best in the country for all its citizens in terms of quality, outcomes and local satisfaction with services

Oxfordshire County Council and the Oxfordshire Clinical Commissioning Group already have well established and effective working relationships, and an ongoing commitment to further integrate services to ensure all the available funding is used to best effect, improves quality and improves outcomes for service users / patients and carers.

The Council and Clinical Commissioning Group have worked together in establishing strong governance arrangements, including the Health and Wellbeing Board and Joint Management Groups overseeing the pooled budgets that engage commissioners, GPs, clinicians, providers and service users / carers in decision making.

Over £330m is currently committed to pooled budget arrangements across all client groups, representing a third of Clinical Commissioning Group resources and 99% of adult social care funding. This includes a significantly expanded pool covering care for older people, and others to improve care and outcomes in physical disability, learning disability and mental health and wellbeing. .

We have joint commissioning strategies that set out our shared intentions and mature risk sharing arrangements that mean we have truly pooled budgets, that in the case of older people we believe this to be unique in the country. Existing pooling of funds is being used to protect adult social care services by paying for the discharge to home service, increase spending on equipment and meeting an increased number of home care packages in response to the demographic challenges.

We are working together to implement an outcomes based contract for services for older people; in 2014/15 we are targeting the acute assessment/admission/discharge / reablement pathway incorporating both community and acute health services. Given our pooled budget arrangements we are working together to determine whether it makes sense for some social care funded services to be incorporated in this approach and are making positive progress.

- In order to support the Clinical Commissioning Groups vision of patient-centred high quality care, which is integrated, cost effective and efficient, it is proposed that the CCG and the County Council work together to join up commissioning and integrate the provider services for the benefit of patients.

- The key points where organisations will join up to deliver the most benefit to people are in the commissioning of services, in individual assessment and in care co-ordination, leading to a coordinated and seamless response to need at both a population level and at an individual level.

We will committed to exploring whether:

- The CCG and the Council create a Joint Commissioning Unit for management of the pooled budget.
- A single assessment process is implemented
- Community providers including GPs integrate to deliver care co-ordination.

Following assessment, where people need ongoing care and support, a diversity of health and social care service provision will be maintained to facilitate choice, innovation and sustainability.

Under the leadership of the Health & Wellbeing Board, joining up commissioning will mean that commissioners in the CCG and the local authority will develop shared vision, plans and pooled budgets. This creates the opportunity to design coherent, reliable and efficient patient pathways, and ensure the incentives are right for providers to provide interoperable services within these pathways. We will share best practice, expertise and intelligence about needs.

The benefits of joint commissioning are that it will help to:

- Target services to give the greatest impact on outcomes
- Share expertise and best practice
- Share intelligence on needs in a systematic way

- Break down silos and gaps between healthcare and social care
- Co-ordinate services by encouraging providers to work together (and with commissioners).
- Produce financial efficiencies by reducing duplication and focusing on value for money for every pound spent.
- Effective and efficient ways of planning leading to major service transformation.

Provider Integration

It is proposed that the Council front line social work and occupational therapy teams join up with the community provision delivered by Oxford Health. GPs, hospitals, health workers, social care staff and others will work side-by-side, sharing information and taking a more coordinated approach to the way services are delivered. At the moment, if someone needs to arrange care from a district nurse, for example, but also needs help to bathe or prepare a meal, they might have two or three different professionals arriving at their door and asking similar questions before help can be put in place. This will be replaced by a single assessment process that is controlled where possible by the patient and reduces unnecessary duplication.

With these changes, the process will become much smoother. Staff such as district nurses, community matrons, social workers and other professionals will be in a position to communicate with each other on a regular basis and share information to support people better. Some patients will have a single care coordinator who is their main contact point.

Staff from all sides can more easily identify which patients are most at risk – for example, of going into hospital – and then put together a combined package of care, support and lifestyle advice designed to keep them healthier and independent for longer. If someone ends up in hospital, staff from the hospital can work with those in the community to help them leave with the right support in place. Joint working will:

- help to get rid of out of date processes that are duplicated across both health and social care
- reduce waste and bureaucracy by working as a more efficient, combined unit
- minimise delays in care and give people the right support at an earlier stage so they are less likely to experience worsening of their condition
- reduce the need to go into hospital and enable people to better manage their condition and live as independently as possible
- improve the sense that services are 'fragmented' by reducing the number of professionals that need to be involved in one person's care, and ensuring those who do are working more closely together.

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

Our approach will be based on furthering the aims and objectives in Oxfordshire's Joint Health and Wellbeing Strategy 2012-2016 and the Clinical Commissioning Group and Oxfordshire County Council Older People's Commissioning Strategy 2013 – 2016. Both of these are based in part on the Joint Strategic Needs Assessment and were developed in partnership with wide partner and user engagement.

The Joint Health and Wellbeing Strategy includes the following priorities for adults:

- Living and working well: Adults with long-term conditions, physical disabilities, learning disabilities or mental health problems living independently and achieving their full potential
- Support older people to live independently with dignity whilst reducing the need for care and support
- Working together to improve quality and value for money in the Health and Social Care System

There are 6 priorities in the Older People's Commissioning Strategy, which are shaped to reflect the patient voice and experience – these seek to achieve the following outcomes:

1. I can take part in a range of activities and services that help me stay well and be part of a supportive community.
2. I get the care and support I need in the most appropriate way and at the right time.
3. When I am in hospital or longer term care it is because I need to be there. While I am there, I receive high quality care and am discharged home when I am ready.
4. As a carer, I am supported in my caring role.
5. Living with dementia, I and my carers, receive good advice and support early on and I get the right help at the right time to live well.
6. I see health and social care services working well together.

These also have resonance across all client groups, so although the focus will be primarily on older people there will be wider benefits for all – particularly when combined with other funding streams in the Better Care Fund that protect existing spending on Disabled Facilities Grants and carers breaks.

In keeping with the aims in the Oxfordshire Clinical Commissioning Group Five Year Strategy, the need for our patients is to have joined up care that provides better care at home and reduces unnecessary time spent in hospitals and care homes. It will;

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

2) Deliver anticipatory care plans and care co-ordination when unstable for those patients.

3) Develop locality based 'hubs' that are community facing and offer rapid access, multi-disciplinary team assessment for diagnosis and care planning (see below)

4) Move to acute hospital stays that are as brief as needed, so the patient moves to the most appropriate place as soon as possible without delay

5) Help primary care develop to work better together and improve joint working with community, social care and secondary care.

6) Develop the primary care provider community so that GP services can contribute and potentially lead integrated care services

7) Have named social and community healthcare link workers assigned to each general practice

8) Have clearly defined roles and responsibilities within urgent and emergency care pathways

9) Delivery of a new jointly commissioned service model that delivers shared outcomes for patients across the system

10) Provide 7 day working in health and social care

The current priorities in the Oxfordshire's Health and Wellbeing Strategy already include a focus on the national measures required by the Better Care Fund (see below) – these indicators are also included in the Older People's Commissioning Strategy and will be used to measure how effectively we achieve the aims and objectives given above:

Better Care Fund Metric	**Local Metric**
Admissions to residential and care homes	Reduce the number of older people (aged 65 and over) per year permanently admitted to a care home (Health and Wellbeing Strategy indicator 6.5)
Effectiveness of reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services (This will be added as a Health and Wellbeing Strategy indicator for 2014/15 onwards)
Delayed Transfers of Care	Reduce the number of delayed days for transfer or discharge from hospital (This will be added as a Health and Wellbeing Strategy indicator for 2014/15 onwards)
Avoidable Emergency Admissions	Reduce the number of emergency admissions to hospital for older people aged 60+ (Health and Wellbeing Strategy indicator 6.3)
Patient / Service User Experience	Achieve above the national average of people very satisfied with the care and support they receive from adult social care (Health and Wellbeing Strategy indicator 7.3) Achieve above the national average of people satisfied with their experience of hospital care (Health and Wellbeing Strategy indicator 7.4) Achieve above the national average of people 'very satisfied' with their experience of their GP surgery (Health and Wellbeing Strategy indicator 7.5)
Locally determined	

measure: People with high level care and support needs supported to live at home	Increase the proportion of older people (aged 65 and over) with an ongoing care package supported to live at home (Health and Wellbeing Strategy indicator 6.7)	

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

We are in a strong position to build on our existing relationships and joint working that has seen us develop (for example) integrated locality teams, a single point of access for health and social care, and Winter Pressures pilots in winter 2013-14 - the evaluation of which will inform an overall model of integration. We have also initiated the South East GP pilot that provides an Adult Social Care Link Worker in six GP practices to share information, signpost and discuss appropriate care for high risk patients requiring both health and social care services.

However, we also recognise the need to do more to address the increasing number of frail older people as the most significant challenge that faces health and social care in the county. There are increasing demands for care from a relatively small proportion of the population. Financial resources are not increasing in line with those demands so we need to focus on intervening early and quickly to limit the extent to which care needs increase.

We also need to do more to address key areas of under-performance, notably the number of people who are admitted to hospital when they didn't need to be and the number who spend longer in hospital than they need to. Although there are relatively few people placed in care homes in Oxfordshire compared to other areas, we want to reduce this further still.

It is proposed that the Better Care Fund is used to protect services in adult social care where there is a clear benefit to the wider health and social care sector and contribution to reducing activity/costs in acute health care, as defined by the aims of the Joint Older People's Commissioning Strategy and the nationally determined metrics for the Better Care Fund. There will be an emphasis on ensuring the right care in the right place, first time, and the vital links between intermediate community care and hospitals.

Through the mechanism of the pooled budgets we will continue to move resources between health and social care to spend on those services which have greatest impact on the demand for health and social care, including bed-based care in particular.

These proposals have been developed in response to the priorities identified in Oxfordshire's Joint Health and Wellbeing Strategy, which is based on the highest priorities for action identified through the Joint Strategic Needs Assessment. This has identified demand for social and health care, particularly from an increasing number of

frail older people, as the most significant challenge facing the county – and this is reflected in the financial and strategic plans of both the Clinical Commissioning Group and the County Council.

Proposals are therefore designed to build on the existing commissioning and activity happening across the health and social care system, individually and collectively amongst partner organisations and providers. A proportion of the funding is already being utilised as part of the existing transfer from health to social care on a range of preventative measures to support people to live independently in their own home for as long as possible. This includes a range of home support packages, equipment and assistive technology, crisis response services, reablement, and carers breaks. All these will continue from 2014 onwards. We will also continue to invest in meeting increased demand across social care and health (including Funded Nursing Care and Continuing Healthcare), and make sure that resources are focused on care in the community rather than in hospitals.

The Better Care Fund will also include capital funding currently used by District Councils to support adaptations to property to support people to stay at home (Disabled Facilities Grants) and additional capital funding used by adult social care to support Extra Care Housing schemes. These will continue to be funded at the same levels as currently, as there is evidence that these are effective in supporting the ambitions in this plan and meeting aims of the Fund.

Adult social care is preparing for the implementation of the Care Bill from April 2015 onwards, and a proportion of the funding within the Better Care Fund is assumed to support this. In particular it will be used to support improved information and advice, including for self-funders, and for improved IT systems to support management and tracking of care accounts once funding details are finalised.

There are also a number of proposals that will be delivered from April 2015 onwards that both support / protect adult social care and will bring reduced activity and costs in the acute sector. These flow across the whole health and social care pathway:

- **Information and advice**
  The provision of good quality information and advice is critical in enabling people to make best use of their resources, empowering and enabling people to assess and then take control of their own support needs and to use information on the quality of provision to make informed choices about their lives.

  We will invest in a new online marketplace for care, building on existing systems to enable people to people to resolve their own problems. This will provide people with a menu of options for how their needs could be met, along with prices, and allow them to choose between without the need for the Council to broker the service. The service will provide real time quality feedback and ratings, and real time availability of care with the ability for providers to upload and maintain their own information.

- **Equipment and assistive technology**
  There is extensive evidence that the use of equipment and assistive technology is an effective way to support independence and allow people to live at home for longer. We will continue to invest in this as an alternative to residential and domiciliary care provided by care workers where suitable.

There is also evidence that this can help reduce admissions and represent savings in the wider system. A recent review showed that over 30% of calls to the emergency services for clients of the Alert Service in Oxfordshire (a countywide service providing telecare alarm equipment to vulnerable and older adults) were handled by a mobile responder rather than needing to refer for an ambulance. This equates to a saving of over £300k per year, plus avoiding further costs for the NHS had the users been admitted to hospital.

- **Create a more personalised approach to home support which will include removing short visits for personal care for older people**

  We will ensure that no home care visit offering personal care is too short for the person to be treated with dignity and respect. Often home support for older people has become too focused on time and task, as opposed to good outcomes for the person. Sometimes visits are too short for the person to be treated with dignity and respect. We will link this funding to an improvement in performance for home support based on the needs of the older person.

  We will continue to invest in new approaches to providing domiciliary care. We will develop a mainstreaming approach that builds reablement into all home care provision rather than seeing it as a separate service.

  We will ensure seven day working in social care and amongst providers of services to avoid the need for hospital admissions at weekends that would be avoided during the week, support effective discharge from hospital, and improve pick up times in intermediate community care.

  We will implement Individual Service Funds that promote a more personalised approach to home support. Home support providers will receive the Individual Service Fund directly from the local authority and work with the older person to organise their care based on a support plan. Individual Service Funds have the benefit of reducing the number of short visits and improving the experience of both the older person and the home support worker – thus they will have a positive impact on both outcomes (including pick up times) and workforce. While they require up-front investment in systems and training, there is potential to save money in the long run.

  We will implement changes over a two year period from October 2014 onwards, to allow time to work with providers to affect any changes that are needed in the range of services or how they operate.

- **Integrated support for hospital admission avoidance**
  Linked to personalisation of home care, we will fundamentally review the provision and accessibility of community services provided across health and social care that support people outside of hospital. This will support our ambition to support people as close to home as possible, and ensure that the right services are available in the local area to enable this.

  We will also invest in improving a range of community-based services that reduce emergency admissions of vulnerable and frail older people by supporting them at home, and to return home as soon as possible after an admission. This will include further development of emergency multidisciplinary assessment pathways, to ensure appropriate medical, nursing, social and therapeutic capabilities in both acute and

community sectors.

We will develop primary care services to enable better management of complex patients with multiple-morbidity/frailty. These services will provide enhanced medical and nursing support for these patients and will work with integrated health and social care teams on localised populations based around GP practice populations.

We will focus on reducing the number of repeat admissions, Accident and Emergency attendances and primary care attendances for younger adults with high needs, often as a result of mental health problems or drug/alcohol dependency. The cost of supporting this relatively small number of individuals is disproportionately high, and investment in services across public health, social care and primary care to address the underlying causes of these admissions will reduce costs and improve outcomes for these individuals.

We will also invest to improve the quality and range of medical and nursing services for care homes through our Quality in Care homes programme, ensuring that residents benefit as much from the development of modern integrated services as people still living in their own home. This is currently being developed into a business case for organisational approval.

We will work to broaden the role of GPs in supporting and delivering a whole systems approach, having input along the whole pathway as with interface medicine capability. This will include the development of an agreed vision and five year strategy for the development of primary care in Oxfordshire which addresses the role of GP practices in:

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

ii. Providing more holistic, integrated care in the community

iii. Ensuring fast, responsive access to urgent care needs

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

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

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

We will also produce and support the delivery of a plan which articulates the preferred function and form of federated working in Oxfordshire so that primary care is in a position to:

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

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

iii. Support effective urgent and emergency care pathways

iv. Address health inequalities more effectively in both urban and rural areas in order to support GPs to increase their role in driving development and delivery of

integrated care in the community, the leadership capacity of primary care will be developed so that leaders are identified and supported to act as strategic partners in provider discussions around changes in service delivery. This will ensure that primary care views are clearly voiced and considered in any system level change.

- **Investment in Carers Breaks jointly funded and accessed via GPs**
  Carers already play an essential role in the development of health and social care services in Oxfordshire. 61,131 of Oxfordshire's residents (9.4% of the population) provide some unpaid care to family or neighbours with ill health or disability.

  There will be continued investment to support family carers, further investment to build on the existing success of carers breaks (where demand exceeds budget) as well as training and support for carers, and intensive support for carers when the person they care for is in hospital.

- **Support to people with dementia**
  We will invest further in supporting people with dementia, building on improved rates of diagnosis and recognising the increased numbers of older people living with the condition. This will be a theme running through a number of the proposals, including targeted training for home care providers to ensure their staff are trained in recognising and supporting people with dementia living in the community.

  We will also build capacity to support people with dementia in nursing homes, including block purchasing beds that are developed to reflect the learning from existing work to create more dementia-friendly environments in health and social care settings. We will also work with the Order of St John to increase their capacity to provide specialist dementia care in care homes, and with other providers to encourage them to do the same.

- **Reablement and rehabilitation**
  The Council will focus on improving the key first response services such as crisis response and reablement. We will also work with the Clinical Commissioning Group to develop multi-disciplinary, integrated front end services that include key clinical inputs such as nursing and therapy as part of the service model.

  Through locality and outcome based contracts we will offer seamless "one stop shop" solutions for crisis, rapid response and enabling support at home which respond more effectively to the needs individual service users to move between service functions without hand-offs between providers. It will also help meet the needs of the wider social and health care system by reducing duplication and improving coordination of care across agencies.

  We will significantly grow the capability of the domiciliary care market to deliver effective enabling care, by working with providers to identify, develop and train care workers to deliver care that restores and enables people to maintain their independence.

- **Support for people to die at home / in residential care**
  Oxfordshire's joint strategy for end of life care aims to improve the quality of end of life care and support more people to die in their place of choice, which will often be in their own home or place of residence. The integration, capability and responsiveness

of social care services is essential for ensuring that people receive the holistic and humane support that they need at the end of their lives, and that family carers are supported both before and after someone dies.

The Council will continue to support OCCG in developing and delivering the end of life care strategy for Oxfordshire, and will lend practical support to the strategy through a range of initiatives. Particular emphasis will be on working with care providers to ensure that care workers and family carers are trained to recognise and supported to respond to the needs of people who are dying. We will also clarify guidance for service users with an end of life diagnosis and their family carers on the support available to them.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

Oxfordshire recognises the need for full alignment of plans across the whole health and social care system. As such we are committed to the principles of long term sustainability for the system as a whole which delivers best outcomes for its population within a challenged resource envelope.

The Clinical Commissioning Group and County Council as co-commissioners, along with our key acute provider Oxford University Hospitals Trust, are considering how best to ensure:

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 Better Care Fund
Good programme oversight of the initiatives set out in the Better Care Fund plan and in particular the role of the Whole Systems Programme Board in ensuring that, when taken as a whole with the work streams of the Older People's Programme and the Urgent Care Improvement Plan, the Better Care Fund initiatives are complementary to the remainder of the work on the urgent care pathway
Production of high quality business cases for the initiatives in the Better Care Fund so that they demonstrate 'clear benefits to the wider health and social care sector and reduce costs in acute health care' and their subsequent monitoring and evaluation and where and how they are best signed off.

Commissioners are currently awaiting an integrated proposal from providers on the development of an older people's pathway on an outcomes basis. Given the interdependence between the Better Care Fund Plan, this proposal and the risk of non-realisation of the necessary savings in the acute sector to support the plan; and given that this risk related principally to 2015/16, the work to agree the above arrangements has been scheduled to be completed in the first quarter of 2014/15.

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

Implementation of the Better Care Fund plan will be overseen by the various organisational governance structures, reporting to the Health and Wellbeing Board and constituent Clinical Commissioning Group and County Council.

The Older People's Joint Management Group meets in public bi-monthly, and has a key role contributing to the delivery of the priorities in the Joint Health and Wellbeing Strategy by monitoring and managing the implementation of the Joint Older People's Commissioning Strategy through the Older People's Pooled Budget, including and performance indicators, activity and spending. It reports regularly and by exception to the Health and Wellbeing Board and Clinical Commissioning Group and County Council.

The Joint Management Group comprises senior officer and member representatives of the County Council and Clinical Commissioning Group, as well as District Councils, health providers, and service user representatives. It is supported by an Older People's Partnership Board that comprises wider representation from service users and providers, that has an advisory role to the JMG, and a Commissioning and Finance officer group that meets monthly to manage and monitor implementation, activity and spending.

3) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services.

We define protecting adult social care as prioritising the services that have the biggest impact on meeting the shared need to reduce demand for health and social care services by ensuring high quality, joined up services that support people to live independent and successful lives for as long as possible.

Please explain how local social care services will be protected within your plans.

Pooled funding will be used to protect services in adult social care where there is a clear benefit to the wider health and social care sector and contribution to reducing activity/costs in acute health care, as defined by the aims of the Joint Older People's Commissioning Strategy and the nationally determined metrics for the Better Care Fund. There will be an emphasis on ensuring the right care in the right place, first time, and the vital links between intermediate community care and hospitals.

Through the mechanism of the pooled budgets we will continue to move resources between health and social care to spend on those services which have greatest impact on the demand for health and social care, including bed-based care in particular.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for

implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

We are committed to delivering 7 day access to health and social care services, and have already implemented 7-day working across a number of elements of the health and social care system. This includes social work teams in hospitals, covering wards and all front doors (Accident and Emergency, community and acute hospitals, and Emergency Medical Units). We have also incentivised social care providers to pick up clients within 72 hours, including Fridays and over the weekend. The Emergency Duty Teams also ensure there is support available 24 hours a day, 7 days a week.

This will be developed further in accordance with the improvement intervention and principle of resource maximisation, and as part of our commitment to shared care coordination.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

See below

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

Oxfordshire County Council are working with Oxford Health to ensure we are able to use the NHS number as the primary identifier for health and care services by April 2014, and this will be built into routine processes from then on.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

We are already working with health colleagues to ensure our respective tender processes for the SWIFT (Adult Social Care) and RIO (Health) replacements are aligned. Integration requirements have been appropriately specified within both statement of requirements.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

Appropriate Information Governance controls are broadly in place for information sharing in line with Caldicott 2. We will undertake further work to build these controls into all training materials, and ensure they are included in work already underway to communicate new information governance policies and procedures to staff.

d) Joint assessment and accountable lead professional
Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

Shared care coordination will form a key part of our commitment to establishing integrated health and social care providing patients, service users, GPs and acute service providers with a single, straightforward route to well joined up, locality based care. This will enable people to stay in their usual place of residence (or as close to it as possible)– for as long as possible, regardless of how many different community based health and social care specialists are involved in providing them with care

Oxfordshire County Council are working with the Clinical Commissioning Group, Oxford Health and primary care to establish an appropriate and efficient model of joint assessments and care planning, including an accountable lead professional for integrated packages of care. Pilot work is underway, targeting the patients within 5 localities with the highest levels of need and risk (including risk of unnecessary admission) and with particular focus on people with a diagnosis of dementia. This aligns with the emphasis in the new GP contract on the 2% of patients at highest risk.

A detailed model of service provision will be confirmed by all partners, using the outcomes of the pilot work to develop shared patient assessment and patient records, protocols and business processes which support the identification of the accountable lead professional, and 7 day service access.

In addition to dementia, this model of provision will also focus on individuals with co-morbidities, in recognition that the risk of admissions increases significantly for this group.

4) RISKS
Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	Risk rating	Mitigating Actions
Increasing demand for services could outstrip benefits accrued from planned schemes	High	Modelling of demand Close scrutiny of proposals and monitoring of implementation. Mature risk sharing.
Proposals are not effective in reducing demand, activity or spending in health and/or social care.	Medium	Close scrutiny of proposals and monitoring of implementation, appropriate remedial action to be taken
Proposals do not reduce the level of activity specifically in the acute sector and therefore allow the transfer of funds.	High	Routine monitoring of acute sector activity Involvement of acute sector on Health & wellbeing board, adult board and JMG

Financial pressures facing the system mean ambitions in plan cannot be implemented	Medium	Close scrutiny of proposals and monitoring of implementation, appropriate remedial action to be taken, open and transparent conversations
Market capacity may not increase in line with demand and appropriate levels of care are not forthcoming in the right place, at the right price and of the right quality	High	Production of market position statement giving clear signal to providers on how much care we expect to purchase Close working with providers in further development of community based care provision Agreeing a charter with clients and providers about care standards Reviewing new personalised home support contracts based on individual needs
Enough people will be willing to work in the health and social care sector at a time of increasing financial pressure for the sector, and in an area of high employment	High	Work with providers and others to develop a workforce plan for the county. Investment in workforce and training as part of Better Care Fund proposals (dementia, carers)

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Association

Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16. It is important that these figures match those in the plan details of planning template part 1 . Please insert extra rows if necessary

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15 /£	Minimum contribution (15/16) /£	Actual contribution (15/16) /£
Oxfordshire County Council - Adult Social Care Capital Grant and Disabled Facilities Grant	Y		*3,677,000*	*3,677,000*
NHS Oxfordshire Clinical Commissioning Group	N		*33,120,000*	*33,120,000*
NHS Swindon Clinical Commissioning Group	N		*353,000*	*353,000*
NHS Aylesbury Vale Clinical Commissioning Group	N		*424,000*	*424,000*
BCF Total		**£ -**	**£ 37,574,000**	**£ 37,574,000**

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

Any pressures on other services caused by not achieving the planned improvements will be managed through the joint management groups, which have the remit to change use of the pooled budget in year to reflect pressures and performance (and many years' experience of doing so). Any changes that result in an overspend or underspend at the end of the year would be made with reference back to appropriate risk share arrangements - currently these are proportionate to the level of funding contributed to the pool, with overspends / underspends being taken back to each organisation accordingly. The expectation would always be that changes would be made in year to allow pressures to be managed within the pool however, with any decisions about resultant reductions in activity and spending in other areas taken jointly and transparently.

Contingency plan:		2015/16	Ongoing
Outcome 1	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		
Outcome 2	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please add rows to the table if necessary.

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent /£	Non-recurrent /£	Recurrent /£	Non-recurrent /£	Recurrent /£	Non-recurrent /£	Recurrent /£	Non-recurrent /£
Alert Service		300				300		*More people supported to stay at home, fewer admissions to care homes and emergency admissions*	
Long term Care Packages		4352				4352		*More people supported to stay at home, fewer admissions to care homes, improved worforce, better patient experience*	
Equipment		750				750		*More people supported to stay at home, fewer admissions to care homes and emergency admissions*	
Crisis response		500				500		*Reduced emergency admissions*	
Existing Protection of ASC		2300				2300		*More people supported to stay at home, fewer admissions to care homes, improved worforce, better patient experience*	
Increased transfer in 2014/15 - Intermediate care		391				391		*More people supported to stay at home, fewer admissions to care homes, improved worforce, better patient experience*	
Protecting ASC - discharge to assess, investment in equipment		1910				1910		*More people supported to stay at home, fewer admissions to care homes, improved worforce, better patient experience*	
Carers Breaks						1300		*Reduced carer brekadown, more people supported at home for longer, reduced admissions to care homes or emergency admissions*	
Existing Investment in reablement						3000		*More people supported to stay at home, less admissions to care homes and emergency admissions, reduce delays*	
Capital Funding - Disabled Facilities Grants						2401		*More people supported to stay at home, less admissions to care homes and emergency admissions*	
Capital funding - Oxfordshire County Council						1267		*Additional ECH sche,mes, alternative to Care Home admissions*	
Capital Funding - care bill						500		*IT system able to deliver Care Bill functionality*	
Other Care Bill Implementation costs						1350		*Successful implementation of Care Bill*	
approach to home support which will include removing short visits for personal care for older people						4000		*More people supported to stay at home, fewer admissions to care homes, improved worforce, better patient experience*	
Equipment and assistive technology						1000		*More people supported to stay at home, fewer admissions to care homes and emergency admissions*	
Support for people to die at home / in residential care						500		*Fewer emergency admissions, better patient experience*	
Information and advice						500		*Savings in customer service Centre, through reduced assessments and income from site advertising and revenue fees*	
Discharge to assess care service						1000		*More people supported to stay at home, fewer admissions to care homes and emergency admissions, reduce delays*	
Improving performance of reablement and rehabilitation						1000		*More people supported to stay at home, fewer admissions to care homes and emergency admissions, reduce delays*	
Increased investment in Carers Breaks jointly funded and accessed via GPs						200		*Reduced carer brekadown, more people supported at home for longer, reduced admissions to care homes or emergency admissions*	
Support to people with dementia						500		*More people supported to stay at home, fewer admissions to care homes, reduced emergency admissions, better patient experience*	
Investment in support for people to die at home / in residential care						500		*Fewer emergency admissions, better patient experience*	
Shared data						100		*Better patient experience and joined up care*	
Shared care coordination - particularly for dementia and comorbidities						200		*Better patient experience and joined up care*	
7 day working (including management costs)						500		*Better patient experience, more people supported to stay at home, fewer emergency admissions, reduced delays*	
Investment to meet increased demand for Funded Nursing Care and Continuing Healthcare						1100		*More people supported to stay at home, fewer admissions to care homes and emergency admissions, reduce delays*	
Integrated Support for hospital admission avoidance						1500		*More people supported to stay at home, fewer admissions to care homes and emergency admissions, reduce delays*	
Contingency (approx 1%)						4653			
Total		£ 10,503	£ -	£ -	£ -	£ 37,574	£ -	£ -	£ -

Outcomes and metrics

Please provide details of how your BCF plans will enable you to achieve the metric targets, and how you will monitor and measure achievement

1. Reduce permanent care home admissions to 10.5 per week; or 546 in the year - a rate of 473. This would be the 17th lowest in the country last year based on last year's figures; lower than any point in the last 5 years and reflects a 17% increase on the expected 2014/15 value. This will be supported by additional investment in community based service and additional personalised home support.

2. Increase the number of older people supported to leave hospital with reablement to 500 between October and December. The current contract expects around 450 episodes. (3750 episodes; 50% from hospital for ¼ of a year). The present estimate for this year is 437 (all ages). 500 would imply 4000 episodes per year at current rate. It will be over 15% increase on this year. Increase the proportion of people still at home 90 days after leaving the service to 80%. This would place us close to the national average. So far this year at the point of leaving the service 18% of people have gone back into hospital; 3% of people have gone into a care home and 2% die. The clear issue is the level of people returning to hospital and reflects the levels of dependency people have when leaving hospital and the entrance criteria for the service. These measures will be supported by additional investment in rehabilitation and reablement and additional personalised home support.

3. The number of days people are delayed in hospital will drop by 37.5% from the baseline 15 months from April 2012. The increase in performance will be shared equally across all 3 responsiblities (NHS; Social Care and both) with an expectation across the 15 month performance period of 1458 days or less lost per month to NHS delays; 1064 to social care and 408 to both organisations. Many of the investments support improved patient flow including reducing hospital admissions by high intensity users; increased 7 day working including pick up for providers; improved information flows; improved co-ordination of shared care and increased market capacity and a consequent drop in the number of people delayed and the number of days lost to delayed patients

4. Avoidable emergency admissions: the aggregate measure includes emergency admissions for ambulatory care sensitive conditions, admissions for acute conditions not normally requiring hospitalisation, and two measures of preventable admissions for the under 19 years old.
i. Our integration and LTC Improvement Interventions will deliver integrated health and social care close to home for the elderly and those with LTCs and integrated physical and mental health care in year 1 of the plan
ii. Our primary care development programme will ensure we can deliver the evolution required in primary care to ensure general practice is contributing fully to this priority from the beginning of year 2.
iii. Our urgent and emergency care improvement intervention will remodel our emergency and sub-acute pathway so that it delivers :
☐ Primary care assessment at ED to improve referral straight to community based services
☐ A dedicated Clinical Decision Unit for Paediatrics, co-located with the Emergency Department at the JR
☐ Enhanced MIU provision
☐ Access to urgent ambulatory care pathways in the acute
☐ Roll out of Emergency multidisciplinary units to provide 1 stop shop alternatives to A&E for those needing a speedy assessment and same day package of community health and social care in order to remain at home.

5.Patient experience. Improving patient experience is a current health and wellbeing priority and is measured by 3 indicators on satisfaction with social care; hospital care and GP care. We will continue to use these measure until the new national metric is developed and will review the existing measure once the new metric is agreed

6. The local measure is to increase the proportion of older people with an on-going care package supported to live at home. This is monitored via reports to the Department of Health in the national RAP and ASC-CAR submission. The scheme will assist the delivery of this objective by increasing the numbers of people supported via home care (or direct payments) as an alternative to care homes

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment.

Patient expericence is currently measured in the health and wellbeing strategy vis 3 separate national measures. These are:
Achieve above the national average of people very satisfied with the care and support they receive from adult social care (Health and Wellbeing Strategy indicator 7.3)

Achieve above the national average of people satisfied with their experience of hospital care (Health and Wellbeing Strategy indicator 7.4)

Achieve above the national average of people 'very satisfied' with their experience of their GP surgery (Health and Wellbeing Strategy indicator 7.5)

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

Assurance of the performance plans for the Better Care Fund plan will be provided by the Older People's Joint Management Group, reporting to the Health and Wellbeing Board. The Older People's Joint Management Group meets in public bi-monthly, and has a key role contributing to the delivery of the priorities in the Joint Health and Wellbeing Strategy by monitoring and managing the implementation of the Joint Older People's Commissioning Strategy through the Older People's Pooled Budget, including performance indicators, activity and spending. It reports regularly and by exception to the Health and Wellbeing Board and Clinical Commissioning Group and County Council.

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB

N/A

Outcomes and metrics

Please complete all pink cells:

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	1334	
	Numerator	10181	9092	
	Denominator	691785	681559	
		(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

* Baseline figures for the four national metrics figures are available on the NHS England BCF webpage (http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/)

Briefing Paper

April 2014

Title	**Oxford University Hospitals (OUH) Annual Quality Account Overview and Consultation Timeline**

Status	This briefing paper is for noting and discussion by stakeholders at their scheduled meetings in April and May 2014, namely: Oxfordshire Joint Health Overview and Scrutiny Committee Oxfordshire Health and Wellbeing Board Healthwatch Oxfordshire Oxfordshire Clinical Commissioning Group
History	This is a one-off briefing paper

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Background

What is a Quality Account?

1. It is a statutory requirement for all providers holding contracts with NHS commissioners exceeding a value of £130,000 per annum to publish an annual Quality Account.
2. The Quality Account is formally submitted to the Secretary of State and published via the NHS Choices website on 30 June each year.
3. Quality Accounts covering the financial year 2013/14 will be published 30 June 2014.
4. The Quality Account is composed of a number of distinct elements (as laid down by relevant regulations), including the following major sections:

    - Foreword from the Chief Executive.
    - Description of quality priorities for 2014/15.
    - Progress report on quality priorities identified last year for 2013/14.
    - Review of various nationally benchmarked data relating to quality and performance.
    - Review of high-level financial performance.
    - Statement on participation in national clinical audits.
    - Information on research participation by patients.
    - Progress report in relation to performance against CQUIN goals for 2013/14.[1]
    - Statement on compliance with CQC (Care Quality Commission) standards.

Consultation

5. It is a statutory requirement that the lead commissioner is offered an opportunity to review a draft of a provider's Quality Account by 30 April, and to offer a view upon its content. The lead commissioner has up to 30 days to provide this view that is then published within the Quality Account.
6. It is a statutory requirement that the local Health (or Joint) Overview and Scrutiny Committee has an opportunity to review a draft of a provider's Quality Account. The Committee may offer a view upon its content and if provided, this view is then published within the Quality Account.
7. It is a statutory requirement that 'patient involvement networks' have an opportunity to review a draft of a provider's Quality Account. The patient involvement network may offer a view upon its content and if provided, this view is then published within the Quality Account. The definition of 'patient involvement networks' has evolved since the 2010 Act and is now taken to mean the local branch of Healthwatch England, and the Health and Wellbeing Board hosted by the Local Authority.
8. The Quality Account is independently reviewed by external auditors in order to provide limited assurance in respect of (1) having the content as laid out by Statute and (2) a review of data quality in respect of two specific measures presented in the Account.

Proposed handling of the Quality Account by stakeholders

9. Timetables for the production of the Quality Account (driven in large part by a lag time until validated end of year data are available, both locally and nationally) and the meeting schedules of governance committees within OUH render it impossible to guarantee that a formal draft will be available at a time to coincide with the meeting schedules of all

[1] CQUIN (Commissioning for Quality and Innovation) is a contractual framework between commissioners and providers whereby achievement of income equivalent to 2.5% of the contract value for the previous year is tied to meeting agreed quality-related goals.

stakeholders.

10. It is noted that Quality Accounts are often long documents, and that many stakeholders will be asked to comment upon the Accounts of several providers.
11. It is therefore proposed that stakeholders receive this briefing paper containing the proposed headline content of the Quality Account and have the opportunity to discuss this paper with a member of the OUH governance team during a routine meeting should they wish. The stakeholder committee can then decide how best to delegate the task of reviewing the Quality Account itself and devolve, should it so choose, the development of a response to members or officers.
12. It is anticipated that an early draft of the Quality Account will be made available to stakeholders on Monday 28th April. Individual stakeholders will chose how to share this draft amongst their membership.
13. The remainder of the paper describes the key content of the OUH Quality Account at a high level, in the following areas:

    - Foreword from the Chief Executive.
    - Progress report on quality priorities identified last year for 2013/14.
    - Description of quality priorities for 2014/15.

Foreword from the Chief Executive

14. It is anticipated that the foreword will:

    - Recognise the major challenges faced by the wider NHS during 2013/14 – namely: the findings of the Public Inquiry into events at Mid-Staffordshire NHS Foundation Trust ('Francis 2') and the relationship between organisational culture and care; increasing emergency hospital attendances; and, the current financial environment in the Public Sector.
    - Outline the key components of the response of OUH to Francis 2, specifically our *risk summits* and *peer review* process.
    - Describe the successes of the Trust during 2013/14 in securing funding and/or recognition as a major contributor to: an Academic Health Science Centre (AHSC); a comprehensive clinical research network (CRN); and, an Academic Health Science Network (AHSN). The potential benefits for local patients from these endeavours will be highlighted.
    - Note achievements made during 2013/14 from a quality perspective whilst recognising the former priority areas in which further work is still required.
    - Recognise the fundamental importance of our staff in delivering the organisation's outcomes, and describe ongoing work in relation to our Trust values and staff development.

Progress report on quality priorities identified last year for 2013/14.

15. The priorities for 2013/14 were arranged in the domains of patient safety, clinical effectiveness and the experience of patients.
16. The patient safety priority was 'safer care associated with surgery' including desired improvements in relation to the consent process. Progress over the year has been mixed and much work remains in relation to embedding cultural change and further optimising substantive staff numbers in post. Highlights include:

    - Oxford University, supported by the Trust, has been awarded funding to develop a Patient Safety Academy.
    - A Cross-Divisional Theatres Group coordinates and leads this programme of work.

- Compliance with the World Health Organisation (WHO) Surgical Safety Checklist is monitored via spot-checks and observational audit, along with other safety critical policies and practices (for example, counting of needles, swabs and surgical instruments). Reported compliance is much improved, ranging between 96 and 100%.
- Clinical supervision skills have been a focus of the leadership development programme attended by Theatre Sisters and Charge Nurses (amongst others).
- A significant recruitment campaign has been undertaken in Europe with the support of external recruitment experts.
- Staff members report an increased number of potential near-miss events, where their interventions have prevented an incident from occurring. Such reporting is held to signify an open and learning culture with a focus on safety.[2]
- Consent forms have been revised with an emphasis on standardising the information provided about risks and their frequency, where appropriate, and upon the need to formally evaluate a patient's capacity to make informed decisions where there is any doubt in this regard (for example patients with cognitive impairment).

17. The clinical effectiveness priority was 'using technology to improve care' including the use of human factors methodologies in improving the functioning of teams. Progress over the year has been good. Highlights include:

- Rollout of a new electronic system for the requesting of tests by colleagues in Primary Care ('ICE').
- Development of a new system for collecting, collating, analysing and reacting to markers of physiological deterioration amongst hospital inpatients. The end result is hoped to be a much improved 'early warning score' to allow clinical resources to be directed to patients who show early signs of deterioration. Major external grant funding has been secured for a project previously funded via the Oxford Biomedical Research Centre.
- A number of human factors training courses were held for teams from a variety of services within the Trust. The training emphasized lessons learned from organizations with a good safety track record such as the airline and nuclear industries. Training focused on how teams communicate together with an emphasis on communicating in a more structured way.

18. The patient experience priorities were 'improving the way we listen to and act on feedback' and 'improving care for people with cognitive impairment'. Progress over the year has been good. Highlights include:

- Agreement of a Patient Experience Strategy.
- Roll out of the national Friends and Family Test (FFT) ahead of schedule to all areas in the Trust.
- Enhanced profile for patient and carer feedback alongside other data for decision-making and service management.
- A number of consultant liaison psychiatrists have been appointed and have made a major contribution to the care provided for patients with cognitive impairment.
- Twenty nurses are being funded to attend an external Dementia Leaders Programme.

[2] High levels of incident reporting are regarded as demonstrating an open safety conscious culture, rather than necessarily signifying high levels of incidents and harm. The ratio of 'incidents with significant harm' to total incidents reported is monitored in order to determine the interplay between reporting practice and the volume of adverse incidents.

Description of quality priorities for 2014/15.

19. The emerging quality priorities for 2014/15, notwithstanding a public engagement event being held on 24th April and ongoing discussions with commissioners around CQUIN goals are as follows:

    - Patient safety – a programme of work to review and improve arrangements in place for the management of inpatients outside normal office hours across the four Trust sites.
    - Clinical Effectiveness – implementation of the outputs of the risk summits held in autumn 2013 examining the care of adult in-patients with diabetes.
    - Clinical Effectiveness – expand the provision of physician input into the care of inpatients in surgical specialties.
    - Patient Experience – improvements to the timeliness and communication around discharge from hospital.
    - Patient Experience – improvements to the overall experience of patients attending outpatient appointments, particularly in relation to communication around booking and scheduling.
    - Patient Experience – develop services to provide integrated psychological support for patients with cancer.

20. Priorities for 2014/15 will again be arranged in the domains of patient safety, clinical effectiveness and the experience of patients. However, the priorities will also be aligned to each of the five key questions now asked of services and Trusts by the Care Quality Commission (safe, caring, effective, responsive, well-led).

Recommendation

21. Stakeholders are asked to receive this briefing paper and determine how best to delegate the task of reviewing the Quality Account itself (and the development of a formal opinion on it) to members or officers. It is anticipated that an early draft of the Quality Account will be made available to stakeholders on Monday 28th April.
22. Oxford University Hospitals NHS Trust welcomes comments from stakeholders at any point in time. However, comments received by 25th May will be incorporated into the draft of the Quality Account and related papers to be considered by the Trust Board's Quality sub-Committee.

Dr Ian Reckless
Acting Deputy Medical Director

22 April 2014

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Oxfordshire
Clinical Commissioning Group

Non-Emergency Patient Transport Service Pre-engagement Paper for Oxfordshire Joint Health Overview & Scrutiny Committee Thursday 1 May 2014, 10:00.

Background

NHS - Non-Emergency Patient Transport Services (known as PTS) are typified by the non-urgent, planned transportation of patients with a medical need for transport to and from a premises providing NHS healthcare and between NHS healthcare providers.

Non-Emergency Patient Transport is provided free of charge to patients that meet an eligibility criteria; however, transportation is not an automatic entitlement and nor should Patient Transport Services be used for social needs, such as where a family member is unable to provide transport to an appointment. A number of free or low cost transport services exist across Oxfordshire to support patients with a social need for transport who otherwise do not meet the NHS eligibility criteria.

It is recognised that the Patient Transport Service plays a vital role for some patients who need to reach hospital, for treatment, outpatient appointments or diagnostic services, do so in a reasonable time and in reasonable comfort, without detriment to their medical condition, where no other means could achieve this.

Approximately 107,000 NHS-funded journeys a year totalling c£3.77m are booked for patients registered with a General Practitioner in Oxfordshire.

Purpose of the Report

Against the backdrop of rising demand and tightening resources, Oxfordshire Clinical Commissioning Group need to make sure that this service can continue to be provided for the most vulnerable patients and at the same time make improvements to the service for those of greatest need that will advance patient experience and the quality of patient conveyance.

This pre-engagement paper outlines how Oxfordshire Clinical Commissioning Group (OCCG) propose to review the eligibly criteria for NHS Funded Non-emergency Patient Transport, describing the wider context that these changes seek to address and the proposed engagement and consultation timeline.

Oxfordshire Clinical Commissioning Group are keen to fully engage with the Oxfordshire public around these proposed changes and recognise the importance of Section 244 of the NHS Act 2006 placing a statutory duty on local NHS bodies to consult their local Overview and Scrutiny Committee (OSC) on proposals.

We are keen to consult with the public and key stakeholders on the proposals to ensure that any changes to the criteria used to determine whether a patient qualifies for NHS funded Non-Emergency Patient Transport are sufficiently robust, that the proposed changes are able to meet the development of modern health care services and there continues to be an

adequate level of NHS funded Non-Emergency Patient Transport in Oxfordshire. In particular we will want to understand any potential risk of widening inequalities in health outcomes.

The Clinical Commissioning Group intends to present its pre-consultation business case, draft consultation document, draft Equality Impact Assessment and consultation plan at the Governing Body, in public on the 29 May, with a view to beginning consultation after this date.

During the coming weeks of engagement and the 12 week consultation period Oxfordshire Clinical Commissioning Group will listen to the public and key stakeholders to ensure that we have gathered their views and taken them into account as part of the decision making process.

National and Local Non-Emergency Patient Transport Guidance

Patient Transport Services are provided to enable patients to get to appointments in outpatient departments or for minor treatments or investigations. A patient's eligibility is currently assessed by a suitably qualified member of staff or health care professional and is based on the following Department of Health quoted principles which states that patients are eligible:

1. Where the medical condition of the patient is such that they require the skills or support of Patient Transport Service staff on/after the journey and/or where it would be detrimental to the patient's condition or recovery if they were to travel by other means.
2. Where the patient's medical condition impacts on their mobility to such an extent that they would be unable to access healthcare and/or it would be detrimental to the patient's condition or recovery to travel by other means.
3. Recognised as a parent or guardian where children are being conveyed.
4. Transport can be provided to a patient's escort or carer where their particular skills and/or support are needed for instance significant communication difficulties or have a mental health condition that requires supervision.

(Department of Health, Eligibility Criteria for Patient Transport Services (PTS), 2007)

In Oxfordshire, the Clinical Commissioning Group has, since a previous Patient Transport Service consultation in 2011 applied the eligibility criteria to include patients who:

1. require continuous oxygen during transportation
2. require a stretcher
3. cannot stand or walk by themselves more than a few steps and,
4. cannot travel by public transport or in a family or friend's car
5. have a disability that prevents them from travelling by private or public transport
6. have a medical condition that may deteriorate if they were to travel by private or public transport.
7. will be attending for treatment likely to cause severe physical side effects, e.g. renal dialysis, oncology treatment or eye surgery affecting visual acuity.

In comparison, Clinical Commissioning Groups elsewhere apply a more restricted eligibility framework than currently in operation here in Oxfordshire. For instance Bristol, North Somerset and South Gloucestershire (BNSSG) CCGs provide transport in the following cases:

1. Patients who require the continual support and skill of patient transport staff on/after the journey and/or where it would be detrimental to the patient's condition or recovery if they were to travel by other means, for example this would include (this list is not exhaustive):
   a) Patients who require Patient Transport Service staff to administer oxygen during the journey
   b) Patients with dementia or other mental health conditions who require patient transport staff to ensure a safe journey

2. Where the patient's medical condition impacts on their mobility to such an extent that they would be unable to access healthcare and/or it would be detrimental to the patient's condition or recovery to travel by other means. This is often a judgement call that the medical staff assessing eligibility must make, and is a judgement based on a combination of the patient's medical condition, the distance and frequency of travel needed, and the alternative transport options open to that patient, for that journey or those journeys, at that time.

3. Renal dialysis patients: BNSSG provides Patient Transport Service for renal dialysis patients to enable them to attend weekly dialysis and related outpatient appointments.

4. Patients who need to travel by stretcher

5. Patients being transferred between hospitals

Comparing these interpretations, Oxfordshire patients can appear eligible for transport when their journey is undertaken by a volunteer car driver, the equivalent of a family or friends car, therefore the consultation will review whether the current criteria are inappropriately being applied where such a journey we believe could be undertaken by private means. Oxfordshire Clinical Commissioning Group would want to explore this as part of the public consultation.

Summary of Proposals

There are 8 mobility types that are used to define the transport requirements for patient transport in Oxfordshire.

Mobility categories	Number of journeys 2013/14	% of journeys
W - Walker	31,446	29.3%
SC – Single crew seated patient	20,531	19.1%
DC – Double crew seated patient	10,701	10.0%
OC1 – Single Crew manual wheelchair	13,901	12.9%
OC2 – Double Crew manual wheelchair	9,776	9.1%
EC – Electric Wheelchair	1,949	1.8%
STR – Stretcher	5,188	4.8%
BP – Bariatric Patient	351	0.3%
Escort	10,006	9.3%
Abort (journey cancelled during transit)	3,639	3.4%

Walker and single crew mobility types are those patients that travel by volunteer driver, minibus or single crew ambulance car. Essentially these are patients who could travel by car and need minimal assistance in getting in and out of a vehicle. Such patients typically do not require management during transit and do not require specialist transport, such as a wheelchair capable vehicle.

The Oxfordshire Clinical Commissioning Group proposes to consult on applying our eligibility criteria more highly, in line with some Clinical Commissioning Groups elsewhere, to those patients that do not require management during transit or specialist transportation. If agreed after public consultation these changes will reduce the majority of the journeys for the 2 mobility types of 'Walker' and 'Single Crews'. The proposed eligibly criteria will build on the previous 2011 consultation that sought to tighten eligibility criteria for 'Walkers'.

Whilst we continue to develop our plans we currently estimate that around a third of journeys for patients whose medical need for transport is considered essential and require 'Walker' and 'Single Crew' transportation e.g. where the patient's medical condition impacts on their mobility, will be protected from the proposed changes to eligibility. These could include those who receiving treatment for dialysis, oncology, eye surgery or similar. A full appraisal of the scale of change will be provided during the consultation period.

As per current regulations, if it is deemed that a patient is no longer eligible they may be entitled to claim under the Healthcare Travel Costs Scheme[1] for the cost of travelling to hospital or other NHS premises for NHS-funded treatment or diagnostic test.

[1] Further information on how to obtain this support can be found in the NHS's 'Health with Health Costs' document

As part of the revision of Patient Transport Services, Oxfordshire Clinical Commissioning Group intends to also explore the need for additional patient transport services to support patients requiring rapid assessment.

The Clinical Commissioning Group will develop a consultation plan to agree how, where and with whom we should seek views from the changes to the patient transport services which we are proposing.

Key Messages

Under the future proposals

a) We propose to protect the non-emergency patient transport service for the most vulnerable.
b) It will be particularly important to reassure those who are patients in greatest need they can still access essential services
c) If the proposals were accepted some patients who have been accessing to use the service will not be able to use it in future.
d) We will explain how we will be checking eligibility for the service.
e) Patients deemed ineligible to access Patient Transport Service will be given support and information on finding alternative low cost and voluntary transportation.
f) Financial support may be available to patients if they have a low income and are eligible under the Healthcare Travel Costs scheme
g) We will explore the needs for additional Patient Transport Service that require rapid assessment

Engagement and Consultation Timeline

Engagement phase June – August	**Milestone**	**May - July**	**Meeting**
	Notification of future consultation and discussion of the pre engagement phase	1st May 2014	HOSC
	Pre consultation business case, Consultation document and Equality Impact Assessment to be agreed at CCG Governing body	29th May2014	CCG Governing body
Consultation 12 weeks 30th May – 8th August	Launch consultation	30th May 2014	
	HOSC meeting during consultation	3rd July 2014	HOSC
	Consultation closes	8th August 2014	
Implementation	Agreement on future approach to Patient Transport Service	26th September 2014	CCG Governing body
	Patient Transport Service apply eligibility for all new patients and notify existing patients	1st October	
	Eligibility applied to all patients	1st November	

Consultation Plan

The Clinical Commissioning Group are keen to agree with HOSC the consultation plan and will seek direction from this committee to ensure our timetable can remain and that we are undertaking an effective fully engaged consultation with the committee and public.

Key stakeholders

Initially the following key stakeholders have been identified. During the course of the consultation it is expected that further stakeholders will be identified and engaged appropriately:

In addition to working extensively with the Health and Wellbeing Board, we have identified the following stakeholders and are keen to hear suggestions of others not presently known.

- Health and Wellbeing Board
- Joint Health Oversight & Scrutiny Committee
- Older Peoples Joint Management Group
- Carer Groups
- Complaints services
- County, district and parish council links
- Current users of the Patient Transport Service
- GPs and practice staff
- Local newsletters
- Other voluntary sector organisations
- Oxfordshire County Council's Integrated Transport Unit
- Oxfordshire Rural Communities Council

- OxTAIL (Oxfordshire Travel Advice Line)
- PALS services, all sectors Oxfordshire Berkshire and Buckinghamshire
- Patient panel at John Radcliffe and The Horton Hospitals
- Patient Participation Groups
- Patient Transport Service Booking staff at hospitals
- Relevant Voluntary sector - Age UK (older people and carers), CABs
- Transport leads in Oxford Health for community services
- Voluntary Sector Groups
- Volunteer Driver Schemes

Recommendations

The Oxfordshire Clinical Commissioning Group:

1. Ask the committee to note the proposal for a full consultation on Non-Emergency Patient Transport
2. We would seek to work with delegates from the HOSC to ensure our consultation approach and plans are comprehensive
3. To agenda the Patient Transport Service consultation at the next HOSC meeting 3 July, at which point we will provide the consultation for review

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Draft HOSC Forward Plan – Proposed Items

Below is a list of forward plan items that have been suggested by HOSC members during previous meetings and discussions held to identify priorities for the year ahead.

3rd July

- Outcomes based Commissioning (CCG, OH OUH)
- Cotswolds Maternity unit (OUH)
- Integrated Business Plan (IBP) CQC inspection (OUH)
- DPH annual report
- Healthwatch

18th September

- Horton Hospital Strategy (CCG, OUH)
- Community Hospitals (CCG, OH)
- Healthwatch

20th November

- Delayed Transfers of Care (annual performance from OCCG, OUH, OCC, OH)
- Healthwatch

Items to be scheduled:

Health Strategy

- Pooled Budgets (CCG, OCC)
- NHS England commissioning:
  - Primary care
  - Specialist services
- Oxford Health Foundation Trust Strategy

Major Service Change

- Remodelling of Adult Mental Health Services

Performance

- Urgent Care Pathway (CCG, OH)
- Community Hospitals (OH)
- Review of Public Health as part of the local authority (PH)
- South Central Ambulance Service performance (annual update)
- Emergency Services in Oxfordshire (Emergency Multi-disciplinary Units)
- Review of the new arrangements for Emergency Abdominal Surgery
- Rapid Nurse Assessment System (OUH,SCAS)

Topics

- Health Advocacy Service (CCG)
- District Nursing and Health Visitors (OH)
- Public Health contracts (PH)
- Public Heath obesity strategy (PH)

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