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NHS Oxfordshire Clinical Commissioning Group

OXFORDSHIRE COUNTY COUNCIL

healthwatch Oxfordshire

To: Members of the Oxfordshire Health & Wellbeing Board

Notice of a Meeting of the Oxfordshire Health & Wellbeing Board

Thursday, 14 July 2016 at 2.00 pm
Meeting Rooms1 & 2, County Hall, New Road, Oxford

Peter G. Clark
County Director

July 2016

Contact Officer: ***Julie Dean, Tel: 07393 001089***
julie.dean@oxfordshire.gov.uk

Membership

Chairman – Councillor Ian Hudspeth (Leader, Oxfordshire County Council)
Vice Chairman - Dr Joe McManners (Clinical Chair, Oxfordshire Clinical Commissioning Group)

Board Members:

Councillor Anna Badcock *(South Oxfordshire District Council)*	Chairman, Health Improvement Partnership Board
Eddie Duller OBE	Chairman, Healthwatch Oxfordshire
Dr Matthew Gaw	Vice-Chairman, Children's Trust
Councillor Mrs Judith Heathcoat *(Oxfordshire County Council)*	Chairman, Older People's Joint Management Group
Councillor Hilary Hibbert-Biles *(Oxfordshire County Council)*	Cabinet Member for Public Health
John Jackson	Director for Adult Social Services
Jim Leivers	Director for Children's Services
Dr Jonathan McWilliam	Director of Public Health
Dr Paul Park	Vice-Chairman, Older People's Joint Management Group
Rachel Pearce *(NHS England)*	Director of Commissioning Operations (South Central)
Councillor Melinda Tilley *(Oxfordshire County Council)*	Chairman, Children's Trust
Councillor Ed Turner *(Oxford City Council)*	Vice - Chairman, Health Improvement Partnership Board

In Attendance: Peter Clark, County Director, OCC
David Smith, Chief Executive, OCCG

Notes:• ***Date of next meeting: 10 November 2016***

Declarations of Interest

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

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

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

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

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

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

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

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

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

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

For a full list of Disclosable Pecuniary Interests and further Guidance on this matter please see the Guide to the New Code of Conduct and Register of Interests at Members' conduct guidelines. http://intranet.oxfordshire.gov.uk/wps/wcm/connect/occ/Insite/Elected+members/ or contact Glenn Watson on (01865) 815270 or glenn.watson@oxfordshire.gov.uk for a hard copy of the document.

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

AGENDA

1. Welcome by Chairman, Councillor Ian Hudspeth

2. Apologies for Absence and Temporary Appointments

3. Declarations of Interest - see guidance note opposite

4. Petitions and Public Address

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

To approve the Note of Decisions of the meeting held on 3 March 2016 (**HBW5**) and to receive information arising from them.

6. Performance Report - end of year 2015/16 (Pages 11 - 32)

2:05
15 minutes

Persons Responsible:	Director of Public Health, Director for Adult Social Services and Director for Children's Services, OCC; Chief Executive. OCCG
Person Co-ordinating reports:	Director of Public Health

To receive an update on performance against the outcomes in the Joint Health & Wellbeing Strategy set for 2015/16 **(HWB6**).

Action Required: to note the report.

7. Revised Joint Health & Wellbeing Strategy for 2016/17 (Pages 33 - 66)

2:20
20 minutes

Person(s) responsible:	All Partners
Person coordinating report:	Director of Public Health

Attached at **HWB7** is the draft revised Joint Health & Wellbeing Strategy for 2016/17 together with the performance against outcomes in the 2015/16 Strategy. The cover report to this document sets out the process for revision and also contains the views of the Oxfordshire Joint Health Overview & Scrutiny Committee put forward at its meeting on 30 June 2016.

The Health & Wellbeing Board is RECOMMENDED to:

(a) consider the views of the Health Overview and Scrutiny Committee, the content of the Joint Strategic Needs Assessment (which was presented to this Board in March 2016) and the performance against outcomes in the 2015-16 JHWBS in suggesting any final amendments to the document; and

(b) accept the JHWBS as the basis for its work in 2016-17.

8. Oxfordshire's Sustainability and Transformation Plan 2016/17

2:40
30 minutes

Person responsible: Chief Executive, OCCG
Person giving report: Chief Executive, OCCG

There will be a verbal update on the draft submission to NHS England **(HWB8).**

9. Oxfordshire's Better Care Fund Plan 2016-17 (Pages 67 - 100)

3:10
10 minutes

Persons responsible: OCCG and OCC
Person giving report: Chief Executive, OCCG

To update the Board on the development and submission of Oxfordshire's Better Care Fund Plan for 2016/17. The cover report and Plan, which has now been submitted, is attached at **HWB9.**

Action Required: to receive the Better Care Fund Plan for 2016-17.

10. Oxfordshire Transforming Care Plan 2016-2019 (Pages 101 - 152)

3:20
10 minutes

Persons responsible: OCCG
Person giving report: Chief Executive, OCCG

A planning template and action plan is attached at **HWB10.**

11. Healthwatch Oxfordshire - Update (Pages 153 - 158)

3:30
15 minutes

Person responsible: Healthwatch Oxfordshire (HWO)
Person giving report: Chairman, HWO

A general update on HWO activities will be given by Eddie Duller, OBE, Chairman of HWO **(HWB11).**

12. Reports from Children's Trust, Older People Joint Management Group and Health Improvement Partnership Board (Pages 159 - 164)

3:45
10 minutes

Attached are written reports on activities since the last Health & Wellbeing Board meeting in March **(HWB12)** from:

- Children's Trust
- Older People Joint Management Group
- Health Improvement Partnership Board

Action Required: to receive the reports.

13. SUMMARY OF COMMUNICATIONS RECEIVED BY THE CHAIRMAN - FOR INFORMATION ONLY (Pages 165 - 166)

A summary of communications received by the Chairman is attached at **HWB13.**

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OXFORDSHIRE HEALTH & WELLBEING BOARD

OUTCOMES of the meeting held on Thursday, 3 March 2016 commencing at 2.00 pm and finishing at 4.30 pm

Present:

Board Members:	Councillor Ian Hudspeth – in the Chair Dr Joe McManners (Vice-Chairman) Councillor Anna Badcock Eddie Duller OBE Councillor Mrs Judith Heathcoat Councillor Hilary Hibbert-Biles John Jackson Jim Leivers Dr Jonathan McWilliam Rachel Pearce Councillor Melinda Tilley
Other Persons in Attendance:	David Smith, OCCG; Peter Clark, OCC
Officers:	
Whole of meeting	Julie Dean, OCC

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

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

	ACTION
19 Welcome by Chairman, Councillor Ian Hudspeth (Agenda No. 1)	
The Chairman extended a welcome to members of the Board.	
20 Apologies for Absence and Temporary Appointments (Agenda No. 2)	

An apology was received from District Cllr Ed Turner.	Andrea Newman
21 Declarations of Interest - see guidance note opposite (Agenda No. 3)	
There were no declarations of interest.	Andrea Newman
22 Petitions and Public Address (Agenda No. 4)	
There were no requests to submit a petition or to make an address.	
23 Note of Decisions of Last Meeting (Agenda No. 5)	
The note of the last meeting was approved and signed as a correct record. With regard to Item 10, Oxfordshire Safeguarding Children Board (OSCB) – Annual Report – Peter Clark undertook to pursue with Maggie Blyth the information which Cllr Mrs Heathcoat had requested in relation to the working relationships/links which had been made with the Safeguarding Vulnerable Adults Board.	Julie Dean Peter Clark
24 Performance Report for 2015/16 Quarter 2 (Agenda No. 6)	
The Board reviewed current performance during Quarter 3, 2015/16 against the outcomes as set out in the Oxfordshire Health & Wellbeing Strategy (HWB6). It was **AGREED** to note the report.	Dr Jonathan McWilliam/Ben Threadgold
25 Joint Strategic Needs Assessment (JSNA) - Annual Report (Agenda No. 7)	
The Board considered this year's draft Joint Strategic Needs Assessment (JSNA) annual report which monitored trends in local data that impact on the Board's work. It also included recommendations for updating the Joint Health & Wellbeing Strategy (HWB7). John Courouble, the County's Research & Intelligence Manager, joined Dr McWilliam in introducing the draft	

JSNA. During the discussion Dr McWilliam undertook to report back on the following questions/issues: • to Councillor Mrs Judith Heathcoat on the question about whether the Defence Academy of the UK had been included within the Vale of White Horse's Armed Forces statistics; • In light of the OCC funding cuts, from whom would future statistics on Air Quality be provided? Would they be provided by the District Councils? • The availability of statistics giving a break- down of ages of patients suffering from diabetes within the county. In the event that it was not possible to produce this information with due accuracy, to study available research on the subject. With regard to air quality, the Chairman made reference to the need for county and district to work more closely together in the creation of by-passes within Housing Development plans which would serve to alleviate problems with air quality in certain areas. The Board **AGREED** to accept the JSNA as the basis for updating the Joint Health & Wellbeing Strategy and to thank the officers for their work in producing it.	Dr Jonathan McWilliam Dr Jonathan McWilliam/John Courable
26 Devolution for Oxfordshire (Agenda No. 8)	
Peter Clark, Head of Paid Service, OCC, reported that since the last meeting, a formal response on devolution had yet to be received from the Department for Communities & Local Government (DCLG) for greater Health and Social Care integration within Oxfordshire. He reminded the Board that these proposals had been supported by the District Councils, the OCCG and a variety of other stakeholders. He addressed the press statement made earlier that week from all Oxfordshire District Councils containing details of a proposed four unitary council model which would incorporate Cotswold District Council and South Northamptonshire Council. He stated that OCC, nor the affected CCGs outside of the current boundaries had been party to these proposals and that, as a consequence, OCC needed to think about how to take matters forward, following consideration of the full implications of this proposal. This would be with a view to conducting a separate	

discussion with the DCLG about how a more 'joined up' approach could be taken which would be both open and transparent and in the best interests of the residents of Oxfordshire.

The Chairman invited the Cabinet portfolio members and their relevant Directors to give their early thoughts on the issues and implications of the above proposal (without detracting from the proposals). These included the following:

- one of the biggest challenges experienced by small unitary councils was that of scale, capacity and cost;
- placements for very specialist care for children were difficult to finance;
- having one large organisation meant an ability for all stakeholders to work in close partnership, and an ability to input real expertise and skill base;
- co-terminosity with organisations such as Thames Valley Police and the OCCG brought great strength – changes to county boundaries could weaken this. Working with three Clinical Commissioning Groups and a number of NHS regional boundaries could result in co-ordination difficulties and would cut across their 5 year planning footprints. For example, there would be questions concerning the direction of travel in relation to the recent regionalisation of adoption services with Berkshire. It was understood that there had been no discussion with Gloucestershire and Nene (which includes South Northamptonshire) CCGs;
- the management of infectious diseases and emergencies, which currently relied on arrangements with Public Health England, would need to co-ordinate with 3 teams, thus making it both more challenging and complex;
- the current JSNA indicated significant areas of disadvantage in the County – the creation of 4 unitary authorities would result in these areas receiving a smaller share of government grant than currently received;
- there was currently 1 adult safeguarding board serving the whole of the county – it was likely that new legislation would be required if there was a split over 4 authorities, which could lead to a poor service for the residents of Oxfordshire.

Dr McManners commented that the OCCG Board had discussed and had decided to explore both the financial risks and governance issues behind the principle of a wholesale integration of Health and Social Care with a single budget and single accountability. The GP Locality Forums had also given reasonable support to the proposals. He added that, although the

Board felt there was much merit in the proposals, it did not wish to be drawn into the politics behind them. David Smith concurred with the comments made by Dr McManners, pointing out that the District Councils had also included the integration of Health and Social Care within their proposals, as well as the county. On being asked about whether any discussions had taken place with the Department of Health about the alternative proposals being put forward by the District Councils, Rachel Pearce clarified that she had not entered into any discussion with the Department of Health on this latest proposal as nothing had been put forward to NHS England about which to support or not to support. She further pointed out that NHS England had no direct relation with the Department for Communities & Local Government, only the Department of Health. She added her view that, to date, there had been good integration working at a strategic level and local level on the Transformation Plan and discussions would be undertaken with the CCGs involved looking at the merit of bringing Health and Social Care together in light of the new proposal. Peter Clark, on summing up the discussion, recognised that there had been no official backing of a particular model at this stage and that all parties had agreed that unification in some form would take place; and there had been an expectation that a model would be produced. However, OCC believed that the people of Oxfordshire required services that were jointly provided and this provision must continue, adding that Health and NHS England were keen on the principle of integration of Health and Social Care. He stated that OCC needed to adopt its own view on a model which was fit for purpose for Oxfordshire residents; and needed to be given an opportunity to air some of the concerns a four unitary proposal would have in relation to services for the people of Oxfordshire.	
27 Health Inequalities Commission - Update and Plan (Agenda No. 9)	
Dr Joe McManners gave an overview of the first, very successful, evidence session that had been held in Exeter Hall, Kidlington in February. Amongst those that had attended were GP representatives and those from the mental health, psychology, midwifery, paediatric services and Children's Centres. The theme of this first session entitled 'Beginning Well' was the first 5 years to teenage years. Much of the discussion concerned 'joined up' working within the community, basing services together on the ground, and the need for better links between schools and the Health services.	

Dr McManners stated that verbatim notes would be available for each of the 4 events and they would also be filmed. He confirmed that the Programme was receiving sufficient technical support. The Board thanked Dr McManners for his update and looked forward to receiving the final report in the Autumn.	Dr Joe McManners
28 Personal Health Budget Local Offer and Roll-Out Plan (Agenda No. 10)	
The Board had before them a report from OCCG which informed them of NHS England guidance which required CCGs to develop and make public a Local Offer for a major expansion of Personal Health Budgets (PHB) and seeking approval of the Oxfordshire Local Offer to be included within the Health & Wellbeing Strategy. Dr McManners informed the Board that the budgets had worked well for people with continuing care needs and confirmed that they were not for emergency use. The Board **AGREED** to: (a) note NHS England Guidance on the roll out of PHB beyond Continuing Health Care and work undertaken to date in Oxfordshire; (b) approve a Local Offer outlining groups who would potentially benefit from PHB and could receive them from April 2016, to be publicised and included in the Health & Wellbeing Strategy; and (c) note the next steps and governance process going forward.	))))) David Smith)))))
29 Oxfordshire's Sustainability Transformation Plan 2016/17, Better Care Fund and OCCG's 2016/17 Operational Plan (Agenda No. 11)	
The Board received a presentation from Stuart Bell CBE, Chief Executive of Oxford Health, and David Smith, Chief Executive of OCCG, on the Oxfordshire Transformation Plan and received information on progress in respect of the OCCG's 2016/17 Operational Plans. The Board was also requested to delegate the signing off of the Better Care Fund Plan 2016/17 and to agree to its endorsement at the next meeting of this Board in July.	

Mr Bell reported that public involvement had already begun on the Transformation Plan in the form of feedback given by GP locality groups. He was keen to continue with further community involvement work. The Board acknowledged that work involving Children, Education and Families was an essential part of the Programme. It was recognised there would always have to be cross boundary unity, together with associated issues relating to the NHS England (South) boundaries. Essentially it was about patient flow, not organisational boundaries.

At the request of the Board, David Smith gave the latest update on the Delayed Transfers of Care (DTOC) statistics, which had fallen from 157 at the end of October 2015 to 122. Although disappointed that the figure had not fallen further, he highlighted the positive factors which had arisen from the joint working within between health and social care staff in the central Hub. Staff had formed a comprehensive team to facilitate patients' move out of hospital care into care homes or to their own home.

The Board discussed the problems peculiar to Oxfordshire which had resulted in the high DTOC statistics relative to other areas. David Smith pointed out that it was the CCG's view that this problem could not be fixed in a few months and there was a very real need to transform the system as a whole. He called for more preventative services and an increase in the management of patient assessments, in addition to the need for more home care, adding that, as part of the planning for Transformation, organisations had got to agree on priorities. He warned that if this did not happen, then DTOC numbers would rise again. Dr McManners pointed out that there were pressures across the board in Oxfordshire including a high rural population and a large, ageing population, half of which suffered from dementia and other complex problems, many of whom were not easy to place. He also cited problems around staff recruitment and retention in Oxfordshire, where housing and letting prices were high, a large increase in Accident & Emergency attendance this winter and an increased demand on the ambulance service.

John Jackson commented that the real problem was that the system as a whole was very close to capacity, including the acute, primary and private sectors and the ambulance system. He agreed that the principle of finding the right equilibrium in the system was of great importance and there was a need to come back to a future meeting to discuss this.

The Board **AGREED** to:

(a) note the need for, and plans to develop a system-wide Sustainability & Transformation Plan by the end of June 2016, via the Transformation Board; (b) note progress with Oxfordshire CCG's 2016/17 Operational Plan; and (c) agree that the Oxfordshire's 2016/17 Better Care Fund Plan be signed off by the Chairman and Vice-Chairman in light of the fact that the Plan is likely to be submitted prior to the next meeting of the Board in July 2016; and that it be submitted for endorsement by the Board at its July meeting.	)) Stuart Bell/David Smith/John Jackson))))))
30 Closer to Home - Health and Care Strategy and Transformation Board update (Agenda No. 12)	
Dr McManners and Rosie Rowe, OCCG, gave a slide presentation on the principles of the Closer to Home Health & Care Strategy as managed by the Transformation Board. An overview was given of some of the OCCG engagements which had already taken place with some of the commissioning group chairs to identify ideas for priority clinical needs in each locality. These would be then be rolled out to a much broader setting for further discussion and debate. Following this the Strategy would be taken to full public consultation, as the proposals would be defined as a significant service change. It was reported that the Health Improvement Partnership Board had welcomed such a well-thought out programme and to hear about how it would be supported. It was confirmed that the Community Safety Partnerships would also have an involvement. The Board thanked Eddie Duller for his suggestion that the consultation document be in plain English and should include both a summary of the Plan and links to individual websites to help give it a unified aspect. This would solve the complications involved in charting for the public the service models which were available. The Board thanked Dr McManners and Rosie Rowe for the presentation.	Dr McManners/Rosie Rowe
31 Healthwatch Oxfordshire - Update (Agenda No. 13)	

Eddie Duller, OBE, Chairman of Healthwatch Oxfordshire (HWO) and Carol Moore, Acting Chief Executive, gave a general update on activities since the last meeting of the Board. Mr Duller reported that HWO was close to approval of its work plan for 2016/17, adding that there would be an overlap in some 2015/16 areas which they were currently working on. He further reported that the Board had found ways of undertaking work in different ways, so ensuring that there would not be a reduction in their workload in light of the 30% reduction in funding next year. Mr Duller confirmed that the HWO Board were to discuss the possibility of the organisation adopting charitable status in the future. The Board **AGREED** to receive the report.	Eddie Duller
32 Shared Working Protocol with Safeguarding Boards (Agenda No. 14)	
The Board considered a report outlining proposed working arrangements between key partnerships and Boards in Oxfordshire. The Board **AGREED** to approve the proposals outlined in the report.	All to note
33 Reports from Children's Trust, Joint Management Group & Health Improvement Board (Agenda No. 15)	
The Chairmen of the Children's Trust and the Older People's Joint Management Group, together with the Deputy Chairman of the Health Improvement Partnership Board briefly presented their written reports on activities since the last full Board meeting. The Board **AGREED** to note the report.	Cllr Melinda Tilley/Cllr Mrs Judith Heathcoat/Cllr Ed Turner
34 PAPERS FOR INFORMATION ONLY (Agenda No. 16)	
Noted.	

..... in the Chair

Date of signing .....

Health & Wellbeing Board
Performance Report 2015/16

Introduction

1. Annex 1 shows 2015/6 performance for all priorities in the Health & Wellbeing strategy. Performance on priorities 1-4 is managed through the Children's Trust; performance on priorities 5-7 is managed through the Joint Management Groups for the Pooled Budgets for adult health and care services and performance on priorities 8-11 is managed through the Health Improvement Board.

2. Priority 4 - is monitored via the Children's Trust in the annual education report. Attainment at all key stages is in line or above the national average. At all Key Stages the gap between disadvantaged and other pupils in Oxfordshire has narrowed this year due to increased performance of the disadvantaged group. However, the disadvantaged gap remains significantly wider than that nationally.

Summary

3. The table below summarises performance on each priority. In total 64 measures are reported, with 53 rated. 29 (55%) hit their target, with 6 (11%) rated amber and 18 (34%) rated red. Looking across all the measures performance is good, with more than half the measures hitting their target for priorities 2, 3, 5, 6, 9 and 10. However in the following priorities half or more measures are missed the target:
    a. Ensuring children have a healthy start in life and stay healthy into adulthood
    b. Support older people to live independently with dignity whilst reducing the need for care & support
    c. Preventing early death and improving quality of life in later years
    d. Preventing infectious disease through immunisation

	Red	Amber	Green	Not Rated	Total
1. Ensuring children have a healthy start in life and stay healthy into adulthood	1	0	1	0	2
2. Narrowing the gap for our most disadvantaged and vulnerable groups	1	1	5	1	8
3. Keeping children and young people safe	1	0	4	3	8
5. Working together to improve quality and value for money in the Health and Social Care System	2	0	4	2	8
6 Adults with long term conditions living independently and achieving their full potential	1	0	6	1	8
7. Support older people to live independently with dignity whilst reducing the need for care & support	5	2	1	2	10
8 Preventing early death and improving quality of life in later years	4	1	2	0	7
9. Preventing chronic disease through tackling obesity	0	2	1	0	3
10. Tackling the broader determinants of health through better housing and preventing homelessness	1	0	4	1	6
11. Preventing infectious disease through immunisation	2	0	1	1	4
Total	18	6	29	11	64

4. The individual indicators rated as red are:
    a. Ensuring children have a healthy start in life and stay healthy into adulthood
        i. 1.1 Waiting times for first appointment CAHMS. 75% of children will receive their first appointment within 8 weeks of referral by the end 2015/16
    b. Narrowing the gap for our most disadvantaged and vulnerable groups
        i. 2.8 Reduce the number of young people convicted of a violence against a person offence excluding common assault (defined as a gravity score of 4 and above)
    c. Keeping children and young people safe
        i. 3.2 Set a baseline for and then increase the proportion of specified outcomes that have been achieved in the child protection plan.
    d. Working together to improve quality and value for money in the Health and Social Care System
        i. 5.2 Reduce the number of avoidable emergency admissions to hospital for older people per 100,000 population from a baseline of 15,849 in 13/14
        ii. 5.6 Increase the percentage of people waiting a total time of less than 4 hours in A&E. Target 95% based on an average from the first three quarters of 2014/15 which is 91.3%
    e. Living and working well: Adults with long term conditions, physical or learning disability or mental health problems living independently and achieving their full potential
        i. 6.5 Reduce the number of emergency admissions for acute conditions that should not usually require hospital admission for people of all ages (2013/14 baseline: 951.4 per 100,000 population)
    f. Support older people to live independently with dignity whilst reducing the need for care and support
        i. 7.1 Reduce the number of people delayed in hospital
        ii. 7.2 Reduce the number of older people placed in a care home
        iii. 7.3 Increase the proportion of older people with an on-going care package supported to live at home from 62.7% in April 2015 to 63.0% in April 2016
        iv. 7.5 Increasing the number of people accessing reablement from the community.
        v. 7.6 Reduce the proportion of people who do not complete their reablement episode from 20.3% in 2014/15 to 17% in 2015/16
    g. Preventing early death and improving quality of life in later years
        i. 8.3 At least 66% of those invited for NHS Health Checks will attend (ages 40-74) and no CCG locality should record less than 50% with all aspiring to 66% (Baseline 46% Apr 2014)
        ii. 8.4 At least 3650 people will quit smoking for at least 4 weeks
        iii. 8.6 The target for opiate users by end 2015/16 should be at least 7.6% successfully leaving treatment and not representing within 6 months
        iv. 8.7 At least 39% of non-opiate users by 2015/16 should successfully leave treatment and not represent within 6 months
    h. Preventing chronic disease through tackling obesity
        i. none

i. Tackling the broader determinants of health through better housing and preventing homelessness
    i. 10.5 people estimated to be sleeping rough in Oxfordshire does not exceed the baseline figure of 70 (2014/15)
j. Preventing infectious disease through immunisation
    i. 11.2 At least 95% children receive dose 2 of MMR vaccination by age 5 (currently 92.5%) and no CCG locality should perform below 94%
    ii. 11.3 At least 60% of people aged under 65 in “risk groups” receive flu vaccination (2014/15 = 51.9%)

Steve Thomas
Performance & Information Manager (Social Care)
June 2016

Annex 1

Oxfordshire Health and Wellbeing Board
Performance Report

Priority One: Ensuring children have a healthy start in life and stay healthy into adulthood

	Target	Q1		Q2		Q3		Q4		Comment
		Fig	RAG	Fig	RAG	Fig	RAG	Fig	RAG	
1.1 Waiting times for first appointment CAHMS. 75% of children will receive their first appointment within 8 weeks of referral by the end 2015/16	61%	Not yet available		50%	R	38%	R	46%	R	Report provided to children's trust. 34% increase in referrals in year. Over 4000 open cases with increasing complexity. There are national recruitment issues. Services are being remodelled on partnership with Barnardo's; specialist pathways are being developed including Specialist Eating Disorder, ASD / ADHD and School In-Reach
1.2 Support secondary schools to have a school health improvement plan which includes smoking, drug and alcohol initiatives.	100%							100%	G	Annual measure

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

	Target	Q1		Q2		Q3		Q4		Comment
		Fig	RAG	Fig	RAG	Fig	RAG	Fig	RAG	
2.1 Reducing inequalities as measured by Public Health measure 1.01i - Children in poverty (all dependent children under 20)	<10.9									Annual measure. Data expected by the end of the year
2.2 Reduce the number of children and young people placed out of county and not in neighbouring authorities from 74 to 70	74	83	R	83	R	78	A	77	A	Increase in number of LAC means this is 12.6% of children. Includes 6 children placed for adoption
2.3 Reduce the level of care leavers not in employment, education or training	< 47%							45%	G	
2.4 Increase the number of young carers identified and worked with by 20% from 1801 at April 1, 2015 to 2161.	2190	1898 97 new	G	2037 236 new	G	2199 398 new	G	2281 480 new	G	480 new young carers identified. Currently 2281 on record. Increase of 26.65%. Revised baseline, target and figures included due to data cleansing
2.5 Reduce the number of children with SEN with at least one fixed term exclusion in the academic year. (Measured on an academic year)	5.1%	2.7%	G	n/a		3.4%	A	4.1%	G	493/12026 (T1-4) 61% of excluded children are SEN
2.6 Increase the proportion of children with a disability who are accessing short breaks services who are eligible for school meals	24%	40%	G	30.0%	G	32%	G	42%	G	
2.7 Reduce the number of first time entrants to Youth Justice Service from 208 in the calendar year 2014	< 208					175	G			Figure for 2015
2.8 Reduce the number of young people convicted of a violence against a person offence excluding common assault (defined as a gravity score of 4 and above)	18	7	R	11	A	20	R	24	R	Data is YTD. Equates to 21% of all violent offences compared with 13% last year

Priority Three: Keeping children and young people safe

	Target	Q1		Q2		Q3		Q4		Comment
		Fig	RAG	Fig	RAG	Fig	RAG	Fig	RAG	
3.1 Set a baseline for and then increase the amount of times the Independent Chair is satisfied that the core group minutes show that the objectives of the CP Plan are being progressed by the Core Group	48.6%	72.8%	G	72.2%	G	72%	G	72%	G	Data is YTD. Measure to be dropped going forward. Not helpful
3.2 Set a baseline for and then increase the proportion of specified outcomes that have been achieved in the child protection plan	48%	52%	G	42%	R	43%	R	42%	R	Significant decrease in the outcomes achieved. Data is YTD. Slight increase in Q3. Dropped this measure going forward as it provides conflicting data to 3.1 above
3.3 Increase the proportion of neglect cases where the neglect tool is used.										Concern raised in Q1. Data only includes tools recorded in social care. Group set up to review use of tool across organisations
3.4 Reduce the number of hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24) (PH OF 2.07ii)	135.4	143.7	R	123.9	G	112.0	G	110.7	G	
3.5 More than 70 schools receive direct support to implement effective Anti-Bullying strategies as evidenced by school action plans to tackle and reduce bullying through increased membership of Anti-Bullying Ambassador scheme, individual support from Anti-Bullying Co-ordinator and provision of training	70	46	G	46	G	111	G	146	G	98 primary & 48 secondary schools supported since March 31st 2015
3.6 Reduce the assessed level of risk for high risk domestic violence victims managed through the MARAC (Multi-Agency Referral Risk Assessment Conference)	80%	75%	G			79%	G	77%	G	

3.7 Female Genital Mutilation										Annual report produced and shared with OSCB; Safer Oxfordshire Partnership and Children's Trust Proposed measure for next year Numbers of consultations at the FGM specialist clinic.
3.8 Monitor the proportion of MASH enquiries leading to a referral where information was shared with partner agencies.	32%	33.5%		31.9%		32%		34%		

Priority Four: Raising achievement for all children and young people

The Annual Educational Attainment Report was discussed at the Children's Trust meeting on 19th January

- Attainment at all key stages is in line or above the national average.
- At all Key Stages the gap between disadvantaged and other pupils in Oxfordshire has narrowed this year. In all instances, this is due to increased performance of the disadvantaged group. However, the disadvantaged gap remains significantly wider than that nationally.

Monitoring Education Strategy measures:

	No	RAG
Early Years, including: • 62% of children in early years & foundation stage reaching a good level of development	66%	G
Levels of attainment and quality across all primary and secondary schools		
Closing the attainment gap, including:		
• Children eligible for Free School Meals o KS2 (%L4+RWM)	22% (20% in 2014)	R
• Children eligible for Free School Meals o KS4 (%5+A*C GCSES inc EM)	31% (34% in 2014)	G
• Children with Special Educational Needs Pupils with SEN but no statement/ EHC plan) o KS2 (%L4+RWM)-	41% (2014 – 39%)	R
• Children with Special Educational Needs Pupils with SEN but no statement/ EHC plan) o KS4 (%5+A*C GCSES inc EM)	15% (2014 – 15%)	A

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

	Target	Q1		Q2		Q3		Q4		Comment
		Fig	RAG	Fig	RAG	Fig	RAG	Fig	RAG	
5.1 Deliver the 6 Better Care Fund national requirements for closer working of health and social care			G		G		G		G	All are on track
5.2 Reduce the number of avoidable emergency admissions to hospital for older people per 100,000 population from a baseline of 15,849 in 13/14	15,849	15,969	R	16,281	R	17,677	R	17,649	R	Figures to the end of Feb We continue to be challenged with regards to ambulatory care being recorded in the national reporting system (SUS) as Non Elective or emergency admissions As a consequence national data collections will include this activity and show an increase in emergency admissions compared to the baseline. We do however know that the number of NELs has not increased in line with what was expected.
5.3 Increase the number of carers known to social care from 16,265 (March 2015) to 17,000 by March 2016	17,000	16,546	G	17,233	G	17,233 +	G	17,233 +	G	Target already exceeded. Figure not available in new system.
5.4 Increase the number of carers receiving a social care assessment from 6,042 in 2014/15 to 7,000 in 2015/16	7,000	1,131	G	3,337	G	4,904	G	7,036	G	Target met
5.5 Increase the number of carers receiving a service from 2,226 in 2014/15 to 2,450 in 2015/16	2,450	304		972		1,306		2,024		Figure is below target due to unforeseen consequence of the Care Act. Only carers with a personal budget or direct payment can be counted as receiving a service and have to be assessed, whereas previously they could directly access direct payments

										from GPs. Figure excludes most services that support carers e.g. over 4000 people receive the alert service, which provides an alarm to a call centre. A recent review of such services showed that in 88% of cases these reduced carers levels of stress and anxiety
5.6 Increase the percentage of people waiting a total time of less than 4 hours in A&E. Target 95% based on an average from the first three quarters of 2014/15 which is 91.3%	95%	96.2%	A	90.6	A	88.2	R	78.9	R	This has been a very difficult time with increased flow and levels of patient acuity. There are a number of initiatives in place to support this measure, such as extended capacity in Ambulatory Units, better coordinated system-wide bed management, and more capacity in Intermediate Care beds and care home placements. A recent Perfect Week has made a number of recommendations to support the improvement of increased flow through the system in general and ED in particular.
5.7 Increase the percentage of people waiting less than 18 weeks for treatment following a referral:										
• Admitted patients target 90%	90%	89.0%	A	87.2%	A	86.9%	A	93.7%	G	The 18 week waits from GP referral to treatment (RTT) targets have combined for 2015 / 16; OCCG reports on those admitted and non-admitted patients who have started their treatment within 18 week. The standard of 92% has been met with 93.7% of patients starting their treatment within 18 weeks of referral over the past year with Q4 achievement being 93%.
• Non-admitted patients target 95%	95%	95.9%	G	96.0%	G	94.8%	A			
• Of patients who do not complete the pathway target 92%	92%	94.2%	G	93.6%	G	93.6%	G			

5.8 Monitor complaints and compliments people raise about health and social care with the Clinical Commissioning Group and the County Council. Set a target to increase next year as a measure of transparency and openness to learning		An annual report covering the number of complaints, key issues and how we have responded will be provided

Priority 6: Living and working well: Adults with long term conditions, physical or learning disability or mental health problems living independently and achieving their full potential

	Target	Q1		Q2		Q3		Q4		Comment
		Fig	RAG	Fig	RAG	Fig	RAG	Fig	RAG	
6.1 20,000 people to receive information and advice about areas of support as part of community information networks	20,000	9078	G	19,808	G	28,220	G	Nya	G	Target exceeded by Q3
6.2 15% of patients with common mental health disorders, primarily anxiety and depression will access treatment	15%	14.6	A	14.4	A	17%	G	18%	G	Total for the year is 16%.
6.3 Improve access to psychological therapies so that more than 50% of people who have completed treatment having attended at least 2 treatment contacts are moving to recovery	50%	52.3	G	54.0	G	47%	R	51%	G	A new contract for an extended IAPT service commenced on 1 April 16. The service is now known as TalkingSpace PLUS and brings together the current Oxford Health, PML and Oxfordshire Mind services. The providers have worked hard through the transition to the new model to ensure they achieve KPIs and the CCG is assured this will be sustained into 2016/17. Total year-end figures reflect this with access at 16% and recovery at 51%
6.4 At least 60% of people with learning disabilities will have an annual physical health check by their GP	60%							33%		Oxon average 33% against a national average of 35%, 3 localities above the average and 3 below. Target and action plan to be reviewed in light of the national figure
6.5 Reduce the number of emergency admissions for acute conditions that should not usually require hospital admission for people of all ages (2013/14 baseline: 951.4 per 100,000 population)	< 951.4	999	R	938	G	1,092	R	1,092	R	Oxfordshire continues to develop its Ambulatory Care Pathways within both the acute and community settings. Recently, we have had further increase of capacity in the acute with the opening of the new Adams Ambulatory Unit and

										increased staffing capacity. Therefore we expect more patients with the appropriate conditions to be managed through an ambulatory pathway.
6.6 Increase the employment rate amongst people with mental illness from a baseline of 9.9% in 2013/14	9.9%	16.9%	G	15.6%	G	19.3	G	17.6	G	On track
6.7 Reduce the number of assessment and treatment hospital admissions for adults with a learning disability to 8 in 2015/16 from 20 in 2014/15	8		A		G		G		G	Target exceeded
6.8 Reduce the length of stay of hospital episodes for adults with a learning disability so that by March 2016 no one has been in a NHS Assessment & Treatment Unit for more than 2 years. It is acknowledged that 2 years remains an unacceptable length of stay and are working to develop a new approach which will improve the pathway.	0		G		G		G		G	All cases tracked on individual bases and exceptions agreed

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

	Target	Q1		Q2		Q3		Q4		Comment
		Fig	RAG	Fig	RAG	Fig	RAG	Fig	RAG	
7.1 Reduce the number of people delayed in hospital from an average of 145 per day in 2014/15.to an average of 96 for 2015/16	96	154	R	173	R	167	R	153	R	The *Rebalancing the System* initiative commenced in December 2015. Current performance has to be seen in the context of over 10% increase in A&E activity in January and February and worsening DTOC position nationally. The rate of occupied bed days as DTOC per thousand showed a significant drop in December – the latter falling from 1005 per 100k down to 791 per 100k and has remained below the November figure. The proportions of DTOCs of 0-7 days delay have shown a 10% increase in the initiative period. This would indicate our impact on bed days is greater than our impact on headcount snapshot. As part of the Better Care Fund plan we have identified a target of 74 people delayed by 3/17 to achieve the national target of no more than 3.5% delayed bed days. Performance has increased considerably since April. By the 16th June figures were under 100 (at 98)

7.2 Reduce the number of older people placed in a care home from 11.5 per week in 2014/15 to 10.5 per week for 2015/16	10.5	13.7	R	12.8	R	11.6	A	12.1	R	629 people were placed in care homes or 12.1 people per week. The rate is above target but in line with performance (595) last year when Oxfordshire's performance was in the top quartile nationally. The reason admissions have not reduced is in part due to capacity issue within the market for home care provision, as care homes are used as an alternative to home care. There has also been a 40% increase in people moving from hospitals directly to care homes - up from 177 last year to 252 this year. This has been particularly noticeable in the last 2 months where 53 people were permanently placed in care homes with the continued focus on delayed transfers of care
7.3 Increase the proportion of older people with an on-going care package supported to live at home from 62.7% in April 2015 to 63.0% in April 2016	63%	62.6%	A	62.1	R	60.0	R	61.0	R	More people than planned have been supported in care homes with the increase in admissions described above
7.4 Over 67% of the expected population (5081 out of 7641) with dementia will have a recorded diagnosis (provisional baseline 59.5% or 4948 people)	67%			65.3	G	66.0	G	66.7	A	

7.5 Increase the number of people accessing the reablement pathway including										
• Increasing the number of people accessing the reablement pathway from a hospital pathway to at least the national average.	1945	440	A	866	A	1245	R	1630	A	The number of people starting reablement has dropped by 16% from 2,743 last year to 2,315 this year when the plan was to increase uptake to 3,750. This is because of a lack of referrals (90% of recorded referrals translate to service starts); service capacity; delays of people in the reablement service waiting for long term on-going home care and a focus on ensuring that people are discharged from hospital in a timely manner, which means there is limited focus on encouraging community based referrals. Agreement to a new strategic care pathway for non-bed based short term care services was reached earlier this year consisting of two services: an Urgent Response and Telecare Service; and a Hospital Discharge and Reablement Service. The new Hospital Discharge and Reablement Service was to be provided by Oxford Health and Oxford University Hospitals. However agreement on tow this will work has yet to be reached and the council is now out to tender for the new service
• Increasing the number of people accessing reablement from the community. Our target for the year is 1875.	1875	178	R	360	R	506	R	685	R	
7.6 Reduce the proportion of people who do not complete their reablement episode from 20.3% in 2014/15 to 17% in 2015/16	17%	18.4%	A	18.8%	A	20.4%	R	20.4%	R	
7.7 Monitor the number of providers described as outstanding, good, requires improvement and inadequate by CQC and take appropriate action where required.										See below

7.8 Increase the number of people supported through home care by social care in extra care housing by 10% (from 114 to 125)	125	107	R	110	A	120	A	135	G	Target met
7.9 Increase the proportion of people on the end of life pathway who die in their preferred place.										This data is collated and reported nationally. They have stopped reporting at county or CCG level so the data is no longer available.

Provider CQC Ratings (as reported 1/4/2016) of providers inspected so far

	Care Homes			Social Care at home			Independent Health Care			NHS Healthcare			Primary Medical Services		
	Oxon No	Oxon %	National %	Oxon No	Oxon %	National %	Oxon No	Oxon %	National %	Oxon No	Oxon %	National %	Oxon No	Oxon %	National %
Outstanding	0	0%	1%	1	3%	1%	0	0%	10%	0	0%	1%	1	4%	4%
Good	61	63%	65%	25	63%	74%	1	50%	67%	4	80%	38%	18	75%	82%
Requires Improvement	36	37%	31%	14	35%	23%	1	50%	21%	1	20%	53%	4	17%	10%
Inadequate	0	0%	3%	0	0%	2%	0	0%	2%	0	0%	8%	1	4%	3%

Multi agency bi monthly care governance and quality meetings are held with the Care Quality Commission to review their reports alongside the council's own contract reports, safeguarding alerts and complaints to see all the intelligence held on the provider market and what further action is needed in working with these providers.

The council reviews all providers it has contracts with at least annually and agrees action plans with any provider which is not delivering care to an acceptable standard. The action plans are then regularly reviewed by the Contracts and Quality Team.

The major issues identified by both the Contracts & Quality Team and the Care Quality Commission are around specifically the capacity and capability of staff in these sectors.

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

	Target	Q1		Q2		Q3		Q4		Comment
		Fig	RAG	Fig	RAG	Fig	RAG	Fig	RAG	
8.1 At least 60% of those sent bowel screening packs will complete and return them (ages 60-74 years)	60%	59.2	A	57.1	A					Data for Q3are not yet available.
8.2 Of people aged 40-74 who are eligible for health checks once every 5 years, at least 15% are invited to attend during the year. No CCG locality should record less than 15% and all should aspire to 20%	15%	5%	G	11.1%	G	15.7%	G	20%	G	Cumulative Q4: North East: 14.2%; North: 18.4%; City: 21.2%; South East 24.6%; South West 21.7%; West 17.3%
8.3 At least 66% of those invited for NHS Health Checks will attend (ages 40-74) and no CCG locality should record less than 50% with all aspiring to 66% (Baseline 46% Apr 2014)	66%	42.2%	A	45.7%	R	48.0%	R	50.2%	R	Cumulative Q4: North East: 54.5%; North: 56.7%; City: 45.2%; South East 40.7%; South West 52.3%; West 58.6%
8.4 At least 3650 people will quit smoking for at least 4 weeks (Achievement in 2014/15 = 1955)	3650	477	R	992	R	1364	R			Data for Q4are not yet available.
8.5 The number of women smoking in pregnancy should decrease to below 8% (recorded at time of delivery). (Baseline 2014/15 = 8.1%)	<8%	7.8%	G	8.5%	A	8.8%	A	7.2	G	
8.6 The target for opiate users by end 2015/16 should be at least 7.6% successfully leaving treatment and not representing within 6 months (baseline 7.8%)	7.6%	6.2%	R	5.6%	R	4.7%	R	4.5%	R	Please note that the completion data is from 01/10/2014 to 30/09/2015, Re-presentations up to: 31/03/2016 (Q4)
8.7 At least 39% of non-opiate users by 2015/16 should successfully leave treatment and not represent within 6 months (baseline 37.8%)	39%	29.0%	R	27.9%	R	27.4%	R	26.2%	R	

Priority 9: Preventing chronic disease through tackling obesity

	Target	Q1		Q2		Q3		Q4		Comment
		Fig	RAG	Fig	RAG	Fig	RAG	Fig	RAG	
9.1 Ensure that the obesity level in Year 6 children is held at no more than 16% (in 2013/14 this was 16.9%). No district population should record more than 19%	< 16%					16.2	A			Cherwell 19.7% Oxford 19.2% All other districts under 15%
9.2 Reduce by 1% the proportion of people who are NOT physically active for at least 30 minutes a week (Baseline for Oxfordshire 23% against 28.9% nationally, 2014-15 Active People Survey)	< 22%			21.9%	G					
9.3 63% of babies are breastfed at 6-8 weeks of age (currently 60.4%) and no individual CCG locality should have a rate of less than 50%	63%	60.9%	A	63.8%	G	57.9%	A	58.2%	A	Problems with Oxford Health IT system – unsure data for Q3 and Q4 are correct – are checking.

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

	Target	Q1		Q2		Q3		Q4		Comment
		Fig	RAG	Fig	RAG	Fig	RAG	Fig	RAG	
10.1 The number of households in temporary accommodation on 31 March 2016 should be no greater than level reported in March 2015 (baseline 192 households)	< 192			218	R			190	G	
10.2 At least 75% of people receiving housing related support will depart services to take up independent living (baseline 91% in 14/15)	75%	84.8	G	86.1	G	88.0	G	87.2	G	
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 83% in 2014/15 when there were 2454 households known to services). Reported 6-monthly	80%			82%	G			85%	G	
10.4 More than 700 households in Oxfordshire will receive information or services to enable significant increases in the energy efficiency of their homes or their ability to afford adequate heating, as a result of the activity of the Affordable Warmth Network and their partners.	>700					1427	G			This represents a cumulative figure for Q1, Q2 and Q3.
10.5 people estimated to be sleeping rough in Oxfordshire does not exceed the baseline figure of 70 (2014/15)	<70					90	R			
10.6 A measure will be included in the performance framework to monitor the success of supporting vulnerable young people in appropriate housing following monitoring to establish a baseline.										Baseline to be established and outcome to be discussed in July 2016

Priority 11: Preventing infectious disease through immunisation

	Target	Q1		Q2		Q3		Q4		Comment
		Fig	RAG	Fig	RAG	Fig	RAG	Fig	RAG	
11.1 At least 95% children receive dose 1 of MMR (measles, mumps, rubella) vaccination by age 2 (currently 95.2%) and no CCG locality should perform below 94%	95%	95.1	G	94.5	A	95.1	G			Q2 North Oxfordshire 93.8 Oxford City 92.7% Data for CCG localities are not available for Q3
11.2 At least 95% children receive dose 2 of MMR vaccination by age 5 (currently 92.5%) and no CCG locality should perform below 94%	95%	92%	A	91%	R	91.9	R	92.5	R	Data for CCG localities are not available for Q3 and Q4. In Q2 only South West achieving over 94% (96.6%)
11.3 At least 60% of people aged under 65 in "risk groups" receive flu vaccination (2014/15 = 51.9%)	60%							45.9	R	
11.4 At least 90% of young women will receive both doses of HPV vaccination. (2014/15 =91.7%)	90%									Final figure for 2015/16 not yet available as Dose 2 being delivered during summer term 2016.

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Draft Joint Health and Wellbeing Strategy, 2016 – 17

Introduction
The Joint Health and Wellbeing Strategy (JHWBS) is a statutory requirement under the Health and Social Care Act (2012).

The Oxfordshire JHWBS was first agreed in 2012 following extensive discussions among partners and a formal public consultation. This strategy has been subject to annual revision since then, drawing from the annual report on the Joint Strategic Needs Assessment to identify emerging priorities in the population and considering performance against targets in the previous year.

The attached document is a revised draft for 2016-17. This has been drafted following a process of discussion with members of the Children's Trust, Joint Management Groups and Health Improvement Board. An earlier draft was presented to the Health Overview and Scrutiny Committee (HOSC) on 30 June and a summary of the views of the members of that committee is given below. This is included for information to members of the Health and Wellbeing Board as a contribution to the discussion on the draft revised strategy at their meeting on 14 July 2016.

Comments from members of HOSC:

- It is recommended that the Health and Wellbeing Board consider a major revision of the Joint Health and Wellbeing Strategy next year (2017-18). This strategy was first written in 2012 and has been revised on an annual basis.

- There were examples of repetition within the document.

- Consideration needs to be made of the impact of wider changes – for example the impact of changes to bus services on the likelihood of people being lonely, the effect of funding changes to housing related support, or the result of changes to Children's Centres. This should be combined with a view of the impact of the work of the HWB on the population.

- The information on reablement is likely to be incomplete as it does not include people who are self-funding their care.

- Some proposed outcomes appear to be reducing the level of ambition – including some topics where proposed targets are lower than they were last year.

- The Delayed Transfers of Care target seems to be too low.

- It would be helpful to include a full summary of the previous year's performance within the strategy document so that the context for the proposed outcomes is more fully understood.

- There is too little detail on who implements the work to meet the outcomes and how they are held to account.

- It is unclear what the plans are to meet the ambition / targets.

- There is no information on how the Joint Health and Wellbeing Strategy links to the Sustainability and Transformation Plan.

- There is insufficient information on why some targets were not met last year e.g. smoking cessation, drugs treatment.

- The narrative on physical activity does not refer to active travel though there is a cross reference within the Local Transport Plan proposals. This should be cross referenced.

Recommendations

The Health & Wellbeing Board is **RECOMMENDED t**o:

(a) consider the views of the Health Overview and Scrutiny Committee, the content of the Joint Strategic Needs Assessment (which was presented to this Board in March 2016) and the performance against outcomes in the 2015-16 JHWBS in suggesting any final amendments to the document; and

(b) accept the JHWBS as the basis for its work in 2016-17.

Oxfordshire's Joint Health & Wellbeing Strategy

2015 - 2019

Version 5, July 2016

**(First Version July 2012,
Revised July 2013, June 2014, June 2015, June 2016)**

CONTENTS

1. Foreword to the Revised Version of this strategy, June 2016

This revised strategy is the work of a mature partnership with a long term perspective on improving health and social care in Oxfordshire. We have now completed four years of work addressing a range of priorities and have kept our focus on measuring the difference that is being made. Progress has been demonstrated in many areas of work. Where we have cause for concern we have been able to keep a focus and renew our resolve to work on those issues together.

As in previous years, revision of this strategy has built on performance in the previous year and the emerging issues highlighted in the Joint Strategic Needs Assessment. In this way we continue to prioritise our work and ensure that the focus for the partnership is directed to the biggest issues.

We have continued the approach of setting outcomes for all our Health and Wellbeing priorities and of receiving updates on performance each time we meet. This revised strategy sets out our ambition for the year ahead. This helps us to drive improvement on the issues that need a partnership approach.

Particular successes in the last year have included

- Many children have a healthy start to life, demonstrated by higher than average rates for breastfeeding and good coverage of immunisations – though there is still room for more improvement.
- More young carers have been identified and are receiving support.
- Progress is being made on the integration of health and social care services.
- Over 30,000 people had information and advice about areas of support through the Community Information Networks
- Uptake of invitations to attend NHS Health Checks has remained steady during the year
- The percentage of children who were overweight or obese in Year 6 last year was lower than in the previous year, helping us towards the target of stalling the general rise in obesity rates and going against the national trend.
- The Affordable Warmth Network has reported full take up of grant aided schemes and also a growth in referrals from health services

There are new developments this year which will inform the work of the Health and Wellbeing Board and which may also bring challenges. This includes the work to produce a Sustainability and Transformation Plan across the health and care system. We look forward to the public consultation on this in the autumn of 2016 and will assimilate responses received in our own strategic approach. The Health Inequalities Commission sponsored through this Board will also be reporting in the autumn and will also inform and challenge us.

We look forward to continuing our work together and building on the solid foundations of the last few years. People in Oxfordshire want and deserve services where and when they need them, to be helped to stay well and to be supported in their own community. The emphasis for all organisations is to focus on efficient, high quality services, to shift to prevention of ill health and to tackle inequalities.

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

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

2. Introduction

A Health and Wellbeing Board was set up in Oxfordshire in 2011 to make a measurable difference to the health and wellbeing of its people. Oxfordshire has a rich history of partnership working which strives to improve the health of Oxfordshire's people and the care they are offered. This Board was, therefore, very much the next logical step for Oxfordshire to take, and through it we also fulfil a key requirement of the Health and Social Care Act (2012).

The Health and Wellbeing Board is the principal structure in Oxfordshire responsible for improving the health and wellbeing of the people of the County through partnership working. The Board is a partnership between Local Government, the NHS and the people of Oxfordshire. Members include local GPs, Councillors, Healthwatch Oxfordshire and senior officers from Local Government. It meets in public, sets out a strategic plan and monitors progress at every meeting. It is also a forum for discussion on new developments.

Early tasks for the board were to look at the biggest challenges facing the wellbeing of Oxfordshire's people and to set out the Board's initial ideas in this strategy for improving the situation. This formed the basis for the Joint Health and Wellbeing Strategy and it has been updated annually since 2012-13.

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

3 Vision

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

By 2019 in Oxfordshire:

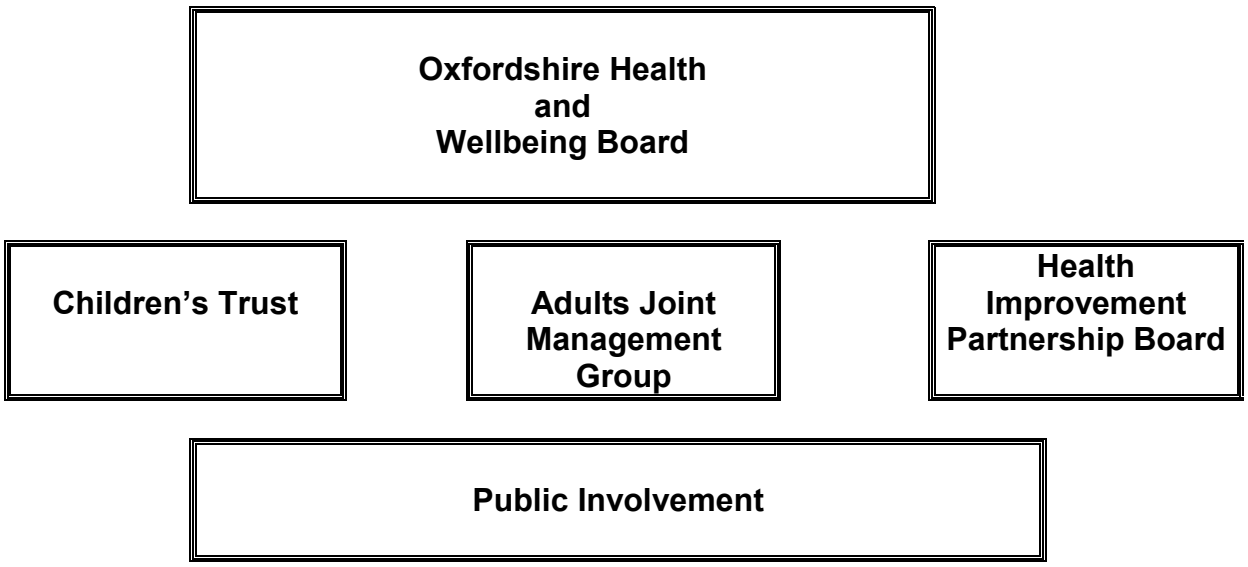
- more children and young people will lead healthy, safe lives and will be given the opportunity to develop the skills, confidence and opportunities they need to achieve their full potential;
- more adults will have the support they need to live their lives as healthily, successfully, independently and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

The priorities set out in this document put flesh on these themes. The priorities will continue to run for the medium term (2015-19), while the measures and targets set out within each priority are for the financial year 2015-16.

4. The structure of the Health and Wellbeing Board

4.1 What does the Health and Wellbeing Board look like?

The Health and Wellbeing Board has Partnership Boards and Joint Management Groups reporting to it and Public Involvement underpinning the whole system. Responsibilities for each are outlined below:



The purpose of each of the Boards, Joint Management Group and for Public Involvement is outlined below:

Adult Joint Management Group	Children's Trust	Health Improvement Board	Public Involvement
To improve outcomes and to support adults to live independently with dignity by accessing support and services they need while achieving better value for money, especially through oversight of our pooled budgets.	To keep all children and young people safe; raise achievement for all children and young people and improve the life chances for our most disadvantaged and vulnerable groups	To add life to years and years to life, focusing on the factors underpinning wellbeing, while levelling up differences in the health of different groups in the County	To ensure that the opinions and experiences of people in Oxfordshire underpin the work of the Health and Wellbeing Board.

4.2 How do decisions get made?

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

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

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

The Health and Wellbeing Board meets in public three times a year and the Health Improvement Board meets in public. The partnership boards also host workshops which include many more service providers, partners, informal/ volunteer carers, faith groups, voluntary sector representatives, the public and advocacy groups.

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

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

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

4.3 The Work of Other Partnerships and Cross-Cutting themes

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

- Better Care Programme Board
- Transformation Board and System Leadership Group
- Better Mental Health in Oxfordshire
- Urgent Care Programme Board that covers the A&E Recovery Plan
- Civilian Military Partnership
- Corporate Parenting Panel
- Alcohol and Drugs Partnership
- End of Life Care Strategy
- Oxfordshire Children's and Adults Safeguarding Boards
- Oxfordshire Domestic Violence Strategy Group
- Safer Oxfordshire Partnership
- Oxfordshire Stronger Communities Alliance
- Oxfordshire Sports Partnership
- Joint commissioning strategies for people with Physical Disability, Learning Disability, mental health issues, dementia or autism, and for older people
- Schools Strategic Partnership Education Commissioning Board
- Young People's Lifestyles and Behaviours Steering Group
- Carers' Strategy Oxfordshire
- Youth Justice Board

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

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

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

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

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

During 2015-16 the Health and Wellbeing Board signed a joint protocol outlining the relationship between the Oxfordshire Health and Wellbeing Board, the Oxfordshire Safeguarding Children Board, the Oxfordshire Safeguarding Adults Board, Oxfordshire's Community Safety Partnerships and the Oxfordshire Safer Communities Partnership. The protocol outlines the distinct role of each partnership board along with their responsibilities and governance arrangements and refers to their relationship with other partnership forums in Oxfordshire. it was developed in response to concerns raised in a Serious Case Review about unclear governance arrangements and lines of accountability

This protocol can be found here:
http://mycouncil.oxfordshire.gov.uk/ieListDocuments.aspx?CId=897&MId=4525

5. A strategic focus on Quality.

Discussion at the Health and Wellbeing Board has continually fuelled our intention to build a strategic focus on quality issues. The role of the Health and Wellbeing Board is to set strategic concerns for the whole system and to receive assurance of good practice. We have been monitoring a range of quality outcome measures and see a fairly good picture overall, but believe there is more to do.

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

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

A process has now been established for giving more assurance on quality issues across the system. This includes continuing to include a range of patient reported outcome measures in this strategy and monitoring performance closely. These patient outcome measures are regularly reported to the Health and Wellbeing Board and to the Joint Management Group. From 2014-15 it was also agreed that Healthwatch Oxfordshire could take a lead role in examining the Quality Accounts of providers of health and social care and working with them to agree priorities for the year ahead. These Quality Accounts are also discussed and scrutinised by the Health Overview and Scrutiny Committee.

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

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

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

This analysis is the scientific bedrock on which this strategy rests. During 2015-16 the data collection was further improved and made more accessible on the Insight web pages. An annual summary report was accepted by the Board in March 2016 which provided a comprehensive overview of the county. It can be found here: http://insight.oxfordshire.gov.uk/cms/joint-strategic-needs-assessment-report-2016

In addition an in-depth needs assessment of older people was completed in March 2016. This formed the third part of a suite of documents covering the whole population which can be found here: http://insight.oxfordshire.gov.uk/cms/joint-strategic-needs-assessment

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

6.2 What are the specific challenges?

1. **Demographic pressures** in the population, Oxfordshire's population is growing, and growing older. In mid-2013 the population was estimated to be 666,100, having risen by about 10% since 2001. There is an increasing number of older people, many of whom need care and may be isolated or lonely. This is markedly higher in our more **rural districts** than in the City.
2. The **proportion of older people** in the population also continues to increase which means that every pound spent from the public purse has further to go.
3. Oxfordshire remains the most rural county in the South East of England. Meanwhile, its population is becoming more diverse
4. There are a growing number of people with **dementia** in the County who require access to new emerging treatments.
5. The persistence of small geographical areas of **social disadvantage containing high levels of child poverty**, especially in Banbury and Oxford but also in parts of our market towns. These areas are also the most culturally diverse in the County **containing ethnic minority groups who have specific needs.**
6. The increase in **'unhealthy' lifestyles which leads to preventable disease**.
7. The need to ensure that services for the **mentally ill and those with learning disabilities and physical disabilities** are prioritised.
8. **Increasing demand** for services.
9. The need to support **families and carers of all ages to care.**
10. The need to encourage and support **volunteering**.
11. An awareness that the **'supply side'** of what we provide does not 'mesh' together as smoothly as we would like - (e.g. hospital beds, discharge arrangements, care at home and nursing home care).
12. The continuing **tightening of the public purse** which has knock-on effects for voluntary organisations.

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

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

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

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

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

6.4 What criteria have been followed in selecting priorities?

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

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

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

Each of the priorities set out in this strategy has associated outcomes to be achieved in the current year. The Board examines progress against all of these outcomes at each meeting along with any associated areas of concern which are identified. At the end of each year of operation the Board reviews successes, analyses on-going need as identified in the Joint Strategic Needs Assessment and proposes revised outcomes to be achieved in the year ahead. Each of the partnership Boards takes responsibility for delivering several of the priorities, as detailed in the list below:

The Priorities of the Health and Wellbeing Board

Children's Trust

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

Joint Management Group (for Older People, Mental Health)

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

Priority 6: Living and working well: Adults with long term conditions, physical or learning disability or mental health problems living independently and achieving their full potential

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

Health Improvement

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

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

Priorities for Children's Trust

Priority 1: <u>All children have a healthy start in life and stay healthy into adulthood</u>

The health and wellbeing of women before, during and after pregnancy is crucial in giving children a healthy start in life and laying the groundwork for good health and wellbeing later on.

There is increasing evidence that demonstrates that children's outcomes for physical and emotional health are determined from very early on in life. For this reason we will look at areas that focus on a healthy pregnancy and continued health and wellbeing in the early years.

There are a number of indicators of which the Children's Trust will retain oversight, but which will be monitored by the Health Improvement Board. These relate to breast feeding; smoking in pregnancy; childhood obesity; preventing disease through immunisation; and tackling homelessness and the number of households in temporary accommodation. All of these significantly impact the health and wellbeing of children.

The number of children in Oxfordshire aged 5 and under was 41,545 in December 2015 and had grown by 1.19% since the last census in 2011. We know there is a year on year increase in the proportion of children and young people admitted to hospital in an emergency. The most common causes of emergency admission to hospital for young children (under 5) are respiratory tract infections, viral infections and gastroenteritis. We therefore need to continue prioritising these children as a focus for our services in the community.

The Healthy Child programme delivers a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, supplemented by advice around health, wellbeing and parenting. The transfer of responsibility for commissioning the Healthy Child Programme delivered by the Health Visiting Service, which includes the Family Nurse Partnership Programme, from the NHS to the County Council Public Health team in the last year occurred smoothly.

We are also keen to focus not only on the transition into parenthood, but also the transitions that many of our more vulnerable children will face at different life stages and ensuring that all services are working together to prepare children for adulthood.

Young people tell us that there is much more we could do to improve the transition between young people's services and younger adults' services. This will be a focus for us in the next year.

Young people also told us that they want more information and support around mental health issues and we made this a priority for the past year and will continue to do so in this coming year. During the last year there has been a new service developed for children who have experienced sexual abuse, a new pathway for Autism Spectrum Disorder and Children and Adolescent Mental Health Services (CAMHS) in-reach has been piloted in schools. The CAMHS Transformation Plan will continue to remodel services, working with third sector partnerships and developing new specialist pathways.

We welcome a strong focus on promoting wellbeing and developing resilience, particularly in children and young people and having increasing awareness of mental health and access to support via schools, in partnership with school nurses and CAMHS, is crucial to this work.

Where are we now?

- There are a number of measures relating to a healthy start in life, such as rates of breastfeeding, obesity levels and immunisations that are reported under the Health Improvement Board's priorities 8-11.
- The overall rate for breastfeeding at 6-8 weeks is still higher than the national average and the aspirational target of 63% has been met. This very high level of success needs to be maintained.
- High coverage rates for most childhood immunisations were achieved across the county. This included the number of children receiving their first dose of MMR vaccine which remained above the 95% target, though parts some districts remained below 94%.
- We have had an increase in referrals to CAMHS by 34% from April 2015 to February 2016 and we have not been able to meet our target for waiting times. However, our urgent referrals continue to be seen promptly and we are performing better than national waiting times.
- All secondary schools have a school health improvement plan which is submitted on an annual basis and includes smoking, drug and alcohol initiatives.

Outcomes for 2016-17

There are a number of outcome measures relating to a healthy start in life, such as rates of breastfeeding, obesity levels and immunisations that are reported under the Health Improvement Board's priorities 8-11.

1.1 Waiting times for first appointment with Child and Adolescent Health Services (CAMHS). 75% of children will receive their first appointment within 8 weeks of referral by the end 2016/17.

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

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

Poverty and disadvantage are known to be strongly linked to poor outcomes and so work focused on reducing the gap between the most disadvantaged and most advantaged groups starting in 'early years' has been seen as a key way of improving outcomes for children and families. Our focus will be on children and young people looked after by the Local Authority, young people leaving care, and Young Carers. We want everyone involved to have the highest aspirations for these children and young people, including the young people themselves.

There is a national focus on helping the most disadvantaged and challenged families and Oxfordshire began its Troubled Families programme named Thriving Families in 2012. This

first programme was focused on working with children not attending school, young people committing crime or families involved in anti-social behaviour and adults who were out of work. The programme has expanded and aims to effect service transformation with partner services by embedding a whole family approach. Oxfordshire has been provided with a target of 2890 families which it needs to work with in order to achieve "Significant and Sustained Progress" by 2020. Within Oxfordshire we are in the midst of integrating Children's Services, the Troubled Families methodology and Think Family approach will be a key feature of this integration. This continues to be a vital strand in the on-going work locally to 'narrow the gap'.

The Family Nurse Partnership is an intensive home visiting service for first time teenage mothers, their partners and their children that starts in pregnancy and continues until the child is two years old. The programme provides 200 places a year to families throughout Oxfordshire that meet the eligibility criteria. Family nurses are trained to provide support on a broad range of issues including parenting, attachment, child development, maternal mental health and makes an important contribution to the Council's aim of 'narrowing the gap' for our most vulnerable children.

The attainment gaps for many vulnerable groups of pupils in Oxfordshire continues to be wider than the attainment gap nationally and remains a focus at all key stages. Persistent absence from school is a key factor impacting on educational attainment of the most vulnerable groups of children and young people. Persistent absence rates in secondary schools continue to be amongst the highest in the country. The number of permanent exclusions from Oxfordshire schools has risen considerably over the last two years. The attainment gap at all key stages of education and the number of school exclusions are greater for specific pupil groups, so there is a particular need to focus on specialist groups of vulnerable learners, in particular, children and young people eligible for free school meals; children and young people with autistic spectrum disorder and children and young people Looked After by the County Council.

Where are we now?

- The percentage of children in poverty has reduced and continues to be significantly better than the England average.
- Although our number of children looked after children (LAC) placed out of county is just above our target the number of children looked after has increased in the last year so the proportion of children placed out of county has decreased.
- During the academic year 2014/15, 17% of Children in Need (defined as those with a current Children in Need plan) and 18% of those subject to a Child Protection Plan in Oxfordshire were classed as persistently absent from school (i.e. missing 15% of sessions throughout the year). This is an increase from the previous year and remains higher than from the same cohorts nationally. The overall persistent absence rate for all pupils in Oxfordshire in 2013/14 was 4%.
- We have increased our number of young carers identified and worked with substantially in the last year.
- We have reduced the proportion of children with Special Educational Needs and disability (SEND) with at least one fixed term exclusion in the academic year.
- We have increased the proportion of children with a disability who are accessing short breaks who are eligible for free school meals.
- The disadvantaged gap is the gap between attainment between disadvantaged pupils and other pupils nationally. Disadvantaged pupils are identified as those who

are known to have been eligible for free school meals in the last six years, are adopted from care or looked after children. The disadvantaged attainment gap in Oxfordshire remains a priority at all key stages with the gap continuing to be wider than that nationally. A Strategy for Equity and Excellence in Education has been launched which takes new steps to address this by providing overarching strategy and specific support for individual cases to ensure improved outcomes for this group of young people. This work is overseen and monitored on a continual basis by the Improvement and Development Manager for Vulnerable Learners and we expect to see improvement this year (2015/16).

- At the end of the Early Years Foundation Stage the disadvantaged gap narrowed from 25 %points in 2014 to 22 %points in 2015. The national gap is 18 %points.
- At key stage 2 the disadvantaged attainment gap widened slightly from 18 %points to 19 %points in 2015 and remains noticeably wider than the national gap of 15 %points.
- At key stage 4 the disadvantaged gap narrowed from 34%points to 30%points in 2015.

Outcomes for 2016-17

2.1. Reduce the number of looked after children and young people placed out of county and not in neighbouring authorities.
Baseline: 77 children in 2015-16

2.2 Reduce the care leavers not in employment, education or training.
Baseline: 45% in 2015-16

2.3 Reduce the proportion of children with Special Educational Needs and Disability (SEND) with at least one fixed term exclusion in the academic year.
Baseline: 6.7% in 2015-16

2.4 Increase the proportion of children with a disability who are eligible for free school meals who are accessing short breaks services.
Baseline: 42% in 2015-16

2.5 Reduce the persistent absence of children subject to Child In Need and a Child Protection plan.
Baseline: Child in Need 18% in 2015-16
Child Protection Plan 17% in 2015-16
(Compared to 4% of all children)

Priority 3: Keeping all children and young people safe

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

Young people have previously told us that the five big safeguarding issues they face are:

- Fear of speaking up
- Feeling safe at home
- Boundaries and safe relationships
- Mental Health and Suicide
- Drugs

Safeguarding is everyone’s business and many different agencies work together to achieve it. The aim is to make the child’s journey from needing help to receiving help as quick and easy as possible by having better joined up services. We know that we need to ‘Think Family’ and support the network of support around the child.

In the last year increased levels of child protection activity have been seen across all organisations in Oxfordshire and all are working to ensure that children and young people are kept as safe as possible despite the increased pressures and reduced budgets. Seventeen organisations have completed impact assessments at a senior level regarding the increased child protection activity and the three overarching themes were managing demand in a collaborative manner, supporting the workforce as they hold potentially more complicated cases and identifying the impact of changes in housing support and how these can be mitigated.

Child Sexual Exploitation, neglect, domestic abuse and transitions for vulnerable children have been highlighted in recent Serious Case Reviews in Oxfordshire and we will continue to look at what is happening to improve work in these areas.

Child Sexual Exploitation continues to be a priority and there has been much work to ensure that there is increased recognition, detection, prevention and protection for children who may be at risk of Child Sexual Exploitation. We have also developed more support services for those children, young people and adults that have been subjected to Child Sexual Exploitation.

A Joint Thematic Area Inspection took place during March 2016 which concluded that Oxfordshire is working well together across all agencies to tackle Child Sexual Exploitation. A significant strength was the ability to learn from previous investigations and work closely with children and young people to help keep them safe.

We know that going missing is a key indicator that a child might be in great danger and missing children are at very serious risk of physical and sexual abuse, and sexual exploitation. We have developed robust processes across the county to identify and respond to children that go missing.

Domestic abuse continues to be a concern in Oxfordshire with increasing numbers of domestic abuse reports to police including children resident in the house in Oxfordshire in the last year. A strategic review of domestic abuse in Oxfordshire will continue this year and

hearing from children will be central to this review, so we can make sure we provide the right services to help keep children safe.

Where are we now?

- A new domestic abuse pathway for young people has been developed by a range of partners and is being implemented in Oxfordshire.
- The number of hospital admissions caused by unintentional and deliberate injuries in young people aged 15-25 has decreased.
- More than 146 schools have received direct support to implement Anti-Bullying strategies, doubling the target of 70 that was set last year.
- Child Protection activity across all agencies including police, children's social care and health has increased, as monitored through the MASH.

Outcomes for 2016 -17

To be confirmed.

All partners are currently being consulted to incorporate the OSCB Data set and Children's Trust into one data set and the performance measures that go forward under this priority into the Health and Wellbeing Strategy will be decided once this dataset is agreed.

In addition, the Children's Trust will maintain oversight of measures used by the Oxfordshire Safeguarding Children Board and Safer Oxfordshire Partnership measures in relation to children.

The Performance Audit Quality Assurance Group is a sub group of the Safeguarding Children Board and the Children's Trust and reports to both, highlighting pressure points and related actions, as well as reporting on performance.

Priority 4: Raising achievement for all children and young people

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

Early Years and primary school results are in line with or better than the national average and this can be built upon. At key stage 4 the proportion of young people in Oxfordshire reaching key threshold measures continued to be above the national average. There continues to be a wide variation in performance between schools at all key stages and also of specific groups of pupils. We know that specific pupil groups in Oxfordshire do not do as well as their peers in similar Local Authorities. This includes children receiving free school meals, children from some Black and Minority Ethnic Groups and those with special educational needs.

There have been improvements in inspection outcomes, in particular the proportion of schools judged by Ofsted as requiring improvements has decreased from 20% in August 2013 to 10% in March 2016. The proportion of outstanding schools remains below the national average. Overall, the picture shows gradual improvement but there is inconsistency across Oxfordshire and for certain groups of children.

Where are we now?

- At the end of March only 3.9% of young people were not in education, employment or training (NEET), below the ambitious target of 5%. However, the proportion of NEETs is not evenly spread throughout the county with low numbers in the South East Oxfordshire Hub area and higher numbers in Littlemore Hub area.
- The proportion of young people for whom their NEET status is not known only narrowly missed the target of 5% and represents a much lower proportion than at March 2014 when it was 11%.
- At the end of March, 87% of Oxfordshire schools were judged by Ofsted to be good or outstanding, slightly above the national average of 86%. There are over 76,500 young people attending schools that are good or outstanding, an increase of 9,000 since August 2013.

Outcomes for 2016-17

The Education Strategy monitors the levels of attainment and quality across all primary and secondary schools in Oxfordshire. The ambition for the county is to be in the top quartile of local authorities on all performance measures by the end of the 2017/18 academic year.

4.1 Improve the disadvantaged attainment gap at all key stages and aim to be in line with the national average by 2018 and in the top 25% of local authorities. Key stage 2 and key stage 4 are new national performance indicators so there are no available baselines from the previous year.

a) Early Years
b) Key stage 2
b) Key stage 4

4.2 Ensure that the attainment of pupils with Special Educational Needs and Disability (SEND) but no statement or Education Health and Care Plan is in line with the national average.

4.3 Early Years - 69% of children in early years & foundation stage reaching a good level of development, Early Years Foundation Stage Profile placing Oxfordshire in the top quartile of local authorities. Baseline is 66 % from 2015.

There are also areas of focus within the Oxfordshire Skills Board of which the Children's Trust will retain oversight:

- Creating seamless services to support young people through their learning –from school and into training, further education, employment or business;
- Up-skilling and improving the chances of young people marginalised or disadvantaged from work;
- Increasing the number of apprenticeship opportunities.

The indicators used to measure these outcomes are to be confirmed

B. Priorities for Adults

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

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

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

The integration of services has progressed in Oxfordshire over the last year with the development of integrated health and social care teams in local areas. The Five Year Oxfordshire Sustainability and Transformation Plan is developing and will describe how to achieve the aims of the Five Year Forward View for the NHS.

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

Where are we now?

- Progress is being made in the integration of services, with a number of further initiatives and plans underway to improve outcomes and make services more accessible for people.
- Better Care Fund national requirements for closer working of health and social care are all continuing in 2016/17.
- We are continue to monitor the number of avoidable emergency admissions to hospital for older people per 100,000 population as in the last year the number has exceeded our baseline from 2013/14 continuing to rise
- Over 17,000 carers are now known to adult social care which is an increase of 968 over last year
- This year's figures for the number of carers receiving a service was below target due to unforeseen consequences of the Care Act. Only carers of people with a personal budget or direct payment can be counted as receiving a service. Our figures exclude over 4000 people who receive the Alert Service which a recent review showed that such services reduce carers' levels of stress and anxiety levels by 88 %.
- We will continue to monitor the percentage of people waiting a total time of less than 4 hours in A&E as the target of 95% was met only in one quarter
- The target of increasing the percentage of people waiting less than 18 weeks for treatment following a referral was not met due to pressures in a number of specialities and we will continue to monitor this closely.

Outcomes for 2016-17
These outcomes link to the Quality Statements agreed with commissioners, partners and Healthwatch outlined earlier in this document, namely joining up people's care when it is being delivered by a range of health and/or social care providers, improving communication between different organisations and with people and their carers, and involving carers in care planning and delivery.

5.1. Deliver the six Better Care Fund national requirements for closer working of health and social care

1. Are the plans still jointly agreed?
2. Are Social Care Services (not spending) being protected?
3. Are the 7 day services to support people being discharged and prevent unnecessary admission at weekends in place and delivering?
4. In respect of data sharing:
    - Is the NHS Number being used as the primary identifier for health and care services?
    - Are you pursuing open Application Programming Interfaces (i.e. systems that speak to each other)?
    - Are the appropriate Information Governance controls in place for information sharing in line with National Guidance.
5. Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?
6. Is an agreement on the consequential impact of changes in the acute sector in place?

5.2. Reduce the number of avoidable emergency admissions for acute conditions that should not usually require hospital admission for people of all ages (2015/16 baseline 996.6)

5.3. Increase the number of carers receiving a social care assessment from a baseline of 7,036 in 2015/16 to 7,500 in 2016/17.

5.4. Increase the percentage of carers, as reported in the 2016 Carers Survey, who are extremely satisfied or very satisfied with support or services received (from a baseline of 43.8% in 2014).

5.5. Increase the percentage of people waiting a total time of less than 4 hours in A&E. Target 95 %.

5.6. Increase the percentage of people waiting less than 18 weeks for treatment following a referral:

- Admitted patients target 90% (2015-16 baseline: 86.9%)
- Non-admitted patients target 95% (2015-16 baseline: 94.8%)
- Incomplete pathway target 92% (2015-16 baseline: 93.6%)

Priority 6: Living and working well: Adults with long-term conditions, physical disabilities, learning disabilities or mental health problems living independently and achieving their full potential

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

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

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

We will continue to monitor how easy people find it to access information and the quality of support offered to people with a long term condition. We will also continue to measure access to psychological therapies and we know that this makes a difference for people to move towards recovery.

Access to good health care is an area for improvement in Oxfordshire for people with learning disabilities and for people with mental health needs. The physical health check target we have set, of at least 60% for adults with learning disabilities, will continue to be a target for 2016/17. Partners recognise that the system needs to provide better treatment of patients with physical and mental health needs, and to improve how it recognises and addresses the psychological component of all healthcare. This is reflected in the measures below which address access to treatment for mental health problems and access to psychological therapies

Where are we now?

- Over 30,000 people had information and advice about areas of support through the Community Information Networks, against a target for the contract year of 20,000
- We will continue to monitor from last year the target of improving access to psychological treatment as the target was not met in every quarter.
- People with Learning Disabilities still do not have good enough access to physical health checks and only 33% received these checks in 2015-16 (national average 35%).
- We have continued to reduce the number of assessment and treatment hospital admissions for adults with learning disabilities.
- Emergency hospital admissions for acute conditions are higher than the target of 951.4 per 100,000 population although Oxfordshire continues to develop its Ambulatory Care Pathways and we will continue to monitor this closely.

Outcomes for 2016-17

6.1. 20,000 people to receive information and advice about areas of support as part of community information networks. (baseline from Q3 of 2015-16: 28,220)

6.2. 15% of patients with common mental health disorders, primarily anxiety and depression, will access treatment. (baseline from 2015-16: 18%)

6.3. Improve access to psychological therapies so that more than 50% of people who have completed treatment having attended at least 2 treatment contacts are moving to recovery. (Baseline from 2015-16: 51%)

6.4. At least 60% of people with learning disabilities will have an annual physical health check by their GP. (Baseline from 2015-16: 33%)

6.5. Increase the employment rate amongst people with mental illness from 2015/16. (baseline from 2015-16: 17.6%).

6.6. Reduce the number of assessment and treatment hospital admissions for adults with a learning disability. (baseline data to be confirmed).

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

We know that living at home with dignity is key to the quality of life that older people want to enjoy and that older people and their carers require access to good quality information and advice. In Oxfordshire we know that the proportion of older people in the population continues to increase and that the number of referrals for support is also increasing along with the cost of caring for older people which increases markedly with age. This is true for both health and social care.

Oxfordshire has one of the highest levels of delayed transfers of care from hospital in the country. All organisations continue to be committed to working together to improve the situation. One of the best ways of doing this is to provide services which help people to learn or re-learn the skills they need to live more independently and to prevent ill health. These services are called “reablement services”. We are committed to offer these services to more people, and will be re-commissioning the reablement services in 2016 to increase capacity.

For all these reasons our priority is to support older people to live at home whilst reducing the need for care and support. The Closer to Home Health and Care Strategy has the aim of enabling people in Oxfordshire to access more care at/or closer to home, achieving a step change in developing community services by

- Increasing their ability for self-care
- Building on the successful UK General Practice model
- Delivering more integrated primary, community, acute and social care
- Managing population health to improve outcomes
- Increasing the capacity of the out of hospital care workforce to provide more care.
- Bringing together organisations to develop a ‘whole Oxfordshire’
- Delivering outcomes based commissioning

In the next year we are focusing together on better use of reablement; reducing emergency admissions to hospital for acute conditions; reducing the number of people permanently admitted to care homes; developing more integrated community services; improved diagnosis of people with dementia; providing additional Extra Care housing units as well as ensuring there is a range of housing options for older people and that people can find the information they need. We continue to set a challenging target for reducing the number of

people admitted to a care home, because this is the ultimate test of whether these alternative services and options are working.

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

Another key issue is the increase in the number of people with dementia who need access to newly emerging treatments. To enable us to develop high quality care for people with dementia we need to diagnose it earlier. In Oxfordshire we have increased our ambition for 2016/17 to 67% of the expected population having a diagnosis.

Where are we now?

- Delayed transfers of care remain a priority issue for organisations involved in health and social care across Oxfordshire however in the last month delays averaged 112 patients compared to last year where there were 155 patients delayed on average.
- The rate of permanent admissions to care homes has dropped, though the overall number exceeded the target set for the year which is due to the capacity issue within the market for home care provision as care homes are used as an alternative to home care.
- The proportion of older people (65 and over) with on-going care supported to live at home has not reached the target set for the year of 63.0%. We will continue to monitor this closely.
- The percentage of the expected population with dementia with a recorded diagnosis has increased.
- The targets for the number of people accessing the reablement pathway have not been reached due to lack of referrals and service capacity. A new strategic care pathway for non-bed based short term care services has been agreed for 2016/17.
- The number of people supported through home care by social care in extra care housing has continued to rise.

Outcomes for 2016 - 17

7.1. Reduce the number of people delayed in hospital from a baseline of 136 in April 2016 to 102 by December 2016 and 73 by March 2017.

7.2. Reduce the number of older people placed in a care home from a baseline of 12 per week in 2015/16 to 11 per week for 2016/17.

7.3. Increase the proportion of older people with an on-going care package supported to live at home from a baseline of 60 % in April 2016 to 62% in April 2017.

7.4. Over 67% of the expected population with dementia (5081 out of 7641) with dementia will have a recorded diagnosis (provisional baseline of 66% or 5244 people).

7.5. Increasing the number of reablement service hours delivered to a target of 110,00 hours per year (2115 hours per week) by April 2017.

7.6. 70% of people who receive reablement need no ongoing support (defined as no Council-funded long term service excluding low level preventative service).

7.7 Monitor the number of providers described as outstanding, good, requires improvement and inadequate by CQC and take appropriate action where required.

C. Priorities for Health Improvement

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

This priority aims to add years to life and life to years – something we all aspire to.
The biggest killers are heart disease, stroke and cancers. Some of the contributing factors to these diseases are beyond the influence of the individual or of health services but we can encourage healthier lifestyles and prevent disease through early detection and screening to improve outcomes. The role of Social Prescribing can also be explored as a prevention strategy.

A gap in life expectancy still remains within Oxfordshire, with women likely to live longer than men, though the gap between women and men is narrowing as life expectancy for women seems to be reaching a plateau while that for men is still increasing. People living in more deprived areas are likely to die sooner and be ill or disabled for longer before death. These health inequalities remain and need to be addressed by targeting those areas and communities with the worst outcomes.

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

There is growing evidence of the link between physical inactivity (lack of physical activity) and preventable disease and early death. For example, regular and adequate levels of physical activity in adults can reduce the risk of hypertension, coronary heart disease, stroke, diabetes, breast and colon cancer, depression and the risk of falls.

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

- To reduce levels of smoking in the county by encouraging more people to quit as smoking remains a major cause of heart disease and cancer.
- To boost our cancer screening programmes so that more people are protected, focusing on the bowel cancer screening programme.
- To promote the 'Health Checks' programme which offer adults a full health 'MOT' and looks at many lifestyle factors such as obesity, physical activity smoking, blood cholesterol levels ,diabetes, blood pressure and alcohol consumption.
- Reducing the harm caused by the over-consumption of alcohol is another priority of the Health and Wellbeing Board. It is being taken forward by the Oxfordshire Alcohol and Drugs Partnership and progress will be monitored by the Health Improvement Board.
- To continue to monitor measures of success for those in drugs or alcohol treatment services with the aim of improving recovery rates.
- Delivery of the Oxfordshire Physical Activity Plan – a multi-agency collaborative approach to increasing participation in physical activity within Oxfordshire
- To consider issues affecting mental well-being in the population and what outcomes could be used to monitor it.

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

best and worst outcomes wherever such reporting is possible. The recommendations of the Health Inequalities Commission in Oxfordshire are awaited and may also influence this work.

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

Where are we now?

- The uptake of bowel screening by people aged 60-74 has improved steadily over the last year but the target of 60% has still not been achieved.
- Uptake of invitations to attend NHS Health Checks has remained steady during the year and all Oxfordshire GPs are working hard to invite 40-74 year olds.
- Smoking quit rates in the county failed to meet the target in the last year by quite a large margin. The Health Improvement Board has considered the potential impact of e-cigarettes on this area of work.
- Smoking rates in pregnancy are lower than the national figures but some women are continuing to smoke.
- The Health Improvement Board has been monitoring the rates of successful completion of alcohol and drugs treatment in the last year and there is still cause for concern as Oxfordshire still lags behind national averages.

Outcomes for 2016-17

8.1 At least 60% of those sent bowel screening packs will complete and return them (ages 60-74 years). ***Responsible Organisation: NHS England***

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

8.3 Oxfordshire performance for those taking up the invitation for NHS Health Checks should exceed the national average (baseline 2015-16 was 51.7% nationally) and aspire to 55% in the year ahead. No CCG locality should record less than 50% ***Responsible Organisation: Oxfordshire County Council***

8.4 Oxfordshire performance for the number of people quitting smoking for at least 4 weeks should exceed 2015-16 baseline by at least 10% (baseline 1923 quitters 2015-16) ***Responsible Organisation: Oxfordshire County Council***

8.5 The number of women smoking in pregnancy should remain below 8% recorded at time of delivery (baseline 2015-16 was 7.2%). ***Responsible Organisation: Oxfordshire Clinical Commissioning Group***

8.6 Oxfordshire performance for the proportion of opiate users who successfully complete treatment should improve on the local baseline in 2015-16 (4.5%) and reach 5% in the year ahead with a longer term aspiration to reach the national average (6.8% in 2015-16) ***Responsible Organisation: Oxfordshire County Council***

8.7 Oxfordshire performance for the proportion of non-opiate users who successfully complete treatment should improve on the local baseline in 2015-16 (26.2%) to reach 30% in the year ahead, with a longer term aspiration to reach the national average (37.3% in 2015-16) ***Responsible Organisation: Oxfordshire County Council***

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

After smoking, obesity is the biggest underlying cause of ill health (obesity is defined by a BMI of over 30). It can lead to high blood pressure, heart disease, stroke, diabetes, cancer and early death. It also increases immobility and makes any other disability more severe than it would otherwise be. There is a national trend for rising obesity rates across the population and although Oxfordshire fares better than the national picture, this remains a local priority and needs a long term perspective.

Surveillance of these issues in the last year show that

- Rates of obesity in the county continue to rise. Data from surveys show a cause for concern.
- The percentage of people diagnosed with diabetes by their GP continues to rise across the county.
- The rates for breastfeeding initiation soon after birth and continuation to at least 6-8 weeks are good in Oxfordshire. These higher rates need to be maintained.
- Measurement of children shows the numbers who are deemed to be overweight or obese at both Reception Class and Year 6 are generally lower than England rates, but show over 16% obesity at year 6. These are year on year snap shot measures so trends cannot be identified.

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

Promoting breastfeeding
Breastfeeding gives the best start to life and has been proven to lead to fewer overweight children and adults. The national figure for breastfeeding prevalence at 6-8 weeks is just under 44% but in Oxfordshire we want to keep the stretching target of 63% and will only achieve this if we focus on the areas where rates are low.

Halting the increase in childhood obesity
Children in Reception class and Year 6 are weighed and measured every year and results show that around 8% of reception year and over 16% of Year 6 children are obese. This feeds through into ever increasing levels of obesity in young adults. Making parents aware of problems early helps them to take action if they choose to. Healthy eating initiatives are part of the approach. Levels of obesity are also linked to social deprivation, with more deprived parts of the County showing higher rates of obesity along with some ethnic groups, so some targeting of effort is called for here too.

Promoting physical activity in adults
Physical activity is an important component of maintaining a healthy weight for all ages and there is local encouragement here, with Oxfordshire still doing well according to the 'Active People' survey. However, the survey showed that almost 22% of the population are inactive – not even attaining 30 minutes of physical activity a week. Regular participation in physical activity will have an impact on mental wellbeing and be critical to good health in the county. For the years ahead we will be encouraging those who are inactive to start to move more.

Where are we now?

- The percentage of children who were overweight or obese in Year 6 last year was lower than in the previous year, helping us towards the target of stalling the general rise in obesity rates and going against the national trend.

- The target for reducing the number of inactive people has been met this year.
- The overall rate for breastfeeding at 6-8 weeks is still higher than the national average though the aspirational target of 63% has not been met.

Outcomes for 2016-17

9.1 Ensure that the obesity level in Year 6 children is held at no more than 16% (in 2015 this was 16.2%) No district population should record more than 19% ***Data provided by Oxfordshire County Council***

9.2 Reduce by 0.5% the percentage of adults classified as "inactive" (Oxfordshire baseline 2015-16 of 21.9%). ***Responsible Organisation: District Councils supported by Oxfordshire Sport and Physical Activity***

9.3 At least 63% of babies are breastfed at 6-8 weeks of age (currently 58.2%) and no individual health visitor locality should have a rate of less than 55% ***Responsible Organisation: NHS England and Oxfordshire Clinical Commissioning Group***

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

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

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

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

These housing issues all have to be tackled in partnership.

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

Concerns remain including

- Changes to local funding and arrangements for commissioning housing related support.
- Changes to the welfare benefit system which have potential to put more households at risk of homelessness

- Fuel poverty is still a risk for a large number of households. New systems for improving energy efficiency of homes have been introduced and need to be established.
- Young people, especially those who have been Looked After, may need support to find and remain in appropriate housing.

Where are we now?

- District councils have reported similar success rates as last year in preventing homelessness and have taken positive action to prevent a higher number of households from becoming homeless.
- The number of households in temporary accommodation has remained at similar levels to last year with 190 such households reported (192 last year).
- A large proportion of people who had received housing related support services were able to leave the services and live independently. New contracts were awarded during the year and monitoring of outcomes under these new arrangements will continue to be an area of focus.
- The Affordable Warmth Network has reported full take up of grant aided schemes and also a growth in referrals from health services for people whose poor heating or insulation in their homes was affecting their health. This has been possible due to grant funding in 2015 for the Better Homes Better Health programme.
- The number of people estimated to be sleeping rough in the county has increased.
- Contracts for housing related support are showing high levels of positive move-on for vulnerable young people.

Outcomes for 2016-2017

10.1 The number of households in temporary accommodation on 31 March 2017 should be no greater than the level reported in March 2016 (baseline190 households in Oxfordshire in 2015-16). ***Responsible Organisation: District Councils***

10.2 At least 75% of people receiving housing related support will depart services to take up independent living (baseline 87.2% in 2015-16). ***Responsible Organisation: Oxfordshire County Council***

10.3 At least 80% of households presenting at risk of being homeless and known to District Housing services or District funded advice agencies will be prevented from becoming homeless (baseline 85% in 2015-16). ***Responsible Organisation: District Councils***

10.4 Outcome measure to be confirmed. ***Responsible Organisation: Affordable Warmth Network.***

10.5 Ensure that the number of people estimated to be sleeping rough in Oxfordshire does not exceed the baseline figure from 2015-16 (baseline 90) ***Responsible Organisation: District Councils***

10.6 Measure on young people's housing related support to be confirmed at the HIB in July 2016. Proposed measure is "at least 70% of young people leaving supported housing services will have positive outcomes in 16-17, aspiring to 95%". ***Responsible Organisation: Oxfordshire County Council Children, Education and Families Directorate.***

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

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

It is important that immunisation rates remain high throughout the population to maintain "herd immunity". Responsibility for commissioning immunisation services sits with NHS England. High levels of coverage need to be maintained in order to continue to achieve the goal of protection for the population.

New immunisations were introduced in 2013-14. From July 2013, a rotavirus vaccination was offered at 2 months and at 3 months, flu immunisation is being given to children, (starting with 2-3 year olds and adding more ages each year), and Shingles vaccinations are offered to people aged 70 and 79.

The Oxfordshire Joint Strategic Needs Assessment shows high levels of coverage but some targets are still not being met. The leadership for these services has changed during the last few years and maintaining our current position will be a real challenge.

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

Where are we now?

- High coverage rates for most childhood immunisations were achieved across the county and Oxfordshire compares very well with other areas. This included the number of children receiving their first dose of MMR vaccine which remained above the national 95% target.
- NHS England has introduced local outreach to improve the coverage of childhood immunisations. It is hoped that this will lead to improvement in the percentage of children receiving the second dose of MMR which is still below the national 95% target.
- Rates of flu immunisations for people aged under 65 who are at risk of illness was still well below targets last year. This has been a national trend but still requires local improvement. The national target has now been set at 55%.
- Coverage of the HPV vaccination for teenage girls remained high.

Outcomes for 2016-17

11.1 At least 95% children receive dose 1 of MMR (measles, mumps, rubella) vaccination by age 2 (currently 95.2%) and no CCG locality should perform below 94% ***Responsible Organisation: NHS England***

11.2 At least 95% children receive dose 2 of MMR (measles, mumps, rubella) vaccination by age 2 (currently 92.5%) and no CCG locality should perform below 94% ***Responsible Organisation: NHS England***

11.3 At least 55% of people aged under 65 in "risk groups" receive flu vaccination (baseline from 2015-16 45.9%) ***Responsible Organisation: NHS England***

11.4 At least 90% of young women to receive both doses of HPV vaccination. (Baseline in 2015-16 tbc) ***Responsible Organisation: NHS England***

Annex 1: Glossary of Key Terms

Terms

Carer	Someone of any age who looks after a relative, partner, friend or neighbour who has an illness, disability, frailty, or addiction. The help they provide is not paid for as part of their employment, and they do not provide the care as a voluntary member of staff.
Child Poverty	Children are said to be living in relative income poverty if their household's income is less than 60 per cent of the median national income.
Child Protection Plan	The plan details how a child will be protected and their health and development promoted.
Commissioning	The process by which the health and social care needs of local people are identified, priorities determined and appropriate services purchased.
Delayed Transfer of Care	The national definition of a delayed transfer of care is that it occurs when a patient is medically fit for transfer from a hospital bed, but is still occupying a hospital bed.
Director of Public Health Annual Report	http://mycouncil.oxfordshire.gov.uk/ieListDocuments.aspx?CId=116&MId=4398
Extra Care Housing	A self-contained housing option for older people that has care and support on site 24 hours a day.
Fuel Poverty	Households are considered by the Government to be in 'fuel poverty' if they would have to spend more than 10% of their household income on fuel to maintain an adequate level of warmth.
Healthwatch Oxfordshire	Healthwatch is the independent 'Consumer Champion' for health and social care for people of all ages
Joint Health and Wellbeing Strategy	The strategy is the way of addressing the needs identified in the Joint Strategic Needs Assessment and to set out agreed priorities for action.
Joint Strategic Needs Assessment (JSNA)	A tool to identify the health and wellbeing needs and inequalities of the local population to create a shared evidence base for planning.
Not in Education, Employment or	Young people aged 16 to 18 who are not in

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

Oxfordshire
Clinical Commissioning Group

Oxfordshire Health and Wellbeing Board Meeting

Date of Meeting: 14 July 2016	**Paper No:**

Title of Presentation: Better Care Fund Plan 2016-17

Is this paper for	**Discussion**	✓			**Information**	✓

Purpose and Executive Summary (if paper longer than 3 pages):

This paper updates the Health and Wellbeing Board on the development and submission of Oxfordshire's Better Care Fund Plan (BCF) for 2016/17.

As per national advice, the BCF Plan for 2016-16 is submitted as a continuance from 2015-16 building on the learning/ achievements over the year. It aims to provide a year of stability and incremental improvement. Overall, the plan articulates our vision for health and social care services locally within the context of other strategic priorities. Further, it offers the detail on how we plan to meet the national conditions, including;

- Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care; and
- Agreement on local action plan to reduce delayed transfers of care (DTOC)

- As part of our submission, we have set a target of avoiding **1000** non- elective admissions using 2015-16 data (including expected demographic growth) as the baseline for this BCF target. This mirrors the ambition set out in the OCCG's operational plan 2016/17. At the time of submission we believed that this was both achievable and realistic and in effect cancels out a proportion of the expected activity growth in year. It is notable that since submission admission levels have risen and are being investigated. There are a number of initiatives which are geared to support the 1000 ambition including Ambulatory Care Pathways, improved access to primary and community services, Falls Pathway, EMUs etc.;
- The submission also includes a DTOC Plan for 2016-17, which builds on the learning from the 2015-16 initiative Re-balancing the System and is designed to reduce both the number of people who are delayed in the Oxfordshire system and the length of time patients stay in hospital when medically fit for discharge.
    - The 3.5% target of bed days lost to DTOC equates at current length of stay to a weekly snapshot of 73 patients delayed, which would represent a 50% reduction in our current system figure. As a system Oxfordshire has reviewed where and how we can reduce our weekly delay across the different forms of delay. Our approach builds on the strengths of the

Re-balancing the System initiative

The plan focusses on the following areas:

- Focus on assessment and choice processes that will reduce unnecessarily delays
- Continued grip on daily and weekly operations to ensure that flow is managed and available resources deployed appropriately
- Planning for discharge from the point of admission
- OCCG's operational plan has prioritised the DTOC Plan and investment in resources will be made available that will support the move to a system that can work in equilibrium.

The plan includes a Risk Share Agreement between OCCG and OCC to support the improvement of the county wide DTOC challenge. The agreement is based on OCC investing in a set amount of home care hours over the course of the year. If the Council does not fully meet this commitment and there is an underspend against the Home Support expenditure budget, the Clinical Commissioning Group will recoup in full any underspend up to the value of £2.1m. Further detail and conditions are found on page 26 of the attachment.

The detailed spreadsheet on funding, planned activity and performance standards is available on request and will be placed on the OCCG Website.

The Plan is currently going through national assurance and we expect to hear the outcome of this process imminently.

Financial Implications of Paper:

In order to deliver the outcomes and ambition as articulated below, Oxfordshire is investing the minimum national amount mandated of £40.607m in the BCF Plan, including:

- £4.532m in the form of Disability Facilities Grant, passported through to the District and City Councils.
- £8.2m for protection of Adult Social Care, this is mandated nationally as part of the BCF legal framework.
- £1.318 which previously paid for the Care Act Implementation (including carers).
- Further support to Social Care includes the continuation of the former NHSE Transfer of £10.3m, and other individual initiatives.

Action Required:

The Board is asked to note:

- The BCF Plan Submission;
- That the BCF Plan 2016-17 was submitted on 03 May 2016, through delegated authority from the Health and Wellbeing Board;
- That the plan is still going through the national assurance process.

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

Equality Analysis completed (please delete tick and attach as appropriate)	Yes	No	Not applicable ✓
Outcome of Equality Analysis			

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Oxfordshire Health and Wellbeing Board

2016/17 Better Care Plan Narrative

NHS Oxfordshire Clinical Commissioning Group

OXFORDSHIRE COUNTY COUNCIL www.oxfordshire.gov.uk Working for you

1.0 Introduction

This narrative provides a context and the detail for Oxfordshire's Better Care Plan (BCF) for 2016-17. As per national advice, it builds on our BCF Plan for 2015-16 and aims to provide a year of stability with continued improvements on patient/system outcomes. The plan articulates the our vision for health and social care services locally, correlating the dependencies/relationships between BCF and the other strategic transformation plans; and the evidence/ governance underpinning the BCF Plan 2016-17. Further, it offers the detail on how we plan to;

- Meet the national conditions, including;
  - Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care; and
  - Agreement on local action plan to reduce delayed transfers of care (DTOC)

In order to deliver the outcomes and ambition as articulated below, Oxfordshire is investing £40.607m in the BCF Plan for 2016-17. £4.532m of it is in the form of Disability Facilities Grant, passported through to the District and City Councils. We continue to invest in Adult Social Care in line with the contribution made last year, including £8.2m for protection of Adult Social Care (uplifted in line with inflation) and £1.318 which previously paid for the Care Act Implementation (including carers). Further support to Social Care includes the continuation of the former NHSE Transfer of £10.3m, and other individual initiatives. In respect to patients that are cross boundary, we are in discussions with Aylesbury Vale and Swindon CCGs to agree how best these patients are supported.

Existing documents/strategies that correspond to any the above will be referenced clearly and are appended as part of the submission.

2.0 Better Care Fund 2016-17

2.1 Context

The Oxfordshire System has a strong history of working together through its Health and Wellbeing Board and pooled budget arrangements. As a system, we have utilised a number of different mechanisms and governance arrangements to support outcomes for patients, including:

- Systems Leadership Group;
- Transformation Board;
- Systems Resilience Group;
- Better Care Fund Programme Board; and
- Joint Management Group.

NHSE representatives attend a number of these strategic Boards, which has increased visibility and improved confidence in the delivery of the BCF schemes. It has also showcased the strong working relationships at system leadership level. This, in our view has allowed the system better develop and share the vision for the local agenda, including oversight of BCF Plans.

The Oxfordshire system has developed its BCF plan as part of a larger and very complex system operating to support transformation. Therefore, the plan is linked to the Transformation Board agenda which has developed a strong case for change and has agreed a Care Closer to Home model and strategy, both of which are submitted as supporting evidence. The strategy sets out our ambition to achieve a step change in developing community based services and reduce demand for hospital care by:

- Developing local systems of care that bring together general practice, community health, social care and the voluntary sector, supported by specialist advice, to proactively manage local population health.
- Integrating care around patients not organisations, promoting self-care and prevention, offering rapid access to community based integrated services for urgent problems and planned care supporting those with long term conditions to stay well longer.
- Engaging partners, front line staff, clinicians and the public in the development of our transformation plans.

Oxfordshire's Transformation Plan will outline new pathways of care and 5 year action plans for:

- Acute and Integrated care (including urgent and emergency, frail older people, long term conditions and sustainable primary care)
- Planned and Specialist Care (and diagnostics)
- Mental Health Services
- Learning Disability Services
- Maternity and Children's Services

The new pathways will describe how we intend to drive transformation to re-shape the system releasing savings for re-investment in services in the community. The footprint for our transformation plan is largely Oxfordshire however we have formed an alliance with Buckinghamshire and Berkshire West (BOB), led by OCCG's Chief Executive, to provide an 'umbrella' transformation plan on a wider footprint for services such as Urgent Care, Ambulance services and workforce planning. Oxfordshire's transformation plan will be aligned with those at a BOB footprint but will describe a more localised footprint sitting below the BOB level plan.

Locally, we feel that there is much to celebrate and be proud of in relation to the progress that has been achieved in implementing/embedding the BCF plan over the

last year. This, we believe, gives us a sound base from which to evolve BCF principles into business as usual, leading to better patient outcomes as part of an integrated system across health and social care. There have been collaborative working arrangements towards achieving BCF targets through a well-attended and robust Programme Board.
Consequently, our BCF Plans for 2016-17 have cross organisational sign up which continues to develop a collaborative system-wide approach to support partners in achieving their ultimate goal of supporting patients within a tight financial envelope.

The plan is aligned to our strategic commissioning plans across the system including the Health and Wellbeing Strategy 2015-19, Oxfordshire Clinical Commissioning Group's (OCCGs) 5 year strategic plan and the OCCG's Operational Plan 2016-17. The plans have been fully been aligned to the operational plans and therefore take account of provider plans also.

2.2 What is different in Oxfordshire's BCF Plan 2016-17?

In the main, our BCF plan for 2016-17 is an improved and better evidenced continuation from last year, and thus aims to further improve performance with incremental changes derived from the results of our programme evaluation findings.

The Plan therefore remains focused on concentrating on parts of the system and care pathways that require further attention to support patient and system requirements. We aim to improve performance in respect of the 95% A&E target through a number of initiatives including an extension of Ambulatory Care Pathways and the use of interface medics to bridge the gap between primary and secondary care. However, unsurprisingly the main area of focus for Oxfordshire has been and will continue to be reducing our enduring record of unacceptable delays in hospital transfer. There is system-wide buy-in to a very ambitious plan to reduce DToCs, based on responding to current system challenges and a longer term set of solutions to achieve system equilibrium based.

As a system, we have agreed to avoid **1000** NEAs based on our growth calculations using 2015-16 data as our baseline as part of the BCF target. This mirrors our ambition as set out in the OCCG's operational plan 2016/17. We believe that this is both achievable and realistic and in effect cancels out a proportion of the expected activity growth in year. There are a number of initiatives which are geared to support this ambition including Ambulatory Care Pathways, improved access to primary and community services. These are explained in more detail below.

2.3 Key successes and challenges from 15/16:

Over the last year, Oxfordshire's BCF Board has overseen a number of comprehensive evaluations as well as other less in-depth reviews to support performance management of the overall Programme targets. Further, the Board was

keen to get schemes to undertake a year-end self-evaluation to support decision making for BCF 2016-17 (please see above the template).

These and other business intelligence methodologies were used to better understand how individual schemes were performing as a result of which some in year changes were made to projects and targets. The continual evaluation of the programme tried to answer the following questions:

- Are we achieving our set BCF targets?
- Are we able to articulate the input from our various different schemes in line with targets?
- Do we have appropriate and robust governance arrangements? and
- Are these the right schemes?

The evaluation and various scheme reviews have found that Oxfordshire has continued to make good progress across the health and social care economy in line with the national BCF requirements, including better integration and more effective personalised services. Some of the overarching achievements over the last year include;

- **Governance**: there are robust governance arrangements in place for both the Programme and the various different composite schemes within it. This has allowed the whole system an opportunity for the management and performance oversight for the BCF Programme. The BCF Governance Chart and TOR are attached below; please note that these will be updated in line with the new BCF Plan.
- **Data Collection and Business Intelligence**: This has been an intense area of work, resulting in the development of a vigorous data gathering and analysis dashboard to allow the BCF Board to track progress and make changes to targets throughout the year where necessary. This approach will be continued and further developed next year.
- **Scheme progress:**
  - **Ambulatory Care (including EMUs):** These projects have made a remarkable impact on reducing (avoiding) non-elective admissions activity. We have had major success in developing and measuring Ambulatory Emergency Care Pathways, which have contributed greatly to the reduction in our overall non-elective admissions. However, difficulties with national coding guidance have meant that the any reduction in non-elective is not reflected within SUS. Representations have been made to NHS England through our BCF Regional Manager, and regular assurance meetings and we are assured that they are aware of this and accept this is a national issue that needs to be resolved. This reduction places us in a very favourable position when benchmarked against other areas.

- **Integrated Neighbourhood Teams:** Our efforts around integration have been recognised nationally and we have successfully bid for monies for project management of a pilot from NHS England. This money has been used to oversee the development of Chipping Norton Out of Hospital Integrated Nursing Pilot as part of our wider locality developments. On-going work in this area looks to further develop locality teams and ensure they provide a timely response to patient needs in the community
- **Primary Care** developments over the last year have meant that patients have better access to GPs in the community and managed to supporting patients though a number of schemes including especially the Early Visiting Service. These services are currently subject to a detailed evaluation and may be included in the BCF at a later date once their success is proven.
- **Adult social care** successfully implementing the Care Act requirements from April 2015, including online self-assessment for carers as part of a redesigned process to identify and meet eligible needs for support.
  We are continuing to meet increased demand for services, including an increased number and complexity of care packages for people remaining in their own home. There are a number of social care measures that are included within the BCF Dashboard and we plan to make these more prominent as part of performance management. We also aim to have DFG related performance measures included within the Dashboard to ensure all the BCF funds are supporting the Programmes overall aims and objectives.

However, we have had a challenging year with increased demand on services, high attendances and low bed capacity. This has reduced the system capacity to move patients from the acute and resulting in lower performance. Further, the acuity of patients attending seems to be higher which has resulted in an increase in the number of patients breaching four hours.

- **NEAs:** It is fair to say that we are unlikely to achieve the 2% NEL admissions target set for Oxfordshire. Please note that this was a net reduction on 2013-14 baselines without taking account of expected growth. There are a number of reasons for this, including; increased demand from older patients who present with increased levels of acuity; difficulties with recruiting & retaining staff; and financial challenges within health and care. However, when achievements from our Ambulatory Care Project are taken into account, we are doing favorably against national benchmarks.
- **DToC:** Oxfordshire has continued to struggle with reducing the level of patients delayed in an acute setting, which in turn has an impact on the rest of the system. It is assumed that the DToC plan will resolve this longstanding issue within the local system; however, there is still an ongoing risk.
- **Progress against plan:** The whole system has been challenged through an increase in demand for services from an ageing and increasingly complex demographic. At month 11, the system is 0.1% above the target set for BCF

last year. Although this is disappointing, it means that we have avoided any growth in the system.

Taking account of our successes, challenges and areas for further concentration BCF Board has agree on the following schemes to be included in the Plan for 2016-17:

1. Ambulatory Emergency Care including Emergency Multi-Disciplinary Units (EMUs)
2. Long Term Conditions (LTC)
3. Enhanced Medical Support to Care Homes
4. Falls Pathway
5. Re-ablement Pathway
6. Supported Hospital Discharge Service
7. End of Life
8. Oxfordshire Care Summary - IT Enabler
9. Adult Social Care Schemes (listed in the Planning Submission).

These schemes are subject to Project Management Governance arrangements from within their perspective organisations (mainly supported by OCCG), reporting to the BCF Board on regular basis.

2.4 Changes from the 15/16 BCF plan including rationale/evidence supporting the changes

As mentioned above our BCF Plan for 2016-17 in the main aims to deliver improvements included within last year's plans which are strengthened, based on the outcomes from this year. This allows the system a year of stability whilst ensuring that we have the ability to embed transformational change leading to better integration of services across the system.

We are proposing to continue with established governance arrangements through existing structures, including the BCF Board, with the Health and Wellbeing Board providing the ultimate guidance and leadership. We also propose to continue to develop our data gathering and monitoring arrangements in place for the Programme which we believe provide, through the Board, a robust assurance for the system overall that progress is driven through an evidence base allowing an on-going circle of evaluation. This allows for the system to intervene and take action when challenges are identified on a timely basis.

However, based on our performance and system challenges, we have made some changes to the schemes included in the BCF 2016-17. These are areas that require further work and attention and we believe allow incremental improvements in addition to the ones in the system already. The following are changes from last year's BCF Plans:

1. **Ambulatory Care Pathways (including EMU)**: We are currently in the process of developing further modelling for these services; however we

expect the changes planned within the year will allow a reduction of around 500+ NEAs avoided.

This is an exciting programme of work which has proven to make a difference to patient outcomes while reducing non-elective admissions over the last year. As a scheme within the BCF programme since its inception, much work has been undertaken to develop, implement and embed principles of Ambulatory Care across the system. We have concentrated on defining and embedding our principles, getting up governance around the project and developing services both in the community and the acute hospital. Our system-wide ambulatory care principles include:

- Patients treated as Ambulatory by Default
- Shared decision making for individually tailored patient care
- Locally driven support for patients, centralised when needed
- Extended hours 7 days a week

The core principles of acute ambulatory care delivery will ensure high quality care that builds on existing work on the ambulatory care pathways including the Daily Diagnostic Unit (DDU), Surgical Assessment Unit (SAU) and more recently the Adams Ambulatory Unit (AAU), while expanding the scope of conditions managed out of hospital with flexible follow up, tailored to risk and patient/carer preference. This will support existing clinical teams in the management of the acute care work stream, support the rapid access gerontology clinic and contribute to optimising the usage of acute medical beds. Therefore the core principles include:

- Rapid assessment by competent senior decision makers supported by multidisciplinary teams
- Point of care diagnostics for:
    - rapid identification of pathophysiological disturbance and initiation of definitive medical therapy where appropriate
    - rapid review of patients returning for assessments
    - supporting shorter care delivery times from presentation to returning home
- Access to plain X Ray, ultrasound and cross-sectional imaging as needed
- Parenteral therapies, delivered if required over several daily attendances to a re-engineered level 4 unit
- Therapist and social care interventions as required
- Access to specialist opinion/coordination of additional investigations and follow up

- 7/7 service provision when clinical capacity has increased
    - currently available for 5/7 within existing staffing
    - Interface Physician duty periods 10:00 – 18:30
- Timely communication of information to GPs about changes to ongoing community management in primary care.

We have also done a lot of work trying to understand how patient activity is coded, counted and charged. This work is on-going in addition to further expansion of ambulatory units. We have continued to keep these services in the BCF as we believe the principles of ambulatory care are absolutely essential to patient flow, NEA reductions and DToC reductions. Further, it supports the development of new pathways and the communication around this with practices.

The chart below visualises patient flow through the urgent care pathway including ambulatory care and demonstrates our ambition.

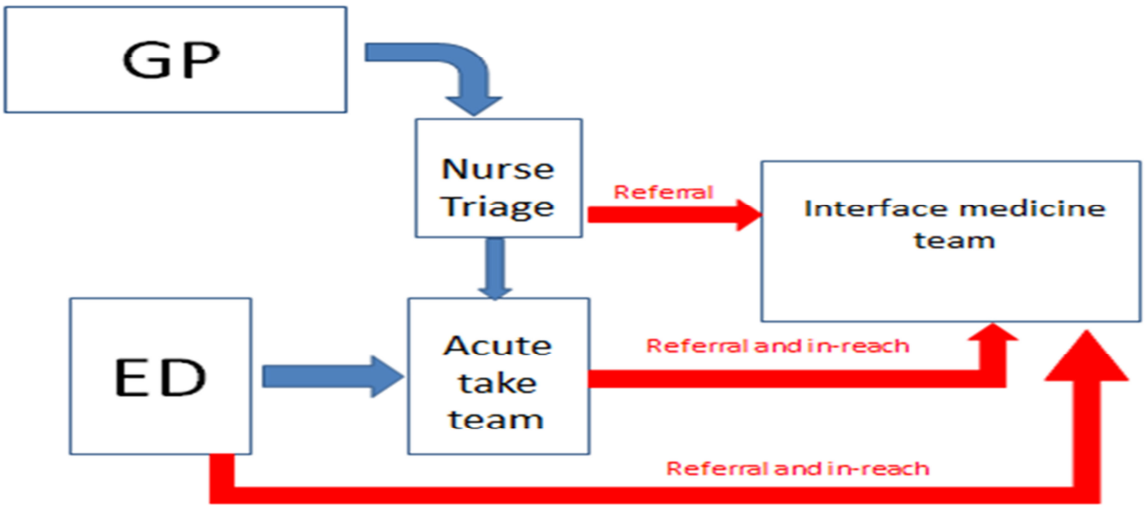


Figure 1: AEC Pathway

2. **Long Term Conditions (Respiratory and Diabetes):** As part of our BCF plans for 2016-17, BCF Board has agreed that we would like to concentrate on the management of LTCs within the community. This includes our proposals to deal with the very high rates of COPD readmissions and Diabetes management in the community.

   Three years ago, a previous attempt was made at having a respiratory task force in Oxfordshire. Respiratory medicine has changed a great

deal in these three years and the ideas from the previous attempt are still as relevant today as they were then.

On 1 April 2013, primary care trusts (PCTs) were formed into clinical commissioning groups (CCGs), which have the means and resources to assist the change of how services are delivered. An objective of the inaugural meeting of the respiratory task force was to create a wish list of how respiratory care could be improved in Oxfordshire. The task force prioritises its work to ensure that improvements are achieved, and to target higher risk factors such as smoking cessation and respiratory A&E attendances for greater benefits. Their work concentrates on the following three areas:

- COPD Readmissions and how to stop patients from going back into the hospital unnecessarily;
- Regeneration of the Respiratory Task Force to support the redevelopment of the pathways;
- Teaching /Training of patients and GPs to increase awareness for better self-management.

3. **Falls Pathways:** Oxfordshire has recently approved a new falls pathway with a view to support more patients from prevention to treatment. The new pathway provides a streamlined service that has greater reach in the community to those that are regular fallers and those that may be at risk of falling based on national and local evidence.

   We anticipate this service to save around 193 NEAs; however detailed modelling is underway to determine what the overall target will be. The service will be operational from October and include both the Oxford Health Foundation Trust and the Age UK.

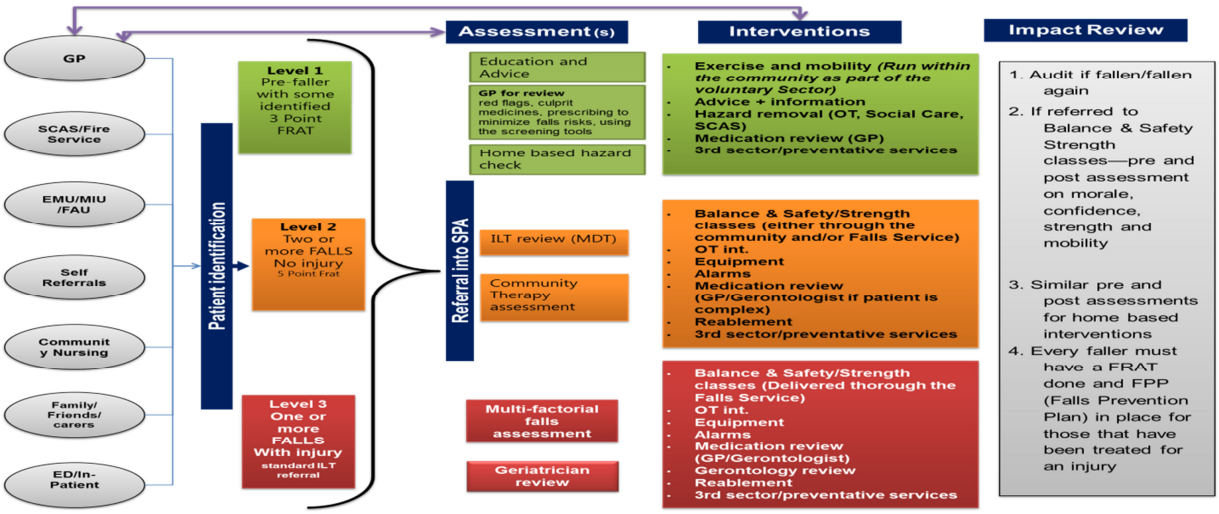


Figure 2: New Falls Pathway

The Falls Pathway has been developed as we know that they are a major cause of disability and the leading cause of mortality injury in people aged over 75 in England. Also, whilst most falls do not result in serious injury, the consequences for an individual of not being able to get up after a fall can include: psychological problems, loss of mobility, depression, increases in dependency and disability, hypothermia, pressure-related injury and/or infection.

We are therefore bringing together commissioners including Social Care, Providers including the voluntary sector and the Fire Service to develop a pathway that;

- Puts Primary Care at the heart of services as the accountable professional;
- Improves prevention;
- Reduces Duplication;
- Improves referral rates and routes; and
- Increases capacity in the community through better trained staff and the use of the Voluntary Sector / Fire Service.

4. **End of Life:** This is an extension of the current EOL projects with better focus and better evidence based interventions. The project aims to set up a palliative care hub and improved access to domiciliary care to support patients that are at the end of life and reduce NELs for this group by about 30% which equates to around 525 NEAs reduced.

5. **Reablement:** The reablement pathway has been redesigned based on a model of the demand requirement to deliver a high performing system (compared to national ASCOF indicators). This will enable us to move

from a fragmented and poorly performing pathway (multiple providers, multiple entry points, unclear criteria, lack of rigor in assessment and move on) to a clear single pathway, focuses on delivering system wide outcomes. When fully mobilised the new pathway will deliver a 10-15% capacity increase, with enhanced response times, greater community pick up and avoidance activity, and improved ambulatory performance.

The new reablement pathway and capacity model have been designed as part of a whole social care post hospital and community support model that includes and enhanced urgent and crisis domiciliary care response (URTS), improved telecare availability, and a new focuses domiciliary care framework (help to live at home).

Investments in an improved social care pathway, including reablement, means that patients will receive appropriate preventative support in the community and will be supported out of hospital in a way that ensures meaningful outcomes. Alongside improved clinical outcomes, this both reduces pressure on acute services – as effective community reablement reduces admissions – and reduces the amount and length of both home care and care home provision – as people are more able to manage independently. This combination of improved patient outcomes, decreased pressure on acute services, and reduced social care cost characterises the overall approach in Oxfordshire.

2.5 Risks/challenges to the success of BCF in 16/17 and any measures in place/planned to mitigate them

We will approach the implementation of the plan as a whole-system, monitoring progress and mitigating risks through the BCF Board, SRG, Joint Management Group, with ultimate responsibility lying with HWB. The development and delivery of the schemes highlighted in this plan reflect the collective efforts of all partners and are evident in the individual strategies and plans of all constituent parties. Every scheme has been assigned a project lead and is subject to the discipline of project management, through the programme management office in the OCCG.

All partners acknowledge their collective responsibility for improving DToC and reducing non-elective admissions. Reducing the proportion of patients who are inappropriately admitted to hospital requires the mobilisation of rapid assessment schemes, the earliest impact of which will come from the care closer to home initiatives (proactive medical support to care homes/anticipatory care plans) and ambulatory emergency care pathways. Ensuring that communication between GPs and medical consultants is timely and responsive is pre-requisite to this set of plans and will be monitored through SRG.

Reducing the proportion of people who spend longer in hospital than they need to is dependent upon the delivery of our DToC plan. This is truly a whole-system plan where interdependencies that is agreed across the stakeholders.

Reducing the proportion of people admitted to residential and care homes across Oxfordshire, is dependent on improving support to people in their own homes. Our plans for introducing neighbourhood teams are an essential component as is protecting adult social care. The interdependencies for the delivery of these initiatives are primarily with OHFT, primary care and OCC.

Finally, whilst the CCG financial position has stabilised, our system partners have seen considerable pressure on their own financial performance and standing. As a health and social care system, taken in aggregate, we may be at breakeven or a marginal surplus (<0.1%) at best.

We have outlined a number of risk that still pose a threat to the delivery of our plan, including mitigating action in the attached Risk Register.

3.0 National Conditions

Oxfordshire system is committed to delivering change through the continuation of BCF in 2016-17. We believe the focus provided by BCF 2015-16 has had a positive impact on the driving service improvements; better relationships across the system and an appetite to better integrate care for our patients.

We have patient involvement in the BCF Plans through various communication and engagement strategies, mainly for the individual schemes that are developed as part of the BCF. Included in this the OCCG's Communication and Engagement Strategy which outline's our commitment and approach to involving the public, patients, carers, partners and other stakeholders in our work. Engaging partners, stakeholders and the public is central to the development of our transformation plans.

There are Patient Advisory Groups for all our current redesign projects, detail can be found in the strategy that has been submitted. In addition there are six voluntary, non-statutory, Public Locality Forums which have been set up to bring the patient voice into commissioning decisions. They were successfully used in the recent consultation on changes to services that were to be provided in the newly built Townlands Hospital in Henley.

3.1 Plans to be jointly agreed

Oxfordshire's plans for 2016-17 are agreed jointly, through the BCF Programme Board and will ultimately have Health and Wellbeing sign-off. The HWB meets three

times per year and assumes ultimate responsibility for the BCF development and delivery of the overarching vision for improving the care and health of local people, aligned to the Oxfordshire Health and Well-being Strategy (2012 – 2016). The HWB has delegated responsibility for delivery of the plan to:

- The BCF Programme Board for co-ordination and assurance against the delivery of the Plan reporting to:
    - The SRG for delivery of the programme.
    - It is proposed that Oxfordshire has a Single Joint Management Group with senior representatives from Oxfordshire County Council and Oxfordshire Clinical Commissioning Group to manage four pooled budgets for adults for effective delivery of health and social care in Oxfordshire. This would replace the four existing Joint Management Groups that currently meet to look at individual pooled budgets for older people, people with learning disabilities, people with mental health conditions and people with physical disabilities.

      A single joint management group for adults will provide an opportunity to
        - have commissioning discussions across all client groups, rather than separately;
        - have an oversight of the issues specific to each client group and common challenges for all;
        - have an overall consideration of issues across the pools or flexibility to match funding to areas of pressure and need irrespective of client group;
        - Streamlined decision making.

      The Single Joint Management Group will meet quarterly, and will be supported by a Pooled Budget Officers Group that will meet on a monthly basis. Commissioners, finance leads and others will meet outside these meetings as appropriate or required. Decision making in relation to the pooled budgets will rest with the Single Joint Management Group unless delegated appropriately.

The BCF Plan 2016-17 HWB sign off is done under delegated authority, which was agreed at the Board Meeting in March, with the following decision:
'*Health & Wellbeing Board agreed with the recommendations in the report which was to delegate the signing off of the BCF to the appropriate officers and to agree that the final version would be submitted to the next meeting of the HWB in July 2016 for endorsement.*

3.2 Maintain Provision of Social Care

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.

OCC is of the view that Adult Social Care is under significant pressure and the County Council under even greater pressure because local government has seen a reduction in funding whilst at the same time an increase in demand. However, the County Council has fully funded the impact on demographic pressures on adult social care. Through the Better Care Fund, there will be a continuation of the same levels of investment as in 2015/16:

- £10.502mm per annum was already being transferred in line with the 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013-14. This continues to be allocated against a broad range of existing schemes, contracts and areas of work. These include equipment and telecare (such as the alert service), intermediate care beds, and crisis response.
- £8m contribution to protecting adult social care services, which provides significant protection for adult social care, not least in avoiding other services having to be cut whilst also meeting increasing demand for care and support.
- £1.350m to meet new burdens arising from the implementation of the Care Act. This has broadly been spent on projects to support transformational work in adult social care designed to help manage increasing demand, both generally and as a direct result of the Care Act including preparing for this implementation of funding reform (although delayed, there is still a need to plan ahead).
- To date, this has included funding for operational teams to support the delivery of Responsible Localities (reshaping the adult social care workforce), development of a new IT system for adult social care including improving recording of Safeguarding, changes to support for carers (from GP-allocated breaks to assessment and support plans), delivery of new duties relating to advocacy, and the e-marketplace / online self-assessment.
- For 2016/17 there remains significant work needed to develop online self-assessment and e-marketplace, and the development of new posts including a Business Support Manager post to support DTOC and a specific Learning Disabilities Care & treatment review post. It is also anticipated that there will be a greater emphasis on support for carers, but we await further guidance and details of the exact breakdown in the Local Authority Social Services Letter, which will be sent by the Department of Health to the Directors of Adult Social Services in due course.

The identified schemes within the Better Care Fund plan protect adult social care through investment in improved delivery, through enhanced pathways that move clients in to more cost effective care pathways, and through the creation of increased flexibility in budgets enabling the identification of shared benefits.

Flexible budgets have enabled the Older People's pooled budget 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. There will be a continued emphasis on ensuring the right care in the right place, first time, and the vital links between intermediate community care and hospitals

Investments in an improved reablement service mean that patients will receive appropriate preventative reablement in the community and will be supported out of hospital in a way that ensures effective functional improvement in ADL performance. Alongside improved clinical outcomes, this both reduces pressure on acute services – as effective community reablement reduces admissions – and reduces the amount and length of both home care and care home provision – as people are more able to manage independently. This combination of improved patient outcomes, decreased pressure on acute services, and reduced social care cost characterises the overall approach in Oxfordshire.

Disabled Facilities Grants
In Oxfordshire there is a strong history of joint-working between the County and District Councils to effectively utilise Disabled Facilities Grants (DFG's) to support people to live independent and successful lives.

The nationally allocated capital sums for DFG's are passported to District Councils and deployed through Home Improvement Agencies to make adaptations to property, informed by close working relationships with adult social care (occupational therapists in particular) to determine need and how to meet this as effectively as possible.

3.3 Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate

The Oxfordshire system is committed to improving the availability of health and social care services 7 days per week, particularly where they support discharge and prevent unnecessary admissions at weekends. It is also important to note that OUH is National Early Implementer for 7 day working. The system completed a scoping exercise to determine the extent of 7 day services currently in operation, together with existing plans to increase the availability of services at weekends that increase discharge/admission avoidance, by organisation. Many of the actions from the scoping exercise have been completed and we know that:

- All organisations across the Oxfordshire system have plans in place to extend routine working across a 7 day week to meet the 20/20 challenge.
- The majority of services delivered by OHFT operate 7 days per week, from 08.00 to 22.00 as a minimum. Recent changes to the working patterns of

community therapists, who now work 7 days a week, have also increased the availability of community services at weekends.

- Adult social care has recently improved operations at weekends so that there is now a social work presence across acute and non-acute inpatient bedded areas; within the EMUs; and in A&E departments.
- OUH ensures that ward rounds take place twice every day, including weekends and bank holidays. The availability of diagnostics and pharmacy services has been recently increased at weekends and there are plans to extend this further. All critical diagnostics are already provided 24/7.
- A number of care agencies and residential care providers have started working flexibly to support the system at the weekend and particularly during high demand holiday periods.
- The evidence suggests that discharges are increasing at weekends. We are working with NHSE as part of the Winter Review Group to develop standardised Shared Operating Procedures for Discharge.
- Oxford University Foundation Trust have an action plan to meet the standards which are agreed with NHSIQ as part of Phase 1 of the early implementer programme for 7 Day Services. The work is currently focussing on 4 of the core standards 2, 5, 6, and 8. There is currently a major data collection process commencing on the 28th March will update our performance against the standards once published in May.
- Improvements against access to primary care over 7 days NHS England has commissioned extended hours in addition to the standard out of hour's provision. The CCG has also commissioned Neighbourhood Hubs at weekends and evenings. We are currently reviewing this provision to ensure we deliver against the standard and meet local need.
- Oxford Health (OH) deliver Emergency Department Psychiatric Service which provides MH assessment and support to staff 24/7 in OUH – JR response time 1 hour and HGH 1.5 hours – all age.
- OUH provide Inpatient Psychological Medicine Services across all wards 7 days a week, providing MH assessment and support to staff – all age
- OH provides crisis cover within mental health teams 24/7 – all age – response time 4 hours.
- Also there is a MH practitioner attached to the Thames Valley Police teams for Street MH triage between 1800 and 0445, to advise and support TVP with MH assessments and reduce the number of inappropriate s136's
- OCCG are testing using a OH MH practitioner being embedded in the SCAS control room, between 1800 and 0445 to provide MH advice and support call handlers and paramedics with 111 and 999 calls to prevent inappropriate conveyance to ED.

Adult social care is moving towards a new structure “Responsible Localities” which will establish a Rapid Response service with the remit to deliver a same day (Monday to Friday) response as required. Combined with improved crisis response services, this will help to reduce the amount of emergency demand at weekends by ensuring people have better planned access to the care they need. Responsible Localities will bring the Adult social care teams into a coterminous arrangement with the CCG and community health providers. Alongside this, we are working on an Estates strategy which will ensure that teams working across similar geographical areas are able to provide joined up services to the local population. Integrated working between partner agencies will ensure 7 day accessibility to the right response which will prevent unnecessary non-elective admissions to acute settings.

It is recognised that the necessary adult social care infrastructure to prevent unnecessary admissions must include the provision of a responsive domiciliary home care and Crisis service. Oxfordshire County Council is reviewing the commissioned service offer to ensure that services available in a crisis are understood, accessible and responsive. With regards to crisis services, the new Urgent Response and Telecare Service will encompass the Alert Service, the Carers Support, and the Crisis Service. This new service will work closely with the new Reablement Service and the new home care services.

- Service users can be referred from
  - Telecare
  - Single point of Access (SPA)
  - Social and Health care Team
  - Emergency Duty Team
  - ASC Locality teams
  - Carers Support Plan

Those entering via telecare will be visited within 45 minutes of their call. Others will be visited at an appropriate time depending on the urgency of the referral. This will be between 4 and 48 hours of referral.

After the first visit this service will provide a further 48 hours of care during which time a referral will be made to Reablement or Home care. Should neither of these services be able to accept the referral, this service will provide Contingency Home Support until one of the above is able to take the referral

3.4 Better data sharing between health and social care, based on the NHS number

The Oxfordshire system continues to work towards better data sharing across health and social care and relishes the advantage of having joined-up technological solutions across agencies, to ensure the safe, secure, timely and contemporaneous sharing of

data in the best interests of people who need to access health and social care and support.

The CCG IM&T Strategy, submitted as supporting evidence, has driven the successful delivery of shared electronic health records, patient consent for information sharing, electronic appointments and repeat prescriptions.

The current strategy will be replaced by a system wide strategy developed by the STP IM&T Work stream as part of the Transformation Programme. Working with the Academic Health Sciences Network (AHSN) we have plans to develop an eHealth Informatics Platform for Oxfordshire that will enable digital health and care transformation.

An interoperability platform has benefits for patients, the health and care system and research by:

- Empowering patients to self-care and improve experience and outcomes
- Facilitating system transformation through improved efficiency, new care models and payment mechanisms
- Providing general insights into patient care and enable digital innovation across the value chain
- Improved access to rich data sources for transformational research

All of the Transformation Board clinical work streams under review are likely to require technical solutions and data interoperability for the success of their plans which could be facilitated by such things as:

- Email/skype consultations to facilitate appointments delivered at places other than hospital outpatient settings or a patients 'own' GP practice
- Access to a single digital health record and patient data in real time to facilitate multidisciplinary assessments and treatment or treatment in a patient's own home
- Telehealth that enables patient participation and full engagement in their own health journey

We intend to take every opportunity to make use of technological solutions as a means of delivering responsive, cost effective and patient friendly services. Further detail will be provided in the STP Transformation Plan. Oxfordshire's Digital Roadmap is being developed in partnership with local providers through the Transformation Board IM&T work group. The Commissioning Support Unit is undertaking a stocktake and a strategy will be developed by the IM&T work group.

The Oxfordshire Care Summary (OCS) is the locally agreed application programming interface (API) system which will accept data from any system, provided the data, the

system and the processes for sharing the data meet clinical safety and information governance standards. The NHS number is the primary identifier for health and social care services within the OCS, and this has been adopted by adult social care and all the health providers across Oxfordshire. The system-wide use of the NHS number is steadily increasing as the rollout of the OCS becomes increasingly widespread.

The OCS commenced implementation in March 2013, and access is currently available to authorised clinicians in OHFT, OUH, SCAS and GP practices. The access is via an N3 connection to a website, controlled by user ID and password protected, or by a single-sign-on context sharing access from within a user's electronic patient record. The consent model is one of 'implied' [1] patient consent to share, and explicit permission to view at the point of care, where possible.

Role-based access (that is to say, restrictions on the data which can be viewed according to the role of the user) is also under development as main access is currently for NHS clinicians only.
Provider organisations and GPs have signed up to information sharing protocols to enable the information to be shared, under the Oxfordshire Information Sharing Framework. All statutory organisations including OCCG, OCC, OHFT, OUH, Principal Medical Ltd (PML: GP deputising service) and the South Central & West Commissioning Support Unit have signed up to the framework, as of March 2015. GPs have signed up practice by practice over the past two years and progress over 2015 has resulted in all Oxfordshire GP practices are now signed up to this agreement. There has been incentivised through the Local Investment Scheme (LIS) for primary care to enable. The framework is an overarching agreement which sets the standards by which information can be shared and was developed by a multi-agency information governance steering group.

Adult social care implemented a new IT system (Liquidlogic LAS) in November 2015. LAS uses the NHS number as an identifier and currently the council has over 90% of service users with an NHS number in the system. The council, provider and partners are currently investigating ways in which the council and community health provider Oxford Health can join the Oxfordshire Care Summary later in 2016 via the MIG. The Oxfordshire Care Summary is a 'single view' platform which enables partner agencies to view specific information held on service users.

3.5 Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

We continue to stratify and support the top 2% of the population most at risk of an emergency admission, supporting the role of the GP co-ordinator through the implementation of advanced care plans for all in the high risk group, with case management to avoid unplanned admission. We know that a majority of NEAs come

from patients within this risk group and therefore acknowledge the importance of targeted work to reduce unnecessary acute activity.
Our top 2% has been identified through a risk stratification exercises involving:

- Age: those over 65 years where Oxfordshire is experiencing above national average population growth.
- The top 2% of patients (9,700) identified as most at risk of an emergency admission using the ARG risk stratification tool.

Over 26% of those most at risk of emergency care in Oxfordshire live in residential care and nursing homes. It is for this reason that the Oxfordshire BCF plan continues to include an initiative to provide greater health prevention support to the independent residential home sector, through 'proactive medical support to care and nursing homes'. From evaluation, we know that this scheme is making an impact in reducing NEAs (please see the BCF Dashboard).

To address these issues, support implementation of a greater level of ambulatory care and our Care Closer to Home plans we are piloting the delivery of integrated care through 17 co-located Community Integrated Locality Teams across 6 localities. The integrated teams bring together health and social care colleagues in neighbourhood teams working alongside 4-6 GP practices. The outcome for individuals is 'one plan and one approach' to meeting their needs, a better experience and more efficient use of resource.

Adult social care is moving towards a new model which will bring health and social care into a coterminous relationship. This is a positive step forward within Oxfordshire and will allow teams of health and social care professionals, working to GP patches of 30,000 to 50,000 to working as multi-disciplinary teams, assessing and jointly planning for local people whose needs would benefit from such an approach.

The changes from Responsible Localities are expected to be implemented during the autumn 2016 with a plan to push forward on closer integrated working and planning once the initial foundations are in place.

Adult social care is scoping the upgrade of its' IT system LAS with a view to the deployment of online portals; enabling better sharing of information between individuals and professionals involved in the delivery of health and social care across the County.

Dementia
Partners across Oxfordshire have been working together to ensure that people with dementia and their carers receive the appropriate level of support wherever they live within the County, and regardless of whether they receive their diagnosis in primary, community or secondary care. We believe that the single dedicated county wide

Dementia Support Service will improve the current level of support by increasing provision and scope. Our OCCG operational Plan references our activity trajectory for dementia diagnosis for 2016/17 shows that we aim to achieve and maintain delivery of the dementia diagnosis target from quarter 2.

The benefits of the single Dementia Support Service are as follows:

- The service provision will be standardised and equally available to all people with dementia and their carers across the county
- Increased capacity that will be achieved by;
  - Redesign of current provision to avoid duplication and maximise effectiveness
  - Increased number of dementia advisors
- Current resources will be more efficiently utilised and staff will be up skilled to achieve better outcomes
- Resources will be allocated following demand analysis ensuring support is offered to people with dementia and their carers according to their need
- On-going support ensuring crises are prevented by proactive management and early identification
- Responsive service according to needs
- Creating a joined up approach between health, social care and voluntary sector.

We also aim to improve the dementia services by:

- Continuing to build capacity for GP diagnosis and management of dementia, building on work undertaken in 2015/16
- Raising GP awareness of post-diagnostic support services, establishing strong links between primary and secondary care and developing a model of specialist nurse support in the community.
- Ensuring that each person with dementia and every GP practice has their own Dementia Advisor creating strong links between GP practices and community support.
- Working with secondary care to improve waiting times from GP referral to diagnosis ensuring referrals for memory assessment are seen within 30 working days.
- Ensuring, where possible, that a diagnosis is given at the first appointment but where a second appointment at a memory clinic is needed ensuring that diagnosis is provided within 70 days of initial referral.
- Monitoring delivery of dementia training by providers
- Working in partnership with OCC to source specialist residential and nursing homes for people with dementia.
- Supporting the Oxfordshire Dementia Action Alliance (ODAA) to encourage communities and local businesses to become more dementia friendly.

3.6 Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans

BCF Plans have been developed in partnership with our providers through the BCF Programme Board. We work on an on-going basis with all of our stakeholders to identify where and how our plans may impact providers financially and in regards to activity.

The current DToC plan is also working to better understand if any proposed or implemented changes will have an impact somewhere else in the system. This is worked through as part of the system equilibrium work and addresses challenges as they arise or are foreseen.

We have also been working to align our operational plans with the provider plans to ensure that parts of our system are not adversely impacted by schemes that are included within this plan.

Finally, the BCF Programme aims to operate a risk arrangement to achieve NEA and DToC target, which aims to reduce the risk for providers/commissioners alike and supports the ambition that money follows the patient.

3.7 Agreement to invest in NHS commissioned out of hospital services

Oxfordshire has a wide range of out of hospital services to deliver better integrated and personalised services supporting patients in the community. These range from preventative service provision (to be developed for diabetes and COPD) to community services for End of Life Services and a new Falls Pathway.

This approach is strengthened by the Transformation Board, which is leading on developing a Care Closer to Home Strategy which sets out our vision to enable more people in Oxfordshire to access care at or closer to home. Our ambition is to achieve a step change in developing community services and to reduce demand for hospital care by:

- Developing local systems of care that bring together general practice, community health and social care, the voluntary sector supported by specialist advice to proactively and comprehensively manage the local population's health.
- Integrating care around patients not organisations, promoting health and wellbeing, offering rapid access for urgent problems and a comprehensive prevention approach for patients and populations at risk of poor health

- Engaging partners and front line staff and clinicians in the development of our Care Closer to Home transformation plans.

This development to enable out of hospital-based care requires greater senior medical presence and outreach into community services, most particularly the EMUs, our DToC incentives and interface with primary care and the integrated neighbourhood teams. It is likely to involve acute sector specialist clinicians adopting new ways of working, including delivering remote interface support and advice via telemedicine, to clinicians delivering services within patient's own homes.

We have therefore agreed to that the 2016-17 BCF Programme will aims to reduce non-elective admissions by 1000 episodes based on projected OCCG activity growth for the same year. As mentioned above, we expect that increased Ambulatory Care and End of Life projects to feed into this to a large extend. The cost savings associated with this are put into the contingency and we are in discussion with stakeholder's relation to the risk share arrangements.

3.8 Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan

The Oxfordshire DTOC Plan for 2016-17 builds on the learning from the 2015-16 initiative *Re-balancing the System* and is designed to reduce both the number of people who are delayed in the Oxfordshire system and the length of time patients stay in hospital when medically fit for discharge.

The plan is part of a broader initiative to design and deliver equilibrium into the Oxfordshire system, creating the right capacity and processes at each stage of the patient's journey. As this larger piece of work is still in development, this DTOC plan focusses specifically on the reduction of delays through until March 2017.

3.8.1 Learning from *Re-balancing the System*

This initiative:

- Released a number of in-patient beds and redeployed the resource into an extended Emergency Assessment Unit
- Purchased intermediate care beds at scale in the community to step down people who were medically fit for discharge but who could yet move to their final destination
- Created a multi-agency hub to manage flow into and out of the intermediate care beds and co-ordinate medical, social worker and therapy cover

As the initiative progressed the hub developed into a full command and control structure and has extended from hospital based teams to include procurement and contracts staff in the local authority. The hub has interrogated processes around assessment and transfer and has been given responsibility for allocating all resource across reablement, domiciliary care, residential and nursing home with the specific

requirement that it allocates resources both to meet patient need and to address pinch points across the system.

This approach has had significant impact:

- 30% reduction in delays in context of average 6% quarter by quarter increase – forecast q4 2015/6 on trend of 181
- Reduced DTOC length = 13% increase in proportion DTOC of less than 1 week
- Delayed days per 100,000 population (BCF Indicator) in January at 890.2 from November figure of 1004.5
- Fewer DTOC days (2,041) in December and January than in same period 14/15
- Reduction in secondary delays within the pathway: people waiting to move on from reablement to domiciliary care packages has reduced from c 30 each day in Dec 15 to 16-20 each day in March 16. This frees up capacity for people awaiting discharge from hospital

Generally there is better flow in the system and a better understanding of barriers to flow when they occur. Resources can be and are being allocated to manage these flow issues as they arise and the daily command and control structure has escalation processes that ensure senior clinical and managerial oversight.

3.8.2 The Oxfordshire DTOC plan for 2016-17

The 3.5% target of bed days lost to DTOC equates at current length of stay to a weekly snapshot of 73 patients delayed, which would represent a 50% reduction in our current system figure. As a system Oxfordshire has reviewed where and how we can reduce our weekly delay across the different forms of delay. Our approach builds on the strengths of the *Re-balancing the System* initiative

The plan focusses on the following areas:

- Focus on assessment and choice processes that will reduce unnecessarily delays
- Continued grip on daily and weekly operations to ensure that flow is managed and available resources deployed appropriately
- Planning for discharge from the point of admission

OCCG's operational plan has prioritised the DTOC Plan and investment in resources will be made available that will support the move to a system that can work in equilibrium.

3.8.3 Operational control

The command and control function that was so effective in the *Re-balancing the System* initiative will be maintained.

- Gold Command and Control daily calls
- The daily teleconference uses shared information on system wide available resource and patients to prioritise to limited resource – e.g. Home care hours, community hospital beds
- Command and control assures consistency and timeliness of assessment and choice processes
- System wide workforce strategy with agreed priorities across the partner agencies
- Escalation of underlying issues to the Chief Operating Officers weekly DTOC Control Group
- Oversight and assurance from the SRG Chief Executive Officers group monthly

3.8.4 DTOC delivery plan

The Oxfordshire system has maintained a level of delay of patients that could be reduced by a more co-ordinated approach to some key processes.

Assessment	• Increased use of discharge to assess models – home (80 Discharge to assess intermediate care beds) and CHC (12 interim funded discharge to assess beds) from May 16 • Assuring integration of assessment functions through the Gold Command and control centre from April 16 • Additional social worker and therapy input into discharge to assess beds to support timeliness of assessment from May 16
Awaiting further non-acute NHS care	• Improving pull through from integrated reablement service (below) [date TBC] • Achieving an optimal length of stay in community hospital of no more than 21 days via 2 weekly MDTS • Additional beds for intermediate care and interim waiting (31 and 18 in phase 1) whilst moving to optimum length of stay in all other intermediate care and community hospital beds and building home carer workforce • Review of all waiting in OUHFT for Community hospital with view to home discharge with rehabilitation model or more intensive rehabilitation on site
Awaiting residential home placement or availability	• Increase the availability of residential and nursing placements through an alignment of commissioning intentions and market availability • Use interim beds for people needing residential/nursing homes where there is no need for them to remain in hospital environments • Tighter choice policy with 7 days to select home – agreed timeline for allocation of
Awaiting nursing home placement or	

availability	care home price. • Dynamic purchasing model for residential and nursing home care from September 16
Awaiting care package in own home	• Purchase an extra 14000 hours of care by 31/3/17, and increase the home care workforce • Integrated reablement and discharge service with more effective pick-up, outcomes and discharge and/or move on to next step in pathway
Choice	• Review the Oxfordshire choice protocol to a 7 day process from June 16 • Assuring integration of choice policy functions through the command and control centre from April 16
Oxfordshire people delayed in other systems	• Development of a Royal Berkshire patient protocol by June 16 • Potential use of beds on the Townlands site from July 16 • Weekly calls with Northamptonshire to plan discharges from April 16

3.8.5 Trajectory and strategic control

Performance against the DTOC plan will be reviewed monthly by the Chief Operating Officers in the DTOC Control Group and escalated to the SRG Chief Executives Group.

The DTOC control group have assessed the system confidence in the elements of the DTOC plan as follows:

	Attributed DTOC at 10/3/16	**Planned DTOC at 31/3/17**	**Trajectory**	**Notes**	**Clear actions to address**
Waiting Community Hospital Beds	**25**	**16**	From Sep	Demand and capacity analysis completed by OUH. Model for accelerated rehabilitation now developed and agreed by providers	Partial
Intermediate Care Beds	**5**	**3**	From May	Additional beds to continue to be purchased	Yes
CHC D2A beds	**0**	(assessment reduction)	From June	Needs to be filtered in through May	Yes
Interim Beds	**4**	**2**	From May	OCC to advise nature and locations	Yes
Nursing Home beds	**15**	**8**	From Sep	OCC introduce dynamic purchasing model by Sep 16; focus on particularly EMI beds	Partial

SHDS / ORS (reablement) Hours	**26**	**17**	From Oct	Awaiting resolution of the integration plan. Procurement solution being sought.	Partial
Domiciliary Care	**8**	**4**	From April	Extra hours managed and deployed through command and control hub	Yes
Assessment	**14**	**8**	From April	(1) CHC interim funding delays addressed by CHC D2A (2) Potential for hub assurance re assessment delays	Yes
Choice	**22**	**11**	From June	New choice policy will need Board ratification in May- need to understand impact of national policy	Yes
Out of county	**8**	**4**	From July	(1) need to consider use of Townlands beds for bed-based D2A (2) need to review processes re RBFT delays	Partial
Total	**127**	**73**			

3.8.6 Implementing the learning from the DTOC summit 22 April 2016

As discussed at the DTOC summit there remain a number of challenges to the plan that will need to be addressed as part of the longer-term equilibrium work:

- Resolution of integrated reablement
- Homecare workforce –part of plan but significant challenge
- How to manage nursing home market at reasonable price
- Out of area protocols
- Rehabilitation whilst waiting for community hospital

Approaches to these were explored with useful advice and insights which are being enacted locally. In addition, the system will develop approaches to care planning at all stages of the patient journey through hospital. We will test this through the use of 7 day stranded patient metric.

3.8.7 DToC Risk Share Arrangements

The Council and the Clinical Commissioning Group are both committed to increasing the hours of home care purchased each week to meet increasing demand, reduce the number of people permanently placed in care homes, and to help avoid hospital admissions and support people to return home as soon as they are fit to do so.
The Council has committed £2.1m of new funding to the Home Support budget within the Older People's pool to purchase additional capacity in the Home Support market. It is calculated that the Council will need to purchase 270 new hours of home care per week over the course of 2016/17. After taking into account the impact of attrition the Council expects to deliver growth of 10% in the number of home support hours commissioned per week from a baseline of 20,400 hours per week.

It is proposed that if the Council does not fully meet this commitment and there is an underspend against the Home Support expenditure budget, the Clinical

Commissioning Group will recoup in full any underspend up to the value of £2.1m. This will help to offset additional costs in the NHS arising from people admitted to and/or delayed in hospital (acute or intermediate care beds) as a result e.g. the additional CCG investment in intermediate care beds.

However, subject to evidence provided by the Council that the inability to source home care was due to capacity in the market rather than sufficient funding, and if there are demonstrable costs to the pool arising from increased admissions to care homes as an alternative to home care, the Clinical Commissioning Group may agree to the reallocation of this funding within the pooled budget.

Progress in sourcing the additional hours of home care will be jointly tracked weekly and monitored on a quarterly basis by the Joint Management Group. This will be measured by the average numbers of new hours commissioned per week in the quarter, cumulative progress towards the 10% increase in total weekly hours per week, and the total spend against the budget.

4.0 National Metric

4.1 Non-elective admissions:

Reduction 2016-17	1,000
Expected activity	**55,724**

We were successful in halting the expected growth for NEAs for 2015-16 and analysis suggests that we are in a good position to repeat this performance again this year. Therefore, we have committed to reducing expected non-elective activity by 1000 episodes.

4.2 Admissions to residential homes and care homes (how you intend to reduce residential admissions)

Forecast 15/16	Planned 16/17
442.8	440.9
526	536
118,780	121,570

Last year (2014/15) Oxfordshire placed 595 or 11.4 people per week in care homes. This was the 34th lowest rate of admissions in the country and in the top quartile nationally. In the first 11 months of this year 546 people (or 11.4) per week have been placed.

The target set - 572 people reflects 10.5 placements per week on average. It is an increase on last year's target but an improvement on actual performance

and reflects the need to review highly expensive care packages as this underpins at least one of our agreed savings. This performance will still put Oxfordshire above the national average

The range of admissions in the last 5 years has varied from 557 to 626. This target, last met in 2011/12, is therefore a challenging target, but still represents a stretch on previous years

The council uses all demographic funding to support care in the home as this is the strategic direction of all partners locally. However the council will be reviewing highly expensive care packages this year, which will put a pressure on meeting this target.

4.3 Effectiveness of reablement (how you intend to increase reablement)

Forecast 15/16	Planned 16/17
83.2%	83.6%
288	418
346	500

A multi-agency project has been set up to improve access to reablement and the performance of the whole reablement pathway. Work streams include developing a commissioning pathway, and improving the interface between the different parts of the reablement pathway.

4.4 Delayed Transfers of Care

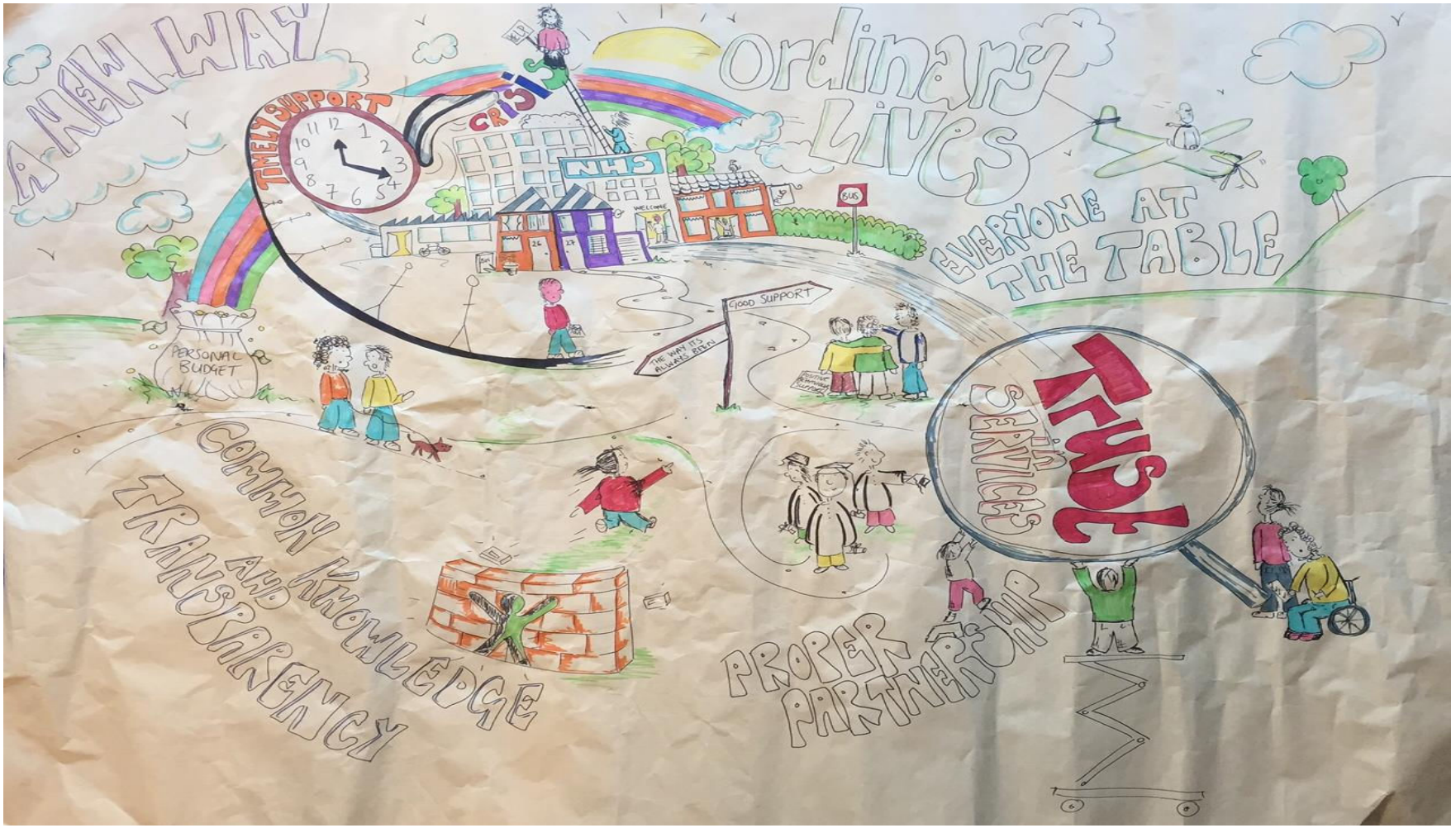
		16-17 plans				
		Q4 (Jan 16 - Mar 16)	**Q1 (Apr 16 - Jun 16)**	**Q2 (Jul 16 - Sep 16)**	**Q3 (Oct 16 - Dec 16)**	**Q4 (Jan 17 - Mar 17)**
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+).	Quarterly rate	2487.7	2333.5	2146.0	1958.6	1535.9
	Numerator	13263.0	12440.8	11441.5	10442.1	8233.8
	Denominator	533,140	533,140	533,140	533,140	536,106

Our DToC action Plan demonstrates how Oxfordshire will reduce DTOC to 3.5% of total occupied bed days by 31/3/2017 and has translated this to a weekly target of 73 DTOC per week.

This amounts to a 50% reduction on the current average monthly performance. Each of the initiatives within the plan has a trajectory for delivery overseen by a SRO appointed from across the system. The Control Group will monitor progress weekly and mitigate any risks to delivery.

The metrics for the DTOC Action Plan 2016-17 will monitor the impact of the range of initiatives that have been developed from local learning and the ECIP High Impact Changes. These measures are currently being tested with a view to signing them off the planned Oxfordshire DTOC Summit hosted by NHS England on 22 April.

Oxfordshire Transforming Care Plan 2016-2019



31st March 2016
Oxfordshire Transforming Care Planning Group

Planning Template - Oxfordshire

1. Mobilise communities

Governance and stakeholder arrangements

Describe the health and care economy covered by the plan

Oxfordshire is home to 672,500 residents and has twenty years' experience of pooled budgets and close joint working across the public sector.

The local government, health and social care economy covered by this plan includes:

- **Single unit of planning** coterminous with the **Oxfordshire County Council** and **Oxfordshire Clinical Commissioning Group** - single local authority and single CCG;
- **Two-tier local government structure** - with **Oxfordshire County Council** being responsible for providing children and adults social care under the Care Act 2014, and **five District / City councils** being the housing authority in their geographical area - Oxford City Council, Cherwell District Council, South Oxfordshire District Council, Vale of White Horse District Council, West Oxfordshire District Council;
- **Oxfordshire Clinical Commissioning Group** representing **76 GP practices** grouped into 6 locality groups
- **3 major NHS providers**
    - Oxford University Hospitals NHS Foundations Trust (provides a wide range of clinical services, specialist services (including cardiac, cancer, musculoskeletal and neurological rehabilitation) medical education, training and research across 4 world renowned teaching hospitals);
    - Oxford Health NHS Foundations Trust (provides physical, mental health and social care for people of all ages);
    - Southern Health Foundations Trust (provides hospital and community based health care for adults with learning disabilities).
- Voluntary sector providers of housing, supported living and other support services

Oxfordshire has over **fifteen years' experience of pooled budgets** and joint-commissioning strategies, with the learning disability pool budget being the oldest.

We have a **single Section 75 agreement** covering four pooled budgets:

- Oxfordshire County Council is the lead commissioner for Learning Disability, Older People and Physical Disability
- Oxfordshire Clinical Commissioning Group is the lead commissioner for Mental Health, which includes Autism and CAMHS

This robust governance and joint-commissioning structure is underpinned by longstanding strong relationships with a wide range of statutory, independent and voluntary sector providers. Oxfordshire has led nationally the roll out of direct payments and supported living for adults with a learning disability. We are one of the areas with the high number of both people in receipt of social care personal budgets and people in receipt of direct payments.

Our commissioning practice across health and social care has transformed over time from large block contracts and small grants to personal budgets and direct payments for individuals, block contracts for population wide health services and a range of new framework agreements with a cross-sector group of partner providers: e.g. Oxfordshire Mental Health Outcomes Based Contract, Help to Live at Home framework, Supported Living framework.

Devolution Bid

In September 2015 Oxfordshire submitted to national government a devolution bid looking under **proposal 6** for "a new way of working across the public sector which includes a wider range of cross county working in the management of health and social care; our intention is to bring health budgets together to deliver better outcomes for Oxfordshire residents". A national government decision is expected in spring 2016.

CA_OCT2015R27 Devolution Annex.pdf

Describe governance arrangements for this transformation programme

Programme governance is provided by the **Oxfordshire Transforming Care Partnership Board** (TCPB).

The TCPB brings commissioners and providers of health and social care services to people with learning disability together with the people and families that use them to assure the development and delivery of the Oxfordshire Transforming Care Plan and within that oversee a process in which specialist adult health services provided by Southern Health NHS FT [SH] are transferred to mainstream mental health and community services provided by Oxford Health NHS FT [OH]. The Board has recently been extended to ensure all age representation so that it is able to develop and deliver the Oxfordshire Transforming Care Plan.

Accountability

The TCPB is accountable to the OCCG Board via the OCCG Chief Executive and will report into the Oxfordshire Transformation Board as part of the developing Sustainability and Transformation Plan process. Progress reports will also be made to the OCCG-OCC Joint Management

Group and the Oxfordshire Health and Wellbeing Board.

Membership

- Independent Chair: Ian Winter CBE (formerly Programme Lead, Winterbourne Improvement Programme)
- Deputy Chair: John Jackson; OCC Director of Adult Social Care
- Paul Scarrott (Real People, Real Voices – user and family / carer representative)
- Pam Bebbington (Real People, Real Voices – user and family / carer representative)
- Gail Hanrahan (Real People, Real Voices – user and family / carer representative)
- Jan Sunman (Real People, Real Voices – user and family / carer representative)
- Alex Brooks (Real People, Real Voices – user and family / carer representative)
- Kathy Erangey, Autism Oxford
- David Smith, OCCG Chief Executive
- Diane Hedges, OCCG Director of Delivery and Localities
- Sula Wiltshire, OCCG Director of Quality
- Kate Terroni, OCC Deputy Director Joint Commissioning
- Seona Douglas, OCC Deputy Director Adult Social Care
- Sarah Breton, Lead Commissioner, Children and maternity OCC/OCCG
- Sarah Ainsworth, Children's Disability Manager, OCC
- Stuart Bell CBE, OHFT Chief Executive
- Dominic Hardisty, OHFT Chief Operating Officer
- Pauline Scully, OHFT Service Director, Children and Families
- Rosie Shepperd, OHFT Consultant Child and Adolescent Psychiatrist, Childrens LDT
- Katrina Percy, SHFT Chief Executive
- Mark Morgan, SHFT Director of Operations, MH, LD & Social Care
- Louise Doughty, Head of Mental Health & Programme of Care Lead (Secure CAMHS), Specialised Commissioning, NHSE
- Jan Fowler, Director of Quality NHS England South Central
- Debra Moore, Independent Clinical Adviser
- Dr David Chapman, OCCG Clinical Lead (LD, MH & ASD)

Attendance by:

- Programme Director, Learning Disability Transition (OHFT, to be appointed)
- Ian Bottomley; Head of Mental Health & Joint Commissioning, OCCG
- Chris Walkling; Senior Commissioning Manager (LD), OCCG
- Annet Gamell; Chief Clinical Officer, Chiltern CCG

Chiltern CCG (on behalf of Aylesbury Vale) will support the TCPB in managing the cross-border implications of the Transition Plan and will sit on the SRO Working Group.

TCPB TOR
09-02-16.docx

The Transforming Care Planning Group

This group will facilitate a number of work streams and ensure that there is appropriate subject matter expert stakeholder representation in each group.

The group has drafted the Transforming Care Plan.

Core Group

- Paul Scarrott, user representative, Real People, Real Voices
- Pam Bebbington, user representative, Real People, Real Voices
- Alex Brooks, support for Paul and Pam, Real People, Real Voices
- Jan Sunman, family and carer representative, Real People, Real Voices
- Gail Hanrahan, family and carer representative, Real People, Real Voices*
- Kathy Erangey, family and carer representative, Autism Oxford
- Ian Bottomley; Head of Mental Health & Joint Commissioning, OCCG
- Chris Walkling; Senior Commissioning Manager (LD), OCCG
- Natalia Lachkou; Commissioning Manager Social & Community Services, OCC*
- Robyn Noonan; Area Service Manager Learning Disability, OCC
- Sarah Ainsworth, Disabled Children's Manager, OCC*
- Lajla Johansson, Senior Commissioning Manager, Children, OCCG

*(*also members of the SEND Reforms Programme Board)*

The Transforming Care Partnership Board agreed that the Planning Group should commence with commissioners, users and carers and draw in the expertise of providers once a draft service model has been completed and as part of the implementation process.

Contributors

- Dr David Chapman, Clinical Lead for MH. LD and Autism, OCCG
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Protocol governing the relationship between the Health and Wellbeing Board, Safeguarding Boards and Community Safety Partnerships

A draft protocol has been developed relating to:

- Oxfordshire Health and Wellbeing Board (HWB) and its associated partnership boards and joint management groups
- Oxfordshire Safeguarding Children Board (OSCB)
- Oxfordshire Safeguarding Adults Board (OSAB)
- Oxfordshire Community Safety Partnerships (CSPs)
- Oxfordshire Safer Communities Partnership (OxSCP)

The protocol sets out the framework within which these Boards/Partnerships will work together to safeguard and promote the welfare of people living in Oxfordshire, including the distinct roles, responsibilities and governance arrangements for each of them.

The OCC-OCCG Joint Management Group includes the Transforming Care Planning Group leads. This will provide the connection between the Transforming Care Plan and the safeguarding and community safety boards / partnerships (as set out in appendix 1).

Autism Services

OCCG and OCC jointly commission Autism services for adults. The lead commissioner is OCCG and investment sits in the Mental Health commissioning pooled budget. The Joint Management Group oversees delivery of the agreed action plan from the Oxfordshire Autism Strategy. The JMG reports to Oxfordshire Health and Wellbeing Board at least annually and the national bi annual self-assessment is signed

off by senior strategic commissioning leads in OCC and OCCG.

For children, the autism diagnostic service is commissioned from Oxford Health. Following review in 2014/15 there is now an integrated pathway in place for both co-morbid and non-co-morbid children. Children with a moderate-severe learning disability are diagnosed and managed through the Specialist CAMHS / LD team also commissioned from Oxford Health.

Programme Interfaces

A number of existing partnerships are delivering activities which contribute to the delivery of the Transforming Care Plan. The following groups will interface with the Planning Group to ensure the transformation programme is appropriately embedded in other work streams:

- SEND Reforms Programme Board
- CAMHS Transformation Board
- MH JMG (autism services, mainstream mental health services)
- Workforce Development Programme
- Housing with Care Delivery Board
- Personal Health Budgets Project Board (first meeting being planned for February)
- Strategic Transitions Group (in development)
- Autism Partnership Board (further details below)
- Oxfordshire Disabled Children's Services Redesign Programme Board

Describe stakeholder engagement arrangements

Stakeholder engagement in the development of the Plan is taking place through two principal routes:

The Transforming Care Planning Group

As detailed above. Additional detail on the core group is provided below:

Organisation	Role	Description
Oxfordshire Family Support Network	Representing families and carers	Aims to support families of people with LD through independent information, advice

- Jan Sunman - Gail Hanrahan		and training, and to ensure that their voices are heard by those who provide services. Has developed the “Real People Real Voices” partnership with My Life My Choice to co-ordinate input into the development of the Plan and the wider programme of work to transform local services.	
My Life My Choice - Paul Scarrott - Pam Bebbington (supported by Alex Brooks)	Service user self advocacy	My Life My Choice is a self-advocacy organisation and ULO. Has developed the “Real People Real Voices” partnership with Oxfordshire Family Support Network to co-ordinate input into the development of the Plan and the wider programme of work to transform local services.	
Oxfordshire County Council - Benedict Leigh - Natalia Lachkou - Sarah Ainsworth - Janet Johnson - Sarah Breton - Jane Rivers - Jacqui Gilbert	Lead commissioner of health and social care LD services to end June 2016.	OCC currently commissions LD health and social care services via a pooled budget agreement. OCCG will take over the contract for provision of LD health services from July 2016. Services for children aged 5-25 are managed through the new Education Health and Care Planning process.	

Oxfordshire Clinical Commissioning Group - Dr David Chapman - Ian Bottomley - Chris Walkling	Lead commissioner for LD health services from July 2016.	OCCG is in the process of taking over the management of the current LD health services contract with Southern Health from OCC and will see the transition of services to Oxford Health FT by 1st January 2018.
Autism Oxford - Kathy Erangey	Representing people with autism and Asperger's and their families and carers	Brings together people who seek knowledge and understanding of the Autism Spectrum and autistic behaviour with those best able to impart it. Signposts and supports the development of autism-specific support services.

Children and Young People

The families and carers of children and young people have been represented to date by Real People Real Voices.

Children and young people with learning disabilities and / or autism and their families / carers will be engaged in the detailed project planning and implementation. We are currently exploring the most effective mechanism to manage this engagement and avoid duplication. For some workstreams it is likely that existing Boards and Partnerships with strong user representation will own and deliver Transforming Care actions. Additional task and finish groups will be created as required, with users and families / carers playing a central role.

Autism:

The Autism Partnership Board is a multi-agency board which includes experts by experience and families / carer representatives.

It has sub groups for:

- Training: led by Autism Oxford
- CYP diagnosis and post diagnostic support: led by OHFT
- Diagnosis and care pathway: led by OCCG through AQP group of providers

The Board will be engaged in the detailed project planning and implementation.


APB Membership Jan 2015.xlsx


APB example of agenda and includes p

The Board is currently reviewing how it works in response to OCC broader review of engagement strategy.

The Oxfordshire Big Plan

The Oxfordshire Big Plan sets out the County's adult learning disability strategy for 2015 – 2018. It is a joint OCC / OCCG plan.


The Big Plan FINAL.pdf

The Big Plan shares many of the key objectives of Building the Right Support:

1. enable people with learning disabilities to have more choice and control over their lives.
2. enable people with learning disabilities to take an active part in their community, through work, volunteering, friendships, and other opportunities.
3. enable people with learning disabilities to make choices about where they want to live, and support them and their families with their decision.
4. have the right support in place for people with learning disabilities to enable them to remain safe and keep well.

In addition to user, family and carer and provider input into the development of the Plan, an extensive public consultation was carried out between November 2014 and February 2015.

A wide variety of engagement methods were used to support the consultation, including sessions specifically for people with learning disabilities. In all:

- 411 people took part by attending consultation meetings;
- 118 people responded to an online questionnaire, with a further 20 email submissions;
- 140 people took part through groups specifically for people with learning disabilities;
- 17 young people with learning disabilities near transition took part in a focus group.

The findings of the consultation have been considered as part of the development of the Transforming Care Plan.

Oxfordshire Young Enablers

The Oxfordshire Young Enablers was a service user group of disabled young people. The group produced a number of reports which have been incorporated into the Plan where appropriate, for example their work on Being safe, risky behaviours and relationships

Describe how the plan has been co-produced with children, young people and adults with a learning disability and/or autism and families/carers

The Oxfordshire Transforming Care Plan is being co-produced with Real People Real Voices, a partnership of LD experts by experience and families / carers. The family / carer representatives have personal experience of children's and adults services.

Kathy Erangey (Autism Oxford) is representing families / carers and service users with autism.

A variety of workshops are planned to ensure the widest possible input from service users, families and carers. The Planning Group is also developing a specific engagement strategy for people with ASC, since the conventional workshop format will not provide the most effective mechanism for engaging with this group.

Please go to the 'LD Patient Projections' tab of the Transforming Care Activity and Finance Template (document 5 in the delivery pack) and select the CCG areas covered by your Transforming Care Partnership

Any additional information

2.Understanding the status quo

Baseline assessment of needs and services

Provide detail of the population / demographics

Adults

In 2010 it was estimated that around 900,000 adults aged 18 and over in England had a learning disability, of whom 191,000 (21%) were known to learning disabilities services.

In 2010 Oxfordshire was home to around 1.2% of England's adults aged 18 and over. On a proportionate basis, this suggests that around 11,100 adults in the county might have a learning disability.

In September 2013, 1,923 people with learning disabilities were known to social services in Oxfordshire.

National estimates predict that demand for services will increase at a rate between 0.6% and 4% per year between 2009 and 2026. Although there has been a steady increase in the number of people open to learning disability teams in recent years (from 1792 in March 2012 to 1923 in September 2013), the number of people in supported living and care homes increased between 2011/12 and 2012/13 but fell in the first 6 months of 2013/14 (Oxfordshire Joint Strategic Needs Assessment 2014).

Of the approximate 11,100 adults with a learning disability in Oxfordshire, 2,600 have a learning disability that is moderate or severe.

In September 2014, 2,066 people received support from a social care learning disability team of whom 1,794 had a paid for service. The other 272 will be open to the teams for low level support and monitoring, including concerns over safeguarding. There were 2,311 eligible for health support, and 820 service users with a current open health referral. The health and social care service users overlap.

Of the 1,794 people who received a paid for service:

- 282 are currently in a care home (190 outside Oxfordshire)
- 659 are currently in supported living
- 469 people are receiving a direct payment and of these 48 people are using their direct payment to pay for a care home or direct payment place
- 82 people are receiving home care
- 54 people are in long term shared lives placements

- 75 people are in short term placements with shared lives
- 429 people are getting day care
- 6 people using hospital services. About half of the people using assessment and treatment hospital services do so for mental health reasons.

Further data on the adult LD cohort is shown in Appendix 3.

Autism

Data obtained from http://www.poppi.org.uk/ and http://www.pansi.org.uk/ predicts that in Oxfordshire in 2015:

4,128 people of 18-64 will have an autism spectrum disorder
1,103 people over 64 will have an autism spectrum disorder

Additional profiling data on this cohort will be used in the detailed Transforming Care project planning.

Additional projected data for Oxfordshire is being used in project planning covering the following areas:

- LD - Baseline estimates
- LD - Moderate or severe
- LD – Severe (18-64 only)
- LD - Living with a parent (18-64 only)
- Down's syndrome
- Challenging behaviour (18-64 only)
- Autistic spectrum disorders

(Source: http://www.poppi.org.uk/ and http://www.pansi.org.uk/)

Children and Young People

In Oxfordshire there are approximately 150,000 children aged under 18 years. In the school age population there are currently about 2,200 children with an Education, Health and Care Plan. The Children's Social Care Disability Teams have a caseload of about 550 children and Oxford Health now have about 98 children receiving Continuing Health Care packages. Most of these will have complex and profound needs

including learning disabilities.

1,859 children and young people aged 0-17 years are on the disability database. A detailed breakdown of this cohort is given in Appendix 2, including:

- Free school meals
- Ethnicity
- Primary Medical Need
- Primary SEN need
- Age
- Gender

Oxfordshire Children's Needs Analysis suggests:

Table 12. P=Primary school, S=Secondary school

Pupils in schools at School Action Plus or with a statement of special education need: rate per 1,000 pupils in Oxfordshire	P	S
Specific learning difficulty	5.4	14.2
Moderate learning difficulty	23.6	28
Severe learning difficulty	1	0.4
Profound and multiple learning difficulty	0.5	N/A
Behaviour, emotional and social difficulties	13.9	20
Speech, language and communications needs	13.8	6.6
Hearing impairment	1	1.1
Visual impairment	0.5	0.5
Multi-sensory impairment	0.1	0
Physical disability	2.4	2.6
Autistic Spectrum Disorder	6.2	9.5
Other difficulty / disability	0.7	0.5

Source: chimat.org.uk

Additional prevalence data from Public Health England is shown at Appendix 3.

Analysis of inpatient usage by people from Transforming Care Partnership

In-patients - non-secure / ATU:

As of 23rd March Oxfordshire has five adults with learning disabilities in non-secure in-patient beds. Years of admission are:

2013: 1
2014: 2
2015: 2

Adult placements are purchased from Southern Health FT on a block basis, with SHFT responsible for providing up to six beds for people with LD and a range of issues, including mental health problems and challenging behaviour, following the closure of the Slade site in Oxfordshire. Where additional beds are needed SHFT are responsible for identifying an appropriate bed with an additional budget held by OCC and at commissioner risk available for spot purchase.

SHFT also has a block contract for the provision of 3 forensic step down community beds.

11 LD patients have been discharged from non-secure / ATU settings since August 2014.

In-patients – secure:

As of 15th January Oxfordshire has eight people in secure in-patient settings, one of whom is a young person. Going forward NHSE is predicting an increase in the number of children and young people needing in-patient care in relation to the effective management of autistic spectrum disorders. These projections will be reviewed as part of this plan.

Oxfordshire has no specialist local beds for children and young people with learning disability and/or autism– the patient is currently in St Andrews, Northampton. This patient will transition to adult services in 2016.

Describe the current system

Adults

For adults with a learning disability in Oxfordshire, Health and Social Care currently jointly purchase some health provision (certain kinds of physical health support, mental health support, and learning disability health support) - from SHFT and all social care is provided by the County Council. This includes six assessment and treatment beds provided out of area (owing to the lack of local provision). The health and social care learning disability teams are located together. This service is available to the 2,000 people who are currently in contact with the Community Learning Disability Team.

Additionally a range of day services, respite, supported living, employment support and advocacy services are provided for people with learning disabilities.

Who uses services?

2,311 people are eligible for health support and 820 people with a current open health referral.

2,066 people receive support from a social care learning disability team of whom 1,794 had a paid for service.

Of the 1,794 people who received a paid for service:

- 282 are currently in a care home
    - 190 outside Oxfordshire
- 659 are currently in supported living
- 469 people are receiving a direct payment
    - 48 people are using their direct payment to pay for a care home or direct payment place
- 82 people are receiving home care
- 54 people are in long term shared lives placements
- 75 people are in short term placements with shared lives
- 429 people are getting day care
- 6 people using hospital services.

*Figures from September 2014

In 2015 - year 1 of the Big Plan 2015-18 strategy - we remodelled the health care contract with the SHFT to reduce the number of contracted inpatient beds from 8 to 6 and to target freed up resource to increase intensive support capacity in the community. The **Oxfordshire Intensive Support Team** became operational in September 2015 and is beginning to make a positive impact on our ability to support people and their

families to remain at home, prevent and de-escalate crisis situations and to avoid hospital admissions.

We also commissioned a new **Wellbeing and Employment Support Service** universally available to 600+ adults across a range of disabilities to help them meet people, make friends, connect to the community and get into paid work. This service went live on 1 January 2016 and is currently transferring in people from previously existing similar services. Its impact will be evaluated in six month time. This is a block contract with Kennedy Scott.

There are no changes planned for supported living services (which have been recommissioned in 2015) and advocacy services (which have been aligned to the Care Act 2014 requirements). We are co-producing with carers and people using services a new **Respite model of care** from adults across care needs, which is currently out for feedback to wider audience.

Plans for changes to day services are being developed and the people who use those services will be involved in this process.

Driving up quality code - OCC and OCCG signed up to this code in 2015 and embedded it in the new commissioning arrangements, e.g. the Supported Living framework for adults with learning disability, physical disability and autism.

Cross-over between vision and challenges

- Higher aspirations
- Care closer to home
- Ordinary lives
- Hospital admissions as last resort

Autism

For adults with mental health problems that also may be complicated with autism presentations, these would be referred for a MH assessment to Oxford Health Foundation Trust (OHFT) which would include an autism diagnostic assessment if appropriate.

<u>Autism specific, current social support providers:</u>

- Includes all voluntary sector provider contracts and Oxfordshire boundary
- Dedicated budget of 214k within the mental health pooled commissioning budget
- AQP contract for Autism Diagnosis for people without a LD or MH problem, with 3 providers, SEQOL Swindon, ADRC, Southampton and OHFT – budget of £50k. Due to be recommissioned from March 2016 with an increased budget of £100k.
- Kingwood Aspirations – practical support service for 16+ - block contract £100K per annum contract until 31.3.2017 option to extend for 2

years.

- Autism Oxford – administer Autism Alert card, Autism awareness training which includes people with autism as trainers, information and pre assessment about the autism diagnosis service in Oxfordshire (the latter is on a cost per case basis) – c£48k
- Wellbeing Employment service for people with LD, autism and physical disabilities
- OCC employ a dedicated Autism specialist social worker to support staff to navigate people with autism who have undergone a Care Act assessment to the appropriate social care team or support services.

Universal services

- TalkingSpace PLUS service, contract held by OHFT, for people with mild to moderate common MH problems, includes supporting emotional wellbeing.
- All NHS contracts are expected to make reasonable adjustments for people with Autism and the free awareness training available has had good up take by health and social care to support a future more autism informed workforce.

Children and Young People

Local authority provided services

1) The Local authority has a Children's Disability Team which provides social care and behaviour support for those with LD and autism (including Asperger). This service also provides additional support where a crisis is imminent. This is to prevent an escalation of crisis situations and to avoid admissions to in-patient care. The team also provide a personal care service which combines respite breaks for families. They work in close partnership with CAMHS LD Service.

2) SEND reforms are fully implemented and include the five groups (identified in the BRS service model) where relevant and the LA oversee the production of EHCP's in partnership with families, schools, social care, CAMHS LD, Continuing Health Care Services. There is a dedicated team in the education arm of the local authority which supports children with ASD in school settings. This includes information, advice, consultation and formulating behavioural plans that then get implemented by schools where necessary.

3) Short Break Service includes services for all five cohorts. The services are to provide a break for families and opportunities for the five cohorts to engage in meaningful activities with their peers. These services are commissioned from a range of third sector providers.

Youth Offending Service. This service works in close partnership with children's social care and CAMHS and does preventative work with young people with learning disabilities (at risk of offending). Oxfordshire now has a comprehensive Local Offer which brings together information about education, health and care services for children and young people from 0 to 25 with SEND.

Many aspects of the local offer have been recognised nationally, and we continue to receive regular praise from the DfE for our new additions, such as animations and videos. The DfE senior advisor rates Oxfordshire's local offer as very good.

i. There have been several initiatives arising as a result of the SEND reforms:

- 18 young people have started 12 month Supported Internships. This has been a collaborative venture involving all four colleges (City of Oxford, Abingdon and Witney, Banbury and Bicester and Henley college), OCC's Employment Service and MENCAP. The employers include Carillion, Oxford United and our Print Finishers.
- A full time Independent travel training co-ordinator has been in post since February and several pilot projects began in September. We are also offering personal transport budgets.
- A key principle of the reforms is listening to young people and person-centred approaches to planning and decision making. Oxfordshire is introducing multi-media advocacy, in the form of a wiki (personal and protected website) to enable young people's voices to be heard.

ii. Number of personal budgets

Since September 2014:

- 244 for short breaks
- 11 for health
- 5 for education
- 450 disabled young adults between 18-25 for Adult Social Care / Health

iii. Education Health and Care Plans

There was an ambitious transfer plan to transfer 720 statements to education, health and care plans between 2014 and 2015. This has partially been achieved; there are approximately 10% plans that haven't yet been issued. DfE praised Oxfordshire for the number of transfers that had been completed compared with other non-pathfinder LAs, (approximately 700 statements need to be transferred each year to ensure that we meet the April 2018 timeframe). This is alongside business as usual; there were 255 new requests for EHCP assessments during the year.

CCG Commissioned Services

The Oxfordshire CCG commissions comprehensive CAMHS for children and young people and Continuing Care Service from Oxford Health NHS Foundation Trust

1) CAMHS LD Specialist Service for moderate to severer learning disability (including ASD) and behaviours associated with a mental health condition. This is a dedicated service for the most complex cases and the majority of work undertaken with done in partnership with the LA, SEND, CAMHS Crisis Team, CAMHS forensic Services and Continuing Health Care Service. This service also provides consultation to partners and Tier 3 CAMHS.

2) CAMHS Generic services (Tier3) for mild to moderate Learning disability, ASD, Asperger. For those children and young people with mental health disorders.

3) PCAMHS for those with signs of emerging mental health problems for all five cohorts. This includes behaviours that may be attributed to emerging mental health problems.

4) CAMHS Crisis Team. This service provides 24/7 crisis support and have dedicated support for those with LD/ASD. They work closely with CAMHS LD, the local authority and other partners

5) CAMHS Neuro Psychiatric Service. This is a specialist service for those with LD/ASD with behavioural problems and associated neuro development problems.

6) Child and Adolescent Harmful Behaviours Service (CAHBS). This service works with young people to reduce reoffending and to improve access to treatment for all five cohorts. The service has a high number of young people with mild to moderate learning disability that receive support from this service. They work in close partnership with forensic services, CAMHS and the local authority.

7) ASD diagnostic pathway and post diagnostic support (0-18). This is a new service that aims to improve access to timely diagnosis. Post diagnostic support is also being commissioned and this will be in place shortly and will include sessions on understanding ASD and managing behaviours.

8) Continuing Care Service. For those children and young people with the most complex health needs. A high percentage of those who currently receive this service have ASD/LD and/or behaviours that challenge. Most of those are placed out of county in residential placement for educational purposes. This service also delivers Personal Health Budgets and works in close partnership with SEND, the LA and CAMHS

NHS England Specialist Commissioned Services

The specialist commissioner in NHSE currently commission in-patient facilities for children and young people with mental health problems and/or learning disabilities. There are currently no commissioned in-patient services in Oxfordshire for children and young people with a

learning disability.

Health and Justice Commissioned Services

It is now well established that young people in the youth justice system are far more likely to have specific vulnerabilities around learning disabilities and mental health problems.

The Health and Justice Board commissions three closely-coordinated services in Oxfordshire for young people who have high-risk behaviours, or who come into contact with the youth justice system.

These come under the general heading of the Thames Valley Young People's Forensic Service provided by Oxford Health NHS Foundation Trust, and consist of:

- Forensic CAMHS (NHSE Specialist commissioned): where there are concerns about mental health or neuro-developmental difficulties in young people who show a range of risky behaviour towards others or are involved with the youth justice system. This is a specialist service covering the Thames Valley.

- Child & Adolescent Harmful Behaviour Service (Jointly commissioned): for children and young people in Oxfordshire about whom there are concerns in relation to sexualised or sexually-harmful behaviour.

- Criminal justice and liaison service for Oxfordshire (NHS England commissioned): for children and young people in Oxfordshire about whom there are concerns in relation to mental health or neuro-developmental difficulty at the first point of contact with the youth justice system.

These services are integrated with the core CAMHS and have a close working relationship to assist comprehensive risk management and a safe discharge back to the community.

Jointly commissioned services

The LA and the CCG currently jointly commission residential breaks for those with complex needs and those services are commissioned from Barnardos.

Additional information:

- Oxfordshire Children and Young People's Plan 2015-2018
- www.oxfordshire.gov.uk/localoffer

What does the current estate look like? What are the key estates challenges, including in relation to housing for individuals?

Adults

Oxfordshire does not have an assessment and treatment unit within the county. OCC currently commissions 6 beds from SHFT. These are in the most clinically appropriate service and cover everyone with an LD who has an inpatient need, including people with mental health issues, autism, and other co-morbidities. SHFT currently provide some beds in the Willows in Southampton, some in the Ridgeway Centre in High Wycombe, and some are purchased by SHFT from other providers.

Oxfordshire County Council are in the process of refreshing their supported living needs analysis. Existing analysis undertaken as part of 'The Big Plan 2012-2014' and 'A strategy for delivering an increased supply of specialist housing for adults with care and support needs in Oxfordshire' suggests 12 places a year are needed; these schemes have either been developed or are in the pipeline.

Supported Living Key Data is provided in Appendix 4.

Oxfordshire has been at the forefront of deregistering long stay residential institutions for people with disabilities. We have a strategic approach to developing and improving a range of options for supported living ranging from living at home with your family to living in independent housing with visiting support (How to Live at Home) to supported living with on-site care and support and use of assistive technology. We do this for younger people and adults with disabilities and social care needs in partnership with local housing authorities, housing and care providers and HCA.

Oxfordshire
Specialist Housing Str

Oxfordshire County Council does not own any supported living units, but has nomination agreements in place with a variety of housing providers.

A large number of properties were transferred in 1998 by the, then, Oxfordshire Learning Disability NHS Trust to housing associations. These properties were remodelled as supported living schemes, with many dispersed as small units. The use of these properties for people with Learning Disabilities is secured by an NHS legal charge.

The County has submitted a PID to NHS England so that the disposal proceeds from the sale of some these properties (those that are no longer fit for purpose) can be recycled into the development of new supported living schemes for the existing residents. NHS England and Oxfordshire Clinical Commissioning Group have both approved the PID.

The process for recycling the disposal proceeds will involve the housing associations disposing of the properties with the proceeds either reverting to NHS England or being held by the County. Once alternative developments have been identified the capital proceeds can be released as a result of submitting a business case to NHS England for each new scheme. The Secretary of State for Health will hold a first charge on the new developments. It is estimated that about £3m capital can be released through this recycling process, although it will not be possible to mix the funding with private finance (as private lenders themselves require a first charge on the properties).

Children and Young People

The vast majority of children with learning disabilities live in and are cared for in their own homes. Where inpatient bed admission is required, it is commissioned by NHS England. There are no CAMHS/LD inpatient beds in Oxfordshire or within a 50 mile radius.

Children with a learning disability/autism/challenging behaviour, who cannot be educated in a mainstream and/or a special PMLD school, will be placed in a residential educational establishment. Currently 97 children are in residential educational establishments in Oxfordshire. A further 101 children are placed out of county for their education.

In 2014 the MacIntyre Trust opened a brand new Academy Trust School in Oxford. This school provides education for up to 25 children with profound and complex LD/Autism and challenging behaviour. The school also provides capacity for extended days (until 6pm) for a small cohort of children and a residential unit of up to 6 young people up to 52 weeks per year.

The NHS Estate

Following the closure of the SHFT Slade site there is no inpatient non-secure provision in Oxfordshire. The owners of the site are understood to be SHFT.

Medium secure beds are commissioned from SHFT on the Littlemore site in Oxford and owned by OH.

What is the case for change? How can the current model of care be improved?

Adults

Prior to the development of the national Transforming Care Plan Oxfordshire had consulted on and agreed the Big Plan 2015-18 for people with learning disabilities. The Plan's vision is:

> Oxfordshire Clinical Commissioning Group and Oxfordshire County Council want people who have a learning disability to have choice and control, to live as independently as possible as part of the broader Oxfordshire community, to live in the right home for them with the right support, and to be healthy and safe.

The Plan has the following four priorities:

1. We will enable people with learning disabilities to have more choice and control over their lives.
2. We will enable people with learning disabilities to take an active part in their community, through work, volunteering, friendships, and other opportunities.
3. Priority three: We will enable people with learning disabilities to make choices about where they want to live, and support them and their families with their decision.
4. We will have the right support in place for people with learning disabilities to enable them to remain safe and keep well.

The Big Plan's Service Model is based around four tiers:

Tier 1: Education, Awareness, and Prevention
Tier 2: General Health and Social Care
Tier 3: Learning Disability Health and Social Care
Tier 4: Intensive Support

The overall intention is to have a clear pathway of support that will enable people to move between levels of support flexibly, building on

individual strengths and capacity so that people live as independently as possible, and are able to quickly enter and leave enhanced support as required.

In the development of the Transforming Care Plan users, carers and commissioners have refined the Big Plan's ambitions and applied them to people of all ages, including autism:

- Making mainstream health services work better
- Improving the care of people with comorbid mental health problems and / or behaviour that challenges
- Increasing the capacity of mainstream services to support the lower level needs of people with LD / autism
- Increasing the level of co-produced resources to support the needs of people with LD, whether through peer support / peer led approaches or personal health budgets

Children and Young People

Children and young people with learning disabilities from part of the cohort which fall within the CAMHS Transformation plan and the associated activity set out in the plan.

CAMHs Transformation Plan 2

Please complete the 2015/16 (current state) section of the 'Finance and Activity' tab of the Transforming Care Activity and Finance Template (document 5 in the delivery pack)

Any additional information

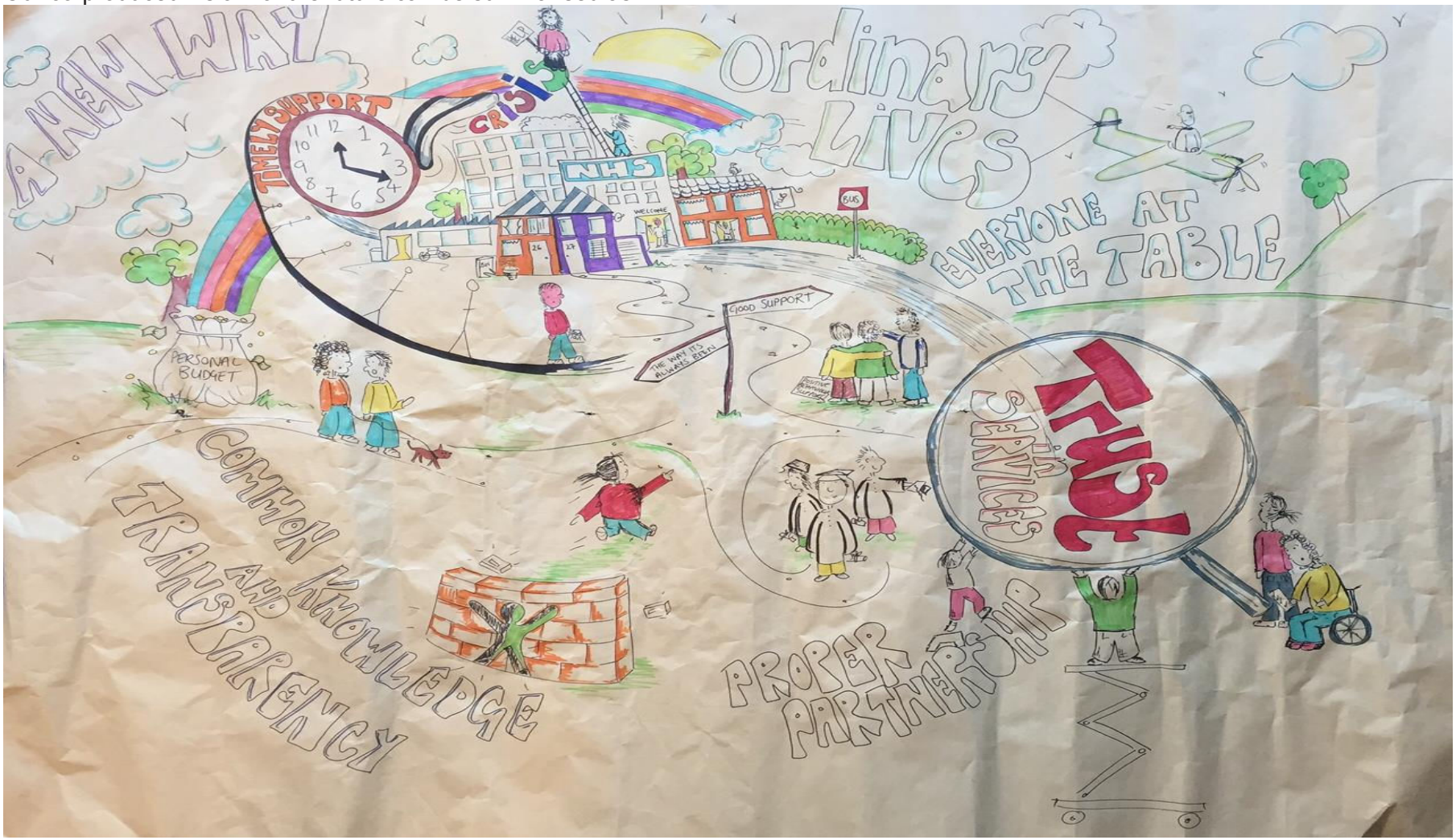
3.Develop your vision for the future (ASPIRATIONS / PRINCIPLES / MEASURES)

Vision, strategy and outcomes

Describe your aspirations for 2018/19.

Vision

Our co-produced vision for the future can be summarised as:



(picture by Real People Real Voices)

In addition to the agreed vision set out in the Oxfordshire Big Plan and describe above, the Transforming Care Planning Group has the following aspirations for people with learning disabilities and / or autism:

1. Having a good, meaningful and “ordinary” life
    a. Social opportunities
    b. Being connected to the community
    c. Positive risk management
    d. Protection from exploitation / helping people stay safe
2. Person centred support
3. Families and people able to design and buy their own services, when they choose to
4. Having the right support close to home
    a. Everyone knows what the options are
    b. Keeping our most vulnerable children close to home
    c. Oxfordshire people are treated in Oxfordshire
5. Easy access to health services when you need them
    a. Services you can trust
    b. Accessibility of mainstream health services
    c. Communication with out of hours services
    d. Reducing diagnostic overshadowing
    e. Well trained workforce and whole system culture change
    f. Help to navigate primary and secondary care
6. Early intervention and prevention for children and families
    a. Positive behaviour support
7. All age support and continuity of care when preparing and / or moving into adulthood
8. Effective management of crises
    a. Mental health crises
    b. Physical health crises
9. Choice, control and equity

Aims

The Transforming Care Planning Group has taken the above aspirations and the principles listed below and developed these into a series of aims. The aims were also informed by:

- The Oxfordshire Big Plan vision and priorities
- Building the Right Support Service Model
- Learning Disabilities Outcomes Star
- Elements of the Health Equalities Framework

The aims provide the framework for the Oxfordshire Transforming Care Plan. All future activity will be aligned against the aims using the following model:

Aims	Planned areas of change we intend to achieve
Objectives	Planned areas of activity through which we intend to achieve aims
Outcomes	Changes, benefits, learning and other effects that happen as a result of activities
Outputs	Detailed activities, services and products
Indicators	Performance indicators evidencing delivery of outcomes and outputs

This will provide a logical model demonstrating how activities commissioned as a result of the Transforming Care Plan (or through parallel plans and strategies, e.g. the CAMHS Transformation Plan) are delivering against the overarching Plan aims.

The aims are:

Overall Aim	
To enable people with LD and / or autism to have a good, meaningful and ordinary life	
Specific Aims	
1	To improve people's physical and mental health, including the effective prevention and management of crises
2	To improve the quality of support
3	To help people stay safe and out of trouble
4	To enable people to have an active voice and role in their community, including employment

5	To improve support for families and carers
6	To improve the continuity of care for children and families when preparing and / or moving into adulthood
7	To improve early intervention and support for children and families
8	To improve people's housing options and choices about where they live

The order of aims reflects their provisional priority for TCP Planning Group activity, not their perceived importance for the cohort.

Building on the list of interfaces identified previously, the Transforming Care Planning Group has started to map all the existing activity which is either in planning or implementation and which is contributing to the delivery of the aims. This has resulted in the Plan's aims being coded using the following key:

	TCP Planning Group has a high influence / ownership. Will be a Planning Group workstream
	Plans / strategies exist. TCP Group will actively input into these, identify gaps and develop work as needed
	Plans / strategies exist. Principle role of TCP Group is to influence and represent the needs of the TCP cohort

Aims 1-3 will be a priority for the Planning Group over the next 12 months, as reflected in the Project Plan.

The vision and aims are consistent with those developed by Oxfordshire in terms of adult mental health and helping people stay out of hospital:

We will ensure in adult mental health that:

- People will live longer
- People will improve their functioning
- Timely access to support
- Carers will feel supported
- People will have a meaningful role
- People will have stable accommodation

- People will have better physical health

To help people stay out of hospital we will ensure that:

- As a vulnerable adult or a carer, I want to be helped to be healthy and active
- As a vulnerable adult or carer, I want to be helped to be as independent as possible in the best place for me
- As a vulnerable adult or carer, I want to be helped to be as independent as possible in the best place for me and when I am in need or care, it is safe and effective
- As a vulnerable adult person or carer, I want to be helped to be as independent as possible in the best place for me and have a good experience and treated with respect and dignity

We will ensure that over the lifetime of this plan the number of people with learning disability and/or autism who are cared for as in-patients is reduced. In terms of locally commissioned beds Oxfordshire is already within the framework set out in the national plan for people with Learning Disability. We are reviewing the appropriate level of ambition for a further reduction in these bed numbers.

We are currently forecasting an increase in medium secure beds. This relates to uncertainty re the number of patients with an autistic spectrum disorder but with no co-morbid learning disability. These people would be typically placed in mental health commissioned in-patient services. The size of that cohort is not yet known, either for NHS England specialist commissioners or for OCCG commissioned services delivered by Oxford Health NHSFT.

OCCG and NHS England are seeking to identify the numbers of people with a co-morbid autistic spectrum disorder in mental health beds. The impact of this additional cohort may mean that the current reported numbers is too low and if this is the case the trajectory cannot yet be known. These patients will be supported within commissioning pathways that currently sit outside of the contracts being reviewed as part of this plan. If they are to be brought into scope these other dependencies will have to be reviewed.

How will improvement against each of these domains be measured?

Measures to demonstrate progress against the achievement of the aims will be developed in line with the model above.

Provisional measures include:

1. Number of people with LD / autism in in-patient beds
2. Length of stay in in-patient beds

3. Number of people with LD / autism with health checks
4. Evidence of use of CTR prior to admission
5. Evidence of use of CTR in discharge plans
6. Number of people with LD / autism in the community with a personal health budget
7. Number of people with LD / autism in the community with a personal budget
8. Number of people in out of area settled accommodation returned to Oxfordshire
9. Development of an outcomes based approach to measure impact of services, to include:
    a. Number of people with a personal care plan based on the learning disability outcomes star
    b. Number of people in work / volunteering / structured education
    c. Number of people with BMI within a normal range
    d. Number of people who have successfully completed smoking cessation courses
    e. Reduction in the number of people making inappropriate use of urgent care systems
    f. Reported rates of carers satisfaction
        i. With support they receive
        ii. With support their cared-for receive
    g. Number of people with LD / autism living independently / in supported living accommodation
    h. Reduction in the number of people with LD / autism living in out of county spot purchased
    i. Reduction in the number of people with LD / autism entering criminal justice system

Final measures will be developed through a co-production process as part of the detailed project work, incorporating NICE recommendations and quality assurance on challenging behaviour and learning disabilities.

Describe any principles you are adopting in how you offer care and support to people with a learning disability and/or autism who display behaviour that challenges.

The principles developed by the Transforming Care Planning Group which will underpin the further development of the plan include:

1. All family, all age
2. Holistic, multi-disciplinary (everyone working together)
3. Treating everybody equally doesn't mean treating everyone the same (equity not equality)
4. Growing the things that we have, that we need more of
5. Behaviour always means something (because it is always a form of communication)

6. Better understanding and communication of care plans
7. Being positive about risk taking, but managing this well
    a. Effective risk assessments
    b. Upskilling clinical colleagues
    c. Providing support to help people take risks
8. Behaviour is not an illness
9. Autism is not an illness
10. Mainstream services are person centred and meet individual needs
11. Co-production in development and management of services
12. Involving experts by experience in helping to manage difficult / complex cases
13. We don't give up on anyone
14. We see the person, not the disability

Please complete the Year 1, Year 2 and Year 3 sections of the 'Finance and Activity' tab and the 'LD Patient Projections' tab of the Transforming Care Activity and Finance Template (document 5 in the delivery pack)

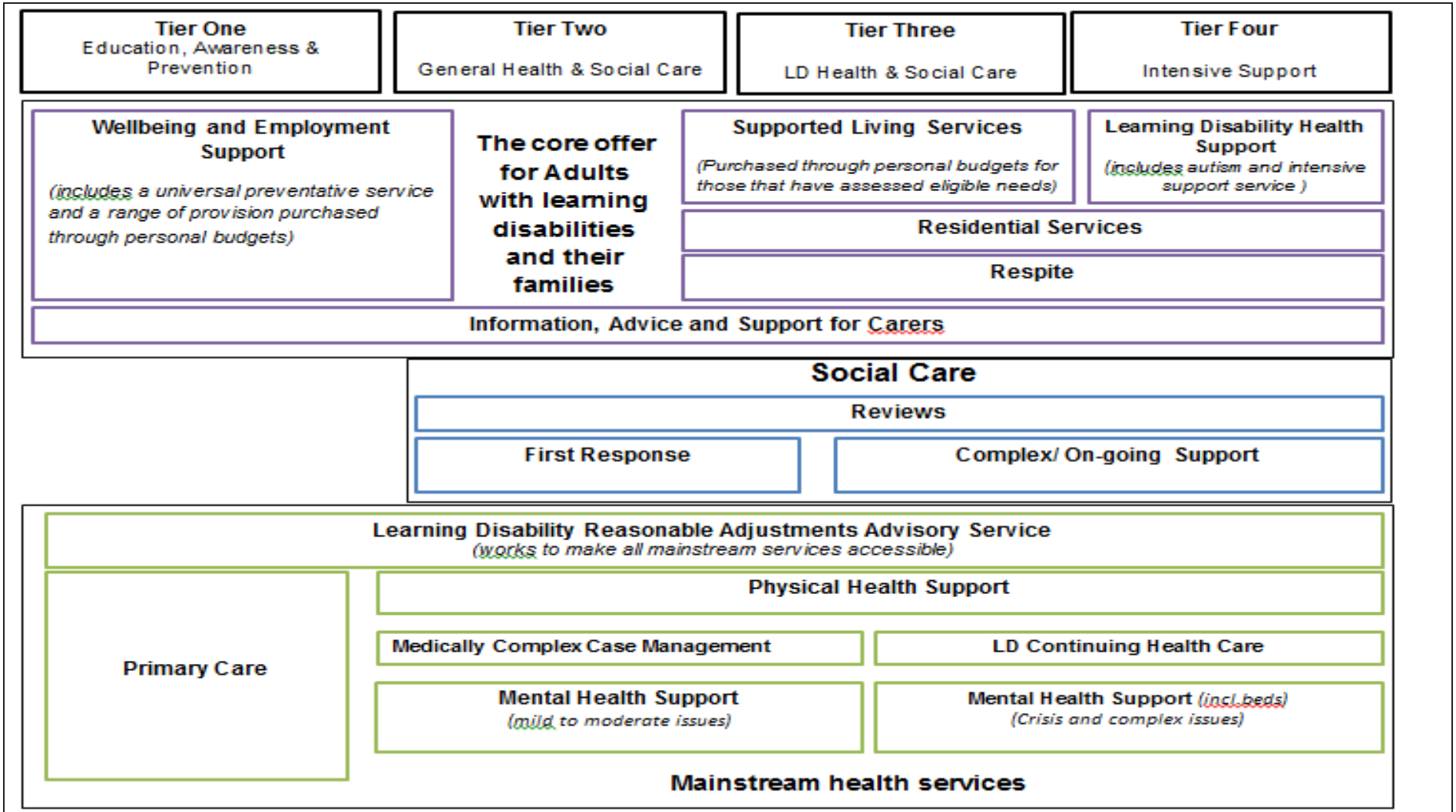
Any additional information

4.Implementation planning

Proposed service changes (incl. pathway redesign *and* resettlement plans for long stay patients)

Overview of your new model of care

The new model of care will be co-produced by the Transforming Care Planning Group. This will form part of the detailed project planning; a proposal will go to Transforming Care Partnership Board in June 2016. It will be based on the model of care established in the Oxfordshire Big Plan developed by OCCG and the County Council in a public consultation in 2014-15:



(Oxfordshire Big Plan 2015-2018)

Our thinking about this model has developed within the Transforming Care planning process and some of the specific features of the plan above may need to be modified. The model will be further informed by the following elements identified by the programme's clinical lead, Dr

David Chapman:

1. Timely diagnostic support;
2. High quality carers with clear knowledge of their clients and ability to support decision making;
3. Active promoter of public health screening programmes with time and skills to help PWLD&A* in their decisions to engage and ability to weigh up mental capacity and best interests;
4. A review of what is required for a good annual health check and proactive system to improved annual health;
5. Health co-ordinator teams supporting primary care to aid patients and their carers with complex/multiple medical conditions. There will need to be some in reach into secondary care;
6. Intensive support teams to help with those with complex mental health/behavioural health issues in the community;
7. Attention to those with LD and dementia especially around diagnosis;
8. Co-ordination of services which add quality to the lives of PWLD&A but which are difficult to access e.g. optometry, audiology, SALT etc;
9. Maintaining or establishing teams who can collect biological data including bloods where it is in the patient's best interests;
10. Practical hands on help in more complex situations around consent and capacity.

*People with Learning Disabilities and / or Autism

Children and Young People

Please refer to CAMHS Transformation Plan.

What new services will you commission?

Please see section **What will care pathways look like?** for a high level overview.

This will form part of the detailed project planning. A proposal will go to Transforming Care Partnership Board in June 2016.

What services will you stop commissioning, or commission less of?

Please see section **What will care pathways look like?** for a high level overview.

This will form part of the detailed project planning. A proposal will go to Transforming Care Partnership Board in June 2016.

What existing services will change or operate in a different way?

Please see section **What will care pathways look like?** for a high level overview.

This will form part of the detailed project planning. A proposal will go to Transforming Care Partnership Board in June 2016.

Describe how areas will encourage the uptake of more personalised support packages

Adults

Oxfordshire has a well-established s75 NHS Act 2006 pooled commissioning budget meeting the health and social care needs of adults with learning disabilities hosted by the County Council. All of those people supported by the pooled budget receive either their social care or continuing healthcare as part of a personal budget.

In its published offer for 2016-17 OCCG will invite people with learning disability to apply for a personal health budget where that will deliver better health outcomes. OCCG will ensure that the potential deployment of a Personal Health Budget will be considered in all Care and Treatment Reviews for people in locally commissioned in-patient settings, and for anybody at risk of admission to locally-commissioned beds.

Oxfordshire has been a leader in the development of Personal Health Budgets in continuing healthcare and has considerable expertise in care planning, risk management and financial flows. On the basis of this experience we have submitted a bid for transformation funding to provide brokerage, advice around employing a personal assistant and extend our current back office functions as we extend into the learning disability cohort.

OCCG will explore with NHS England specialist commissioning how we can deploy personal health budgets for those patients detained in secure settings. This will involve exploring how current budgets can be mobilised to fund a future personal health budgets.

The Oxfordshire offer of a Personal Health Budget from April 2016 will include:

- The right to receive Continuing Health Care as a personal health budget (all ages)
- The right to receive rehabilitation funding in relation to acquired brain injury as a personal health budget
- The right to ask for a personal health budget where you are someone living with a learning disability and/or autism who is in hospital or at risk of hospital admission in relation to your learning disability and/or autism

During 2016-17 OCCG will develop its offer in relation to personal health budgets in line with national expectations: Oxfordshire is expected to achieve 660 budgets by 2020. Based on numbers of people at risk of or admitted to hospitals in 2015-16 we would expect there to be 6-10

personal health budgets delivered within that plan together with around 20-30 people with learning disability and/or autism who may receive continuing healthcare in this way.

Children and Young People

Oxfordshire has a fully compliant personal health budget offer for children who are eligible for continuing care. The numbers of personal budgets are as follows:

Since September 2014:

- 244 for short breaks
- 11 for health
- 5 for education
- 450 disabled young adults between 18-25 for Adult Social Care / Health

We will review the use of personal health budgets for children and young people detained in or at risk of detention as part of this plan.

What will care pathways look like?

The Oxfordshire Transforming Care Plan is based on the principles established in the Oxfordshire Big Plan developed by OCCG and the County Council in a public consultation in 2014-15. The key features of this plan have been further developed in consultation with commissioners and experts by experience in the development of this plan:

- Wherever possible, people with learning disability will receive their care in mainstream settings and these will be accessed by self or GP referral in the normal way. Mainstream providers will be supported through training and peer-led approaches to make those reasonable adjustments to their service offer that will deliver this objective
- We will explore the use of technology and/or hand held records to support access to mainstream services and response to people in contact in the urgent care system
- We will commission care navigators that support people in accessing and working through mainstream care pathways, especially high activity service areas such as general practice, Out of Hours and Emergency Department
- Where people have mental health problems and/or behaviours that challenge we will commission a dedicated response within our mainstream mental health services. This response will mirror our mainstream services and deliver
    - 24/7 access to crisis care, aligned to 111/999 and out of hours services
    - Urgent access within 1 week

- Routine access within 4 weeks
- All services delivered 7 days a week with out of hours cover
- Links through from those services commissioned to deliver our Crisis Concordat (emergency department psychiatric liaison, street triage, ambulance triage, Approved Mental Health Practitioner and s12 doctors) linked into the existing partnership arrangements with police and ambulance services
- Access to in-patient beds where indicated by a care and treatment review
- A crisis space that supports people away from admission and an intensive support team that provides this facility in the community
- Outcomes based community health services that support people in achieving their goals, closing the health gap and pro-actively managing crisis in partnership with housing and supported living providers and social work teams which will be modelled on those used in adult mental health
- Personal Health Budgets where these will help deliver these outcomes

- A parallel process will be developed for children and young people in line with our Local Transformation Plan

The services that we commission will be personalised, outcomes focussed and provide positive behavioural support.

Where people are admitted to in-patient services

- All patients will be reviewed in the Care and Treatment Review process and a personal health budget be considered to support effective discharge planning
- In the case of people detained under home office section we will work with specialist commissioners to develop a forensic stepdown pathway that works also to prevent readmission

This remains an area of the plan that is in development. There are some specific areas that need further work:

- The epilepsy pathway for people with learning disability
- A proposed step down pathway for people in social care funded placements out of county which is being developed as part of a bid for Social Investment Bond funding (application to be completed by June 16)
- A dedicated service to support people with autism who are at risk of admission. This will include people with co-morbid mental health and learning disability.
- Forensic pathway as above
- How this work aligns with OCCG's broader Care Closer to Home Strategy

Currently services for people with a learning disability are mostly provided in a specialist service that also includes other services such as continuing healthcare, speech and language therapy, physiotherapy, and some epilepsy care. These will be transitioned as part of this plan during the period to Dec 2017.

How will people be fully supported to make the transition from children's services to adult services?

When a young person approaching adulthood is likely to have needs for care and support after they turn 18, the council will undertake a transition assessment that fully involves the young person and the key people supporting them. This assessment ideally takes place at a time when it will most benefit the young person, which may be as early as 16½ for people with complex needs.

Key agencies, including Health, Education and Social Care, work together and share relevant information with each other to identify as many young people as possible who are likely to need support as an adult. This enables responsive and flexible forward planning to ensure continuity of services and cost effectiveness. There is also a process in place to support vulnerable young people and those with complex needs to access support as an adult where there is no clear referral route into adult services.

If a young person is receiving support from children's services and has a transitions social worker, they will have a good understanding of the young person's needs, family situation and surroundings, and there may already be a transition plan or Education, Health and Care Plan (EHC Plan) that outlines the young person's preferences and aspirations. This valuable information is drawn on when planning the care and support they will receive as an adult and wherever possible the assessment for adult social care is undertaken jointly with the transitions social worker.

Transition assessments are carried out as part of a regular process: a child's needs assessment, young carer's assessment or, a child's carer's assessment, and adult services are involved early to help plan the provision of care and support. This gives an indication of which needs are likely to meet the eligibility criteria for adult social care, so that parents/carers and young people are informed and can plan accordingly.

Parents and carers can access impartial information, advice and support from the Special Educational Needs (SEN) and Disability Information, Advice and Support Service and young people can find out about local opportunities, activities and services for them through oxme.info. The council's Local Offer also has a wide range of information and advice about education, health and care services for young people with SEN and disabilities and their parents/carers, including a section on moving into adulthood which covers key aspects of life as an adult. In particular, the online video explaining the assessment and planning process for an EHC Plan has been recognised nationally as good practice, as well as Oxfordshire's EHC Plan process itself. The process is designed to place young people and their families at the centre and to empower young people to take control of planning their future.

How will you commission services differently?

OCCG currently commissions health and social care services (including supported living) for adults with learning disability through a s75 NHS act 2006 pooled budget hosted by Oxfordshire County Council. These arrangements will form the basis of future commissioning approaches with the following changes that will need to be developed:

- It is the intention of both commissioners that health services will revert to OCCG as contract holder and that this will be a staging point before services are moved within existing OCCG contracts
- The process of pooled approaches with NHS England Specialised Commissioning has still to be worked through and will inform the development of the proposed step-down/community forensic pathway
- Although adult and children and young people's commissioning is aligned (commissioning for children and young people is led by a joint OCCG-OCC post) it is not pooled and more work will need to be done to develop appropriate commissioning alignment across transition
- Commissioners in Oxfordshire have already developed outcomes based and incentivised contracts structures across a range of services and we will explore how this approach might be used to help people manage without an admission to hospital and to close the health gap.
- A key part of effective care for people with learning disability and autism is the support received in primary care. Subject to progress with OCCG's plans to commission primary care services we will explore how practices and federations can support these aspirations
- It is the intention of commissioners to continue to co-design and wherever possible co-produce services for people with learning disability with those who use them and those who care for them
- The use of personal health budgets will require a different contracting mechanism for services commissioned from our health providers.

How will your local estate/housing base need to change?

OCCG is currently reviewing its estate strategy. There are challenges for Oxfordshire in that currently there are no suitable locally commissioned in-patient beds in the county. The existing estate has been declared unusable and is not owned by the CCG nor, we understand, NHS PropCo.

OCCG will apply for capital funds within the Transforming Care Programme to support the redesign and redevelopment of existing estate both for potential in-patient units and crisis provision and for supported living that meets the needs of people with autistic spectrum disorders. OCCG will also explore the need for a bespoke place of safety for people with learning disability or autism.

As part of the bid for Social Investment Bond funding to support the step down of people with complex needs (including learning disability/autism) OCCG will identify those housing needs that are not currently met by the Oxfordshire estate and how these might be met as part of the SIB.

Alongside service redesign (e.g. investing in prevention/early intervention/community services), transformation in some areas will involve 'resettling' people who have been in hospital for many years. What will this look like and how will it be managed?

Oxfordshire has very few people who will need to be resettled after very long stays in hospital and none in locally commissioned beds who would qualify for the dowry payment.

The CTR process will provide the planning mechanism for ensuring that in every case a highly personalised and bespoke plan is produced which meets the individual and specialist needs of the person.

The plan will involve a multi-agency team response across commissioners and providers to provide the best chance of successful resettlement.

The step down from NHS England specialist commissioned beds will need a substantial review of the forensic pathway and this forms part of our submission for investment.

How does this transformation plan fit with other plans and models to form a collective system response?

This plan has been developed directly to reflect the legislative and planning requirements as set out above. In addition the plan reflects local planning around Care Closer to Home, the development of primary care, and the development of co-commissioning approaches with specialist commissioners.

Any additional information

5.Delivery

Plans need to include key milestone dates and a risk register

What are the programmes of change/work streams needed to implement this plan?

Bucks transfer to HPFT 1st July

As set out in the attached:

TCP Project Plan (31-03-16).xls

Who is leading the delivery of each of these programmes, and what is the supporting team.

As set out in the attached TCP Project Plan.

What are the key milestones – including milestones for when particular services will open/close?

As set out in the attached TCP Project Plan.

What are the risks, assumptions, issues and dependencies?

The risk register for the Transforming Care Plan Partnership Board is being reviewed by the Board in the light of the proposed SHFT transition work and report from external consultants MBI. It will be sent as an addendum to the Plan.

External policies which may impact on delivery of the Plan include:

- Welfare reform, including bedroom subsidy and the regulations for exempt and non-exempt accommodation
- Personal health budgets and implications for existing contracts and providers

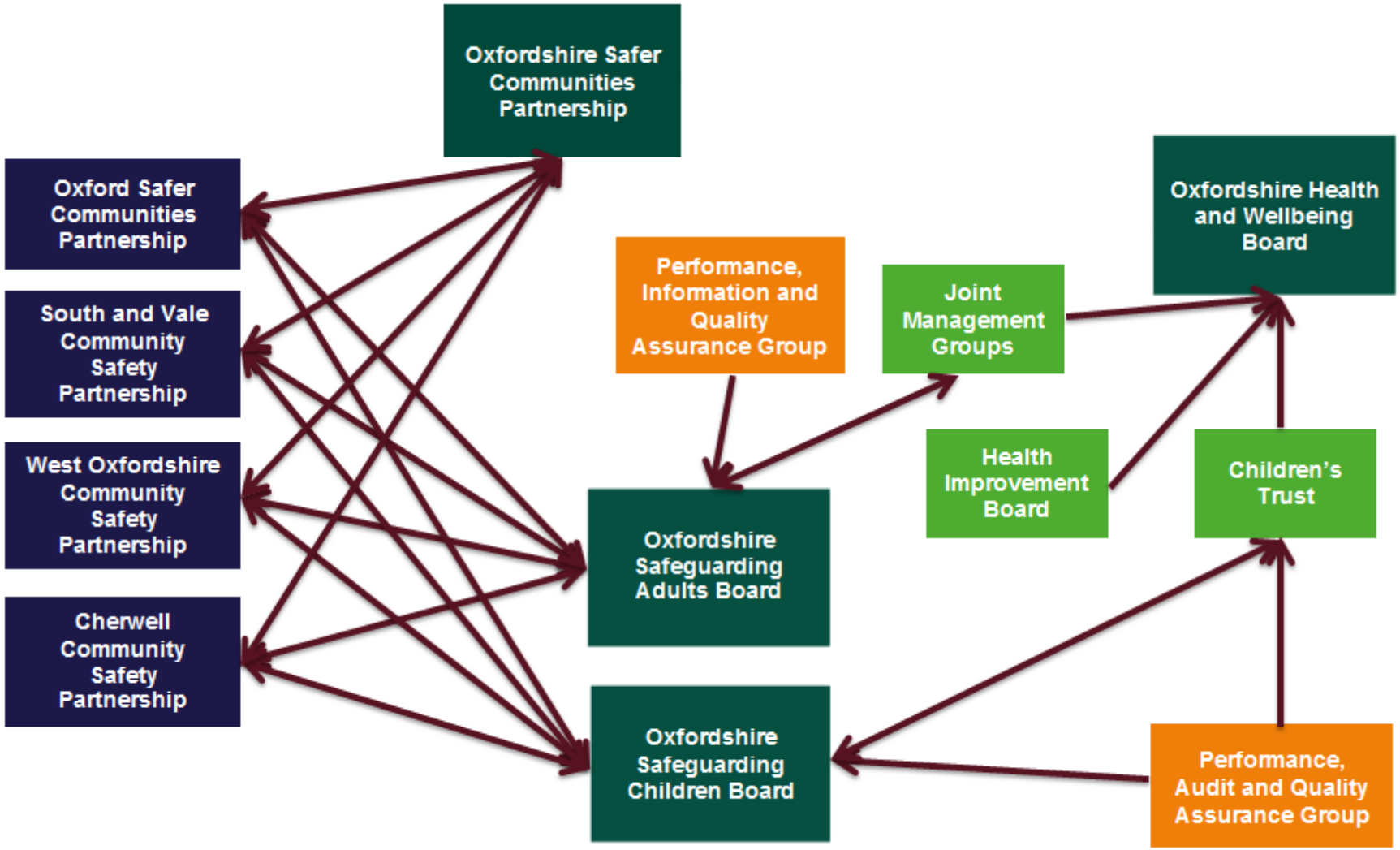
What risk mitigations do you have in place?

As set out in the attached TCP Risk register.

TCP Risk register (10-02-16).xlsx

Any additional information
6.Finances
Please complete the activity and finance template to set this out (attached as an annex).
End of planning template

Appendix 1: Governance Structure / Map for H&WB Board, Safeguarding and Community Safety Joint Protocol



Appendix 2: CYP Disability Register (15 December 2015) Overview

1859 individual CYP aged 0-17 years are on disabilty database of which 69 are not on ONE (limited details)

Includes short breaks data from 2012 to - 2015 (to Q2) and 271115 Disability caseload information

Free School Meals — 1789 CYP

No information for 70 cyp

Yes	491	27%
No	1298	73%

Gender — 1840 CYP

No information for 19 cyp

Male	1297	**70%**
Female	543	**30%**

Ethnicity — 1763 CYP

No information for 96 cyp

			Oxfordshire[1]
ABAN - Bangladeshi	5	0%	0%
AIND - Indian	10	1%	1%
AOTH - Any other Asian backgro	28	2%	1%
APKN - Pakistani	56	3%	2%
BAFR - Black African	36	2%	1%
BCRB - Black Caribbean	17	1%	0%
BOTH - Any other Black backgro	15	1%	0%
CHNE - Chinese	9	1%	1%
MOTH - Any other Mixed backgro	23	1%	1%
MWAS - White/Asian	24	1%	1%
MWBA - White/Black African	13	1%	0%
MWBC - White/Black Carribbea - White/Black Carribbea	33	2%	1%
NOBT - Info not obtained	21	1%	
OOTH - Any other Ethnic Group	9	1%	0%

[1] Ethnicity in Oxfordshire 2011 Census: shows basic information from the 2011 Census about the ethnic backgrounds of children and young people aged 5 - 17years living in Oxfordshire.

REFU - Refused	6	0%	
WBRI - White British	1404	80%	83%
WENG - White English	3	0%	
WIRI - White Irish	5	0%	0%
WIRT - Traveller - Irish Herit	2	0%	0%
WOTH - Any other White backgro	41	2%	4%
WROM - Roma/Roma Gypsy	2	0%	0%
WTUK - Turkish	1	0%	

Primary medical need

1859 CYP

Group A	767	41%
Group B	185	10%
Group Other	308	49%
No information for	599	

Group A: Children and young people with Autistic Spectrum Disorder (who have severe learning disabilities or behaviour which is challenging) OR those children and young people whose challenging behaviour is associated with other impairments such as severe learning disabilities.

Group B: Children and Young People with complex health needs including this with disability and life limiting condition, and/or those who require palliative care and/or those with associated impairments such as cognitive or sensory impairments and/or have moving/handling needs and/or require special equipment/adaptations

Primary SEN need

1156 CYP

No information for 703 cyp

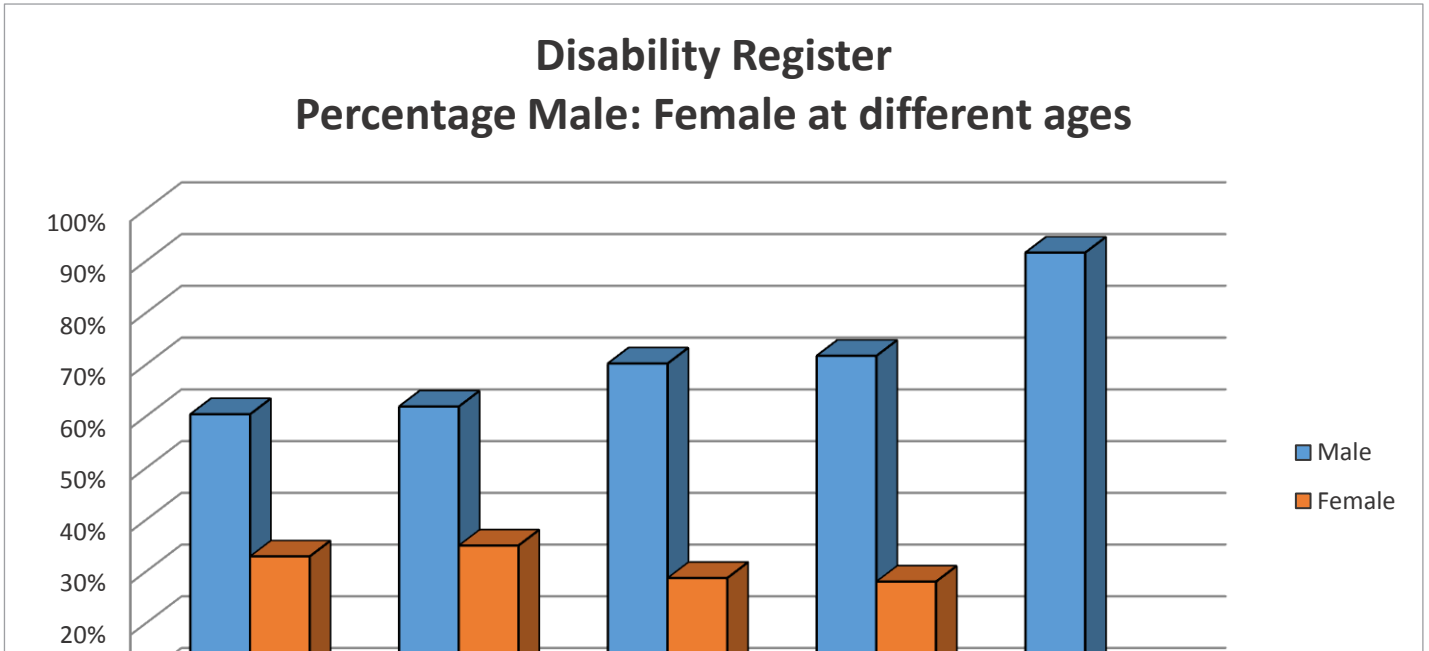
Autistic Spectrum Disorder	306	26%
Behaviour, Emotional and Social Difficulties	212	18%
Hearing Impairment	8	1%
Moderate Learning Difficulty	137	12%

Other difficulty/Disability	11	1%
Physical Disability	82	7%
Profound & Multiple Learn Difficulties	66	6%
Severe Learning Difficulty	201	17%
Social, Emotional and Mental health	2	0%
Specific Learning Difficulty	13	1%
Speech, Lang & Comm Needs	106	9%
Visual Impairment	12	1%

Ages 1840 CYP

No information for 19 cyp

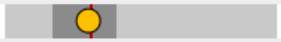
Age range	Total	M	F	Male	Female
0-4 years	91	55	30	60%	33%
5 - 7years	134	83	47	62%	35%
8 - 11 years	521	366	150	70%	29%
12-17 years	1082	776	304	72%	28%
18+	12	11	1	92%	8%



Page 147

Appendix 3: Population and Demographic Charts

1. Learning Disability Population – Oxfordshire (Public Health England)

Indicator	Period	Oxon		Region	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Learning disability: QOF prevalence (All ages)	2014/15	2,572	0.36%	0.39%	0.44%	0.21%		0.78%
Adults (18 to 64) with learning disability getting long term support from Local Authorities	2014/15	1,595	3.84	3.71	3.73	1.78		7.29
Children with Moderate Learning Difficulties known to schools	2014	4,026	37.2	26.4	28.6	6.6		66.4
Children with Severe Learning Difficulties known to schools	2014	370	3.41	3.44	3.80	1.12		8.31
Children with Profound & Multiple Learning Difficulty known to schools	2014	-	*	1.01	1.29	-	*Insufficient number of values for a spine chart*	-
Children with Autism known to schools	2014	1,140	10.5	11.7	10.8	4.1		25.1
Children with learning disabilities known to schools	2014	4,396	40.6	30.8	33.7	4.5		71.4
(Superseded) - Learning disability: QOF prevalence (18+)	2013/14	2,162	0.4%	0.4%	0.5%	0.2%		0.7%
(Superseded) - Adults (18 to 64) with learning disability known to Local Authorities per 1,000 population	2013/14	1,595	3.9	4.1	4.3	2.1		8.8
(Superseded) - Children with Moderate Learning Difficulties known to schools	2013/14	2,211	20.7	13.8	15.6	5.8		50.7
(Superseded) - Children with Severe Learning Difficulties known to schools per 1,000 pupils	2013/14	363	3.40	3.34	3.73	1.05		7.67
(Superseded) - Children with Profound & Multiple Learning Difficulty known to schools per 1,000 pupils	2013/14	-	*	1.04	1.27	-	*Insufficient number of values for a spine chart*	-
(Superseded) - Children with Autism known to schools per 1,000 pupils	2013/14	917	8.6	10.0	9.1	3.5		22.1
(Superseded) - Children with learning disabilities known to schools per 1,000 pupils	2013/14	-	*	18.2	20.6	-	*Insufficient number of values for a spine chart*	-

2. [Learning Disability Health – Oxfordshire](#) (Public Health England)

Indicator	Period	Oxon		Region	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Proportion (%) of eligible adults with a learning disability having a GP health check	2013/14	1,024	47.4%	29.6%	44.2%	4.4%		76.1%

3. [Learning Disability Accommodation and Social Care](#) (Public Health England)

Indicator	Period	Oxon		Region	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Supported adults with learning disabilities living in settled accommodation (%)	2014/15	1,315	82.4%	68.5%	72.9%	0.0%		94.4%
Supported adults living in unsettled accommodation (%)	2014/15	280	17.6%	30.8%	26.7%	64.9%		0.0%
Supported adults whose accommodation status is not known to LA (%)	2014/15	0	0.0%	6.9%	5.6%	56.6%		0.0%
Supported adults whose accommodation status is severely unsatisfactory (%)	2014/15	0	0.00%	0.08%	0.14%	1.18%		0.00%
Supported adults with learning disability in paid employment (%)	2014/15	135	8.5%	7.5%	5.9%	0.0%		28.6%
Supported adults (age 18-64) receiving direct payments (%)	2014/15	370	23.2%	15.6%	17.4%	0.0%		78.2%
Rate of referral of people with learning disability for adult safeguarding	2014/15	245	95.3	66.3	62.2	0.0		207.9
(Superseded) - Adults with learning disabilities in settled accommodation	2013/14	1,315	82.4%	70.6%	74.9%	47.6%		94.4%
(Superseded) - Adults with learning disabilities in non-settled accommodation (%)	2013/14	280	17.6%	26.5%	21.7%	42.0%		1.6%
(Superseded) - Adults with learning disabilities living in accommodation whose status is unknown to LA (%)	2013/14	5	0.31%	2.82%	3.38%	36.11%		0.00%
(Superseded) - Adults with learning disabilities living in severely unsatisfactory accommodation (%)	2013/14	0	0.00%	0.19%	0.25%	10.24%		0.00%
(Superseded) - Adults with learning disabilities in employment	2013/14	150	9.4%	8.1%	6.7%	0.8%		22.5%
(Superseded) - Adults with learning disabilities receiving direct payments (%)	2013/14	460	26.8%	29.3%	30.5%	4.3%		96.2%
(Superseded) - Rates of referral for abuse of vulnerable person per 1,000	2012/13	160	113.1	104.6	109.3	7.4		430.4

Appendix 4: Supported Living Key Data

The demand for supported living for adults with a Learning Disability/ autism and complex or high support needs is on average 12 new people each year (net of attrition).

Adults with a Learning Disability	**Demand**[1]				**Supply e.g. no. of places**				
	2011/ 2014	**2015/ 2017**	**2018/ 2020**	**Total**	**2013/14** (as of Sept 2013)	**2014/15**	**2015/16**	**2016/17**	**2017/ 18**
Cherwell 21%	8	8	5	21	139 (21%)	142 or +3	144 or +2	147 or +3	149 or +2
West Oxfordshire 16%	6	6	4	16	116 (18%)	114 or -2	112 or -2	110 or -2	108 or -2
Oxford City 26%	9	9	6	24	145 (22%)	175 or +30	178 or +3	181 or +3	185 or +4
South Oxfordshire 19%	7	7	5	19	155 (23%)	135 or -20	133 or -2	130 or -3	128 or -2
Vale of White Horse 18%	6	6	4	16	107 (16%)	121 or +14	124 or +3	125 or + 1	127 or +2
TOTAL	**36 places**	**36 places**	**24 places**	**96 places**	**662**	**674**	**686**	**698**	**710**

Key messages

- The data does not differentiate between complex needs and low level needs
- The data does not recommend the size of accommodation needed but this can be found in *'A strategy for delivering an increased supply of specialist housing for adults with care and support needs in Oxfordshire, May 2013 - Nigel Holmes'*
- We need to increase the supply of supported living for adults with a Learning Disability in Cherwell, Oxford City and the Vale of White Horse and reduce supply in West Oxfordshire and South Oxfordshire

[1] *'A strategy for delivering an increased supply of specialist housing for adults with care and support needs in Oxfordshire, May 2013 - Nigel Holmes'*

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healthwatch Oxfordshire

1. Introduction

The key areas of work for the Healthwatch Oxfordshire team since the last HWBB meeting include:

i. Restructuring the staff team given funding cuts and moving premises.
ii. Publishing seAp's report into the experiences of Oxfordshire's Gypsy and Traveller Populations' experiences of health services.
iii. Fieldwork and reporting for our study into people's use and experiences of minor injuries units.
iv. Fieldwork and reporting for our pilot 'young healthwatch' project at Icknield School, Watlington.
v. Reporting for our work looking into themes across CQC inspection reports of care homes requiring improvement.
vi. Publishing our 'this month we heard' feature on our website, which is a precis of all of the feedback we heard in the preceding month.
vii. Contributing to the Transformation Board's work, particularly supporting communication and engagement.
viii. Working with OCCG Locality forum chairs to initiate a project looking at administrative problems reported to us at the OUH eye hospital.
ix. Publication of our own annual report, which can be found here: http://healthwatchoxfordshire.co.uk/annual-report-2015-16

1. Organisational Development

The HWO staff team has reduced by 1.4 FTE since December to refocus work after a loss of 1/3 of funding. Thus far the impact has mostly been felt in the ability to field staff to the various meetings to which the organisation is asked to contribute, rather than the Healthwatch initiated projects and outreach activities.

2. Grant aided projects

a) Healthwatch is currently supporting the following groups to produce reports on their service user experience through the final tranche of its grant programme. The majority of these reports will be published between now and October:
   a. **Oxford Parent and Infant Project (OXPIP)** is reviewing the experiences of parents in the period from conception to 2 years of age.
   b. **Refugee Resource** is looking at access to primary care services of refugee and asylum seeker populations.
   c. **Oxford Against Cutting** is looking to evaluate people's experiences of current support services for women who have experienced FGM and identifying any gaps in current services.

d. **Cruse Oxfordshire** is working on a project assessing experiences of bereavement services in the north of Oxfordshire.

b) seAp's report into Gypsy and Traveller experiences:

seAp was awarded a grant from Healthwatch Oxfordshire to carry out a project looking into how members of the Gypsy and Traveller community in Oxfordshire access health services, and their experiences of the NHS. The project also looked at the experiences of the health professionals who treat and support the travellers to understand better the issues from their perspective.

The findings show that on the whole the Gypsy and Traveller population have a similar experience to the general population, with much of their comments focusing on access and waiting times. It also shows that local GP practices have been working hard to meet the needs of their patients from the Gypsy and Traveller Communities. However, it also shows the importance that the key worker and health advocate have in building relationships and explaining the health system and in facilitating their access to health services. The report made four key recommendations:

1. **Outreach keyworker** – the role was seen as critical in facilitating access and trust in the system and ultimately in reducing health inequalities; it was recommended that this role be strengthened.
2. **Access to GPs** – there are a few ways which access could be facilitated for the Gypsy and traveller community, such as phone back services and information sessions about services like health checks.
3. **Dental services** – further work could be done to encourage registration with dental practices.
4. **Further research into mental health** – further work could be done to better understand travellers' experiences and concerns about mental health.

The full report, and responses from local services can be found here: http://healthwatchoxfordshire.co.uk/reporting-back

3. Supporting Voluntary Sector groups to report their work:

Following the loss of our project fund, we looked to find another way of hearing from members of seldom heard groups. We are providing support to voluntary sector organisations working with such groups in a number of ways, from advising on designing a project or methodology, to assisting with fieldwork, where possible / necessary, to simply helping with reporting and editing reports. At present we are supporting 2 groups with their reports:

a) **Clean Slate** – they are looking into whether there is a gap in provision of mental health support to people who have been victims of sexual abuse, this seems particularly prevalent for male survivors.
b) **Oxfordshire Advocacy's Cancer Advocates -** They have a number of concrete recommendations from their work supporting cancer patients in Oxfordshire. We are working with them to publish these as a report.

4. Outreach programme

a) The outreach programme scheduled or attended in the summer months includes:

Date	Event
Sat 2/7	Play and Activity Day - Bicester Garrison
Sat 9/7	RAF Benson
Sun 10/7	Cowley Road Carnival
Sat 16/7	Play and Activity Day – Abingdon
Fri 22/7	Play and Activity Day – Eynsham
Sat 23/7	Riverside Festival
Fri 29/7	Play and Activity Day - Dalton Barracks
Sat 30/7	Play and Activity Day - Grandpont, Oxford
Wed 3/8	Play and Activity Day – Bicester
Tues 16/8	Thame Community Day
Sat 20/8	Elder Stubbs Festival
Sun 4/9	Abingdon Dragon Boat Festival
Sat 17/9	Wantage PPG Event
Sun 2/10	Banbury Canal Festival

5. "This month we heard"

In order to feedback what we're hearing more regularly with providers and commissioners we have created a new, 'This month we've heard' feature on our website. It is a thematic review of all of the information we've received through our outreach work, phone calls and email. We aim to publish feedback from each month no later than the 15th of the following month. Where we name individual services we write to our lead contact at those organisations to make them aware and offer them an opportunity to respond to the feedback. The first two months' of work are found below, but the feature can be found at http://www.healthwatchoxfordshire.co.uk/hot-topics.

May 2016

During May 2016, we heard from approximately 45 people, and three organisations. These are the main areas of concern that people or voluntary groups have been talking to Healthwatch Oxfordshire about:

- **GP surgeries** – praise for surgeries in Abingdon, Wallingford and Witney; some complaints about receptionists; issues surrounding poor communication between GP surgeries and other service providers such as community hospitals; concerns over waiting times.

- **Pharmacies:** Problems concerning repeat prescriptions and shortage of stock; delays caused by smaller pharmacies referring prescriptions to larger branches.

- **Social services**: Staff at the Citizens Advice Bureaux are seeing clients who have mental health problems but are unable to get the support they need and feel there is a real lack of support for people with mental health difficulties; two complaints concerning lack of compassion by social work teams.

- **Mental health services**: Concern over lack of services in the south east of Oxfordshire – problems include poor public transport and the need to travel further afield to places such as High Wycombe; praise for the complex needs service, concerns about the difficulty in car parking at the Wallingford GP surgery where the adult mental health team is also located adding to the anxiety of people using the services; concern over lack of services in Bicester following the closure of the Julian Centre.

- **John Radcliffe Hospital**: Difficulty in bringing forward appointment with neurology; numerous concerns around the Oxford Eye Hospital, including administration errors, lack of access, and lack of information for patients; praise for speech therapy service, complaints about condition of toilets on Levels 3 and 7, long waits in A&E department.

- **Churchill Hospital**: Several comments concerning parking and public transport, especially for those travelling from outside Oxford; praise for radiology staff.

- **Talking Space**: Concerns over access to the service and communication, which could be improved by improved information.

- **Hospital transport**: Praise for service but concerns over the length of time in advance appointments have to be booked.

- **General communication problems**: why services cannot communicate with each other to avoid people having to go through their details with every initial assessment; also why the hospital departments do not speak to each other to ensure a more fluid care pathway for the individual rather than being treated for each separate condition rather than in a holistic manner.

April 2016

During April 2016, we heard from approximately 50 people, and five organisations. These are the main areas of concern that people or voluntary groups have been talking to Healthwatch Oxfordshire about:

- **Poor communication** – letters arriving after appointment dates, unanswered telephones, miscommunication by and between hospital departments.

- **Delayed discharges** owing to waits for prescription drugs.

- **Too early discharge** – people discharged without adequate care package in place.

- **Parking** – Lack of provision and cost.

- **Lack of compassionate care** –accounts of nursing staff who have not demonstrated compassion or concern and stories of patients not being given adequate pain relief and "overlooked". People have expressed to us their concern about people who do not have family or friends to "advocate" for them, and referred to "a constant battle to get basic care".

- **Cleanliness** - unclean hospital ward and toilets at the John Radcliffe Hospital.

- **Mental health services** - Long waits for mental health support and lack of one-to-one support. Mental health services and GPs not understanding OCD (Obsessive Compulsive Disorder).

- **GP surgeries** - long waiting times for GPs – also complicated telephone menus can make getting through difficult for people with memory problem, particularly in the north and west of the county, Also praise for a responsive Oxford GP for helping patient access hospital care quickly.

- **Health provision** - concern about health provision for new housing estates.

- **Support services** - concerns over funding for support services for people who have experienced sexual abuse, particularly men. For more information visit www.cleanslate.org.uk or email office@cleanslate.org.uk or telephone 01869 232461.

- **Advocacy** - An advocacy service exists for people aged over 50 who have been diagnosed with cancer, but not enough people are being referred to by their GP to this free service. The organisation asked how GPs can be made aware of the service. Greater awareness in general is needed.

- **Talking Space** - Frustration that Talking Space does not cater for people who are dealing with the physical and mental health consequences of historic sexual abuse like post-traumatic stress disorder. Also the limit of six sessions offered by Talking Space is not felt to be long enough for some people to be able to deal with some complex mental health issues.

- **Dementia** - concerns at possible loss of specialist day services for people with dementia because of budget cuts.

- **Children's Centres** - continued concern over proposed closures.

6. Healthwatch Oxfordshire projects

We are currently finalising three Healthwatch initiated projects, which are in final review before publication:

a) CQC Care Home inspection project:
We reviewed the CQC inspection reports of care homes in Oxfordshire to see if there were any themes in those rated as 'requiring improvement'. We followed up with conversations with 4 care home managers including some who had 'Good' inspection ratings to understand their perspective. This report will be published in July.

b) Use and experiences of MIU project:
We spoke to 62 people across 5 sessions in the county's minor injuries units about their pathway to attending the minor injuries unit, following up with a questionnaire on their experiences after they had been seen. Preliminary

results show overall people have good experiences, and use the service appropriately. The full report will be published in July.

c) Icknield school / Young Healthwatch pilot:
We conducted focus groups with students at Icknield School about their experiences of primary care. We believe working with schools will be a good model for future engagement with young people. This report will be published over the summer.

Health and Wellbeing Board
14 July 2016
Children's Trust Briefing

This paper outlines the activity of the Children's Trust since the last update which was provided to the Health and Wellbeing Board in March 2016. The Trust has met twice since the last update.

Members of the Trust have discussed and fed into issues including:

1. **The impact of increased levels of child protection activity** across all agencies in the system. The Trust discussed concerns raised by partners across the system as a result of an impact assessment conducted by Oxfordshire's Safeguarding Children Board. In particular, housing was identified as a key theme, as well as the workload of the judiciary, the management of service thresholds across agencies and the need to align and integrate services. The Trust accepted oversight of a number of actions to address these issues and tasked individual organisations / officers with activities to report back on later in the year. The Trust will also keep a watching brief on the impact of the transformation work in Children's Social Care and Child and Adolescent Mental Health Services, which aim to reduce caseloads and improve access to services.
2. **Oxfordshire Youth Voice.** The Trust endorsed the concept of a new, inclusive Youth Council to give children and young people across Oxfordshire a greater voice. It was agreed that the Trust would facilitate and oversee Oxfordshire Youth Voice and a practical approach to including children and young people's voices in future Trust meetings would be developed.
3. The **Young Person's Domestic Abuse Review.** The Trust supported the introduction of a new pathway for young victims and perpetrators of domestic abuse, particularly in light of the findings from the Serious Case Review into Child J. The Trust encouraged further engagement with young people to identify a name for the pathway that will be understood by children/young people as well as professionals. The Trust will continue to receive updates on the implementation of this pathway.
4. The **Joint inspection of Child Sexual Exploitation (CSE) and Missing Children in Oxfordshire.** The Trust considered the learning points from a deep dive inspection of Oxfordshire's response to CSE and missing children. Areas for improvement include the front door of services (including the Multi-Agency Safeguarding Hub), standards of practice in assessment teams and management of resources and performance linked to point 1. These areas match those identified by partners in the local self-assessment and actions plans are already well developed in response to this. Overall, the inspection report reassured the Trust that young people in Oxfordshire are significantly safer from sexual exploitation as a result of all agencies' heightened levels of understanding and investment. The Trust will continue to seek information on progress against the action plan arising from this.
5. **Child and Adolescent Mental Health Service (CAMHS) pressures and Transformation Plans.** The Trust was updated on the approach Oxford Health is taking to address key service pressures, including long waiting times, increased case complexity and recruitment issues. The Trust was assured that the

remodelling of CAMHS will further address these challenges. Regular updates will be provided to the Trust on progress with the CAMHS Transformation, including how these plans link in with the reconfiguration of Children's Social Care and Early Intervention Services.

After reaching the end of the first year of a new Children's Plan the Trust considered how effective it has been and agreed to hold a workshop in July to review its role and purpose. The results of this workshop will inform a comprehensive revision of the Children's Plan and will be reported to the Health and Wellbeing Board in November.

Tan Lea / Katie Read
July 2016

Health and Wellbeing Board
14th July 2016
Older People's Joint Management Group Briefing

This paper outlines the activity of the Older People's Joint Management Group since the last update provided to the Health and Wellbeing Board in March 2016.

The Older People's Joint Management Group monitors activity, performance and spending from the pooled budget to meet the six priorities of the **Older People's Joint Commissioning Strategy**, which are:

- I can take part in a range of activities and services that help me stay well and be part of a supportive community.
- I get the care and support I need in the most appropriate way and at the right time.
- 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.
- As a carer, I am supported in my caring role.
- 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.
- I see health and social care services working well together.

The Group has met twice since the last update, on 29th March and 19th May 2016, and had discussions on performance, finance and activity for older people in addition to matters on the agenda and arising from the previous meetings.

On 29th March, the group discussed ongoing reviews of daytime support, carers' strategy and respite services and made suggestions on joint working with health. The group also received an update on 'choice policy', which was adopted by the Clinical Commissioning Group to tackle choice delays to reduce the delayed transfers of care within Oxfordshire's acute and community hospitals. The overall level of choice delays has fallen over the 12 months to 10 March 2016 (based on a 10 week rolling average) at both Oxford University Hospitals NHS FT (OUH) and Oxford Health NHS FT (OH). However, the fall has not been substantial and has not been consistent.

The implementation of the policy showed that a 'choice delay' is usually related with someone waiting for a private nursing home or a private home care package (normally 8 or 9 of the weekly 10-12 delays per week) with a few problems relating to family issues and normally only 1 or 2 people delayed owing to choice issues in relation to a public funded offer of onward care. A new process to improve this is being developed.

On 19th May, the group discussed the proposed measures for 2016/17 for priorities 5-7 of the Joint Health and Wellbeing Strategy in the scope of annual review of the strategy. It is not proposed to change the priorities in the strategy, but the measures and targets need to be updated to reflect current performance, and emerging or changing priorities. The group agreed the proposals and agreed to make further comments as required.

The group approved 2015/16 Outturn Report showed that the final outturn position of older people and equipment budget is an overspend of £2.413m.

Fulya Markham, Policy Officer

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An update of the work of the Health Improvement Board
Report to the Oxfordshire Health and Wellbeing Board
July 2016

The Health Improvement Board (HIB) has held 3 workshops with a range of partners since the last report to the Health and Wellbeing Board. It has also met once to conduct its ongoing business of implementing the Joint Health and Wellbeing Strategy in public.

A summary of the business of these meetings is given below.

1. Healthy Weight Strategy Workshop –April 2016

A range of partner organisations joined members of the HIB to discuss priorities for helping the population of Oxfordshire achieve and maintain a healthy weight. A range of informative presentations included the latest data on the local situation and some examples of good practice already underway.

Discussion groups focused on healthy eating, physical activity and environmental factors which can promote healthy weight (such as infrastructure that promotes cycling and walking, for example). The participants then discussed practical ways in which schools and workplaces can be used as settings for promoting healthy weight initiatives.

The priorities discussed have been drafted into action plans for all partners to implement and will be monitored at the Health Improvement Board.

2. Housing Related support workshops, April and June

Members of the Health Improvement Board have met twice in closed session with District and County Council portfolio holders for housing / social care. With input from officers they have discussed collaborative working on issues related to housing and homelessness in the county. Officers are working on detailed plans which will be made public in the autumn.

3. Health Improvement Board meeting, 7th May 2016

The Board met to discuss the final draft of the Joint Health and Wellbeing Strategy in the light of the end of year performance report for 2015-16. They were also able to examine the housing related indicators that are reported twice a year and take stock of the changes in the report in the last year. A paper setting out details of young people's supported housing pathway was also discussed. The agenda for the meeting also included the draft Healthy Weight Action Plans already referred to, above.

Jackie Wilderspin, July 2016

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Communications received by the Chairman February – June 2016
Report to the Health and Wellbeing Board, July 2016

The Chairman of Health and Wellbeing Board receives correspondence from a range of partners and stakeholders. The Board agreed a process by which this correspondence can be responded to or directed to the most appropriate individual, organisation or group for action. The table below summarises activity from February to June 2016

Date received	Communication topic	Action taken
6.3.2016	Local Pharmaceutical Committee "Support your Local Pharmacy Campaign"	The letter was noted and forwarded to Public Health colleagues who led the Pharmaceutical Needs Assessment work.
22.3.16	Thames Valley Priorities Committee – Severe and Complex obesity commissioning transferring from NHSE to Clinical Commissioning Groups	The contents of the letter were noted.
7.4.16	Mednet and One Day Creative – information about mindfulness in schools	The letter was acknowledged and information passed to officers in Children, Education and Families Directorate at the County Council.
29.4.16	Funding of HIV support services	A response was sent by the Chairman.
13.6.16	Southern Health NHS Trust – changes to Learning Disabilities Services	The letter was acknowledged and the briefing circulated to HOSC and HWB members

Any questions on this report can be directed to jackie.wilderspin@oxfordshire.gov.uk

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