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*Notice of a Meeting*

# Adult Services Scrutiny Committee
## Tuesday, 12 June 2012 at 10.00 am
## County Hall

**Membership**

Chairman - Councillor Jim Couchman
Deputy Chairman - Councillor Mrs Anda Fitzgerald-O'Connor

| *Councillors:* | Jenny Hannaby | C.H. Shouler | Alan Thompson |
|---|---|---|---|
| | Alyas Ahmed | Dr Peter Skolar | David Wilmshurst |
| | John Sanders | Richard Stevens | |

***Notes:***

***Date of next meeting:*** *25 September 2012*

**What does this Committee review or scrutinise?**
- Adult social services; health issues;

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

**For more information about this Committee please contact:**

| | | |
|---|---|---|
| Chairman | - | Councillor Jim Couchman<br>E.Mail: jim.couchman@oxfordshire.gov.uk |
| Committee Officer | - | *Simon Grove-White, Tel: (01865) 323628*<br>*simon.grove-white@oxfordshire.gov.uk* |

Peter G. Clark
County Solicitor

May 2012

**About the County Council**
The Oxfordshire County Council is made up of 74 councillors who are democratically elected every four years. The Council provides a range of services to Oxfordshire's 630,000 residents. These include:

| | | |
|---|---|---|
| schools | social & health care | libraries and museums |
| the fire service | roads | trading standards |
| land use | transport planning | waste management |

Each year the Council manages £0.9 billion of public money in providing these services. Most decisions are taken by a Cabinet of 9 Councillors, which makes decisions about service priorities and spending. Some decisions will now be delegated to individual members of the Cabinet.

**About Scrutiny**

Scrutiny is about:
- Providing a challenge to the Cabinet
- Examining how well the Cabinet and the Authority are performing
- Influencing the Cabinet on decisions that affect local people
- Helping the Cabinet to develop Council policies
- Representing the community in Council decision making
- Promoting joined up working across the authority's work and with partners

Scrutiny is NOT about:
- Making day to day service decisions
- Investigating individual complaints.

**What does this Committee do?**
The Committee meets up to 6 times a year or more. It develops a work programme, which lists the issues it plans to investigate. These investigations can include whole committee investigations undertaken during the meeting, or reviews by a panel of members doing research and talking to lots of people outside of the meeting. Once an investigation is completed the Committee provides its advice to the Cabinet, the full Council or other scrutiny committees. Meetings are open to the public and all reports are available to the public unless exempt or confidential, when the items would be considered in closed session

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

**A hearing loop is available at County Hall.**

# AGENDA

## 1. Apologies for Absence and Temporary Appointments

## 2. Declarations of Interest - see guidance note

## 3. **Minutes** (Pages 1 - 8)

To approve the minutes of the meeting of April 24th (**AS3a**) and note matters arising from them.
To also approve the minutes of the meeting on 15th May 2012, (**AS3b**) to appoint the Chairman & Deputy Chairman.

## 4. Speaking to or petitioning the Committee

## 5. Director's Update

10:00

John Jackson, Director for Social and Community Services, will update the committee on local and national issues in Adult Social Care.

## 6. **Health and Wellbeing Strategy** (Pages 9 - 30)

10:45

John Jackson will present the draft Joint Health and Wellbeing Strategy (**AS6a** and **AS6b**) for Oxfordshire. The consultation started on 15th May and will run until the 22nd June 2012.

Members are invited to comment on the priorities identified and the draft strategy.

## 7. **Joint Physical Disability Commissioning Strategy** (Pages 31 - 60)

11:15

Sara Livadeas, Deputy Director for Joint Commissioning, and Ian Bottomley, Deputy Head of Partnerships at Oxfordshire Clinical Commissioning Group, will present the Joint Physical Disability Commissioning Strategy (**AS7**). A further report covering the results of the recent consultation will be distributed to the committee prior to the meeting.

Members are invited to comment on the strategic direction outlined in the paper and consider its implications.

## 8. **Integrated Community Services** (Pages 61 - 64)

11:45

John Dixon, Deputy Director for Adult Services, will deliver a report on the integration of community services teams. The report (**AS8**) covers the ways in which Health and Social Care teams are joined up at a locality level.

The committee are invited to note the findings and comment on the direction of travel.

## 9. Equality Act and Equality Duty (Pages 65 - 68)

12:15

Ben Threadgold, Senior Policy and Performance Officer, Chief Executive's Office, will provide an update on the Equality Act 2010 and the Equality Duty and its relevance to scrutiny (**AS9**).

## 10. LINk Update (Pages 69 - 70)

12:30

Adrian Chant, LINk Host Manager, and a member of the LINk Core Group will deliver an update from the Local Involvement Network and answer the committee's questions (**AS10**).

## 11. Close of Meeting

12:45

## Declarations of Interest

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

### The duty to declare …

You must always declare any "personal interest" in a matter under consideration, i.e. where the matter affects (either positively or negatively):

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

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

### Whose interests are included …

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

### When and what to declare …

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

In making a declaration you must state the nature of the interest.

### Taking part if you have an interest …

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

### "Prejudicial" interests …

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

### What to do if your interest is prejudicial …

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

### Exceptions …

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

### Seeking Advice …

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

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# Agenda Item 3

## ADULT SERVICES SCRUTINY COMMITTEE

**MINUTES** of the meeting held on Tuesday, 24 April 2012 commencing at 10.00 am and finishing at 12.30 pm

**Present:**

| | |
|---|---|
| **Voting Members:** | Councillor Don Seale – in the Chair<br><br>Councillor Mrs Anda Fitzgerald-O'Connor (Deputy Chairman)<br>Councillor Jenny Hannaby<br>Councillor Ian Hudspeth<br>Councillor Larry Sanders<br>Councillor Dr Peter Skolar<br>Councillor Richard Stevens<br>Councillor Alan Thompson<br>Councillor David Wilmshurst<br>Councillor Patrick Greene |
| **Other Members in Attendance:** | Councillor (for Agenda Item ) |

**By Invitation:**

**Officers:**

Whole of meeting

Part of meeting

| **Agenda Item** | **Officer Attending** |
|---|---|

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

### 206/12 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS
(Agenda No. 1)

Councillor Patrick Green attended as a substitute for Councillor Peter Jones.

### 207/12 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE
(Agenda No. 2)

None

## 208/12 MINUTES

(Agenda No. 3)

The minutes of the meeting of March 6th were signed and approved.

## 209/12 SPEAKING TO OR PETITIONING THE COMMITTEE

(Agenda No. 4)

In anticipation of possible changes to the cabinet, Councillor Arash Fatemian, Cabinet Member for Adult Services, thanked the committee for it's valuable challenge during his time as Cabinet Member for Adult Services.

## 210/12 DIRECTOR'S UPDATE

(Agenda No. 5)

John Jackson, Director of Social and Community Services, updated the committee on local and national issues in Adult Services. The key points and actions arising are summarised below.

**National Items**

**Adult Social Care White Paper**

There are lots of stories in the media about what this will include (in particular whether it will address the recommendations from the Dilnot Commission). There are also reports (such as in this week's Observer) that it will not be issued this month. From my perspective I have no intelligence about when it will be published except that it will not be published in April (due to the local elections in early May). If it does not address Dilnot then this will be an opportunity missed in my opinion.

**Local Items**

**Oxfordshire Care Partnership**

I promised the Committee that I would update you on developments. However, at this stage I have nothing to report other than that the negotiating team are discussing a series of very detailed issues with the Orders of St. John and Bedford Pilgrims Housing Association. We are still working to the approach agreed by the Cabinet. Nick Graham has responded to some questions raised by Cllr Stevens. Members of this Committee have been copied into that correspondence. Cllr Stevens came back with some further questions yesterday. Nick Graham will respond to those questions as soon as possible.

It was **AGREED** that future correspondence between Cllr Stevens and the Monitoring Officer will continue to be shared with committee members.

**Four Seasons Healthcare**

Members have understandably shown a key interest in what is happening to the homes that Four Seasons Healthcare took over in Oxfordshire that were currently previously run by Southern Cross. Southern Cross ran 6 homes in Oxfordshire, 5 of which were transferred to Four Seasons Healthcare, bringing the total number of Four Seasons Healthcare homes in Oxfordshire to 6. We have carried out quality monitoring visits to all the former Southern Cross homes in Oxfordshire including those that transferred to Four Seasons Healthcare. Staff who carried out the monitoring visits noted an improvement in quality at all of them. There is a notable improvement in staff morale coupled with significant investment (reported by Four Seasons to be in the region of £200,000) in the buildings and equipment. All the homes have new managers and staff training for all staff is being refreshed. New care documentation from Four Seasons Healthcare will be launched next month and we believe this will lead to further improvements.

**The Crown, Harwell**

That said I do need to report that Four Seasons Healthcare announced last Friday that one of the homes transferred from Southern Cross will close – The Crown in Harwell. This is a very small home (only 16 places) with a proportionately high number of vacancies (there are only 7 residents currently – 4 funded by the County Council and 3 funded privately). Significant financial investment would be required to improve the home and Four Seasons Healthcare has received no applicants for the post of Home Manager, which is currently vacant. The home was transferred to Four Seasons Healthcare under a management agreement; the landlord has now decided to sell the building. Whilst its closure is not necessarily a surprise, the 7 residents and their families are concerned are worried about their future. We were present when they residents and relatives were informed and we shall be providing all the necessary support to make sure that they are transferred to an alternative care home that meets their needs. The local member, Cllr Lilly has been informed and is keen to be kept briefed on what is happening.

**Care Home Fees**

Members will be aware that in some areas care home fee reviews have received national media attention and in a small number of cases have been challenged by providers. In Oxfordshire we have had initial exploratory discussions with Oxfordshire Care Homes Association about how we might approach the market to discuss the same. Our view is that we need to engage with a broad range of care home providers about the cost of care in Oxfordshire and to this end we are about to begin a consultation process to help support this work. The outcome of this consultation will be reflected in a report to the Cabinet in due course and this will help to inform proposals for future care home fees reviews. I will of course keep Members informed of progress as we move through this exercise.

**Adult Social Care Crisis Response Service**

The Crisis Response Service is a new service being trialled (started January 2012) countywide in Oxfordshire for older people or adults with a disability, who are genuinely in crisis, at risk of admission to hospital or a care home, and need an

immediate (within 4 hours) social care response. The service is available 24/7 and can be up to a maximum of 72 hours, 24/7. As the Service is a pilot, it hasn't been advertised to the general public but anyone can refer via the Council's Social and Health Care Team via Customer Services during working hours or during out-of hours via the Emergency Duty Team, to the Provider, Community Voice. Community Voice are working towards full strength in terms of numbers of staff, which means that during the initial period of operation – to end March 2012 – we may not be able to respond in all cases that would otherwise be eligible. So far we have received 73 enquiries from people who meet the eligibility criteria and have been able to provide a service to 57 of them. 81% of those service users were still in their own home after receiving the Service.

It was **AGREED** that a report covering the range of services aimed at preventing unnecessary admission and accelerating discharge will be brought to the September meeting of the committee.

It was **AGREED** that a further report should come to the next meeting of the committee covering developments in integrating community services teams at the locality level.

**Ridgeway Trust**

This Learning Disability Trust decided that they had to look to a larger partner since they were judged too small to become a Foundation Trust. There has been a lengthy merger and acquisitions process which has been overseen by the Strategic Health Authority. Ann Nursey has provided input into the process on behalf of both the Primary Care Trust and the County Council. Southern Health NHS Foundation Trust has been selected as the preferred acquisition partner. This news has been communicated to employees of the Trust, employees of the County Council who work closely with them and also with service users and carers.

**Joint Commissioning Service**

The Joint Commissioning Service is undergoing a restructure to centralise commissioning and contracting activity for adults and children. The cross cutting support service – Strategy & Performance and Public Engagement is largely in place. The proposals for Commissioning and Contracting are out to staff consultation. This includes strengthening our contract management function, bringing procurement support into the team and improving our communication with external providers. We have beefed up the website sourceoxfordshire.com to include information on the joint commissioning team and posted up all our most recent commissioning strategies – to help providers.

## 211/12 IMPROVING THE REABLEMENT SERVICE

(Agenda No. 6)

Alan Sinclair, Lead Commissioner for Older People, and David Bradley, Chief Operating Officer at Oxford Health, introduced the committee to recent changes to

the reablement service contract with Oxford Health. Discussion covered the reasons for the underperformance of the service in recent years and the benchmarks against which future success will be judged.

The contract changes mean that future payment will be based on the number of episodes completed with further bonus payments being made for meeting targets. In addition the Director will meet regularly with the Chief Executive of Oxford Health to ensure that operational objectives are aligned with those of the wider care system. The changes have led to an improvement in performance during the past quarter.

Members queried whether the system of provider led monitoring reports would be sufficiently reliable and requested further detail on the monitoring process.

Alan Sinclair assured the committee that Oxford Health uses the same system as the Council to log episodes and **AGREED** to send further detail on the monitoring process outside of the meeting.

The committee **AGREED** that Oxford Health should be present at the September meeting for the item covering the range of services aimed at preventing unnecessary admissions and accelerating discharge.

**212/12 EQUALITY AND HUMAN RIGHTS COMMISSION REPORT ON HOME CARE FOR OLDER PEOPLE 'CLOSE TO HOME'**
(Agenda No. 7)

Councillor Stevens introduced the item on the Close to Home report, stating that at the local level the findings may be of particular relevance to the externalisation of Home Support Provision. Three key questions were identified:

1) Should there be a target for the reduction of 15 minute visits?
2) Should the council be doing more to monitor the pay and conditions of external home support staff?
3) Do we need a clearer route for complaints?

On the issue of 15 minute visits, Sara Livadeas, Deputy Director for Joint Commissioning, stated that this was possible but would have a resource implication to the council.

It was **AGREED** that a report outlining the resource implications would be discussed at a future meeting of the Quality Assurance Workgroup.

John Jackson responded to the issue of pay and conditions, stating that the council currently pays a relatively high price for an hour of care at around £19. This is moving towards the £15 target set for the resource allocation system but will remain above the level of a number of other authorities (£12) The rates of pay for external home support workers are equivalent to those received through the internal service although this excludes pension contributions.

Regarding the question of a clearer route for escalating complaints, Cllr Fatemian highlighted the ongoing work to ensure that people feel comfortable raising concerns. Key to this is creating an environment where people feel comfortable . This issue will continue to be discussed at length by the Quality Assurance Workgroup.

Members applauded the quality of the discussion paper, stating that it offered an excellent template for future scrutiny papers.

It was **AGREED** that the paper and the content of discussions would be considered by the Quality Assurance Workgroup.

**213/12 LINK UPDATE**
(Agenda No. 8)

Adrian Chant, LINk Host Manager, updated the committee on the recent activity of the Local Involvement Network.

The LINk are working closely with the Contracts Team and the Workgroup in their program of visits to care homes. A full report will be shared with the committee following the completion of the program of visits.

The recent Hearsay event picked up issues on how relatives can raise concerns. Through attendance at the meetings of the Quality Assurance Workgroup, the LINk will input these findings into wider discussions about the escalation of concerns.

It was **AGREED** that a report on the Hearsay event will be shared with the committee at a future date.

Further discussions covered the timetable for the procurement of Healthwatch and the establishment of new links with the Military.

**214/12 CLOSE OF MEETING**
(Agenda No. 9)

The Meeting closed at 12:30.

.................................................................................... in the Chair

Date of signing ....................................................

# ADULT SERVICES SCRUTINY COMMITTEE

**MINUTES** of the meeting held on Tuesday, 15 May 2012 commencing at 11:38 am and finishing at 11.42 am

**Present:**

**Voting Members:**

Councillor Jim Couchman
Councillor Mrs Anda Fitzgerald-O'Connor
Councillor Alyas Ahmed
Councillor Jenny Hannaby
Councillor John Sanders
Councillor C.H. Shouler
Councillor Dr Peter Skolar
Councillor Richard Stevens
Councillor Alan Thompson
Councillor David Wilmshurst

**Officers:** Peter Clark, County Solicitor & Monitoring Officer; Sue Whitehead (Chief Executive's Office)

*The Scrutiny Committee considered the matters referred to in the agenda for the and agreed as set out below.*

## 215/12 ELECTION OF CHAIRMAN FOR THE 2012/13 COUNCIL YEAR

(Agenda No. 1)

Councillor Fitzgerald-O'Connor moved and Councillor Skolar seconded that Councillor Couchman be elected Chairman of the Committee for the 2012/13 Council Year.

Councillor Hannaby moved and Councillor John Sanders seconded that Councillor Stevens be elected Chairman of the Committee for the 2012/13 Council Year.

Following a vote by a show of hands it was:

**RESOLVED:** that Councillor Couchman be elected Chairman of the Committee for the 2012/13 Council Year.

## 216/12 ELECTION OF DEPUTY CHAIRMAN FOR THE 2012/13 COUNCIL YEAR

(Agenda No. 2)

Councillor Couchman moved and Councillor Thompson seconded that Councillor Fitzgerald O'Connor be elected Deputy Chairman of the Committee for the 2012/13 Council Year.

Councillor Stevens moved and Councillor John Sanders seconded that Councillor Hannaby be elected Deputy Chairman of the Committee for the 2012/13 Council Year.

Following a vote by a show of hands it was:

**RESOLVED:** that Councillor Fitzgerald-O'Connor be elected Deputy Chairman of the Committee for the 2012/13 Council Year.

.......................................................................................... in the Chair

Date of signing .......................................................

Oxfordshire Health & Wellbeing Board

# Oxfordshire's Joint Health & Wellbeing Strategy

## 2012 - 2016

## Summary for public consultation – May/June



Oxfordshire Clinical Commissioning Group

NHS

OXFORDSHIRE COUNTY COUNCIL

Oxfordshire LINk

# Oxfordshire's Draft Joint Health & Wellbeing Strategy

Oxfordshire's draft Joint Health & Wellbeing Strategy aims to say what we want to do to improve the health and wellbeing of children, young people, families, adults and older people in the county. It explains how the Health & Wellbeing Board plans to do this by working with people in different organisations, like health services and local authorities. We have chosen 11 of the most important issues because we think that if all organisations work together on these, as a priority, we can make a real difference.

## Why now?

The aim is to make sure we work better together to improve everyone's health and wellbeing, especially those who have health problems or are in difficult circumstances. There has been a new Health and Social Care Act which says that everyone should be more involved in making these decisions – not just a few people or those that 'shout loudest'! So we want your views and ideas about the priorities we're suggesting.

## What do we already know?

We have collected lots of useful information which tells us who lives in Oxfordshire, what we are doing well and what the problems are. This report, called the Joint Strategic Needs Assessment (JSNA), tells us what we need to be planning for. It tells us which parts of the population are growing the most, how we are doing compared to other parts of the country and where we need to improve. For instance, we know we need to plan for an increasing number of older people and their carers in Oxfordshire so we can make sure people are cared for well. The JSNA also tells us that some areas of the county and some people have poorer health and poorer opportunities in life and that there are some persistent problems which we need to tackle. We use this knowledge to improve how people who live in Oxfordshire get help with health, care and education.

## Who decided that these were the priorities?

The new Health & Wellbeing Board has decided the priorities after lengthy discussions. The Board includes councillors, GPs, directors of services and the Chair of the Local Involvement Network (representing the views of the public in Oxfordshire). It is chaired by the Leader of the County Council, and the Vice Chair is the Lead GP for the Oxfordshire Clinical Commissioning Group (which plans and pays for health services). We have also used information from consultations which tell us what's important for you, and what helps you most.

**We want your views and ideas about the priorities we're suggesting**

## So, what are the proposed priorities?

### For adults . . .

1. Joining up of health and social care services to improve services for older people and their carers.
2. Supporting older people to live with dignity whilst reducing their need for care and support through, for instance, reablement services which increase independence and enable people to stay in their own homes.
3. Supporting adults with long-term health conditions, physical or learning difficulties or mental health problems to live independently and achieve their potential, for instance through independent living, self-management of their disability/illness, education opportunities etc.

### For children and young people . . .

4. Keeping all children and young people safe.
5. Raising achievement for all children and young people – at primary, secondary and special schools, colleges and for school leavers.

Making sure our most disadvantaged and vulnerable children and young people, do as well as they can.

Making sure all children have a healthy start in life and stay healthy into adulthood, by, for instance, preventing self-harm and supporting those with mental health problems.



### For health improvement . . .

8. Preventing early death and improving the quality of life in later years, e.g. by reducing the numbers of smokers, and increasing numbers of people having health checks.
9. Preventing chronic disease by tackling obesity, (unhealthy weight), for instance, by increasing the numbers of people who take regular exercise.
10. Improving housing as poor/overcrowded housing is linked with poor health.
11. Preventing infectious disease through immunisation.

**There are also some issues that cut across all of our priorities such as mental health, housing and poverty.**

**To make sure we know whether we're improving, we have set ourselves some targets for each of the priorities.** These can be seen in the Joint Health & Wellbeing Strategy consultation draft on pages 8 to 16 at the following link: http://bit.ly/health-wellbeing-strategy

## So – we'd really like to hear your views on the following questions:

**a) Have we got our priorities right?**

**b) Have we got our targets right?**

**c) What else should we include?**

**d) Are there any other comments that you would like to make?**

## To find out more and let us know your views …

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Give us your feedback and have your say on the proposed Joint Health & Wellbeing Strategy by completing our survey, attending a workshop, or commenting on the full strategy document.

You can complete the questionnaire or find out more at: http://bit.ly/health-wellbeing-strategy or, by contacting us:

Email: talking.health@oxfordshirepct.nhs.uk

Phone: **01865 323625**

You can also write to us with your views at:

Communications & Engagement
FREEPOST RRRKBZBTASXU
NHS Oxfordshire, Jubilee House, 5510 John Smith Drive
Oxford Business Park South, OXFORD OX4 2LH

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# Oxfordshire's Joint Health & Wellbeing Strategy

# 2012 - 2016

# Consultation Draft May 2012

Oxfordshire Clinical Commissioning Group NHS OXFORDSHIRE COUNTY COUNCIL Oxfordshire LINk

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## 1. Foreword by Chairman and Vice-Chairman of Oxfordshire's Health and Wellbeing Board

We are delighted to launch this consultation of our first Health and Wellbeing Strategy for Oxfordshire and we believe this document is a significant step forward for health in the County.

We are used to positive partnership working between Local Government and the NHS in Oxfordshire and we are also used to working hand in hand with the public. This document finds us all speaking with one voice on behalf of the new Health and Wellbeing Board in an attempt to tackle the most pressing health problems our County faces today.

Health and Wellbeing in Oxfordshire is good overall, but we are determined to make it better still by working together for the long term.

It is important that we can measure the changes to services we intend to make and the positive changes in health outcomes we hope to achieve. We have therefore included progress measures throughout the document. All of these measures are ambitious and we intend to achieve them all or use any near-misses to focus our attention on these areas further.

We have set out our ambitions and we now need your help. Please do respond to this consultation and have your say. We are eager to know whether your views agree with ours and we want to use the consultation to improve the strategy.

We look forward to hearing from you and to having you join us in this joint venture.

**Keith Mitchell CBE**, **Chairman of the Board**
Leader of Oxfordshire County Council

**Dr Stephen Richards, Vice Chairman of the Board**
Chief Executive of the Oxfordshire Clinical Commissioning Group

## 2. Introduction

A Health and Wellbeing Board has been set up in Oxfordshire to make a measurable difference to the health and wellbeing of the people of Oxfordshire. Oxfordshire has a rich history of partnership working to improve health care. This new Board is, therefore, very much the next logical step for Oxfordshire to take and through it we also fulfil a key requirement of the Government's new Health and Social Care Act.

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, the Local Involvement Network and senior Officers from Local Government.

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

This document is that draft strategy, (technically called the 'Draft Joint Health and Wellbeing Strategy') and the Board now wishes to consult with the people of Oxfordshire and a wide range of organisations in a debate to refine and improve these initial proposals.

We are seeking the answers to four questions:

1) **Have we got our priorities right?**

2) **Have we got our measures right?**

3) **What else should we include and why?**

4) **Are there any other comments that you would like to make?**

Once the priorities are agreed following this consultation, they will be the main focus of the Health and Wellbeing Board's work. The consultation will also help us to create the detailed action plans we will need if these changes are to become a reality.

We expect this to be a 'living document'. As priorities change, our focus for action will need to change with it. 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:

By 2016 in Oxfordshire:

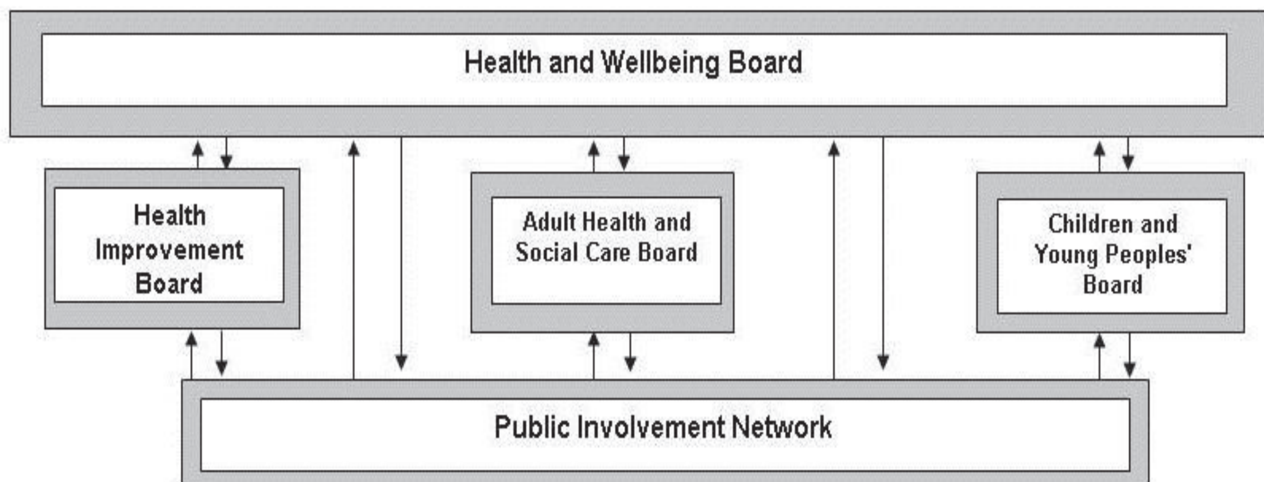
- more children and young people will lead healthy, safe lives and will be given the opportunity to develop the skills, confidence and opportunities they need to achieve their full potential;
- more adults will have the support they need to live their lives as healthily, successfully, independently and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

The priorities set out in this document put flesh on these themes. The priorities are intended to run to 2016 while the measures and targets set out within each priority are for the financial year 2012/13.

## 4. The structure of the Health and Wellbeing Board

### 4.1. What does the Health and Wellbeing Board look like?

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




The purpose of each of the Partnership Boards and the Network are outlined below:

| Adult Health and Social Care Board | Children and Young People's Board | Health Improvement Board | Public Involvement Network |
|---|---|---|---|
| To improve outcomes and to support adults to live independently with dignity by accessing the support and services they need while achieving better value for money. | 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 genuine opinions and experiences of people in Oxfordshire underpin the work of the Health and Wellbeing Board. |

### 4.2. How will decisions get made?

The Health and Wellbeing Board is ultimately responsible for making decisions jointly about health and wellbeing. Its members are committed to working with its three Partnership Boards and its Public Involvement Network to make those decisions. They will also be accountable to their constituent organisations – the Oxfordshire Clinical Commissioning Group, County, District and City Councils and HealthWatch.

In turn, the Partnership Boards are committed to working with a wide range of health care providers, voluntary agencies and advocacy groups. In this way, the decisions of the Health and Wellbeing Board will be truly inclusive.

The Health and Wellbeing Board will meet in public three times a year. Each of the three partnership Boards will also meet in public three times each year and will also host workshops which will include many more service providers, partners, voluntary sector representatives and advocacy groups.

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

a) they will want to take careful account of the evidence base provided by the Joint Strategic Needs Assessment and

b) given that there will never be enough resources to meet all of people's needs, it will be the duty of the Health & Wellbeing Board to balance needs carefully and to make difficult decisions about priorities.

The terms of reference for each of the boards and the membership can be found at the links below-

http://mycouncil.oxfordshire.gov.uk/ieListDocuments.aspx?CId=776&MId=3447
http://mycouncil.oxfordshire.gov.uk/ieListDocuments.aspx?CId=776&MId=3410

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

### 5.1. 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.

The analysis set out below is rooted in the JSNA, amplified by five Director of Public Health annual reports and the views and experience of members of the Health and Wellbeing Board.

### 5.2. What does this analysis tell us?

Oxfordshire is mainly a rural County in which approximately 649,000 people live. The County is the most rural in the South East region. Over 50% of the population live in settlements of less than 10,000 people. However, there are also urban areas, such as Oxford and Banbury. Future population growth is expected to be concentrated around the major towns of Banbury, Bicester, Didcot, Witney, Grove and Wantage, where several thousand new homes will be built over the next 15 to 20 years.

Health and wellbeing in Oxfordshire has been improving for many years. In general the population is healthy and compares well with the rest of the country. The growth in the number of people aged 85+ is roughly the same as the England average but the growth in the number of older people is not uniform across the County. It is highest in the rural areas.

The Child Poverty Strategy shows there are 15,660 children living in poverty, which is almost 12% of all children in the County. Four out of five children living in poverty live in our towns and in Oxford City.

In addition, there are important groups in society whose needs must not be forgotten, including those with mental health problems, physical disabilities and those with learning disabilities.

Although Oxfordshire is relatively well-off overall, the distribution of income among the local population is very uneven. There are pockets of relative 'social deprivation' scattered across

the County in both rural and urban areas but mostly affecting Oxford and Banbury, where physical and mental health are poorer, school results are lower and life chances are generally less good. The same group of wards tends to come to the forefront as having the poorest health and wellbeing. In general, many of these areas tend to be the ones with the highest proportions of people from minority ethnic groups and are the wards with the greatest levels of social deprivation.

The Joint Strategic Needs Assessment also shows that there are an increasing number of people engaged in caring for elderly friends and relatives and many more people volunteer their help. Many of these people are elderly themselves. We are dependent upon these friends, relatives and volunteers to continue caring.

### 5.3. What are the specific challenges?

- **Demographic pressures** in the population, especially the increasing number and proportion of older people, many of whom need care. This is markedly higher in our more **rural districts** than in the City.
- 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.
- There are a growing number of people with **dementia** in the County who require access to new emerging treatments.
- The persistence of small geographical areas of **social deprivation containing high levels of child poverty**, especially in Banbury and Oxford but also in parts of our market towns.
- The increase in **'unhealthy' lifestyles which leads to preventable disease**.
- The need to ensure that services for the **mentally ill and those with learning disabilities and physical disabilities** are not overlooked.
- **Increasing demand** for services.
- The need to support **carers to care** and the need to encourage volunteering.
- 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).
- The recent **tightening of the public purse** which has knock-on effects for voluntary organisations.
- The need to work with and through a **wide patchwork of organisations** to have any chance of making a real difference in Oxfordshire.
- The changing face and **roles of public sector organisations.**

### 5.4. What are the overarching themes?

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

1. The need to shift services towards the prevention of ill health.
2. The need to reduce inequalities, break the cycle of deprivation and protect the vulnerable.
3. The need to give children a better start in life.
4. The need to reduce unnecessary demand for services.
5. The need to make the patient’s journey through all services smoother and more efficient.
6. The need to improve the quality and safety of services.

7. The need to streamline financial systems, especially those pooled between organisations, and to align all budgets more closely.

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

## 6. What are the priorities for Oxfordshire's Draft Health and Wellbeing Strategy?

The priorities are based on the analysis set out previously. We have also used the following checklist to help us focus our priorities:

1) Is it a major issue for the long term health of the County?
2) Are there some critical gaps to which we need to give more attention?
3) Where are we most concerned about the quality of services?
4) Where can the NHS, Local Government and the public come together and make life better for local people?

A summary of the priorities can be found in Annex 1 on page 16.

### A. Priorities for Adult Health and Social Care

**Priority 1: Integration of health and social care**

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

- More efficient use of existing resources and a reduction in the demand on expensive health and social care services by avoiding duplication and ensuring people receive the right care, in the right place at the right time
- Improved access to, experience of, and satisfaction with, health and social care services

The County Council and Oxfordshire Clinical Commissioning Group are committed to integrating health and social care further – 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.

We are proposing the following targets for achievement during 2012/13:

**Integration of health and social care**

- a single point of access to fully functioning integrated health and social care community services will be provided by Oxfordshire County Council and Oxford Health NHS Foundation Trust by 31st October 2012
- moving towards a single Section 75 agreement to cover all the pooled budget arrangements with substantial progress made by April 2013
- an older people's commissioning strategy implemented by the County Council in April 2012. The intention is to develop a joint older people's commissioning strategy and joint commissioning arrangements by December 2012
- Oxfordshire's Clinical Commissioning Group will be authorised by April 2013

- More than 60% of people who use social care services in Oxfordshire will say they are very satisfied with their care and support (currently 59.4%)
- Establish a baseline for measuring carer satisfaction of services by May 2013
- Achieve above the national average of people satisfied with their experience of hospital care (when the nationally sourced information for Oxfordshire is available)
- Achieve above the national average of people 'very satisfied' with their experience of their GP surgery (when the nationally sourced information for Oxfordshire is available).
- 800 carers' breaks jointly funded and accessed via GPs (currently 709)

**Priority 2: Support older people to live independently with dignity whilst reducing the need for care and support**

We know that the proportion of older people in the population continues to increase and that the cost of caring for older people increases markedly with age. This is true for both health care and social care.

We also 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.

For all these reasons our priority is to support older people to live at home whilst reducing the need for care and support. For this reason we are proposing targets to reduce the number of people permanently admitted to nursing homes, to provide additional extra-care housing units and to make sure older people find the information they need more easily.

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. This gives us another of our priorities. Currently only 38% of people with dementia in Oxfordshire have a diagnosis. This is below the national average of 42% (within a range of 27% - 59%). We would welcome views (especially from GPs) on what target should be set. We have suggested a target of 50% for this year which would be a step increase in performance but would still leave performance in Oxfordshire below the best achieved elsewhere.

In 2011/12 we had the highest level of delayed transfers of care between the NHS and social care in the country. All organisations are committed to improving the situation and one of the best ways of doing this is to provide services which help people to learn or re-learn the skills they need to live more independently. These services are called "reablement services". We are committed to offer these to more people.

We are proposing the following targets for achievement during 2012/13:

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

- a reduction in delayed transfers of care so that Oxfordshire's performance is out of the bottom quarter (current ranking is 151/151)
- No more than 400 older people permanently admitted to a care home (currently 546)
- 50% of the expected population with dementia will have a recorded diagnosis (currently 37.8%)
- 3,250 people will receive a reablement service (currently 1,812)
- 55% of the people completing the reablement service will be successfully supported so

that they need no on-going care (currently 47%)
- By the end of March 2013, commission an additional 130 Extra Care Housing places, bringing the total to 407 and by the end of March 2015 an additional 523 places, bringing the total number of places to 930
- 55% of older people who use adult social care say that they find information very or fairly easy to find (currently 52.2%)

**Priority 3: <u>Living and working well: Adults with long-term conditions, physical disabilities, learning disabilities or mental health problems living independently and achieving their full potential</u>**

Adults living with physical disability, learning disability, severe mental illness or another long-term condition consistently tell us that they want to be independent, to have choice and control, and to be able to live "ordinary lives" as fully participating members of the wider community. This priority aims to support adults of working age 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 are, therefore, proposing a series of targets which aim to:
- ensure that information is easy for service users to find
- increase the number of people with mental health conditions who are in employment
- ensure that people with long term conditions feel supported
- ensure people with severe mental health problems or learning disabilities receive good care for their physical health

The detailed targets for achievement during 2012/13 are:

**Living and working well: Adults with long-term conditions, physical disability, learning disability or mental health problems living independently and achieving their full potential**
- 55% of working age adults who use adult social care say that they find information very or fairly easy to find (currently 54.2%)
- 15% of people with severe mental illness using secondary mental health services are in employment (currently 10.7%)
- 86% of people with a long-term condition feel supported to manage their condition (currently 84%)
- 95% of people living with severe mental illness will have an annual physical health check by their GP (currently 93.7%)
- 50% of people with learning disabilities will have an annual physical health check by their GP (currently 40%)

## B. Priorities for Children and Young People

### Priority 4: Keeping all children and young people safe

This is a key priority because children need to feel safe and secure if they are to reach their full potential in life.

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.

Practitioners in all agencies work together to prevent harm and to identify and protect children living in abusive and neglectful situations. There is excellent joint work around domestic abuse aimed at reducing its impact on children.

We know nationally the number of children who have Child Protection Plans has increased. The 0-4 year olds are the largest single age group with Child Protection Plans and in Oxfordshire we have more children with a Child Protection Plan, compared with previous years. Our priority in Oxfordshire is to reduce the number of children who need a subsequent Child Protection Plan (following a previous completed plan) to no more than 15%.

To improve this situation, we are proposing the following targets for achievement during 2012/13:

**Keeping all children and young people safe**

- No more than 15% of children who become subject to a child protection plan have previously had a plan (in 2010/11 18.2%)
- A regular pattern of quality assurance audits is undertaken and reviewed through the Oxfordshire Safeguarding Childrens Board covering the following agencies: children's social care; children and adult health services; early intervention services; services provided by the police. Over 50% of interventions showing positive overall impact (baseline to be confirmed in 2012/13)

### Priority 5: Raising school achievement for all children and young people

This is a priority because, in Oxfordshire, school exam results are often poorer than expected. In 2011 GCSE results were disappointing. Overall, the picture shows gradual improvement but there is inconsistency between Districts and for certain groups of children.

Early Years results are better than the national average and this can be built upon. However we know that specific pupil groups in Oxfordshire do not do as well as their peers in similar Local Authorities. This includes children receiving free school meals, children from some Black and Minority Ethnic Groups and those with special education needs. The attainment of children whose first language isn't English is lower than that of their peers at Key Stage 4, and the attainment of boys is lower than that of girls at both Key Stage 2 and 4. There is currently also a specific concern about reading standards at Key Stage 1 in some primary schools.

The Health and Wellbeing Board aspires to see every single child being successful and reaching their potential, thriving in an outstanding learning environment throughout their

education wherever they live across the County. We aim for every single school to be rated at least as ‘good’ and to be moving towards ‘outstanding’.

We are proposing the following targets for achievement during 2012/13:

**Raising achievement for all children and young people**

- 63% (3,900) of young people achieve 5 GCSEs at A*-C including English and Maths (currently 57.4%)
- 80% (4,880) of children achieve Level 4 or above in English and Maths at the end of Key Stage 2 (currently 74.8%)
- 76% (5,000) children achieve Level 2b or above in reading at the end of Key Stage 1 (currently 74.3%)
- Reduce the number of young people not in education, employment or training to 5% or 864 young people (currently 5.7%)
- 88% (204) primary schools and 86% (28) secondary schools with be judged by Ofsted to be good or outstanding (currently 61% of primary schools and 65% of secondary schools)

**Priority 6: Narrowing the gap for our most disadvantaged and vulnerable groups**

This is a priority because we know that outcomes for children from vulnerable groups and disadvantaged communities are much worse than for their peers.

Poverty and deprivation 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 is seen as a key way of improving outcomes for children. There is a renewed national focus through the ‘Thriving Families’ programme working with families to reduce worklessness, antisocial behaviour and crime and to increase school attendance. This will be a vital strand in the ongoing work locally to 'narrow the gap'. Reducing the number of teenage pregnancies in the County has proved to be useful overall focus for this work.

Performance at Key Stage 4 is an area of further work: in 2010/11, 8% of Oxfordshire’s looked after children achieved 5 or more GCSE A* to C including English and Maths compared to 6.4% in 2009/10. There are also more boys than girls who are Not in Education, Employment or Training (NEET).

We are therefore proposing the following targets for achievement during 2012/13:

**Narrowing the gap for our most disadvantaged and vulnerable groups**

- A sustainable decrease in the teenage conception rate (in 2010 this was 251 young people)
- Thriving Families programme targets will be available from the Department of Communities and Local Government framework when published
- Targets for improving achievement at school are included within priority 5

**Priority 7: All children have a healthy start in life and stay healthy into adulthood**

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

This section should be read together with priorities 9 and 11 below which propose the promotion of breastfeeding and improved immunisation for children as further priorities.

In addition to breastfeeding and immunisation, we have selected a number of areas where things could be improved. We know that there is a year on year increase in the number of children and young people admitted to hospital as 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 propose to reduce this number.

Another common cause of emergency admission for young people (11-17 years old) remains 'ingestions and poisoning' (both alcohol and drug related). We propose to reduce this number also.

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. We are determined to act on this.

We are therefore proposing the following targets for achievement during 2012/13:

**Having a healthy start in life and staying healthy into adulthood**

- Reduce the number of young people admitted to hospital for episodes of self-harm by 5% year on year. This means reducing by approximately 10 young people every year (currently 156)
- Reduce the number of young children admitted to hospital with infections by 10% year on year. This means reducing emergency admissions to 2,890 children (currently 3,100)
- Review and redesign transition services for young people with mental health problems. This would mean there would be a new service in place from 1st April 2013

## 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.

The following priorities for action are proposed:

- 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 new bowel cancer screening programme.
- To promote the new 'Health Checks' programme which offer adults a full health 'MOT' and looks at many lifestyle factors such as obesity, exercise, smoking, blood cholesterol levels ,diabetes, blood pressure and (soon), alcohol consumption.
- Reversing the rise in the consumption of alcohol is another priority of the Health and Wellbeing Board. It is being taken forward by the Oxfordshire Community Safety Partnership and progress will be monitored by the Health Improvement Board.

In addition to this our work must focus 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.

We are proposing the following targets for achievement during 2012/13:

**Preventing early death and improving quality of life in later years**

- 100 smoking quitters above the national target (the nationally set target for Oxfordshire is 3,476)
- 2,000 adults receiving bowel screening for the first time (the nationally set target is 60% of 60-69 year olds)
- 30,000 people invited for Health Checks for the first time (currently 25,000)

**Priority 9: Preventing chronic disease through tackling obesity**

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

Director of Public Health annual reports show that there is an upward trend in prevalence of obesity in adults in Oxfordshire, though this is still slightly below the national level. Chronic disease associated with obesity, such as diabetes, is also increasing.

To tackle obesity we have set targets in the following areas:

**Promoting breastfeeding**
Breastfeeding gives the best start to life and has been proven to lead to fewer overweight children and adults. Increasing the number of breastfed babies is the foundation of an obesity strategy for the County. The national figure for breastfeeding prevalence at 6-8 weeks is 47% but in Oxfordshire we are setting a stretching target of 60% and aiming to address inequalities issues.

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

**Promoting physical activity in adults**
Physical activity is an important component of maintaining a healthy weight for all ages and there is local encouragement here, with Oxfordshire topping the latest 'Active People' survey as the sportiest and most active county in England. The survey showed that 26% of the population participate in regular activity each week. Maintaining this position will be critical to good health in the County.

We are proposing the following targets for achievement during 2012/13:

**Preventing chronic disease through tackling obesity**

- Ensure that the obesity level in Year 6 children is held at no more than 15% (in 2011 this was 14.9%)

- 60% of babies are breastfed at 6-8 weeks of age (currently 58.4%)
- 5,000 additional physically active adults (2010/11 information will be available in July 2012)

**Priority 10: Tackling the broader determinants of health through better housing**

The interdependent relationship between health and housing is well known. Many of the most significant gains in health have stemmed from Local Authority public health measures, such as clean water, sanitation, reduction in overcrowding and reduced exposure to extreme cold. We need to maintain our focus on the contribution that decent housing makes to health improvement and especially on the needs of more vulnerable communities. We propose to approach this issue in several ways:

**a. Reducing Fuel poverty**:
A household is said to be in fuel poverty if it needs to spend more than 10% of its income on fuel to keep warm. The calculation takes account of household income, fuel prices and energy efficiency of the home. Often the most vulnerable people, the elderly, the disadvantaged and those in poverty, are the most likely to be affected. All types of housing in both rural and urban areas can be affected. Helping people to escape from fuel poverty will do a great deal to improve the health of the worst off in the county. Latest figures show over 1 in 10 households in Oxfordshire are in fuel poverty, with some rural wards having rates as high as 1 in 5.

**b. Inequalities**
These housing issues also have to be tackled in partnership. Work is currently underway to determine the specific focus for this work and to identify and recommend outcomes and indicators. These will be advised in due course.

We are proposing the following targets for achievement during 2012/13:

**Tackling the broader determinants of health through better housing**
- 250 households per year helped to escape fuel poverty as a pilot (the baseline is not available until the pilot is complete)
- A second outcome measure relating to inequalities will also be agreed

**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.

The Oxfordshire Joint Strategic Needs Assessment shows high levels of coverage but some targets are still not being met and there are early signs that our high rates have begun to slip a little.

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.

We are proposing the following targets for achievement during 2012/13:

**Prevent infectious disease through immunisation**

- 8,000 children immunised at 12 months, maintaining the high coverage (the national target is 96.5%)
- 7,700 children vaccinated against Measles Mumps and Rubella (MMR) by age 2 (the national target is 95%)
- 7,300 children receiving MMR booster by age 5 (the national target is 95%)
- 3,000 girls receiving Human Papilloma Virus vaccination to protect them from cervical cancer (the national target is 90% of 12-13 year old girls)
- 80,000 flu vaccinations for people aged 65 or more (the national target is 75% of people aged 65+)

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

### Adult Health and Social Care

**Priority 1**: Integration of health and social care

**Priority 2**: Support older people to live independently with dignity whilst reducing the need for care and support

**Priority 3**: Living and working well: Adults with long term conditions, physical or learning disability or mental health problems living independently and achieving their full potential

### Children and Young People

**Priority 4**: Keeping all children and young people safe

**Priority 5**: Raising achievement for all children and young people

**Priority 6**: Narrowing the gap for our most disadvantaged and vulnerable groups

**Priority 7**: All children have a healthy start in life and stay healthy into adulthood

### 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

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

## Annex 2: Glossary of Key Terms

**<u>Terms</u>**

| Term | Definition |
| --- | --- |
| **Carer** | Someone of any age who looks after a relative, partner, friend or neighbour who has an illness, disability, frailty, or addiction. The help they provide is not paid for as part of their employment. |
| **Child Poverty** | Children are said to be living in relative income poverty if their household’s income is less than 60 per cent of the median national income. |
| **Child Protection Plan** | The plan details how a child will be protected and their health and development promoted. |
| **Commissioning** | The process by which the health and social care needs of local people are identified, priorities determined and appropriate services purchased. |
| **Delayed Transfer of Care** | The national definition of a delayed transfer of care is that it occurs when a patient is medically fit for transfer from a hospital bed, but is still occupying a hospital bed. |
| **Director of Public Health Annual Report** | http://www.oxfordshirepct.nhs.uk/about-us/publications/public-health-annual-report.aspx |
| **Extra Care Housing** | A self-contained housing option for older people that has care support on site 24 hours a day. |
| **Fuel Poverty** | Households are considered by the Government to be in 'fuel poverty' if they would have to spend more than 10% of their household income on fuel to maintain an adequate level of warmth. |
| **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. |
| **Local Involvement Network (LINk)** | Oxfordshire LINk is made up of individuals and community groups who care about our health and social care services and work together to make improvements. http://oxfordshirelink.org.uk/ |

| | |
|---|---|
| **Not in Education, Employment or Training (NEET)** | Young people aged 16 to 18 who are not in education, employment or training are referred to as NEETs. |
| **Oxfordshire Clinical Commissioning Group** | The Oxfordshire Clinical Commissioning Group is the new organisation in Oxfordshire that has the responsibility to plan and buy (commission) health care services for the people in the County. It is currently in shadow form until it takes over from Oxfordshire Primary Care Trust in April 2013. |
| **Oxfordshire Safeguarding Childrens 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 partner if it would lead to an improvement in the way those functions are exercised. |
| **Thriving Families Programme** | A national programme which aims to turn around the lives of 'Troubled' families by 2015. |
| **Transition** | This is the process through which a person with special needs transfers from children's services to adults services. |

Oxfordshire Clinical Commissioning Group

OXFORDSHIRE COUNTY COUNCIL
www.oxfordshire.gov.uk

NHS
Buckinghamshire and Oxfordshire Cluster

# A Joint Physical Disability Strategy for Oxfordshire

# A draft for consultation

Oxfordshire Clinical Commissioning Group    OXFORDSHIRE COUNTY COUNCIL www.oxfordshire.gov.uk    NHS Buckinghamshire and Oxfordshire Cluster

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Oxfordshire Clinical Commissioning Group

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# Executive Summary

***These headings are expanded in the full draft strategy below. For a fuller account of these headings see the section and page number indicated***

## Introduction (Section 1, page 6)

1 Oxfordshire County Council and Oxfordshire Clinical Commissioning Group are developing a joint health and social care commissioning strategy to meet the needs of people living in the County with physical disability.

2 Oxfordshire County Council is responsible for social care and support of people with a physical disability. Oxfordshire Clinical Commissioning Group is the body that will in future commission health services in line with the Health and Social Care Bill. Together we believe that a joint approach will work better for people with physical disability. We need to put in place a more integrated approach to care where services are built around the individual and reflects personal needs. We think this will help people to live as independently as possible for as long as possible.

## How can you have your say? (Section 3, page 7)

**Unlimited** is running a consultation regarding this draft strategy on behalf of the Commissioners to get the public's views on what disabled people need. Unlimited is a user led organisation of people living with a physical or a sensory disability.

The Commissioners want views on this new draft strategy to meet the needs of people living in the County with a physical disability. You can comment on the strategy using the survey designed by Unlimited. The survey can be filled in on-line at http://www.oxfordshireunlimited.org/ or http://www.oxfordshire.gov.uk/cms/public-site/consultation

Unlimited will be facilitating a number of events for service users and carers which will be publicized locally. For more information please contact Unlimited through their website or on 0845 121 4112.

We would prefer responses to the consultation to use the survey, but if you wish to send in any other comments or raise any queries these can be sent to the writer of this draft, Ian Bottomley at Oxfordshire Clinical Commissioning Group ian.bottomley@oxfordshirepct.nhs.uk

**The deadline for responses is 16TH MAY 2012**

All responses to the survey will be used to form a report on the consultation which will be used to finalise the strategy. The report will form an appendix to the final strategy.

## Vision-what are we trying to achieve? (Section 4, page 7)

1 We believe all people living with disability should have the right and the opportunity to fulfil their potential.
2 We believe that we can translate this ambition into practice through an approach designed to deliver the following outcomes

- The best possible assessment, care and support
- Helping people live as independently as possible for as long as possible through approaches that support prevention and enablement
- A better deal for carers that recognizes both their role in supporting the delivery of this vision, and their own needs within that role
- A model of care that works now and in the lifetime of this strategy, which can deal with increasing pressure on budgets and which is accountable to people with physical disability and the wider population of Oxfordshire

## Outcomes: What would success look like? (Section 5, page 8)

1 If this strategy is successful people living with physical disability …

- will have the same choices as anyone else.
- should be supported to meet their ambitions and aspirations
- should have the information, care and support to motivate and enable them to live as independently as possible for as long as possible.
- And commissioners will be able to demonstrate that they are delivering these outcomes, and are managing effectively with the money available.

2 We will work out how successful we have been by measuring

- How easily people can find information about support
- How many people feel supported to manage their own condition
- how many people living with a physical disability are in a job
- the number of people who have to go into hospital in an unplanned way and how often this happens
- how many people using social care receive self directed support and how many receive direct payments
- how many people who use services feel safe
- how satisfied carers are with the quality of their lives

## Scope: who and what services are covered by this strategy? (section 6, page 11)

- People aged 18-65 who meet the definition of disability in the Equality Act
- People with neurological and other long-term conditions who might meet the definition of the disability at some point in the course of their life and for whom preventative services may help them maintain independence
- People with an Acquired Brain Injury
- Children and Young People in transition to adult services
- Older people who do not otherwise meet the thresholds for care who have a long-term condition and may benefit from preventative services
- Older people with disability who are transitioning to older people’s services
- All those community assessment and health and social care services that are designed to meet the needs of people with physical disability
- Those physical and mental health services based in hospital that are designed to help people living with a physical disability return to the community with the maximum level of independence
- Personal budgets in social care and health
- Housing and housing support services for people with physical disability
- Employment services
- Equipment and transport services for people with physical disabilities

## Plan of action: how might the strategy be delivered? (section 9, page 13)

The full draft strategy sets out a list of actions that we could take to ensure that we are successful. We believe that the main areas for action are to

- Ensure that any assessment for physical care or support, mental health, and support for carers, or equipment should be built around the needs of the individual and their carer
- Ensure that people living with a physical disability should be able to access services easily and be able to return to them quickly after any gap in use
- Review and commission new preventative and reablement services that help people to live independently in the wider community
- Ensure we address the needs of children and young people coming into adult services
- Ensure that services should meet the specific needs of people from minority groups protected under the Equality legislation
- Implement the Oxfordshire Physical Disability housing strategy
- Review the options for helping people retain or get into work

## Getting started (section 10, page 21)

A full implementation plan, with our priorities for action will be published after we consider the feedback from consultation in June 2012. The strategy will be live from July 2012.

Oxfordshire Clinical Commissioning Group

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# A Joint Physical Disability Commissioning Strategy for Oxfordshire

## 1. Introduction:

1.1 Oxfordshire County Council and Oxfordshire Clinical Commissioning Group intend to develop a joint health and social care commissioning strategy to meet the needs of people living in the County with physical disability.

1.2 The County Council and the Clinical Commissioning Group currently put social care and health funds together within a s75 NHS Act 2006 pooled budget. This fund seeks to address the needs of people with physical disability alongside the needs of older people.

1.3 Oxfordshire County Council is responsible for meeting the social care and support needs of people with a physical disability in the county.

1.4 Oxfordshire Clinical Commissioning Group is the body that will in future commission health services in line with the Health and Social Care Bill. From April 2012 the Clinical Commissioning Group takes shadow responsibility for this activity from Oxfordshire Primary Care Trust. Formal legal transfer of responsibility will take place in April 2013.

1.5 The County Council and the Clinical Commissioning Group believe that a joint commissioning strategy supported by a dedicated pooled budget arrangement will better meet the needs of people with physical disability. A joint commissioning strategy will support a more integrated approach to care where services are built around the individual and reflects his or her individual needs. This will deliver better outcomes and help people to live as independently as possible for as long as possible.

1.6 This document is a draft. It has been developed through conversations with a range of patients and service users, carers and voluntary organizations, social work professionals, clinicians and GPs. These groups, and what they told us, are listed at Appendix 1.

1.7 The County Council and the Clinical Commissioning Group invite views on this draft commissioning strategy. They aim to agree a joint strategy, including their priorities for action by July 2012. The final agreed strategy will provide a work plan for commissioners for the period 2012-15. The County Council and Clinical Commissioning Group intend that the final commissioning strategy should accurately reflects the needs of disabled people in Oxfordshire and their carers , and that its aims, intended outcomes and priorities for action are informed by the views of the people who will be supported by the strategy, and those that will deliver it. The report on this consultation will form an Appendix to the final strategy.

## 2 What is a *Commissioning Strategy*?

2.1 This is a draft joint *commissioning* strategy. The final version will

- Identify the outcomes that are required and how these outcomes will be measured
- Support the design of any services the commissioners will buy from providers (health, social care, voluntary and community or independent sector) to deliver these outcomes
- Support the design of the procurement and contracting model: how these services will be purchased, how they will be contracted, how this will fit with other models such as personalization, self-help and peer support
- Set out our quality expectations of any contracts that are issued to deliver the outcomes
- Set out the timeframe for this activity
- Assess the needs over the lifetime of the strategy and allocate the resources available to deliver the outcomes
- Set out the accountability, assurance, and governance arrangements that will ensure and demonstrate that the strategy is meeting its intended outcomes

## 3. How do you have your say?

**Unlimited** is running a consultation regarding this draft strategy on behalf of the Commissioners to get the public's views on what disabled people need. Unlimited is a user led organisation of people living with a physical or a sensory disability. Unlimited are represented on the Physical Disability Joint Management Group that manages the budget for people living with a physical disability. They have been set up to handle issues related to physical disability and can be contacted on 0845 121 4112.

The Commissioners want views on this new draft strategy to meet the needs of people living in the County with a physical disability. You can comment on the strategy using the survey designed by Unlimited. The survey can be filled in on-line at http://www.oxfordshireunlimited.org/ or http://www.oxfordshire.gov.uk/cms/public-site/consultation

Unlimited will be facilitating a number of events for service users and carers which will be publicized locally. For more information please contact Unlimited through their website or on the number above.

We would prefer responses to the consultation to use the survey, but if you wish to send in any other comments or raise any queries these can be sent to the writer of this draft, Ian Bottomley at Oxfordshire Clinical Commissioning Group ian.bottomley@oxfordshirepct.nhs.uk

**The deadline for responses is 16TH MAY 2012**

All responses to the survey will be used to form a report on the consultation which will be used to finalise the strategy. The report will form an appendix to the final strategy.

## 4. Vision

4.1 Oxfordshire believes all people living with disability should have the right and the opportunity to fulfil their potential.

4.2 Oxfordshire believes that the best way of achieving this ambition is to adopt the social model of disability, and to develop and implement this strategy using an approach based on co-production. So this strategy is not driven by medical diagnoses, and it will not be delivered by "doing things to people"

4.3 Instead Oxfordshire believes that the way in which we can translate this ambition into practice is through an approach designed to deliver the following outcomes

- The best possible assessment and care and support
- Helping people live as independently as possible for as long as possible through approaches that support prevention and enablement
- A better deal for carers that recognizes both their role in supporting the delivery of this vision, and their own needs within that role
- A model of care that works now and in the lifetime of this strategy, which can deal with increasing pressure on budgets and which is accountable to people with physical disability and the wider population of Oxfordshire

4.4 This vision supports Oxfordshire County Council's Corporate objective to achieve *Healthy and Thriving Communities* and *Efficient Public Services*. It supports Social and Community Services strategic aims to deliver Prevention, Personalization, Protection and Partnerships.

4.5 The vision supports the Oxfordshire Clinical Commissioning Group intention that all patients will receive the right care in the right place first time, and that wherever appropriate and safe the patient should be enabled to sleep in their own bed at night

4.6 This vision supports the developing Health & Wellbeing Strategy for Oxfordshire which aims to

- Make real improvements to the health of the people of Oxfordshire
- Reduce inequalities
- Expand and develop life chances for people
- Ensure that people who use services experience "nothing about us without us"
- Maintain or improve quality of care and support
- Make more efficient use of services and public money

.

## 5. Outcomes: what is this strategy trying to achieve? What would success look like?

5.1 The needs of people living with physical disability have been considered both nationally and locally on several occasions. There is a current national consultation entitled *Fulfilling Potential*. These reports are detailed at Appendix 3. Essentially the aspirations of people with disability are the same as those of anyone who does not live with a disability:

> *As regards my own sense of what is important to me, I like to be properly included in discussions and actions regarding my health and care. I have largely self-managed my disability throughout the 47 years it has been a part of my life. I don't want to lose that…care should be enabling, it should enable me to live as active a life as is possible, both physically and intellectually.*
> [Person living with Physically Disability]

If this strategy is successful

- people living with physical disability will have the same life choices as someone without a physical disability.
- They should be supported to fulfil their ambitions and aspirations
- They should have the information, care and support to motivate and enable them to live as independently as possible for as long as possible.
- Commissioners will be able to demonstrate that they are delivering these outcomes, and are achieving the best possible use of resources.

5.2 The outcomes set out in the Vision above were identified in the development of this draft strategy. Based on feedback from service users, carers and professionals to this draft document, the detailed outcomes might include the following.

5.2.1 **A better experience of care**: *much more real co-ordination and co-operation between the organisations that have an input in to health and care issues* [Person with Physical Disability]

- People living with a disability will experience a holistic assessment of their needs. This will include appropriate expert input relevant to their condition as necessary. It will include such matters as support to maintain independence, equipment, the needs of their carers, mental as well as physical health.
- People living with a disability will experience a *personalized approach* to needs assessment and care planning. Self-directed support and personal budgets will deliver choice and control, and better outcomes for the individual. Our systems for delivering self-directed support will not create unintended unreasonable burdens to the person and their carer.
- Everyone who needs one should have a care plan that sets out who is responsible for their care, who they should contact when they need help, a plan for managing crises, and what elements of the plan the person will deliver for him/herself
- People living with a disability will have packages of care that meet Care Quality Commission standards. We will support these quality measures with personal feedback from the people receiving the service, and those who care for them.
- People living with a disability will have a positive and effective experience of general medical care.
- Children and Young People, and their carers will experience an orderly and personalized transition to adult services
- Older people with physical disability will experience an orderly and personalized transition to older person's services where necessary, but would remain within the scope of this strategy if there is no clinical or care reason for transfer
- Services must be culturally competent and address the needs of all people with protected characteristics as defined by the Equality Act 2010

5.2.2 **Prevention and independence**: **helping people manage their own lives as independently as possible for as long as possible**

- People living with a disability will be able to access the right information at the right time to help them understand their condition and the options that are available to them to support self-care
- People living with a disability will be able to access support that helps them plan and manage better, and live more independently for longer prior to meeting the threshold where they qualify for social care

- People living with a disability will be encouraged to develop care plans that are built on the principle of living as independently as possible
- People living with a disability will be able to access assessment and care in way that flexes around the individual, putting in support when it is needed in such a way that it can be easily "stood up or stood down"
- People living with a disability will be able to use personal social care and (where possible) health budgets to support their needs in the wider community
- People living with a disability will have access to a range of housing options that will help them live independently
- People living with a disability will have access to opportunities for meaningful activity that support independence
- People living with a disability will be supported to retain and/or access employment
- People living with a disability will have access to the wider community and will not live in isolation

5.2.3 **A better deal for carers**: *we were told if we had any problems we should ring 999. As it was the only people who gave us the help we needed were the paramedics.* [Carer of someone with neurological condition]

- Carers' needs will be assessed as part of the same process as the needs of the person they care for
- Carers will have access to the right information at the right time to help them understand the needs of the person they care for and the options that are available to them
- Carers will have access to forms of respite care that reflect their needs and the person they care for

5.2.4 **A model of care that works** now and in the lifetime of this strategy, **which is sustainable** at times of increasing pressure on health and social care budgets and **which is accountable** to people with physical disability and the people of Oxfordshire

- We will bring together the various health and social care budgets needed to deliver this strategy in one pooled budget
- We will develop a financial plan which supports preventative and self-help approaches and meets need from the within the allocated resources
- We will develop a dedicated body within the developing Health & Wellbeing Board structures to deliver this strategy for Oxfordshire with appropriate involvement and participation from the people who use services and those who care for them
- We will align this strategy with those external strategies that impact on its delivery
- We will monitor performance against the outcomes specified in this strategy and within the Health & Wellbeing Board reporting structure, and review this strategy and the Commissioning Intentions annually

5.3 **How will success in meeting these outcomes be measured?** There are national and local targets that the strategy needs to deliver through the new Health & Wellbeing structures arising out of the Health and Social Care Bill. The Adult Health and Social Care Partnership Board for Oxfordshire plans to

- increase the proportion of people who use services or who care for them who find it easy to find information about support
- increase the proportion of people feeling supported to manage their own condition
- increase the employment of people living with a physical disability
- reduce unplanned hospitalisation for chronic conditions
- increase proportion of people using social care who receive self directed support and receive direct payments
- increase the proportion of people who use services who feel safe
- increase carer reported quality of life

5.4 The Adult Health and Social Care Partnership Board will also require that this strategy is delivered within budget, and that it meets any efficiency targets that are set in the future.

5.5 These measures will broadly indicate if this strategy is successful in delivering the outcomes identified above, but in the lifetime of this strategy it will be necessary to develop more sensitive user and carer feedback monitoring to provide assurance that the strategy is working.

## 6. Scope: who and what services are covered by this strategy?

6.1 The Joint Physical Disability Strategy for Oxfordshire is designed to meet the needs of adults aged from 18-65 and to deliver the outcomes set out below. In terms of physical disability it is possible to describe 3 broad groups of people:

- Those people with a lifelong disability and/or people who became disabled in childhood
- Those people who become disabled following some trauma (accident, impact of illness), including those with Acquired Brain Injury
- Those people with a long-term condition who become disabled as a consequence of their illness: this may include people with a neurological condition, as well as people with illness such as diabetes or chronic obstructive pulmonary disease.

6.2 This strategy is not designed to address specific diagnoses, but rather will seek to address the needs of people meeting the definition set out in the *Equality Act 2010*

- A person has a disability if:
    - they have a physical or mental impairment
    - the impairment has a substantial and long-term adverse effect on their ability to perform normal day-to-day activities
- For the purposes of the Act, these words have the following meanings:
    - 'substantial' means more than minor or trivial
    - 'long-term' means that the effect of the impairment has lasted or is likely to last for at least twelve months (there are special rules covering recurring or fluctuating conditions)
    - 'normal day-to-day activities' include everyday things like eating, washing, walking and going shopping

6.3 Currently the needs of people with a physical disability are addressed as part of the Older People and Physical Disability pooled budget between the County Council and the NHS. However, this budget does **not** include all of the expenditure on health

and social care that might support someone with a physical disability in order to help them meet the outcomes above. Therefore this strategy needs to consider other services provided within the current health and social care commissioning. A list of services that might be included are set out in Appendix 5.

6.4 This strategy also needs to consider its relationship to services commissioned by other agencies such as housing (District councils), housing support (Oxfordshire Supporting People, employment services (Department of Work and Pensions), travel and so on.

6.5 The age range within the strategy is determined by the historical way in which health and social care services have been commissioned in Oxfordshire. Although the strategy is designed to meet the needs of people aged 18-65, it will need to identify how it will help children and young people make the transition to adult life, and older people.

6.6 The strategy should meet the needs not just of those people who meet the thresholds for social care, but it should develop responses that meet the needs of people who are still living independently so that they can continue to live as independently as possible as long as possible.

6.7 ***People and services within scope of the strategy***

- People meeting the definition of disability in Equality Act aged from 18-65
- People with neurological and other long-term conditions who might meet the definition of the disability at some point in the course of their life and for whom preventative services may help maintain independence
- People with an Acquired Brain Injury
- Children and Young People in transition to adult services
- Older people who do not otherwise meet the thresholds for care who have a long-term condition and may benefit from preventative services
- Older people with disability who are transitioning to older people’s services
- All community assessment and health and social care services designed to meet the needs of people with physical disability set out in Appendix 5
- Those physical and mental health services based in hospital that are designed to help people return to the community with the maximum level of independence
- Personal budgets in social care and health
- Housing services for people with physical disability
- Employment services
- Equipment and transport services for people with physical disabilities

6.8 ***People and services outside of the scope of this strategy***

- The needs of people with sensory impairment. This group was considered in connection with this strategy, but there is a proposal that there should be a dedicated strategy for this work. However, there is much that this Joint Physical Disability strategy can learn from the rehabilitative approach adopted in sensory impairment approaches. The two strategies will need to have a relation to each other.
- GP services and pharmacy. Although services in primary care will be a key part of the integrated care pathway for people living with physical disability, these specific services will not be commissioned locally in Oxfordshire in the new health structures.

- Acute in-patient health services. This strategy starts from the premise that it should be helping prevent people going into hospital in an unplanned way, and should be working to help people return home to a life of independence and self-care. Rehabilitative services are therefore within scope, but medical care within the hospital setting is not.

## 7. The level of need in Oxfordshire

7.1 The development of this strategy has not been informed by a formal needs assessment. Oxfordshire County Council's current strategy *Promoting Independence* did consider this in 2009-10 and a summary of its findings is presented at Appendix 4
7.2 Further to that needs assessment there are a number of additional factors that support the case for the outcomes set out above:

- The Physical Disability expenditure within the current s75 NHS Act Older People and Physical Disability pool has been consistently over budget. The County Council has committed further investment to address this.
- Service user, professional and carer feedback as set out in Appendix 1 tells us that more needs to be done to deliver quality services and support independence for people living physical disability
- The reports set out at Appendix 3
- The requirements of the Equality Act 2010 that require commissioners to develop culturally competent services

## 8. Resources available to support the delivery of this strategy

8.1 The expenditure on the needs of people with physical disability that is within the Older People/Physical Disability budget does not represent all of the resource that support the needs of this group. In addition to some specific health and social care budgets, there are the costs of staff employed by the County and the NHS who actually deliver services (staff costs for external organizations are included already). These budgets and resources need to be mapped into the final strategy. See Appendix 5.
8.2 A number of the priorities for action listed below represent work streams that are already being taken forward. These resources may also need to be mapped into the final strategy. These initiatives are set out in Appendix 2.
8.3 The structure of commissioning both within the County Council and within the Clinical Commissioning Group is currently under review, and so the resource that may be available to implement this strategy is not yet certain. This work will form part of the portfolio of the Lead Commissioner for Adults at the County Council.

## 9. Plan of action: how might the strategy be delivered?

9.1 Respondents to the preliminary engagement activity have urged commissioners to set out how this strategy will be implemented, how we might deliver the outcomes if they are endorsed through consultation. The view is that potential respondents to the consultation will be better placed to give their views if they can understand the implications on the ground.

9.2 Therefore a list of ***possible*** actions to implement the strategy are set out below as draft *Commissioning Intentions*. This list is intended to illustrate how the strategy might be put into action.

9.3 This strategy has not been developed and will not be delivered in isolation. The strategy will be delivered in some areas through existing work-streams. These are highlighted in the draft *Commissioning Intentions* below and listed at Appendix 2.

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**9.4. Draft Commissioning Intentions to deliver the outcomes of the Joint Physical Disability Strategy**



| Strategic Outcome | Draft Commissioning Intention | Output-what might possibly be done to deliver the commissioning intention<br><br>Where this builds on existing work these are highlighted and further details appear in Appendix 2 |
|---|---|---|
| **People living with physical disability will have a better experience of care/support** | People living with a disability will experience a holistic assessment of their needs | ▪ Specify needs of people with PD within the developing integrated care teams<br>▪ Ensure that the integrated care teams include specialists such as Physical Disability Physiotherapists and Community Neuro nurse specialists<br>▪ Ensure that relevant 3rd sector agencies are involved in integrated care planning as appropriate<br>▪ Build holistic approaches to assessment into preventative services |
| | People living with a disability will experience a *personalized approach* to needs assessment and care planning. | ▪ Ensure that integrated care planning is built around and owned by the individual<br>▪ Ensure that relevant 3rd sector agencies are involved in integrated care planning as appropriate<br>▪ Ensure that integrated care planning includes self-care and reablement planning to support independence with scope for review<br>▪ Ensure that the personalized approach works through the patient pathway |
| | Everyone who needs one should have a care | ▪ Ensure that the model of integrated care planning |

| Strategic Outcome | Draft Commissioning Intention | Output-what might possibly be done to deliver the commissioning intention<br><br>Where this builds on existing work these are highlighted and further details appear in Appendix 2 |
|---|---|---|
| | plan that sets out who is responsible for their care, who they should contact when they need help, a plan for managing crises, and what elements of the plan the person will deliver for him/herself | includes a plan that can be used to support the needs of people with physical disability |
| | People living with a disability will be able to access community support at times of a health crisis | ▪ Develop a "crisis" service to provide 24/7 support, learning from the current County pilot for older people |
| | People living with a disability will be assessed for and offered support in respect of their mental health needs | ▪ Ensure that mental health screening forms part of the care assessment<br>▪ Integrate this into the developing Mental health for long-term conditions planning<br>▪ Review mental health support around diagnosis for potentially disabling long-term conditions |
| | People living with a disability will have packages of care that meet Care Quality Commission standards | ▪ Continue to review all care packages and placements against CQC standards and take action as necessary<br>▪ Review user and carer feedback mechanisms |
| | People living with a disability will have a good experience of general medical care. | ▪ Commission user-led training for GPs and other health professionals<br>▪ Ensure that integrated care planning has "red flags" to be triggered when people go into |

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| Strategic Outcome | Draft Commissioning Intention | Output-what might possibly be done to deliver the commissioning intention<br><br>Where this builds on existing work these are highlighted and further details appear in Appendix 2 |
|---|---|---|
| | | hospital for elective surgery<br>▪ Improve flagging of people with neurological conditions to specialist staff from general wards |
| | Children and Young People, and their carers will experience an orderly and personalized transition to adult services | Review current transition arrangements and services. |
| | Older people with physical disability will experience an orderly and personalized transition to older person's services where necessary, but would remain within this strategy if there is no clinical or care reason for transfer | Build monitoring of these arrangements into contract reviews. |
| | Services must be culturally competent and address the needs of all people with protected characteristics as defined by the Equality Act 2010 | • Develop a cultural toolkit to support assessment and care planning in integrated care planning and other commissioned services<br>• Adopt the toolkit within procurement and contracting processes |
| | People living with a disability will be able to access the right information at the right time to help them understand their condition and the options that are available to them to support self-care | ▪ Ensure that appropriate information is available to teams involved in integrated care planning<br>▪ Review information services available in Oxfordshire<br>▪ |
| | People living with a disability will be able to access support that helps them plan and | ▪ Review the current day service provision, and seek to commission information, well-being and |

| Strategic Outcome | Draft Commissioning Intention | Output-what might possibly be done to deliver the commissioning intention<br><br>Where this builds on existing work these are highlighted and further details appear in Appendix 2 |
|---|---|---|
| **People living with a physical disability will be supported to live independently and achieve their full potential** | manage better, and live more independently for longer prior to meeting the threshold where they qualify for social care | support services that provide advice, orientation, information and help with self-care for people for people still able to live independently<br>▪ Review the role of user led or peer support approaches |
| | People living with a disability will be able to access assessment and care in way that flexes around the individual, putting in support when it is needed in such a way that it can be easily "stood up or stood down" | ▪ Develop a model of care planning within the social care pathway that allows people to access services in a way that reflects their fluctuating needs<br>▪ Ensure people can access specialist health advice in the community when they need it<br>▪ Review and clarify the range of support available across community and acute health services, and the pathway across them |
| | People living with a disability will be encouraged to develop care plans that are built on the principle of living as independently as possible | ▪ Develop motivational approaches and peer-led examples that encourage hope, ambition and goal setting within care planning, at all levels |
| | People living with a disability will be able to use personal budgets to support their needs in the wider community | ▪ Support the current review of brokerage options to develop a package where people can draw down brokerage support as their needs change, and to mitigate some of the pressures of holding a personal budget<br>▪ Work with User Led organizations and providers |

| Strategic Outcome | Draft Commissioning Intention | Output-what might possibly be done to deliver the commissioning intention<br><br>Where this builds on existing work these are highlighted and further details appear in Appendix 2 |
|---|---|---|
| | | to develop the market place for people holding personal budgets |
| | People living with a disability will have access to a range of housing options that will help them live independently | ▪ Implement Oxfordshire Physical Housing Plan (2011-15);<br>○ Develop new accessible homes including supported living to meet local needs<br>○ Adapt existing homes to make the best use of grant resources<br>○ Create an easy system for people to find a solution to their housing need through advice and support and the ability to find available properties across different tenure types<br>○ Provide an adequate level of support for those who need it to live an independent life |
| | People living with a disability will have access to opportunities for meaningful activity that supports independence | ▪ Promote a range of self-help activities in the community that increase a sense of achievement, confidence and independence<br>▪ Support providers around “reasonable adjustments” to meet Equality requirements |
| | People living with a disability will be supported to retain and/or access employment | ▪ Review employment options for people living with a physical disability, with a view to commissioning a service that supports access to |

Oxfordshire Clinical Commissioning Group

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NHS Buckinghamshire and Oxfordshire Cluster

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| Strategic Outcome | Draft Commissioning Intention | Output-what might possibly be done to deliver the commissioning intention<br><br>Where this builds on existing work these are highlighted and further details appear in Appendix 2 |
|---|---|---|
| | | jobs as well as job retention |
| | People living with a disability will have access to the wider community and will not live in isolation | ▪ Encourage the development of peer support, user led and facilitated groups that enable people to build friendships, offer mutual support and develop their own plans to fulfil their potential |
| **Carers of people with physical disability will be better able to manage their caring role** | Carers' needs will be assessed as part of the same process as the needs of the person they care for | ▪ Ensure carers' needs are considered within the integrated care planning teams |
| | Carers will have access to the right information at the right time to help them understand the needs of the person they care for and the options that are available to them | ▪ Ensure that the same information available to patients/service users is available to carers<br>▪ Ensure that carers are offered "orientation" around diagnosis to support longer-term planning, and managing expectations |
| | Carers will have access to forms of respite care that reflect their needs and the person they care for | ▪ Identify and bring together dedicated carers' budgets<br>▪ Inform the review of Carers services in Oxfordshire: identify the specific needs (if any) for carers for people with physical disability |
| | We will support the carer-cared for relationship in a way that meets the needs of both parties | ▪ Where indicated by mental health screening, or where requested by the parties we will seek to develop a family therapy capacity to support the care planning process |

| Strategic Outcome | Draft Commissioning Intention | Output-what might possibly be done to deliver the commissioning intention<br><br>Where this builds on existing work these are highlighted and further details appear in Appendix 2 |
|---|---|---|
| **A model of care that works now and in the lifetime of this strategy, which is sustainable at times of increasing pressure on health and social care budgets and which is accountable to people with physical disability** | We will bring together the various health and social care budgets needed to deliver this strategy in one pooled budget | ▪ We will draw together the relevant budgets to form one pooled budget for physical disability from April 2013 |
| | We will develop a financial plan which supports preventative and self-help approaches and meets need from the within the allocated resources | ▪ We will identify resources to support preventative approaches as detailed above on an invest to save basis<br>▪ We will review the costs of care packages as part of contract negotiation<br>▪ We will explore payment structures that incentivise reablement and allow for reduction of care packages |
| | We will develop a dedicated body to deliver this strategy for Oxfordshire with appropriate involvement and participation from the people who use services and those who care for them | ▪ We will develop an interim body within the current JMG to take this work forward from April 12<br>▪ We will develop a dedicated Physical Disability Joint Management Group reporting to the Adult Health and Social Care Partnership Board from April 13 |
| | We will align this strategy with those external strategies that impact on its delivery | Influence outcomes of the following strategies through representation on the following strategies in development<br>• Equipment strategy |

| Strategic Outcome | Draft Commissioning Intention | Output-what might possibly be done to deliver the commissioning intention<br><br>Where this builds on existing work these are highlighted and further details appear in Appendix 2 |
|---|---|---|
| | | • Information strategy<br>• Integrated Community Services development<br>• Transport<br>• Physical Disability Housing Plan<br>• Stroke pathway development<br>• Review of Carers strategy<br>• Oxfordshire End of Life Strategy<br>• Oxfordshire Supporting People<br>• Sensory Impairment Strategy |
| | We will monitor performance against the outcomes specified in this strategy and within the Adult Health and Social Care Partnership Programme Board, and review this strategy and the Commissioning Intentions annually | ▪ We will set annual Key Performance Indicators for the Joint Management Group<br>▪ We will review these KPI annually in line with our Commissioning Intentions |

## 10. Implementation: a possible time-line for this strategy

10.1 This strategy is designed to run for 3 years at a time of considerable change in the commissioning environment both within health and within social care. Therefore in some cases the commissioning intentions need to be phased over the lifetime of the strategy, and reviewed annually to check progress and developing priorities.

10.2 A final timeline will not be published until the strategy has been agreed but there are priorities partly driven by external factors:

| Deadline | Activity |
|---|---|
| July 2012 | Adopt joint commissioning strategy<br>Agree interim governance arrangements within current joint management group<br>Identify commissioning support resource to implement strategy |
| Mar 2013 | Ensure needs of people with disabilities are built into Oxfordshire's integrated community services development<br>Review preventative day services and commission in line with strategy<br>Review housing support provision with Oxfordshire Supporting People<br>Align the strategy with other strategic developments and ensure they map back to this strategy<br>Develop a financial plan for 2013-14 |

## 11 Risks

**11.1** There are a number of high level risks associated with the development of this strategy

| Risk | Mitigation |
|---|---|
| There is a risk that the draft strategy does not reflect the needs and aspirations of people with physical disability in Oxfordshire | The process of consultation and the prior engagement mean that all people affected by this strategy will be able to have their say. This should endorse the strategy or indicate where it needs to change |
| There is a risk arising from the rapidly changing health, social care and commissioning environment that the strategy does not map onto local and national drivers | The strategy is owned by the Older People/Physical Disability Joint Management Group, and has been developed to meet the objectives of the Oxfordshire system. The strategy will be reviewed in the light of the outcome of the national strategy, *Fulfilling Potential* |
| There is a risk that there are insufficient resources to support the implementation of the strategy | This issue will be addressed by the OPPD JMG prior to approval of the strategy |

## 12 Timeline for the development of this strategy

12.1 The next steps for this strategy are as follows

- Consultation phase 16 April to 18 May

- Consultation report: 11th June
- Develop Commissioning Intentions and Implementation Plan in the light of Consultation report by 15 June
- Final draft strategy to Older People and Physical Disability Joint Management Group for approval 22 June
- Strategy adopted through Oxfordshire County Council and Oxfordshire Clinical Commissioning Group governance processes by 31 July 2012

## Appendix 1-People consulted in the preparation of this draft strategy and what they had to say

In the period January to March 2012 we sought views from a number of stakeholders on the scope of this draft strategy and what they saw as the priorities for action. The groups we met were

- Abbey Wanderers user group (Abingdon)
- West Oxfordshire MS User Group
- Headway Carers and User Group
- OXSRAD Neurological Conditions group (users and carers)
- Oxfordshire Unlimited
- Oxfordshire Clinical Commissioning Group: South-East, North-East and City GP locality groups
- Oxfordshire Neurological Long term conditions implementation group
- Oxfordshire Supporting People Core Strategy Group
- Staff from Oxfordshire County Council, including Oxfordshire Employment Service and operational managers from adult and children and young people's services

In addition we received a number of responses to a discussion paper from professionals and service users and carers.

The key themes from this feedback were:

- Independence
- Quality of Care
- Prevention
- Support for carers

There were a number of elements to these themes that cut across each other. There was broad support for the idea that a future strategy should

- Not be based on diagnosis
- Should have a strong emphasis on prevention and reablement
- Deliver a model of care that is personalized, based on holistic assessment, flexes according to the needs of the individual and seeks to mitigate rather than heighten the pain, exhaustion and stress that is often attendant on long-term disabling conditions

Respondents raised the possibility that there may be broadly 3 different types of disability and suggested that these may benefit from some specific approaches:

| "type of disability" | "specific approach" that might be a priority |
|---|---|
| Lifelong levels of disability (possibly including trauma disability that began in childhood); | transition into adult life |
| Trauma-based disability (including Acquired Brain Injury) that "happens" at any time and can lead to a sudden and dramatic change of life | Support around "orientation" for user/carer over and above "standard" assessment and review |

| Disability arising out of long-term (particularly neurological) conditions | Opportunities for peer supported and user led initiatives that help people "life plan" before they meet the formal thresholds for care |
|---|---|

Respondents acknowledged that these 3 categories are not always clear cut.

Priorities identified by our respondents:
*Assessment and review*
- Must be timely and holistic.
- Must have an "easy-in"/crisis support approach.
- Must include carers needs
- Must be clear on the scope and the offer-strong sense at the moment that people feel they need to be good advocates for their own needs
- Must include Mental Health needs: help at point of diagnosis; support around orientation post diagnosis; psychological well-being; maybe family therapy
- People made the case for specific pathway approaches for some conditions- such as for Acquired Brain Injury or Huntingdon's disease?

*Personalization*
- The *personalized approach* is vital; but we need to recognize the potential burden of personalized budgets, particularly on carers
- Lack of a market place-and fear that services may not be there for people holding personal budgets

*Prevention*
- There are 2 issues: (1) the question of supporting people in such a way that they can live as independently as possible for as long as possible; and (2) mitigating the impact of short term crises so that people do not suffer significant deterioration. People describe the experience of unplanned hospital admission as being particularly difficult.
- Information. People have different approaches to this. Many people describe how they rely on their specialist nurses/people to relate the available information to their specific needs and peer support. Many people describe "finding out for yourself" to be a key part of maintaining independence/motivation. But carers describe the sense of information being "privileged". That useful info is only available after digging/hassling people.

Independence
- Strategy needs to align with developing housing plan . Sense that it may work best if we commit to an integrated pathway approach which governs the various aspects of housing: Disabled Facilities Grants; floating support; suitable housing provision; support in the private sector.
- Employment. Needs a 2 way focus: job retention and getting employment. Need to understand the "offer" to potential employers, and decide how we deliver reablement/employment or a join up of the two approaches
- Equipment and travel: -when it is not available-it is a problem. There seems to be a variety of experience amongst professionals and service users

Carers
- Burdens created by personalization, crisis management
- Need for family therapy.

## Appendix 2-local initiatives mentioned in this draft strategy

**1. Integrated health and social care.** Oxfordshire is developing a more integrated approach to providing health and social care services in the community to support better outcomes. It aims to offer patients, GPs and hospitals one quick and simple route to joined up care based in the community that will enable patients to stay in their usual place of residence as much as possible – regardless of how many different community based health and social care specialists are involved in providing them with that care. The key features of this service are

- A single point of access to community services
- A common assessment process across health and social care, and different disciplines within each area which develops a single integrated care plan owned by a single named care professional for each person
- An approach based on keeping people at home, and helping them return home when they are in hospital

Integrated community teams are in development and will be implemented across Oxfordshire during the lifetime of the strategy. T**his strategy must incorporate and map onto this development to address the health and social care needs of people with physical disability.**

2. **The Joint Housing Strategy for People with Physical Disabilities** is the first joint County and District strategy to improve the availability and access to adapted or accessible properties. It specifically looks at the needs of those aged between 18 and 65 but in practice the improvements will also affect provision to older people and families with children with a disability. The strategy recommends a 4 pronged approach to addressing this issue

- Develop new accessible homes to meet local needs
- Adapt existing homes to make the best use of grant resources
- Create an easy system for people to find a solution to their housing need through advice and support and the ability to find available properties across different tenure types
- Provide an adequate level of support for those who need it to live an independent life
- The strategy has an action plan and was designed to be delivered across the period 2011-14. An OPDHG ( Oxfordshire Physical Disability Housing Group )has been established consisting of senior officers across the districts and county to facilitate the implementation of the strategy. The first meeting is planned for the 27 February 2012.  It is suggested that this work is incorporated into the new joint strategy

**3. Oxfordshire Supporting People** provides a range of housing support services for people with Physical Disability. A strategic review of these services has been recently been undertaken and has concluded that these services should be aligned within the Joint Housing Strategy and incorporated into the new joint strategy.

## Appendix 3-National and local strategies

1. The current Oxfordshire County Council strategy: ***Promoting Independence, a commissioning strategy for people with a physical Disability 2010-15*** developed action plans to deliver the following priorities:

- improving price and outcomes in care homes
- developing housing and support
- improving accessibility in transport and streets
- improving access to employment
- improving information
- improving home support service countywide
- reviewing present equipment services
- increase access to community involvement
- increase confidence to manage direct payments
- improve outcomes in day care
- the strategy can be read at http://www.oxfordshire.gov.uk/cms/content/promoting-independence

2. The Office for Disability Issues is currently consulting on a proposed national strategy, ***Fulfilling Potential***. The Ministerial foreword identifies the following broad priorities:

- We want to realise the aim of independent living, where "all disabled people have the same choice, control and freedom as any other citizen – at home, at work, and as members of the community. This does not necessarily mean disabled people 'doing everything for themselves', but it does mean that any practical assistance people need should be based on their own choices and aspirations"… This Government wants disabled people to be able to achieve their full potential, so that they can have the opportunity to play their role in society. It is critical that wherever we can, we remove barriers to enable disabled people to fulfil their potential.
- The consultation report can be read at http://odi.dwp.gov.uk/odi-projects/fulfilling-potential.php
- The outcome of this consultation is expected in May. It's findings will be reviewed and incorporated into the final strategy.

3. The *Sayce Review* considered particularly the national role of employment in supporting independence and well-being and how this could be delivered. Its recommendations:

- Employment matters. Work is positive for health, for income, for social status and for relationships. Employment is a core plank of independent living and for many people work is a key part of their identity.
- Public money should be used to deliver the best outcomes – for as many people as possible, on the most equitable basis possible.
- There should be a clear recognition of the role of the individual, the employer and the State in achieving equality for disabled people.
- Disabled people should have choice and control over the support we need to work. Resources and power should be allocated to individuals who, where they wish, have the right to control that resource to achieve agreed outcomes.
- There is a clear role for specialist disability employment expertise – as a resource not a world apart from mainstream support – available to those

who demonstrably have the greatest support needs and/or labour market disadvantage, and also to those who support or employ them.
- The report can be read at http://www.dwp.gov.uk/docs/sayce-report.pdf
- The government has now published a response which can be read at http://www.dwp.gov.uk/consultations/2011/specialist-disability-emp-prog.shtml

4. The National Audit Office has recently reviewed the impact of the National Service Framework for Long-Term Neurological Conditions. The original framework had the following 11 objectives:
    - A person-centred service
    - Early recognition, prompt diagnosis and treatment
    - Emergency and acute management
    - Early and specialist rehabilitation
    - Community rehabilitation and support
    - Vocational rehabilitation
    - Providing equipment and accommodation
    - Providing personal care and support
    - Palliative care
    - Supporting family and carers
    - Caring for people with neurological conditions in hospital or other health and social care settings.
- The NAO report raises a number of comments re the impact of the NSF. The overall assessment is that the performance of the NSF has been "poor". Whilst there are examples of good practice nationally, and access has improved, there are problems around: diagnosis; information and support for carers; poor co-ordination of ongoing care.

# Appendix 4-Needs Analysis

**National and local analysis**

In Oxfordshire there are 439,000 people between the age of 18 and 64. Pansi (Projecting Adult Needs and Service Information System) estimates that by 2015 there will be 40,537 people with a physical disability living in Oxfordshire . Of this group 9,007 are reported to have a serious physical disability. The geographic spread across the county is fairly even with Oxford City having a slightly higher number of people at 23%. Thirty six percent of this group are between the age of 55 and 64, in contrast 9% are between the age of 18-24. Local and national statistics show that despite the small numbers there is evidence of younger people living longer with more complex health conditions, for example, Duchene Muscular Dystrophy. An Oxford Brooks University Study predicted there would be 16 more new people in 2011 with an acquired brain injury who would require some level of support.

An analysis of people receiving high and low rate mobility ( DWP: 2011) shows there are 15,875 people receiving high and low rate disability living allowance ( mobility) in Oxfordshire. Approximately 9160 people, 58% of this group receive high rate mobility. Further analysis of both levels show a range of number of people receiving this allowance across the county, for example 26% in Oxford City, 15% in Banbury and on the lower end 3% in both Charlbury, Chipping Norton and Woodstock area and Goring and Henley.

There are currently 796 people (this excludes people funded in care home ) living in the community receiving assistance through social and community services . These include services like personal budgets, equipment (with no ongoing cost) and day care. An analysis by locality showed that 28% of this group lived in Oxford City, 17% in Banbury as opposed to 3% in Goring and Henley, Grove and Wantage and Burford and Carterton.

**Who are the people with physical disability.**

Broadly speaking there are three groups of people within this group.

1. People who are born with a physical disability, for example, people with spastic quadriplegia ( severe form of cerebral palsy), muscular dystrophy or spina bifida.

2. People who suddenly acquire a trauma based disability for example, a spinal injury accident or an acquired brain injury. The Royal College of Physicians ( 2003) define acquired brain injury as 'an inclusive category that embraces (rapid onset) brain injury of any cause, including:

- Trauma- due to head injury or postsurgical damage
- Vascular accident- stroke or subarachnoid haemorrhage
- Cerebral anoxia or other toxic /metabolic insult
- Infection (for example: meningitis, encephalitis, or other inflammation).'

3. People who acquire a disability, from a long term condition for example multiple sclerosis or rheumatoid arthritis. For some people these conditions fluctuate with rapid declines at times.

A large proportion of the group will be people with neurological conditions. The Oxfordshire Neurological Health Needs Assessment (2011-of people 18 and above) estimated that the prevalence of the most common conditions included traumatic brain injury (7,387), epilepsy (3,087) and chronic fatigue syndrome( up to 2,462) .

## Appendix 5: Finance and Resources

Health and social care financial investment to support the needs of people with physical disability is currently pooled within a s75 NHS Act 2006 pooled budget that covers Older People and Physical Disability.

The contributions to the Pooled Budget in respect of Physical Disability in 2011/12 were as follows:

Oxfordshire County Council: **£6.92m**

This budget covers:
- Placements in care homes
- Support for people in their own homes (including equipment)in older peoples pool

These budgets are spent through personal budgets

- External contracts for day opportunities for people with physical disabilities, including dedicated resource for people with acquired brain injury

Oxfordshire PCT: **£6.28m**

This budget covers
- Continuing Healthcare
- Residential nursing support for people with Acquired Brain Injury
- Delegated healthcare tasks and funded nursing care for people under the care of social services
- Personal health budgets in continuing healthcare

The pooled budget is forecast to overspend by £1.8m in 2011/12, but this pressure has been met by an additional payment from Oxfordshire County Council

There are other areas of expenditure which currently sit outside of the pooled budgets but support the needs of people with physical disability and would currently be considered to be aligned with the pooled budget expenditure:

- Oxfordshire County Council expenditure on care homes and home support for people with acquired brain injury. Budget 2011/12 £305k.
- Supporting people funding for housing and housing-related support. Budget 2011/12 £137k.

There are other areas of expenditure that supports the needs of people with physical disability. In taking forward this work forward, there may be a case for bringing these resources within scope of the strategy:
- Assessment and care planning (staff costs)
- Rehabilitative services, in the hospital and community
- Specialist community services
- Housing and housing support

**Adult Services Scrutiny Committee- 12th June 2012**

## Integrated Community Services - Adult Social Care Scrutiny Briefing

The purpose of this paper is to brief the Adult Social Care Scrutiny committee on why the integrated localities project has been started. The details of what is happing will become clearer over the coming months as the preferred models of integration are developed and agreed.

### 1. Background

i. National framework: The 2012/13 Operating Framework for the NHS in England identifies integration as key to sustainable improvement ("*It will be equally important that, as more decision making is taken locally to reflect the needs of patients and the clinicians who support them, the NHS does more to integrate service delivery, not only across primary and secondary care between mental and physical health but also with social care organisations*"). Recent papers by the Futures Forum have identified that "centrally dictating a model for integration will not work" and any integration "should be around the patient not the system"[1].

While the Association of Directors of Social work see integration as: *"a potential solution to the immense challenge that faces the whole public sector from greatly reduced budgets, changing demography and an increased/different type of demand for services."*

ii. Local Framework: The Oxfordshire Clinical Commissioning Group (OCCG) circulated a commissioning intentions consultation paper in January 2012. The paper was agreed separately by the commissioning arm and the provider services from Adult Social Care. The paper contained details on the outcomes that integration would deliver, and a vision on the key characteristics of an integrated service: "*Patients, GPs and Acute Service providers will have one quick and simple route to well joined up, locality based care that enables patients to stay in their usual place of residence as much as possible – regardless of how many different community based health and social care specialists are involved in providing them with that care."*

iii. Local Expectations: Following the National and local drivers there is an expectation that Oxfordshire begins moving towards integrated community services involving Health and Social Care teams. The establishment of a joint front door to access services is seen as one of the first steps towards integration. The Government has made integration one of the key aims of its radical restructuring of the NHS in England[2]. It is accepted that although integration must not be an aim in itself, it should be something that local authorities consider if it is believed that by working more with others better outcomes can be achieved; improved or faster access to appropriate services or reduced costs to deliver outcomes that are at least as good.

[1] NHS Future Forum Summary Report- Second Phase, 10 January 2012
[2] Dennis Campbell, The Guardian Newspaper, 21st December 2011

iv. Efficiencies

From initial enquiries there is little hard evidence of savings being made elsewhere in the country as a result of integrating social and health care services. Reporting has concentrated on the ‘service benefits’ of integration, such as better access and improved response to growing demand, rather than real savings in terms of reduced expenditure. It is also difficult to separate the savings achieved by a single service, like a single point of access, from a larger integration scheme. However, although not quantifiable there are implied financial savings in the business case below in setting up a Single Point of Access.

## 2. The Integrated Community Localities Project

i. The Project

The Integrated Community Localities Project was formally set up in February 2012 with Oxfordshire County Council Social and Community Services writing a joint Project initiation Document with Oxford Health NHS Foundation Trust following the commissioning intentions paper. Reflected in the Project Initiation document is a decision, by the project board, to deliver a Single Point of Access for Health and Social Care community services. The service is aimed at reducing hospital admissions by General Practitioners (GP’s) and supporting discharge from Acute Hospital settings.

ii. The Project Vision

The vision for the project is to provide a quick and simple route to well joined-up, locality based care that enables patients to stay in their usual place of residence as much as possible. The first phase is for Oxford Health NHS FT to aggregate their service contact numbers into a single telephone contact number for GP’s to refer to. Phase two is the integration of the Adult Social Care social and community services to create a joint integrated service.

iii. The Business Case

The primary reason for setting up the Single Point of Access follows a steer from some of Oxfordshire’s GP’s that navigation into and around community services can, at times, be confusing and difficult. There is anecdotal evidence that due to the complexity of accessing the most appropriate services, and finding the relevant contact points, some GP’s are referring directly to Social Care teams or deferring to hospital admission in cases of emergency.

Some elements of the business case that will benefit Oxfordshire County Council are:

- A reduction in inappropriate referrals to services
- Improved outcomes for patients; reduce unnecessary hospital admissions
- A reduction in number of long term social care placements
- A reduction in Delayed transfers of Care
- Using the Single Point of Access to build a business case for further integration of Health and Social services.

iv. Project stages

The project is split into 3 phases:

a) Phase 1 is Oxford Health NHS FT going live with the Single Point of Access for their community services. The dedicated number went live on April 30th and is accessible by Primary Health staff.

b) Phase 2 is the integration of Social and Community services into the Single Point of Access. An options paper is currently being drafted to determine what the model of integration will look like; it is expected to be low impact by making use of the established processes and referral pathways already existing within the Social and Health Care team. As the Single pint of Access is a dedicated service for Primary Health staff the Social Health Care team will continue to function as it currently does. The current estimated go-live for phase 2 is September 3rd 2012.

c) Phase 3 is the integration of Mental Health services into the single Point of Access with a go-live by October 31st 2012.

## 3. Next steps

v. The proposed model for phase II integration will be finalised and agreed corporately before being shared with Oxford Health NHS Foundation Trust for project sign off. Detailed process maps, referral pathways and performance indicators will be fully developed and agreed by all parties prior to go-live.

vi. Scrutiny Committee is asked to:
   a) Agree the principles.
   b) Discuss the advantages and disadvantages of this approach and provide guidance.

John Dixon/ Nick Horn | Date: 28th May 2012

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# Equality Act and Equality Duty - Briefing for Adult Services Scrutiny Committee

## Purpose

This note is to provide the Committee with information about the Equality Act 2010 and the Equality Duty, and the possible impacts of these for the Committee.

## The Equality Act 2010

The Equality Act 2010 (the Act) replaces the previous anti-discrimination laws with a single Act. It simplifies the law, removing inconsistencies and making it easier for people to understand and comply with it. It also strengthens the law to help tackle discrimination and inequality. The majority of the Act came into force on 1 October 2010.

## The Equality Duty

The new Equality Duty is a duty on public bodies and others carrying out public functions. The Equality Duty is designed to reduce bureaucracy while ensuring public bodies play their part in making society fairer by tackling discrimination and providing equality of opportunity for all. It ensures that public bodies consider the needs of all individuals in their day to day work – in shaping policy, in delivering services, and in relation to their own employees.

The new Equality Duty supports good decision-making – it encourages public bodies to understand how different people will be affected by their activities so that policies and services are appropriate and accessible to all and meet different people's needs. By understanding the effect of their activities on different people, and how inclusive public services can support and open up people's opportunities, public bodies are better placed to deliver policies and services that are efficient and effective. The Equality Duty therefore helps public bodies to deliver the Government's overall objectives for public services.

The new Equality Duty replaces the three previous public sector equality duties – for race, disability and gender. The new Equality Duty covers the following protected characteristics:

- age
- disability
- gender reassignment
- pregnancy and maternity
- race – this includes ethnic or national origins, colour or nationality
- religion or belief – this includes lack of belief
- sex
- sexual orientation

It also applies to marriage and civil partnership, but only in respect of the requirement to have due regard to the need to eliminate discrimination.

The Equality Duty has three aims. It requires public bodies to have ***due regard*** to the need to:

- **eliminate unlawful discrimination**, harassment, victimisation and any other conduct prohibited by the Act;
- **advance equality of opportunity** between people who share a protected characteristic and people who do not share it; and
- **foster good relations** between people who share a protected characteristic and people who do not share it.

Having ***due regard*** means consciously thinking about the three aims of the Equality Duty as part of the process of decision-making. This means that consideration of equality issues must influence the decisions reached by public bodies – such as in how they act as employers; how they develop, evaluate and review policy; how they design, deliver and evaluate services, and how they commission and procure from others.

Having due regard to the need to **advance equality of opportunity** involves considering the need to:

- remove or minimise disadvantages suffered by people due to their protected characteristics;
- meet the needs of people with protected characteristics; and
- encourage people with protected characteristics to participate in public life or in other activities where their participation is low.

**Fostering good relations** involves tackling prejudice and promoting understanding between people who share a protected characteristic and others.

Complying with the Equality Duty may involve treating some people better than others, as far as this is allowed by discrimination law. For example, it may involve making use of an exception or the positive action provisions in order to provide a service in a way which is appropriate for people who share a protected characteristic – such as providing computer training to older people to help them access information and services.

## Service and Community Impact Assessments

The Equality Act 2010 requires all public authorities to assess the impact of their policies on communities. In this context, 'policies' is a general term that could include strategies, projects or contracts.

In Oxfordshire County Council, this process is termed Service and Community Impact Assessments (SCIA). A SCIA is intended to ensure policies meet the diverse needs of individuals and communities.

- Assessments are available to Councillors when making a decision on whether to agree a new policy or not.

- Any new or amended policies, strategies, projects and contracts should have an initial assessment. This should be proportionate to the significance of the change and the potential impact.
- For example, a small change in procedure may require only one page, whereas a significant budgetary decision should have a full assessment. This must demonstrate what data or research has been used, feedback from consultations with affected groups and an action plan to mitigate any impacts. Partners, staff or stakeholders should also be involved to check the assumptions match the experience on-the-ground.
- Assessments should demonstrate that the impact on groups has been considered, identify risks and any explain mitigating actions that will be taken if the policy is implemented.
- We assess the impact of decisions on any relevant community, but with particular emphasis on:
    - Groups that share the nine protected characteristics
    - Rural communities
    - Areas of deprivation
- We also assess the impact on:
    - Staff
    - Other council services
    - Other providers of council services
- Once a decision is made the assessments are updated and then reviewed on a regular basis over the implementation of the project or policy or contract to ensure that the initial assessments were accurate, and that the impact of any changes in approach and learning from implementation are included.
- Completed Service and Community Impact Assessments are published on the public website at: www.oxfordshire.gov.uk/cms/public-site/equality-and-cohesion

## Key Points for Consideration

- Meeting the Equality Duty does not mean difficult decisions can't be taken, or mean that impacts on particular groups can always be avoided.
- However, we must be able to demonstrate we have considered the impact as part of decision-making, and that proportionate actions are being taken to mitigate the potential impact as much as possible.
- All reports should include information about how they contribute to meeting the three aims of the Equality Duty.
- Significant changes in policy should be accompanied by a Service and Community Impact Assessment that demonstrates that consideration has been given to the potential impact and mitigating actions.

**Ben Threadgold**
**Senior Policy and Performance Officer**
**June 2012**

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**Oxfordshire Local Involvement Network**
**Update for Adult Services Scrutiny Committee**
**meeting 12th June 2012**

Public, patient and carer concerns, issues and compliments collected through LINk engagement and outreach activities have resulted in the following projects being taken forwards. Further Health and Social care issues will be prioritised during this year.
**N.B. The following concise update refers to LINk projects which have a Social Care remit only, unless there is joint interest, or commissioning, with Health.**

**LINk Core Group**

All members are welcome to attend the next Core Group meeting in public, which will take place at **Wallingford Methodist Church** on **Thursday 12th July from 1.30pm** (networking) – meeting from **2.00pm until 4.00pm**. Agenda topics will be:
Oxford University Hospitals Trust discussing their recent work on:

- The Productive Ward initiatives
- Food and Nutrition
- Discharge Planning

The LINk will be presenting their **Annual Report for 2011-12** and promoting support for improving and developing public engagement through **Patient Participation Groups** in collaboration with local representatives and the PCT. The LINk has developed a PPG 'Toolkit' for this purpose.

**Ongoing projects and engagement:**

**Social Care Hearsay – third annual report**

The report is due to be published later in June, following the agreement of an action plan for 2012-13 with SCS Officers. The report will cover all recommendations and actions completed, still in progress or incomplete over 2011-12, together with the views of service users and carers as to what has improved, remained the same or become more problematic over the last 12 months as a result of changes to services. The report will be circulated to all Hearsay participants with a request to feedback their comments and views on the action plan.

An update event in another part of the County during October or November will provide an opportunity for local service users, carers and commissioners to hear and to contribute views about Social Care services in their locality. Venue and date will be promoted once agreed.

A further full Hearsay event will be planned for the end of January 2013 in order that the report can be published in advance of the transition to local HealthWatch in April next year.

Oxfordshire LINk

**Self Directed Support (Personal Budgets)**

Following LINk supported for the SDS event on 1st March, delivered in partnership with Oxfordshire Wheel and Oxfordshire Family Support Network, information & feedback obtained from service users and carers from this event has been compiled into a report, which will be available at this Scrutiny meeting. There are recommendations contained within the Hearsay report which are related to SDS and together with contributions form the SDS Forum, the various sources of information will reflect a wide consensus of recent views about the effectiveness and implementation of Personal Budgets. Responses to issues raised will be requested from SCS in due course.

**'Enter and View' visits to Care Homes**

The second series of visits to 23 care homes has been ongoing from April 2012 with a report due later in the year. Delivery and publication timescale will be agreed once the visits have been completed.

*'Assuring Quality in Externally Provided Social Care'.* LINk has been invited to contribute to this joint ASSC / SCS working group, specifically to add to the monitoring of concerns raised by carers and recipients of externally provided social care services. LINk is collaborating in the development of an action plan, to include knowledge and feedback gained from Care Home visits and other information collected from SCS Hearsay and the SDS Forum.

**Update from other projects:**

**Mental Health 'Hearsay'** engagement: An action plan for the year is being agreed with Oxford Health and the PCT Commissioners. The delayed report will be published in June and a feedback event planned with service users and carers for later this year.

The first formal meeting for the **Patient Participation Group** attached to Luther Street Medical Centre has taken place. Although low in attendance, the positive responses received are being used to further develop engagement, with LINk facilitation, through existing support groups in the homelessness hostels.

A **Maternity Services review** has been proposed in collaboration with a HOSC working group, Commissioners and OUH. The likely focus will be on post-natal care.

**Local HealthWatch**
An update on the procurement process will be provided by the LINk lead officer for the County Council.

*Adrian Chant (LINk Locality Manager)*
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*Update 31/05/2012*