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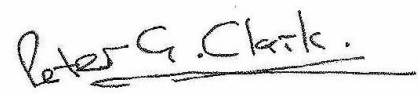
**To: Members of the Oxfordshire Health and Wellbeing Board**

# *Notice of an Informal Meeting of the Shadow Oxfordshire Health and Wellbeing Board*

## Thursday, 24 November 2011 at 11.00 am

## County Hall, Oxford OX1 1ND



Peter G. Clark
County Solicitor

November 2011

*Contact Officer:* ***Julie Dean/Roger Edwards Tel: (01865) 815322/810824***
*Email: julie.dean@oxfordshire.gov.uk / roger.edwards@oxfordshire.gov.uk*

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**Membership**

Chairman – Councillor Keith R. Mitchell CBE
Vice Chairman - Dr Stephen Richards

*Board Members:*

| | |
|---|---|
| Councillor Mark Booty *(West Oxfordshire District Council)* | Chairman of the Health Improvement Board |
| Sue Butterworth | Chair of Public Involvement Board |
| Councillor Louise Chapman *(Oxfordshire County Council)* | Chairman of the Children & Young People's Board |
| Councillor Arash Fatemian *(Oxfordshire County Council)* | Chairman of the Adult Health & Social Care Board |
| John Jackson | Director for Social & Community Services |
| Dr Mary Keenan | Vice Chairman of the Children & Young People's Board |
| Dr Joe McManners | Vice Chairman of the Adult Health & Social Care Board |
| Dr Jonathan McWilliam | Director of Public Health |
| Councillor Val Smith *(Oxford City Council)* | Vice Chairman of the Health Improvement Board |
| Meera Spillett | Director for Children, Education & Families |

## 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, ie 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.

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

# AGENDA

## 1. Welcome by the Chairman, Councillor Keith R. Mitchell CBE

## 2. Apologies for Absence and Temporary Appointments

## 3. Declarations of Interest - see guidance note opposite

## 4. Petitions and Public Address

## 5. Draft Terms of Reference for the Board (Pages 1 - 2)

11.15
The draft Terms of Reference for the Board are attached **(HB 05)**. The paper will be presented by Peter Clark, County Solicitor and Monitoring Officer. Members of the Board are requested to consider the terms of Reference and agree or suggest amendments to them.

## 6. Setting the Scene (Pages 3 - 6)

11.25
Dr Jonathan McWilliam, Director of Public Health, will present the attached paper **(HBO6)**. This brief paper aims to set the scene for the work of Oxfordshire's Health and Wellbeing Board. It paints a high-level picture of the task before the Board and gives an overview of the possible priorities for discussion.

## 7. General Principles (Pages 7 - 8)

11.40
John Jackson, Director for Social and Community Services, will present the attached paper **(HB07)**, which describes how the structure of the Health and Wellbeing set up in Oxfordshire is envisaged.

## 8. The Role of the other Boards (Pages 9 - 20)

11.55
In addition to the Health and Wellbeing Board it is planned that there should be four other Boards with responsibilities for specific areas. These will be:

The Health Improvement Board
The Adult Health and Social Care Board
The Children and Young People's Board
The Public Involvement Board

The attached papers **(HB08 a, b and c)** describe the anticipated roles of the first three of these boards. The papers will be presented by Jonathan McWilliam, John Jackson and Jim Leivers (Deputy Director for Children's Social Care) respectively.

## 9. Development of the Public Involvement Board (Pages 21 - 24)

12.40
Development of the fourth of the Boards mentioned in the previous item, the Public Involvement Board, is continuing. It is linked to the development of HealthWatch which will evolve from the Oxfordshire Local Involvement Network (LINk). The attached report **(HB09)** outlines progress and plans towards the commissioning of Oxfordshire's Local HealthWatch and plans for developing the Public Involvement Board within the proposed Health and Wellbeing Board arrangements.

The paper will be presented by Alison Partridge, Engagement Manager for Oxfordshire County Council.

## 10. Towards a Joint Health and Wellbeing Strategy

12.55
This will be a verbal summary from John Jackson.

## 11. Next Steps

13.05
A summary of "what comes next" from Jonathan McWilliam. To include frequency and dates of future meetings.

## 12. Close of meeting

13.10

**Papers for Information Only**

## 13. The following papers have been included for information only (Pages 25 - 34)

**HB13a** Health and Wellbeing – information on relevant legislation
**HB13b** Performance Framework for Public Health
**HB13c** Outcome Framework for Adult Health and Social Care
**HB13d** Outcome Framework for Children and Young People

**Oxfordshire Shadow Health and Wellbeing Board**

**Terms of Reference**

**Purpose:**

The Oxfordshire Shadow Health and Wellbeing Board is the principal structure in Oxfordshire with responsibility for promoting the health and wellbeing of the people of the county.

**Responsibilities:**

To achieve its purpose, the Health and Wellbeing Board has the following responsibilities:

- To oversee the development and improvement of effective partnership working across Oxfordshire to meet peoples' health and social care needs and to achieve effective use of resources
- To prepare a Joint Health and Wellbeing Strategy (JHWS) for the whole population of Oxfordshire that drives the development and delivery of services to meet agreed priorities;
- To ensure a Joint Strategic Needs Assessment (JSNA) is in place to help determine priorities and objectives for health and social care services across Oxfordshire
- To oversee the joint commissioning arrangements for health and social care across the County;
- To maintain oversight of the commissioning intentions of both the Clinical Commissioning Consortium and the Council;
- To establish and monitor three Partnership Boards and a Public Involvement Board to deliver required service change and improved outcomes.

**Membership**

The core membership of the Board is:

- The Leader of the County Council – who is also the Chairman of the Board;
- The Chief Executive of the Oxfordshire Clinical Commissioning Group as Vice Chairman;
- The County Council Cabinet Members for Adult Services (Chairman of the Adult Health and Social Care Board) and Children, Education and Families (Chairman of the Children and Young People's Board);
- The Chairmen and Vice-Chairmen of the three Partnership Boards and the Chairman of the Public Involvement Board ;
- The Oxfordshire County Council Directors for Public Health; Children, Education and Families; and Social and Community Services (Statutory members).

In attendance

- The Chief Executive of Oxfordshire County Council
- The Chief Executive of the Oxon/Bucks NHS Cluster (as a transitional arrangement until April 2013)

**Governance**

The meetings of the Board and its decision-making will be subject to the provisions of the County Council's Constitution including the Council Procedure Rules and the Access to Information Procedure Rules, insofar as these are applicable to the Board in its shadow form.

The Board will also be subject to existing scrutiny arrangements with Oxfordshire's Health Overview and Scrutiny Committee providing the lead role.

Members of the Group will be subject to the Code of Conduct applicable to the body which they represent.

The frequency and timing of Board meetings will be determined following the first meeting. Dates, times and places of meeting will be determined by the Chairman of the Board.

The County Council's Law and Governance team will service meetings of the Board and the partnership boards, including the preparation and circulation of agendas and minutes and the giving of procedural advice.

**Partnership Boards and Public Involvement Board**

The Health and Wellbeing Board will participate with the following partnership boards to deliver the service change required:

- Adult Health and Social Care Board
- Children and Young People's Board
- Health Improvement Board
- Public Involvement Board

The Health and Wellbeing Board will agree terms of reference and membership for each of the Partnership Boards and the Public Involvement Board. It will also agree their priorities, proposed outcomes and performance measures.

Peter Clark

County Solicitor and Monitoring Officer

November 2011.

# Health and Wellbeing Board, 24th November 2011

## Setting the Scene: An Overview of What We Need to Achieve and Our Emerging Priorities.

**Introduction.**

This brief paper aims to set the scene for the work of Oxfordshire's Health and Wellbeing Board. It paints a high-level picture of the task before us and gives an overview of the possible priorities for discussion by this Board.

**What are we here for as a Health and Wellbeing Board?**
Our purpose is to lead and coordinate the actions of many individual organisations and individuals so as to:

- Make real improvements to the health of the people of Oxfordshire in its broadest terms.
- Make more efficient use of services and public money
- Maintain or improve quality of care.

We do this in the face of a number of potent challenges which are:

- **Demographic pressures** in the population, especially the increasing number and proportion of older people, many of whom need care. This is a major issue particularly for our more rural areas.
- The persistence of small geographical areas of **social deprivation**, especially in Banbury and Oxford but also in parts of our market towns.
- The increase in **'unhealthy' lifestyles** which leads in due course to chronic disease and disability (eg the behaviours that lead to obesity which in turn increases levels of diabetes, heart disease, stroke and cancers).
- The need to ensure that services for the **mentally ill and those with learning disabilities** are not overlooked.
- **Increasing demand** for services.
- An awareness that the **'supply side'** of what we provide does not 'mesh' together as smoothly as we would like - (eg hospital beds, discharge arrangements, care at home and nursing home care)
- The recent increase in **financial stringency** and tightening of the public purse which affects all public sector organisations and 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 coherent plans for 'One Oxfordshire'.
- The changing face and **roles of public sector organisations** - the need to welcome new ways of working such as 'localism' and 'GP Commissioning' alongside a stronger voice for the public as Healthwatch develops and the need to provide more choice for individuals is recognised.

This list of challenges suggests that there are a number of overarching themes the Health and Wellbeing Board will want to ensure that its four subsidiary Boards addresses.

These overarching themes are:

1. The need to prevent ill health.
2. The need to reduce inequalities and protect the vulnerable.
3. The need to improve the skills of our children, young people and some adults
4. The need to reduce unnecessary demand for services.
5. The need to make slick and efficient use of the 'supply side' of services from care at home, through primary care, to hospital and back home with the right levels of care.
6. The need to improve the quality and safety of services.
7. The need to streamline financial systems, especially those around pooled budgets and to align all budgets more closely

**Do The Emerging Priorities For This Board Fit Within This Framework?**

Yes they do. There is a clear coherence between the themes we need to work on listed above and the emerging priorities proposed in the supporting papers for this Board. The emerging priorities can be tentatively 'mapped' against these themes as follows:

| Theme | Emerging Priority | Accountable Supporting Board |
|---|---|---|
| Prevention | ➢ Preventing an early death and promoting a healthy old age.<br>➢ Preventing chronic disease. (tackling obesity)<br>➢ Preventing infectious disease.(improving immunisation) | Health Improvement Board. (HIB)<br>HIB<br>HIB |
| Inequalities | ➢ Breaking the Cycle of Deprivation/ Child Poverty.<br>➢ Early Intervention Services for Families.<br>➢ Action on groups with specific needs (eg the Armed Forces and their families) | CAYP Board<br>CAYP Board<br>HIB |
| Improving Skills for Life | ➢ Educational Attainment.<br>➢ Improving reading skills. | CAYP Board<br>CAYP Board |
| Reducing Demand for services | ➢ Tackling outliers in referrals at all levels including self referral, GP referral and specialist referral. | Adult Health and Social Care Board (AHSCB) |
| More Efficient 'Supply' of services | ➢ The 'Appropriate Care for Everyone' Programme.<br>➢ Delayed Transfers of Care.<br>➢ The Supported living/social care interface. | Adult Health and Social Care Board |
| Improving Quality of services | ➢ Getting people with long term conditions or mental health problems into work.<br>➢ Safeguarding.<br>➢ A better transition from child to adult mental health services. | AHSCB<br>CAYP Board<br>CAYP Board |
| Better Financial Management | ➢ Improved management of pooled budgets and their 'Joint Management Groups'. | AHSCB |

**Does This List of Emerging Priorities 'Fit' With the Remit of This Board?**

This list is a sound start for debate. It responds to the needs of our County described in our Joint Strategic Needs Assessment and it helps to close the gaps identified in the Director of Public Health's Annual Report.

This list also provides a framework which we could incorporate into the Joint Health and Wellbeing Strategy which we will be creating together over the coming months.

**Summary and Conclusion.**

The role of the new Health and Wellbeing Board is clear.

It will only succeed if we all work together to make a real difference to the problems of Oxfordshire.

The emerging priorities to be discussed during this meeting make a useful start in the process of leading the way forward.

However, the proof of the pudding is in the eating. Making a start is one thing: making a difference is another. The success of this Board will need to be measured in terms of real outcomes achieved for the population we all serve.

Jonathan McWilliam, Director of Public Health for Oxfordshire

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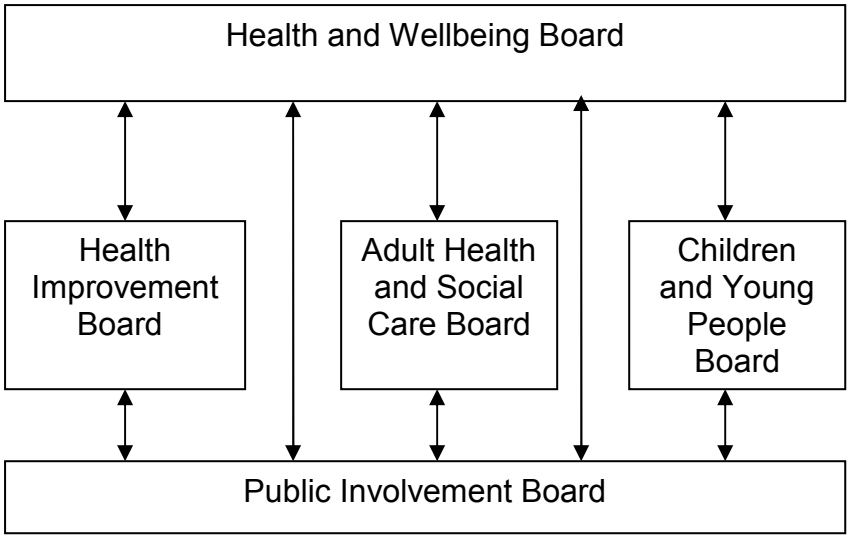
**Health and Wellbeing Board, 24th November 2011**
**General principles for work of the Health and Wellbeing Board**

1. The Health and Wellbeing Board will be supported by four other Boards. Three of them will focus on the issues of Health Improvement, Children and Adults. A fourth will ensure that there is effective public involvement in addressing the health and wellbeing of the population of Oxfordshire. Paper **HB9** on your agenda explains what is happening to create the Public Involvement Board. The overall structure is set out below:




2. Health and Wellbeing Board members need to consider the proposed role for each of the other three Boards shown in the diagram above, and their proposed priorities. These proposals are set out in papers **HB 8a, b and c**. Members of the Health and Well Being Board are asked to give their reactions to those proposals which will then be considered at the first meeting of the relevant Boards. More detailed final proposals will then be brought for agreement at the next meeting of your Board.

3. You are asked to agree some key principles which should govern the way that the Boards operate as follows.
    a. In terms of style of working, it is important to stress that the purpose of the Boards is to take an authoritative overview, to set priorities and to take action when plans go awry. It is not the purpose of the Board to add another layer of bureaucracy or to duplicate the work of existing groups.
    b. The focus of the Boards should be on those areas where joint working will have the most impact.
    c. We anticipate that some cross-cutting issues will need to be addressed by the Health and Wellbeing Board. Examples include the quality of transition as individuals progress from being a young person to becoming an adult, safeguarding, quality issues more generally (including concerns about a significant provider who serves the population as a whole) and key infrastructure issues notably housing.

John Jackson, Director for Social and Community Services
Oxfordshire County Council

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**Health and Wellbeing Board 24th November 2011**
**Proposed role of the Health Improvement Board**

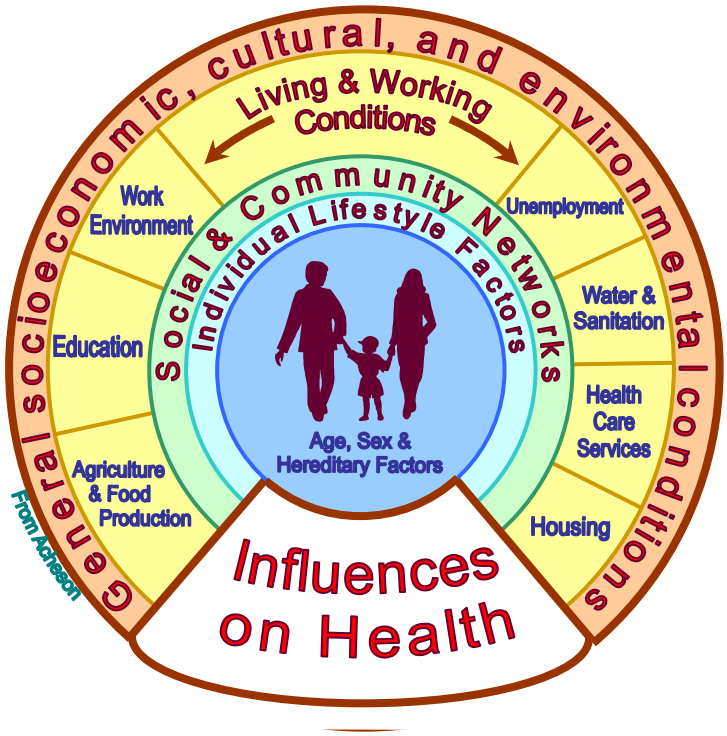
**Vision**
Improving health is everyone's business. We can only tackle pressing issues like rising levels of obesity and preventing heart disease and cancers if we all work together. The purpose of this board is to work together on these topics where we add value to achieve real results.

The Board also allows us to focus the energy of many organisations on a small number of priority topics: this is how we will achieve real improvement in Oxfordshire.

In a nutshell then, the role of the board is to:

- Agree priority areas where working together to improve health will make a real difference.
- Agree actions which will make that improvement a reality
- Hold ourselves to account for making the agreed change and report progress to the Health and Wellbeing Board.

**Context**
The diagram below shows the breadth of the factors that influence the health of Oxfordshire's people. These "determinants of health" can be influenced by a range of organisations in the public, voluntary and private sector as well as through the individual responsibility of citizens. It is clear that only when this effort and activity is meshed together that there can be improvement. The Health Improvement Board is the vehicle to bring a coordinated and coherent approach.



The Board also needs to be supported and guided by a wide network of influential and committed people who are working to improve outcomes and reduce inequalities across a wide range of topics.

**Proposed membership**

The precise membership of the Health Improvement Board requires further discussion and negotiation among partners before it is finalised. The views of the Health and Wellbeing Board are sought on this matter. The Chairman of the Health Improvement Board is Councillor Mark Booty of West Oxfordshire District Council and the Vice Chairman is Val Smith of Oxford City Council.

Following initial conversations with the Chairman and Vice Chairman it is envisaged that the Health Improvement Board will be a small, core group of representative membership and will operate by drawing on expertise from a very wide range of specialists and existing groups as needed to deliver health improvement. The initial proposal is that this core membership will include:

Chairman and Vice Chairman – District Councillors (already named)
County Councillor
Director of Public Health and Assistant Director of Public Health
District Council Officer representative
Clinical Commissioning Group GP nominee
Public Involvement Board representative

**Priorities for Working Together.**

An initial analysis of the Joint Strategic Needs Assessment , Director of Public Health Annual Report and existing strategic documents suggests the following list of initial priorities:

1. **Preventing early death and improving quality of life in later years**. For example, this will be through health checks (e.g. blood pressure, smoking status, blood cholesterol), lifestyles advice, support for behaviour change and through cancer screening programmes.

2. **Preventing chronic disease**. For example a comprehensive Obesity Strategy for Oxfordshire, involving all partners, will be finalised by June 2012.

3. **Preventing infectious disease**. For example through delivery of high quality immunisation services.

4. **Tackling the broader determinants of health**, locality by locality across the county. These factors lead to worse outcomes for deprived areas of the county and some vulnerable groups (including, for example, armed forces, their families and veterans). This work will focus on different issues in different localities. We hope to stimulate local work between District Councils, Clinical Commissioning Group localities, schools and other local groups.

5. **Monitoring performance** by finalising a performance framework for county wide Public Health indicators and outcome measures once the national outcomes framework is published in December 2011. This framework will be monitored and performance managed by the Health Improvement Board.

**Performance framework**

An Outcomes Framework for Public Health is expected to be published in December 2011. Further information on the current performance framework has been circulated for information.

Jonathan McWilliam, Director of Public Health for Oxfordshire
Jackie Wilderspin, Assistant Director of Public Health

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**Health and Well Being Board 24th November 2011**
**Proposed role of the Adult Health and Social Care Board**

## Vision

This Board will Improve outcomes for adults who are most likely to need care in Oxfordshire by promoting joint working (where appropriate) across public organisations. Outcomes for all will include maximising their independence, maximising their enjoyment of life and minimising their need for health and social care. Those people who need care should be happy with the quality of that care.

## Context

People live longer in Oxfordshire and tend to enjoy better health in their old age and overall, outcomes are good. Outcomes for people with mental health problems and learning disabilities are also relatively good compared with other parts of the country. However, there are significant variations across Oxfordshire. In addition, there are opportunities to improve outcomes for all client groups still further. Indeed, this is essential if we are to cope with the resource pressures that all organisations face. The most effective way to reduce costs is to reduce the demand for both health and social care through prevention and early intervention.

There are existing joint working arrangements in place within Oxfordshire. The proposals in this paper seek to build on the best practice within those arrangements and move on from those arrangements which are less effective because they do not promote joint working as well as they should or they are not driven by clear strategies.

There is widespread support for joint commissioning across health and social care and the pooling of resources to support that joint commissioning. These arrangements are governed by formal legal agreements under Section 75 of the National Health Service Act 2006.

Key decisions are taken at **Joint Management Groups (JMGs)** which meet monthly and bring together adult social care and health service commissioners, key providers, service users and carers. JMGs exist for adults with learning disabilities, adults with mental health problems and currently, one group overseeing older people and adults with physical disabilities.

There is an emerging view that the remit of the latter group is too broad. It is proposed that instead, there should be a group which focuses exclusively on the needs of frail older people with the needs of younger adults with physical disabilities being addressed by a different JMG.

Each JMG needs to discuss commissioning intentions and then monitor in detail performance and money. The JMGs cannot agree the overall strategy for their client group (see below). However, there will be a range of much more specific commissioning issues which do need to be agreed by the JMG.

Examples include the use of intermediate care for older people, supported living arrangements for people with a mental health problem, meeting the general health needs of adults with learning disabilities.

JMGs should be responsible for:

1. Owning the overall strategy for their client groups. This means that they should be the place where the draft strategy is developed and provisionally agreed by the various parties (Adult Social Care, the Clinical Commissioning Group, providers and service users). They need to really understand the strategy. The strategy will need to contain relevant performance outcomes targets
2. Once the strategy has been improved formally then the JMG are responsible for its delivery. This means that they need to turn the commissioning strategy into detailed commissioning decisions (reflected in outcome specifications).
3. They should agree the detailed budgets and financial plans for the next year (and the medium term).
4. They need to monitor performance monthly against the targets, activity levels, spending and the delivery of efficiency savings targets.
5. If performance or finance is out of line then the JMG must decide what should happen in response. They should have the freedom to agree any operational actions providing they are within the context of the agreed overall strategy.

**The role of the Adult Health and Social Care Board** in this context is to:

1. Agree the overall strategy for each client group which will include the key outcome measures
2. Hold the JMGs to account for delivery based on performance against both the key outcomes and financial management.
3. Consider cross-cutting issues that cut across the JMGs. Examples might include major provider issues that impact on more than client group, safeguarding/quality issues, housing issues, workforce/market issues.

**Proposed Membership of the Board:**

Chairman County Council Cabinet Member Adult Services
Vice Chairman GP (Dr Joe McManners nominated)
Director for Social & Community Services, County Council
Director for Transition & Partnerships, Clinical Commissioning Consortium
Additional GP representative
District Council representative (Councillor)
Two representatives from LINk/Healthwatch

It is expected that this Board would need to meet quarterly.

**Proposed Key priorities**

There are a number of pressing priorities for the Adult Health and Social Care Board to consider. These include:

- Examining and reducing unnecessary variations in demand for care, looking closely at variations in GP referrals and consultant to consultant referrals.
- Improving the "supply" side of health and social care provision through the work of the "Appropriate Care for Everyone" (ACE) programme which will include tackling delayed transfers of care, reducing unnecessary hospital readmissions and reducing inappropriate use of residential and nursing home care.
- Improving the interface between "supported living" and social care.

An initial list of proposed outcome measures for these areas of work and also for service quality outcomes is set out below. These form a list of potential key priorities for the Adult Health and Social Care Board as follows[1]:

<u>All Client Groups</u>

1. Enhancing quality of life for people with care and support needs
2. Overall satisfaction of people who use services with their care and support
3. The proportion of people who use services who have control over their daily life
4. The proportion of people who use services who feel safe
5. Carer-reported quality of life

<u>Older People</u>

1. Permanent admissions to residential and nursing care[2]
2. Helping Older People to recover their independence after illness or injury
3. Emergency admissions within 28 days of discharge from hospital
4. Delayed transfers of care from hospital and those which are attributable to adult social care (as part of the wider "ACE" programme).

<u>Mental Health</u>

1. Employment of people with mental illness
2. Improving experience of healthcare for people with mental illness

<u>Learning Disabilities</u>

1. Health-related quality of life for people with long-term conditions
2. Proportion of adults with learning disabilities who live in their own home or with their family

[1] These key priorities are based on the national outcome frameworks. The reason for using those national frameworks is twofold. Firstly, they do make sense in terms of measuring outcomes for the relevant groups. Secondly, they enable us to measure the comparative performance of Oxfordshire against other areas.

[2] A good outcome is where this figure is <u>low</u>.

(Other) Long Term Conditions

1. Health-related quality of life for people with long-term conditions
2. Proportion of people feeling supported to manage their condition
3. Employment of people with long-term conditions

**Outline Work Programme**

1. Agree new commissioning strategy for older people (March 2012).
2. Agree new commissioning strategy for adults with physical disabilities (September 2012).
3. Agree updated commissioning strategies for adults with learning disabilities and mental health problems (March 2012)
4. Have a comprehensive understanding of the issues about delayed transfers of care and agree actions in response to those issues (March 2012)
5. Endorse proposed Section 75 agreement (June 2012)
6. Understand Oxfordshire's performance against the outcome measures for all groups and agree targets for 2013/14 (September 2012)

**Performance Framework**

The Government has published proposed outcomes for health and social care over the summer. These are relevant and it is suggested that these are applied. They are set out in a separate paper circulated for information.

John Jackson, Director for Social and Community Services
Oxfordshire County Council

**Health and Well Being Board 24th November 2011**
**Proposed role of the Children and Young People's Board**

**Vision**
In Oxfordshire we are ambitious about improving outcomes for all children and young people. Our vision is:

- Keeping all children and young people safe
- Raising achievement for all children and young people
- Narrowing the gap for our most disadvantaged and vulnerable groups

**Context**
There are 155,700 children and young people aged 0 to19 years living in Oxfordshire, out of a total population of 639,800 (mid 2008).

Despite the overall affluence of the county, there are several areas of serious deprivation, particularly in Oxford City and Banbury. In these areas children and young people experience ill health, are less successful at school, are more likely to become involved in or experience crime, may become teenage parents, face higher unemployment, lower earning capacity and, ultimately, an earlier death than their peers. There are nine urban areas across the county which are in the worst 10% of areas in the UK for child poverty and a further 16 wards (out of a total of 136) are in the top 25%. Additionally there are small pockets of poverty in some of our rural areas which can be masked by the general affluence of the population. Poor transport can compound the problem of deprivation in rural areas, making access to services difficult and contributing to feelings of isolation.

There is a significant military presence in the county which means some of our children and young people in military families experience unsettled lives and live with anxieties that sometimes impact upon their well-being, but also bring rich diversity and experience to the local community.

There has been a single Children and Young People's Plan (CYPP) in Oxfordshire since 2006. This overarching plan is endorsed by all partner agencies and sets out an ambitious plan to improve outcomes for particular groups of young people. The current CYPP runs until 2013. There has also been a Children and Young People's Trust since 2006 and although its membership and governance has changed over time, the overall aim – to deliver the CYPP – has remained.

Part of the CYPP has been a plan to strengthen the joint commissioning function of the children's trust. In May 2010 a Joint Commissioning framework was agreed and has made some progress. There is now widespread support for joint commissioning across health and social care and the pooling of resources to support that joint commissioning. These arrangements are governed by formal legal agreements under Section 75 of the National Health Service Act 2006. Key decisions are taken at **Joint Management Groups (JMGs)** which meet monthly and bring together commissioners, key providers, service users and carers. This is planned for Child and Adolescent Mental Health Services from 1st April 2012.

**The proposed role of the Children and Young People's Board**
This Board will provide strategic leadership, oversight and challenge to the delivery of better outcomes for children and young people, their families and other carers. It will champion the rights of children and young people and ensure that they and parents are engaged throughout the process of decision making and local implementation. The board will add value by ensuring that the whole system joins up effectively around the needs of individual and groups of children. The aim will be to reduce bureaucracy, reduce duplication, increase choice and accessibility and to put young people at the centre of partnership working.

In order to do this it will:

- Develop and agree the strategy for children's services (currently CYPP2)
- Hold the Mental Health JMG to account for delivery based on performance against both the key outcomes and financial management for the CAMHS budget
- Develop use and governance of pooled budgets for children
- Develop integrated pathways, models of provision
- Deliver the outcomes and targets agreed by the HWB Board

The Board will have representation from the Oxfordshire Safeguarding Children Board (OSCB). There will be a protocol agreed to ensure that the requirements of the OSCB statutory functions to hold agencies to account for all safeguarding issues, can be addressed in line with statutory guidance[1] in its relationship to the sub board of the Health and Wellbeing Board.

**Proposed Membership of the Board**:

| | |
|---|---|
| Chairman: | Louise Chapman, County Council Cabinet Member Children's Services |
| Vice Chairman | Dr Mary Keenan, Oxfordshire Clinical Commissioning Group |

The membership will be discussed at the first meeting to reflect the new responsibilities of the Board. In addition it is proposed that the current structure of the existing Children's Trust is reviewed and a revised structure implemented by April 2012.

It is proposed that the Board will meet every 2 months.

**Proposed Key Priorities**
Priorities for the board in 2012/13 will include delivery of Year 3 of the current Children and Young People Plan:

- Raising educational achievement for all young people in Oxfordshire.

[1] Working Together to Safeguard Children: (2010)

- Focusing on evidence based early intervention services where we know they are most needed.
- Joining up young people and adult services around mental health so that transitions between services are seamless and appropriate and so that the needs of the whole family are considered where adult mental health problems exist.
- Integrating provision around the 'foundation years' in order to give young children the very best start in life.
- Building on the recommendations of the Munro Report in order to strengthen our approach to intensive early intervention and to child protection.
- Keeping children and young people out of the Emergency Department and hospital beds where we know they can be safely cared for closer to home.
- Building on the good practice from the Breaking the Cycle of Deprivation initiatives in Oxford and Banbury to address the causes and effects of child poverty in local areas.

**Outline Work Programme**

1. Understand Oxfordshire's performance against key performance indicators for children and young people and agree targets for 2013/14
2. Hold the Mental Health JMG to account for delivery of a CAMHS Commissioning Strategy by March 2013.
3. Develop a Commissioning Strategy for children and young people.
4. Focus local action plans on reducing child poverty by building on the lessons learned from the Breaking the Cycle initiative.

**Performance Framework**

The current dashboard of indicators is monitored regularly and it is suggested that these are still relevant and that they will be cross referenced and amended to reflect the indicators to be agreed for the Health Improvement Board. They are set out in a paper that was circulated for information.

Sarah Breton, Lead Commissioner, Children and Young People.
Oxfordshire County Council

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# Health and Wellbeing Board 24th November 2011
# Establishing the Public Involvement Board

This report outlines:

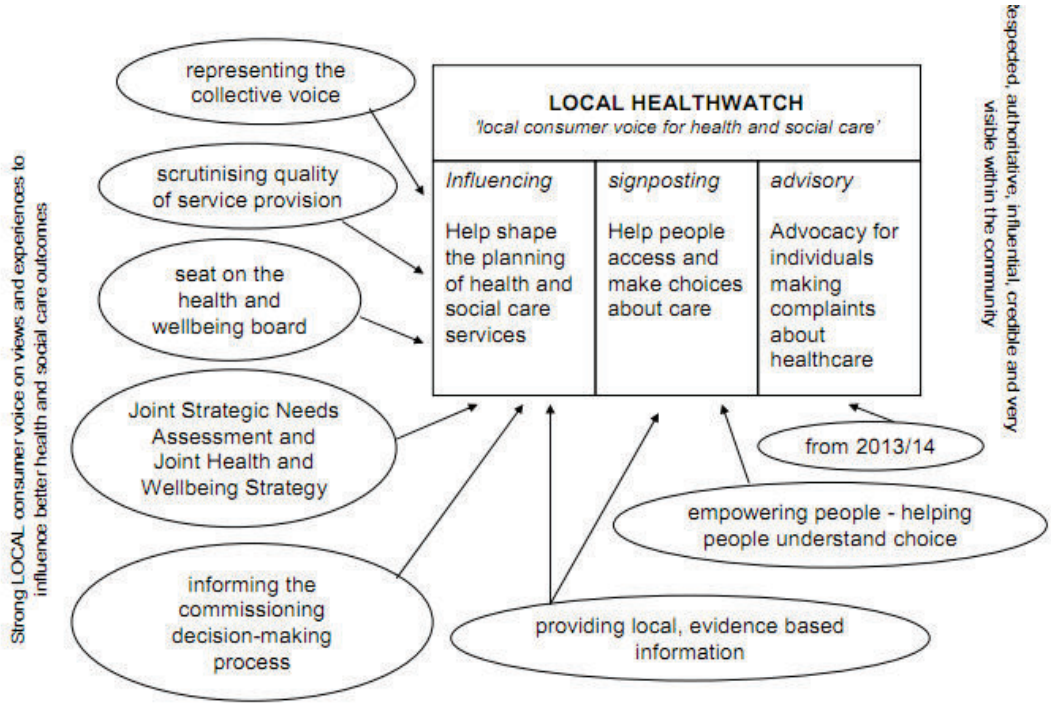
- Progress and plans towards commissioning of **Oxfordshire's Local HealthWatch**
- Plans for developing the **Public Involvement Board** within the proposed Health and Wellbeing Board arrangements

## Oxfordshire's Local HealthWatch

Under the Equity and Excellence: Liberating the NHS 2010[1] and the Health and Social Care Bill 2011[2], new proposals were announced for establishing a new national and local Healthwatch. The vision for the Local Healthwatch is to be a new independent 'consumer champion' for users of health and social care services. The national HealthWatch will provide intelligence from people's experience and views locally, provide appropriate training to influence and advise the Care Quality Commission, Monitor and the Secretary of State, so as to influence and shape national policy and planning in the overall provision of high quality Care.

Locally, it is proposed Oxfordshire HealthWatch will:

- Support and enable people to share experiences, views and be involved in shaping policy and services
- Make those views known, with recommendations for improvement
- Provide advice and information about access and choices
- Provide an advocacy service and make available a complaints service (from 2013)




## What are the plans in Oxfordshire?

The Local Authority will have responsibility for commissioning the Local HealthWatch, drawing on the significant experience of existing providers (e.g. the Local Involvement Network (the LINk)

[1] www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117794.pdf
[2] www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Actsandbills/HealthandSocialCareBill2011/index.htm

and others). Oxfordshire was successful in submitting a bid to the Department of Health to be a 'Local HealthWatch Pathfinder' and aims to agree a model for commissioning through an extensive engagement exercise, developed with the Interim Steering Group (which includes the LINk, Primary Care Trust (PCT) and users/carers). The consultation will run through late November, culminating in a Stakeholder event on 28th November 2011. It includes:

- Questionnaires in a range of formats distributed through the OCC e-portal, facebook and partners routes (e.g. Talking Health, City and District Council Citizen Panels etc)
- 2 café-style workshops for users and carers (including children, young people, parents, carers, adults and older people drawn from a wide range of diverse groups)
- 4 focus groups for the LINk members, Council Members, Voluntary and Community Groups, and professional stakeholders
- Discussion at Oxfordshire Youth Parliament and Oxfordshire Children's Parliament
- Outreach to targeted/marginalised groups

An independent consultant, Jessie Cunnett, who has extensive national experience in supporting Local Authorities to develop their Local HealthWatch, and has been employed to support and advise the Interim Steering Group in shaping and facilitating the consultation.

The findings will be collated through December and final commissioning specifications agreed in January 2012.

**Health and Wellbeing Board**
The current Chair of the Oxfordshire LINk, will, on an interim basis (pending the commissioning of HealthWatch), act as the representative on the Health and Wellbeing Board, and will Chair the Public Involvement Board.

**Public Involvement Board**
The Public Involvement Board (PIB) will be developed in collaboration with the LINk, Oxfordshire Clinical Commissioning Group (OCCG), existing user-representative organisations and users/carers.

It will aim to:

- bring together the many diverse voices of children, young people, parents, carers, adults and older people in Oxfordshire, who receive and use public services (including health, social care, leisure, transport, housing, schools, community safety, arts, play etc)
- ensure everyone has the opportunity and democratic right to have a voice (including the most vulnerable, disadvantaged and vulnerable people)
- strengthen and formalise their voice and co-participation in strategic planning and evaluation, ensuring a clear focus on prioritised outcomes, which people want and are considered will make a difference
- hold a 'challenge' role within the Health and Wellbeing Board structure, which strengthens customer accountability and ensures direct feedback on impact
- join-up and rationalise engagement and involvement activity across OCCG and Oxfordshire County Council (OCC), to prevent duplication and maximise resource, in collaboration with HealthWatch
- create a joint Engagement Strategy (from 2012/3).

In order to create a board which involves a balance of users, carers, representative groups and the general public, it is proposed that findings from two consultations which are completing in

November 2011are drawn on: the Local HealthWatch consultation (outlined above), and a consultation on a proposed Communications and Engagement strategy and model for the OCCG (involving six workshops held in locality areas across Oxfordshire).

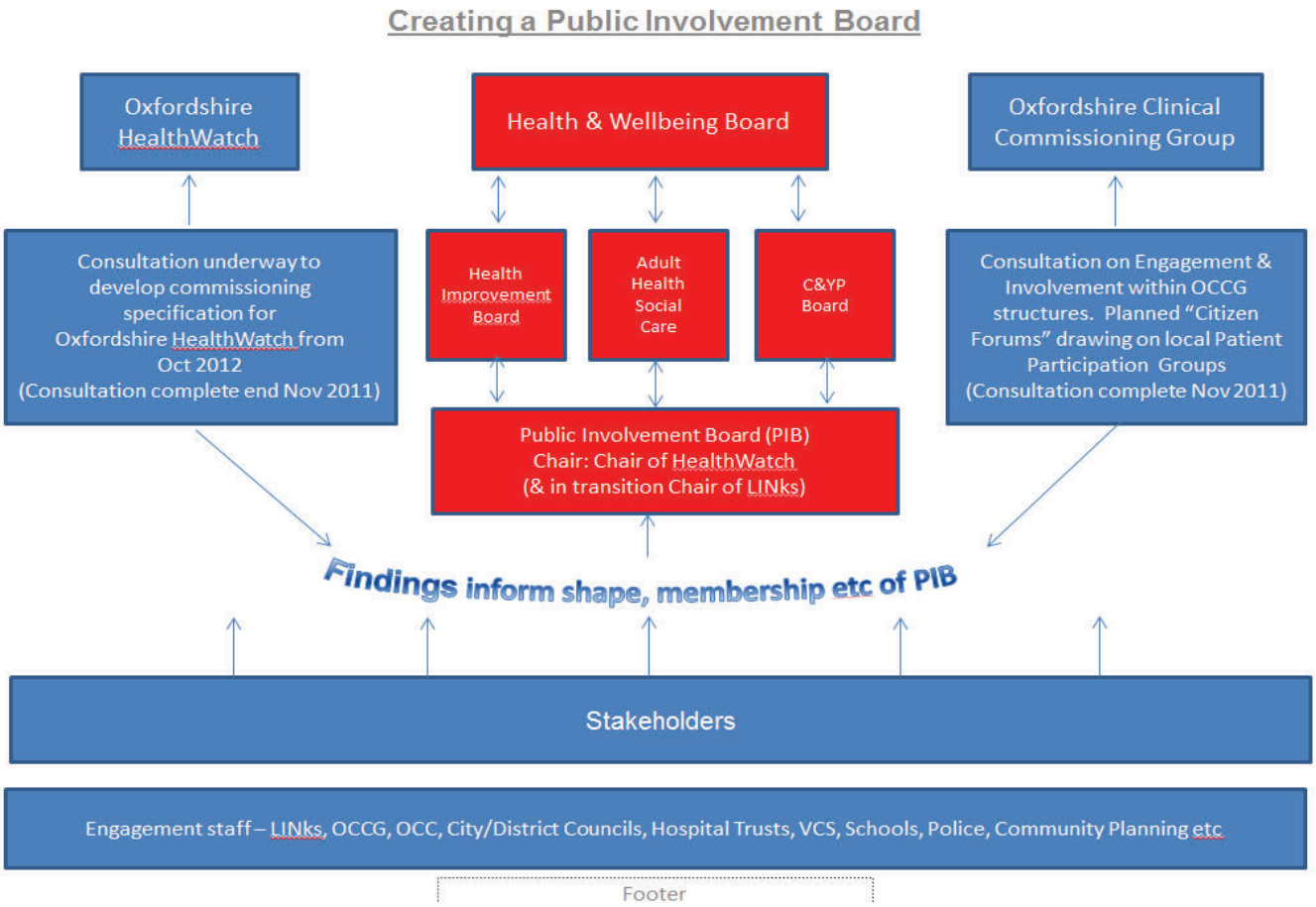
These consultation findings will be collated and will provide the framework for a Workshop in February 2012, convened by OCC Engagement Manager, to discuss and agree:

- the vision and role of the Public Involvement Board
- performance and outcome measures for the Board
- membership of the Board
- terms of reference
- support and co-ordination of the Board

A Stakeholder Audit will ensure invitations are extended to user-representative organisations, engagement forums and users/carers, with a balance between all stakeholder groupings. The balance will include people/forums of all ages, including children, young people, parents, carers, adults and older people, (see diagram below).

The outcome of these discussions will lead to an agreed model, with a first PIB meeting planned for April 2012.

Alison Partridge, Engagement Manager, Oxfordshire County Council



(for information) HB13a

**Oxfordshire Health and Wellbeing Board**
**Information on relevant legislation and implications**

The shadow Health and Wellbeing Board (H&WB) is being formed in response to the Government's plans for the radical reorganisation of how health services in England are managed, commissioned and delivered. The Health and Social Care Bill continues to spark lively debate and challenge during its passage through Parliament but it is going through the Committee stage in the House of Lords and should receive the Royal Assent early next year. While the final shape of the legislation is still not absolutely clear there are a number of certainties:

**Purpose of the Bill**

The Bill will establish Health and Wellbeing Boards in all upper tier local authorities, to promote integrated health and care services and increase accountability. The boards should increase local democratic legitimacy significantly in the commissioning of health and care services, bringing together locally elected councillors, clinical commissioning groups (CCGs) of GPs, local HealthWatch and Directors of Adult Social Services, Children's Services and Public Health to jointly assess local needs and develop an integrated strategy to address them.

Elected councillors will be involved in this process and will be held to account by the local electorate if they are ineffective. Local HealthWatch will ensure patients and the public have a direct say in their health and wellbeing board and so in the strategic planning for meeting the health and care needs of their area.

Health Overview and Scrutiny Committees will be responsible for scrutinising the work of the Boards.

**Health and Wellbeing Boards (H&WBs)**

The responsibilities proposed by Government for H&WBs can be summarised as follows:

- Preparing a Joint Health and Wellbeing Strategy (JHWS) for the whole population of Oxfordshire, covering all age groups. This will drive the development and delivery of services to meet agreed priorities.
- Ensuring that there is a Joint Strategic Needs Assessment (JSNA) that provides for the Board a strong evidence base and a clear analysis of population need. This will inform priorities and objectives for the Board and Clinical Commissioning Groups (see below).
- Having oversight of the joint commissioning arrangements for health and social care across their area of responsibility.
- Building on and developing further a range of partnership arrangements to drive the strategy and service delivery.
- Having in place robust arrangements for the involvement of HealthWatch in establishing and agreeing the Board's objectives and priorities.
- Oversight of the involvement of the CCG in joint planning across the County.

The H&WB would be expected to ensure that:

- There is a greater involvement of service users and the public
- Stronger joint commissioning and better integrated provision between health, public health and social care takes place

- They have close involvement with the CCG as GPs develop their commissioning plans
- CCG commissioning plans (and other commissioning plans) are in line with the Joint Health and Wellbeing Strategy as set out by the H&WB
- Plans that are not in line with the Joint Health and Wellbeing Strategy are referred back to the CCG, or, in extreme cases, to the NHS Commissioning Board

**Clinical Commissioning Groups**

The Bill proposes that groups of GPs should take on the responsibility for commissioning. Working alongside local authorities, particularly the H&WBs, commissioners will be expected to deliver a sustainable and patient-focused system of healthcare.

The premise behind this is that patient care will be improved and money used more effectively if it is based on input from those closest to patients – doctors, nurses and other health and social care professionals – in discussion with patients and carers, the voluntary sector and other healthcare partners.

GP practices will be formed into Clinical Commissioning Groups (CCGs) and will organise services for their local populations, supported by a national NHS Commissioning Board. Better commissioning should improve quality and save money at the same time, for example by providing more services at or close to home thus reducing the need for patients to go to hospital.

A nurse, a hospital doctor and lay people must be appointed to the CCG governing body to ensure that there is a broad perspective on health and care issues to underpin the work of the CCGs.

**National Commissioning Board**

A National Commissioning Board will be set up to help support and develop CCGs and hold them to account. The Board should ensure that the whole of the health service set up is cohesive, co-ordinated and efficient. In addition it will commission primary care and a large number of specialised services.

**Local Authorities**

The Bill outlines a new role for local authorities for the co-ordination, commissioning and oversight (including scrutiny) of health, social care (both adults and children's), public health and health improvements. Following the enactment of the Bill, Oxfordshire County Council, as the upper tier authority, will have the following key duties:

- Creation of a Health and Wellbeing Board
- Public Health and health improvement functions (transferred from the PCT)
- Expansion of the health and social care scrutiny functions
- Establishment of the local HealthWatch

Closer working between all partners involved in the health and wellbeing agenda is clearly a necessity for the future. The Health and Wellbeing Board has a pivotal role in ensuring that health and social care arrangements are developed to achieve that end.

Roger Edwards

# KEY NATIONAL AND LOCAL NHS INDICATORS 2011/12

**07/11/11**

| Indicator Code | Description | Type | Target 11/12 unless stated | Actual to date | Current / Predicted RAG Rating 2011/12 | Benchmark | Date of benchmark | RAG Rating/ Performance 2010/11 | Actual data Frequency | Next Data Due | Who to chase / Link |
|---|---|---|---|---|---|---|---|---|---|---|---|
| HQU01 | MRSA new cases | N | 2011/12 limit=15<br>7/11/11 9 | 12 | | ORH 1/8 SC | 09/10/11 | 19/26 | Weekly | Monday | JD (AIC) |
| HQU02 | Clostridium Difficile | N | 2011/12 limit=282<br>7/11/11 170 | 162 | | ORH 1/8 SC | 09/10/11 | 360/420 | Weekly | Monday | JD (AIC) |
| SQU08 | Cumulative number of Carers Breaks | Lnew | Q1 70<br>Q2 200<br>Q3 380<br>Q4 610 | Q1 159<br>Q2 347<br>Q3 XXX<br>Q4 XXX | updated 14/10/11 | | | | Quarterly | Jan-12 | MH (BC) |
| SQU18 | Smoking Quitters | N | 2011/12 3559<br>Target 11/11/11<br>1404 | 1448 | | quit rate per 100,000 pop rank 7/9 | 2010/11 | 3517 quitters | Weekly (2 months in arrears) | Friday | ABa |
| SQU18a | Smoking Quitters | L | 2011/12 3650<br>Target 11/11/11<br>1439 | 1448 | | quit rate per 100,000 pop rank 7/9 | 2010/11 | 3517 quitters | Weekly (2 months in arrears) | Friday | ABa |
| SQU19a | 6-8 weeks Breast Feeding Coverage | N | 95% | Q1 98.9%<br>Q2 99.2%<br>Q3 xx.x%<br>Q4 xx.x%<br>YR xx.x% | | SC rank 5/9 | Q4 10/11 | 98.84% | Quarterly | Q1 July | ABa |
| SQU19b | 6-8 weeks Breast Feeding Prevalence | N | 59.8% | Q1 59.7%<br>Q2 58.1%<br>Q3 xx.x%<br>Q4 xx.x%<br>YR xx.x% | | SC rank 1/9 | Q4 10/11 | 59.80% | Quarterly | Q1 July | ABa |
| SQU20 | Started Breast Screening age extension | N | Y | Y | | SCSHA rank 1/9 impl Sep 11 all digital | Oct-11 | | | | PJ |
| SQU20a | Cumulative number of women invited for breast Screening aged 47-49, 71-73 | Lnew | Q1 0<br>Q2 250<br>Q3 1333<br>Q4 1227 | Q1 0<br>Q2 266*<br>Q3 XXXX<br>Q4 XXXX | Q2 - provisional data | SHA 3/9 | Q3 10/11 | Not Started<br>5 | - | Aug-11 | PJ |
| SQU21 | No of people 70-75 invited for Bowel screening | N | 0 | 0 | | | | Not able to start<br>5 | - | 2012/13 | PJ |
| SQU22 | Cervical test result delivered in 14 days (lab 10 days proxy) | N | 98% | Q1 97.5%<br>Q2 98.9%*<br>Q3 XX.X%<br>Q4 XX.X% | Q2 - provisional data | rank 6/9 SCSHA | May-11 | > 99%<br>2 | Quarterly | Aug-11 | PJ |
| SQU23 | Diabetic Retinopathy screening (offered) | N | >=95% | Q1 100%<br>Q2 XX.X%<br>Q3 XX.X%<br>Q4 XX.X% | updated 25/7/11 | Rank 38/152 England 100.162 Oxon 104.468 | CQC Oct 09 using 08/09 data | 100% | Quarterly | Q1 July | PJ |
| SQU27 | Cumulative Coverage of NHS health checks (offered) 18% | N | Q1 8267<br>Q2 16534<br>Q3 24802<br>Q4 33070 | Q1 2104<br>Q2 11411*<br>Q3 XXXX<br>Q4 XXXX | Updated 18/10/11 | 4/9 SC-SHA 13/30 Southern | SC-SHA Q1 Sept 2011 | | Quarterly - cummulative | Oct-11 | PJ |
| SQU27a | Coverage of NHS health checks (seen) 10.8% - cummulative | N | Q1 4960<br>Q2 9920<br>Q3 14881<br>Q4 19842 | Q1 294<br>Q2 3644*<br>Q3 XXXX<br>Q4 XXXX | Updated 18/10/11 | 4/9 SC-SHA | SC-SHA Q1 Sept 2011 | | Quarterly - cummulative | Oct-11 | PJ |
| SQU27a | Coverage of NHS health checks (offered) | L | Q1 0<br>Q2 4483<br>Q3 8966<br>Q4 13449 | Q1 2104<br>Q2 9307*<br>Q3 XXXX<br>Q4 XXXX | Updated 18/10/11 | 13/30 Southern | SC-SHA Sept 2011 | | Quarterly | Oct-11 | PJ |
| SQU27a | Coverage of NHS health checks (seen) | L | Q1 0<br>Q2 2690<br>Q3 5380<br>Q4 8070 | Q1 294<br>Q2 3350*<br>Q3 XXXX<br>Q4 XXXX | Updated 18/10/11 | 4/9 SC-SHA | SC-SHA Sept 2011 | | Quarterly | Oct-11 | PJ |

*Provisional

## Statutory and Mandatory Training and Appraisal

| | | | | | |
|---|---|---|---|---|---|
| Appraisal | **October** | L | 90% | 96% | |
| Mandatory training | Fire | L | 90% | 96% | |
| | manual Handling | L | 90% | 100% | |
| | Equality & Diversity | L | 75% | 96% | |
| | Information Governance | L | 100% | 100% | |
| | H&S / Risk Assessment | L | 75% | 96% | |
| | Safeguarding | L | 75% | 95% | |



KEY = 1(Safe) - 5 (Very Risky)

# PROVISIONAL PUBLIC HEALTH OUTCOME FRAMEWORK INDICATORS 2011/12

| Indicator Code | Description | Type | Target 11/12 unless stated | Actual to date | Current / Predicted RAG Rating 2011/12 | Benchmark | Date of benchmark | RAG Rating/ Performance 2010/11 | Actual data Frequency | Next Data Due | Who to chase / Link |
|---|---|---|---|---|---|---|---|---|---|---|---|
| PHOC | CVD Mortality <75 | Lold | 2010 50.5 | 2010 = | | Rank 30/152 SC rank 4/9 | 2008 | 2008 55.67 2009 42 | Annual | 2010 due Nov 11 | ABa |
| PHOC | Cancer Mortality <75 | Lold | 2010 100.7 | 2010 = | | rank 16/152 SC rank 3/9 | 2008 | 2008 102.5 2009 92.7 | Annual | 2010 due in Nov 11 | TP |
| PHOC | Conception rate per 1000 females aged 15-17 | Lold | 2010 200 (17.25) Q1 50 Q2 50 Q3 50 Q4 50 | 2010(rolling rate) Q1 67 (26.3) Q2 71 (25.8) Q3 xx (xx.x) Q4 xx (xx.x) | As at 24/08/11 | England 37.2 South East 29.9 rank 18/151 Eng rank 6/13 in SC | Q1 2010 | 2009 26.1 conceptions 302 | Annual (15 months in arrears) | Nov-11 | ABa |
| PHOC | Childhood Obesity Coverage: Year R & Year 6 | Lold | 2011/12 Year R>=89.1% Year 6>=87.3% | School year Sept 2010 reported 2011/12 Year R= 93.1%* Year 6= 90.7%* | As at 02/08/11 (provisional data) | YR Eng 92.9% SC 92.9% 8/9 Y6 Eng 89.9% SC 87.4% 7/9 | NCMP Dec 10 | School year Sept 2009 reported 2010/11 Year R= 90.5% Year 6= 86.6% | Annual | end Aug | ABa |
| PHOC | Childhood Obesity Prevalence: Year R & Year 6 | Lold | 2010/11 Year R<=8.2% Year 6<=15.3% | School year Sept 2010 reported 2011/12 Year R= 7.40% Year 6=14.94% | As at 19/08/11 (provisional data, final due in Jan 2012) | YR En 9.8% 13th SC 8.9% 1/9 Y6 Eng 18.7 7/152 SC 16.4% 2/9 | NCMP Dec 10 | School year Sept 2009 reported 2010/11 Year R= 8.0% Year 6=15.1% | Annual | Jan-12 | ABa |
| PHOC | DTaP/IPV/Hib 1 yrs (Diptheria, Tetanus, Acellular Pertussis / Inactivated Polio Vaccine / Haemophillus Infuenzae B ) | Lmain | 2011/12 96.5% | q1 95.4% q2 xx.x% q3 xx.x% q4 xx.x% | | England 94.2% SC 96.0% SC Rank 1/9 Eng rank 2/152 | Q4 10/11 | 97.40% | Quarterly (6 weeks in arrears) | Q2 end of Nov | PJ (GS) |
| PHOC | PCV 2 yrs (Pneumoccocal C Vaccine) | Lmain | 2011/12 95% | q1 94.3% q2 xx.x% q3 xx.x% q4 xx.x% | | England 89.7% SC 91.3% SC rank 2/9 Eng rank 30/152 | Q4 10/11 | 94.50% | Quarterly (6 weeks in arrears) | Q2 end of Nov | PJ (GS) |
| PHOC | Hib/MenC 2 yrs (Haemophillus Infuenzae B/ Meningoccal C) | Lmain | 2011/12 95% | q1 95.5% q2 xx.x% q3 xx.x% q4 xx.x% | | England 91.7% SC 93.0% SC rank 1/9 Eng rank 21/152 | Q4 10/11 | 95.00% | Quarterly (6 weeks in arrears) | Q2 end of Nov | PJ (GS) |
| PHOC | MMR 2 yrs (Measles, Mumps, Rubella) | Lmain | 2011/12 95% | q1 94.3% q2 xx.x% q3 xx.x% q4 xx.x% | | England 89.5% SC 91.6% SC rank 1/9 Eng rank 12/152 | Q4 10/11 | 93.40% | Quarterly (6 weeks in arrears) | Q2 end of Nov | PJ (GS) |
| PHOC | DTaP/IPV 5 yrs (Diptheria, Tetanus, Acellular Pertussis/Inactivated Polio Vaccine) | Lmain | 2011/12 95% | q1 93.2% q2 xx.x% q3 xx.x% q4 xx.x% | | England 86.0% SC 90.2% SC rank 1/9 Eng rank 9/152 | Q4 10/11 | 94.70% | Quarterly (6 weeks in arrears) | Q2 end of Nov | PJ (GS) |
| PHOC | MMR 5 yrs (Measles, Mumps, Rubella) | Lmain | 2011/12 95% | q1 91.2% q2 xx.x% q3 xx.x% q4 xx.x% | | England 84.5% SC 87.3% SC rank 1/9 Eng rank 7/152 | Q4 10/11 | 92.70% | Quarterly (6 weeks in arrears) | Q2 end of Nov | PJ (GS) |
| PHOC | HPV 12-13 yrs (Human papillomavirus) | Lmain | 2011/12 90% | date -yr 8 dose1=xx.x% dose2=xx.x% dose3=xx.x% | | SC rank 1/9 | 2009/10 | Cohort 1 (yr 8) 1 dose=xx% 2 dose=xx% 3 dose=xx% | Quarterly (6 weeks in arrears) | Oct-11 | PJ (GS) |
| PHOC | Td/IPV 13-18 yrs (Tetanus, Diptheria / Inactivated Polio Vaccine) | Lmain | 2011/12 90% | xx.x% | | | | 94.30% | weeks in arrears) | May-12 | PJ (GS) |
| PHOC | Seasonal flu 65+ | N | >75% | | | England 72.8% | 2010/11 | 75.00% | | Mar-12 | TP (GS) |
| PHOC | Seasonal Flu HCWs | N | >60% | | | England 34.7% | 2010/11 | 37.50% | | Mar-12 | TP (GS) |
| PHOC | Seasonal Flu Pregnant women | N | >60% | | | England 38% | 2010/11 | 30.40% | | | |
| PHOC | Seasonal Flu <65 at risk | N | >60% | | | England 50.4% | 2010/11 | 47.50% | | Mar-12 | TP (GS) |
| PHOC | Chlamydia Screening (cummulative) **including GUM screens (will be included from April 2012)** | Lold | Q1 7738(7.8%) Q2 15476(17.5%) Q3 23214(26.2%) Q4 30954(35%) | Q1 5394(6.1%) Q2 xxxx(x.x%) Q3 xxxx(xx.x%) Q4 xxxx(x.x%) | updated 14/10/11 | Rank 76/150 E Rank 5/8 SC England 6.5% SC 6.3% | Q1 (2011/12) | 17% (16386 screens) | Quarterly | Official Q1 due Sept | ABa |
| PHOC | Chlamydia Screening (cummulative) | Lnew | Q1 4923 Q2 9636 Q3 16651 Q4 24002 | Q1 2735 Q2 xxxx Q3 xxxx Q4 xxxx | updated 21/9/11 | Rank 102/150 E Rank 5/8 SC England 4.5% SC 4.3% | Q1 (2011/12) | 12.3% (11783 screens) | Quarterly | Official Q1 due Aug | ABa |
| PHOC | Cervical Screening coverage wpmen aged 25-64 screened in last 5 yrs | QA | >80% | Mar 11 78.1% Jun 11 78.2% Sept 11 XX.X% Dec 11 XX.X% | | Rank 6/9 SHCSHA | Jun-11 | | quarterly | | PJ |
| PHOC | Breast Screening coverage women aged 53-70 screened in last 3 years | QA | >70% | June 10 = 79.8% Sept 10 = 79.9% Dec 10 = 79.68% Mar 11 = xx.x% | updated 12/10/11 | Rank 4/9 SHCSHA | Dec-10 | | quarterly | | PJ |
| PHOC | Bowel Screening eligible men & women aged 60-69 adequately FOBt screened | QA | >60% | Mar 11 55.10% Jun 11 56.18%* Sept 11 XX.X% Dec 11 XX.X% | | rank 5/5 in SCSHA | Jun-11 | | quarterly | | PJ |
| PHOC | Bowel Screening eligible men & women aged 70-75 adequately FOBt screened | L | 0% | Not age extended | N/A | | | | quarterly | | PJ |
| PHOC | Smoking at time of delivery | L | <8% | q1 8.29 q2 8.13% q3 xx.x% q4 xx.x% | | rank 3/9 in SCSHA | Oct-11 | 7.9% | quarterly | | ABa |
| PHOC | Breast Feeding Initiation | L | >78% | q1 78.8% q2 xx.x% q3 xx.x% q4 xx.x% | | Eng 73.7% SC 79% rank 6/9 | Q2 2010/11 | 78.1% | quarterly | | ABa |
| ID1 | Antenatal Infectious disease screening - HIV coverage | NSC | >90% | Q1 99.5% | updated 30/9/11 | | | | | | VM |
| ID2 | Antenatal Infectious disease screening - Timely referral of hepatitis B positive women for specialist assessment | NSC | >70% >90% | Q1 33% | updated 30/9/11 | | | | | | VM |
| FA1 | Down's syndrome screening - completion of laboratory request forms | NSC | >97% 100% | Q1 95.9% | updated 30/9/11 | | | 87% | | | VM |
| ST1 | Antenatal sickle cell and thalassaemia screening - coverage | NSC | >95% >99% | Q1 95% | | | | | | | VM |
| ST2 | Antenatal sickle cell and thalassaemia screening - timeliness of test | NSC | >50% >75% | Q1 34.6% | updated 30/9/11 | | | | | | VM |
| ST3 | Antenatal sickle cell and thalassaemia screening - completion of Family Origin Questionnaire | NSC | >85% >95% | Q1 92.4% | updated 30/9/11 | | | | | | VM |
| NB1 | Newborn bloodspot screening - coverage (PCT responsibility at birth) | NSC | >95% >99.9% | Q1 99.9% | updated 30/9/11 | | | 99.43% | | | VM |
| NB2 | Newborn bloodspot screening - avoidable repeat tests | NSC | <2% <0.5% | Q1 1.9% | updated 30/9/11 | | | Q1 2.5% Q2 1.4% Q3 1.4% Q4 1.9% | | | VM |
| NB3 | Newborn bloodspot screening - timeliness of result availability | NSC | 95% 98% | Q1 100% | updated 30/9/11 | | | 98.55% | | | VM |
| NH1 | Newborn hearing screening - coverage | NSC | >95% 100% | q1 xx.x% q2 xx.x% q3 xx.x% q4 xx.x% | | | | Q1 97.6% Q2 97.6% Q3 95.5% Q4 96.8% | | | VM |
| NH2 | Newborn hearing screening - timely assessment for screen referrals | NSC | >95% 100% | | | | | Q1 45.5% Q2 47.6% Q3 40.0% Q4 94.4% | | | VM |
| NP1 | Newborn and Infant Physical examination - coverage (newborn) | NSC | >95% 100% | N/A | | | | | | | VM |
| NP2 | Newborn and Infant Physical examination - timely assessment of developmental dysplasia of hip | NSC | >95% 100% | N/A | | | | | | | VM |
| DR1 | Diabetic Retinopathy Uptake | NSC | >70% >80% | q1 81.4% q2 xx.x% q3 xx.x% q4 xx.x% | updated 27/7/11 | | | Q1 79.2%, Q2 80.6%, Q3 80.7% Q4 80.5% | | | PJ |
| DR2 | Diabetic Retinopathy results issued within 3 weeks of screening | NSC | >70% >95% | Q4 96.2% Q1 97% | | | | 90.10% | | | PJ |
| DR3 | Diabetic Retinopathy treatment within 4 weeks of R3 screen positive | NSC | >70% >95% | Q4 100% | | | | 65% | | | PJ |
| AA1 | Abdominal Aortic Aneurysm Screening - completeness of offer | NSC | >90% 100% | N/A | | | | N/A | | | PJ |
| AA2 | Abdominal Aortic Aneurysm Screening - uptake in suveillance group | NSC | >90% 95% | N/A | | | | N/A | | | PJ |



KEY = 1(Safe) - 5 (Very Risky)

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| (for information only)<br>AA3 | Abdominal Aortic Aneurysm Screening - post operative mortality | NSC | <8%<br><6% | N/A | | | | N/A | | | PJ |



KEY = 1(Safe) - 5 (Very Risky)

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# Proposed outcomes for Adult Health and Social Care Board

## Older People

National health measures[1]:

1. Emergency admissions within 28 days of discharge from hospital
2. Improving recovery from stroke
3. Helping Older People to recover their independence after illness or injury[2]

Social care measures:

1. Enhancing quality of life for people with care and support needs
2. The proportion of people who use services who have control over their daily life
3. Permanent admissions to residential and nursing care
4. Proportion of Older People (65 & over) who were still at home 91 days after their discharge from hospital into reablement/rehabilitation service
5. Delayed transfers of care from hospital and those which are attributable to adult social care
6. Overall satisfaction of people who use services with their care and support
7. The proportion of people who use services who feel safe

## Mental Health

National health measures:

1. Reducing premature death in people with serious mental illness
2. Proportion of people feeling supported to manage their condition
3. Employment of people with mental illness
4. Improving experience of healthcare for people with mental illness

Social care measures:

1. Enhancing quality of life for people with care and support needs
2. The proportion of people who use services who have control over their daily life
3. Proportion of people using social care who receive self-directed support, and those receiving direct payments
4. Proportion of adults in contact with secondary mental health services in paid employment
5. Proportion of adults in contact with secondary mental health services who live independently, with or without support
6. Overall satisfaction of people who use services with their care and support
7. The proportion of people who use services who feel safe

[1] National Health measures were published in September 2011. Adult Social care measures were published in the early summer 2011.
[2] This is actually the same measure as social care measure 4.

## Learning Disabilities

National health measures:

1. Health-related quality of life for people with long-term conditions
2. Proportion of people feeling supported to manage their condition
3. Employment of people with long-term conditions

Social care measures:

1. Enhancing quality of life for people with care and support needs
2. The proportion of people who use services who have control over their daily life
3. Proportion of adults with learning disabilities in paid employment
4. Proportion of adults with learning disabilities who live in their own home or with their family
5. Overall satisfaction of people who use services with their care and support
6. The proportion of people who use services who feel safe

## (Other) Long Term Conditions

National health measures:

1. Health-related quality of life for people with long-term conditions
2. Proportion of people feeling supported to manage their condition
3. Employment of people with long-term conditions

Social care measures:

1. Enhancing quality of life for people with care and support needs
2. The proportion of people who use services who have control over their daily life
3. Overall satisfaction of people who use services with their care and support
4. The proportion of people who use services who feel safe

# Dashboard of Children's Services Assessment Indicators - September 2011

**Paper 1**

**Last updated: 12/09/2011 - latest monthly social care data is as at end of August except where indicated**

| | 2009/10 | | | 2010/11 | | | 2011/12 | | | Latest Performance | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Indicator** | **Targets** | **Actuals** | **Underlying data** | **Targets** | **Actuals** | **Underlying data** | **Targets** | **Actuals** | **Underlying data** | **Latest RAG-rating** | **DoT** |
| 1. Take up of school lunches - primary | No target | **31.3%** | n/a | 30% | nya: Oct 2011 | Annual | 33% (?) | nya: Oct 2012 | Annual | Not RAG-rated | nya |
| 2. Take up of school lunches - secondary | No target | Not returned | n/a | 28% | nya: Oct 2011 | Annual | 31% (?) | nya: Oct 2012 | Annual | Not RAG-rated | nya |
| 3. Obesity - Reception: percentage obese | No target | **7.9%** | n/a | No target | nya: Dec 2011 | Annual | No target | nya: Dec 2012 | Annual | Not RAG-rated | nya |
| 4. Obesity - Year 6: percentage obese | 15.3% | **15.1%** | n/a | 15.2% | nya: Dec 2011 | Annual | No target | nya: Dec 2012 | Annual | Green | nya |
| 5. Referrals leading to initial assessments | 65% | **58.4%** | 3292/5635 | 65% | **61.3%** | 3373/5501 | 65% | **55.0%** | 1467/2666 | Red | ↓ |
| 6. Percentage of initial assessments within 10 days of referral | 68% | **57.9%** | 1908/3292 | 75% | **79.2%** | 2673/3373 | 75% | **88.3%** | 1295/1467 | Green | ↑ |
| 7. Percentage of core assessments completed within 35 days | 82% | **65.9%** | 868/1317 | 82% | **82.5%** | 1534/1859 | 80% | **84.4%** | 777/921 | Green | ↑ |
| 8. Duration of child protection plans: percentage lasting 2 years or more, of those ceasing | <10% | **8.8%** | 27/306 | 7% | **5.5%** | 19/345 | 7% | **5.6%** | 8/142 | Green | ⇅ |
| 9. Percentage of children becoming subject of a child protection plan more than once | 10-15% | **18.2%** | 59/325 | 13% | **18.2%** | 76/418 | 15% | **19.1%** | 45/236 | Red | ↓ |
| 10. Timeliness of reviews of child protection cases: percentage held on time | 100% | **98.5%** | 203/206 | 100% | **99.1%** | 214/216 | 100% | **98.5%** | 263/267 | Amber | ⇅ |
| 11. Placed for adoption within 12 mths | 86.7% (prov) | **88.0%** | 22/25 | 89% | **91.7%** | 22/24 | 89% | **87.5%** | 7/8 | Amber | ↓ |
| 12. Stability of placements: 3+ in year - overall | 11.7% | **11.6%** | 52/449 | 11.0% | **12.6%** | 54/427 | 10% | **5.6%** | 8/430 (e) | Green | ↑ |
| 13. Long-term stability of placements: 2+ yrs | No target | **74.8%** | 86/115 | 70% | **77.7%** | 80/103 | 70% | **77.8%** | 91/117 (p) | Green | ⇅ |
| 14. Timeliness of reviews of looked after children: percentage held on time | 91% | **88.4%** | 372/421 | 93% | **93.7%** | 359/383 | 93% | **84.9%** | 219/258 (June) | Red | ↓ |
| 15. Early Years development measured by Foundation Stage Profile | 55.0% | **59.2%** | 4244/7174 | 57.2% | **62.9%** | 4606/7321 | 62% | nya: Sept 2012 | Annual | Green | nya |
| 16. KS1-KS2 2 levels progression - English | 89% | **87.0%** | 4100/4700 (rounded) | 90% | **87%** | nya | 89% | nya: Nov 2012 | Annual | Amber | ⇅ |
| 17. KS1-KS2 2 levels progression - Maths | 87% | **85.0%** | 4100/4800 (rounded) | 87% | **85%** | nya | 88% | nya: Nov 2012 | Annual | Amber | ⇅ |
| 18. KS 2 level 4 English & Maths | 79% | **74.8%** | 3709/4959 | 80% | **75%** | Annual | 80% | nya: Sept 2012 | Annual | Red | ⇅ |
| 19. KS2 level 4 English - Looked after children | 46% | **46.2%** | 6/13 | 10% | nya: Dec 2011 | Annual | 57% | nya: Dec 2012 | Annual | Green | nya |
| 20. KS2 level 4 Maths - Looked after children | 54% | **30.8%** | 4/13 | 30% | nya: Dec 2011 | Annual | 50% | nya: Dec 2012 | Annual | Red | nya |
| 21. Key Stage 2 attainment for minority ethnic groups | See BAME attainment dataset | | | See BAME attainment dataset | | | See BAME attainment dataset | | | See BAME attainment | n/a |

| | 2009/10 | | | 2010/11 | | | 2011/12 | | | Latest Performance | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Indicator** | **Targets** | **Actuals** | **Underlying data** | **Targets** | **Actuals** | **Underlying data** | **Targets** | **Actuals** | **Underlying data** | **Latest RAG-rating** | **DoT** |
| 22. GCSE: 5+ A*-C inc E/M | 60% | **57.3%** | 3651/6371 | 62.3% | **58.4% (prov)** | nya | 63% | nya: Sept 2012 | Annual | Red | ↑ |
| 23. Looked after children 5+ GCSE A*-C inc E/M | 16% | **6.4%** | 3/47 (prov) | 17.12% | **nya: Dec 2011** | Annual | 16.1% | nya: Dec 2012 | Annual | Red | nya |
| 24. GCSE: 2+ A*-C Science | No target | **62.8%** | 4002/6439 (EPAS) | 63.2% | **64.1% (prov)** | nya | (Around 59%) | nya: Dec 2012 | Annual | Green | ↑ |
| 25. Key Stage 4 attainment for minority ethnic groups | See BAME attainment dataset | | | See BAME attainment dataset | | | See BAME attainment dataset | | See BAME attainment | | n/a |
| 26. Secondary schools with Good or Outstanding standards of behaviour | No target | **75.0%** | 24/32 | 74.0% | **83.9%** | 26/31 | 78% | nya: Dec 2012 | Annual | Green | ↑ |
| 27. Secondary school persistent absence rate: 20%+ absence | 5.0% | **4.1%** | 1302 | 4.78% | **4.84% (prov)** | 1512 | 4.5% | nya: Dec 2012 | nya | Not RAG-rated | ↑ |
| 28. Under-18 conceptions: rate per 1000 | 22.3 | **29.5** | 347 | 19.8 | **26.1** | 302 | 15.7 | **25.8** | 71 | Red | ⇆ |
| 29. Under-18 conceptions: change from 1998 baseline | -29% | **-6.0%** | 347 | -37% | **-17.1%** | 302 | -50% | **-17.8%** | 71 | Red | ↑ |
| 30. 17 year-olds in education or training (in learning) | 83% | **84.3%** | nya | 89% | **86.6%** | nya | 89% | **88.4%** | nya | Amber | ↑ |
| 31. Young people in NEET: school years 12-14 | 4.0% | **6.5%** | 1067 | 4.8% | **5.9%** | 1016 | 6% | **5.9%** | 904 | Green | ⇆ |
| 32. Care leavers aged 19 in EET | 76.0% | **83.7%** | 41/49 | 80% | **78.4%** | 40/51 | 80% | **70.5%** | 43/61 (p) | Red | ↓ |
| 33. 19 year olds achieving Level 2 | 78% | **79.4%** | 6,617/8,337 | 84.4% | nya: Apr 2012 | Annual | 85.6% | nya: Apr 2013 | Annual | Green | nya |
| 34. 19 year olds achieving Level 3 | 56.6% | **58.0%** | 4,834/8,337 | 63.0% | nya: Apr 2012 | Annual | 64.2% | nya: Apr 2013 | Annual | Green | nya |
| 35. Low income background yp into higher education: attainment gap | No target | **23.5 ppt** | (2007/08 data) | 25 ppt | nya: Aug 2013 | Annual | 24 ppt | nya: Aug 2014 | Annual | Not RAG-rated | nya |
| 36. Care leavers aged 19 in suitable accommodation | 90% | **91.8%** | 45/49 | 90% | **90.2%** | 46/51 | 90% | **86.9%** | 53/61 (p) | Amber | ↓ |

Note: Red-Amber-Green (RAG) ratings are assigned according to performance against target for the most recent year for which there is data.
Green = on, or better than target ; Amber = within 5% of target ; Red = More than 5% from target
If no target was set, then the indicator is not RAG-rated.

Direction of Travel (DoT) is based on a 2% change from last year's result: Upwards = better, Downwards = worse, Horizontal = No significant change.

Results for educational attainment indicators in academic year 2010/11 are provisional at this stage.

Abbreviations :

| | |
|---|---|
| (e) | Current data, extrapolated to end of the year to give the rate or percentage figure |
| (p) | Prediction for end of year |
| (prov) | Provisional |
| nya | Not yet available |