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OXFORDSHIRE COUNTY COUNCIL
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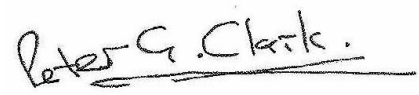
To: Members of the Shadow Oxfordshire Health & Wellbeing Board

Notice of a Meeting of the Shadow Oxfordshire Health & Wellbeing Board

Thursday, 26 July 2012 at 2.00 pm

Meeting Rooms 1 & 2, County Hall, Oxford OX1 1ND



Peter G. Clark
County Solicitor

July 2012

Contact Officer: ***Julie Dean Tel: (01865) 815322***
Email: julie.dean@oxfordshire.gov.uk

Membership

Chairman – Councillor Ian Hudspeth
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 Network
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
Jim Leivers	Director for Children's Services

Notes:

- ***Date of next meeting: 22 November 2012***

Declarations of Interest

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

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

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

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

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

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

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

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

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

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

For a full list of Disclosable Pecuniary Interests and further Guidance on this matter please see the Guide to the New Code of Conduct and Register of Interests at Members' conduct guidelines. http://intranet.oxfordshire.gov.uk/wps/wcm/connect/occ/Insite/Elected+members/ or contact Rachel Dunn on (01865) 815279 or Rachel.dunn@oxfordshire.gov.uk for a hard copy of the document.

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

AGENDA

1. Welcome by Chairman, Councillor Ian Hudspeth

2. Apologies for Absence and Temporary Appointments

3. Declarations of Interest - see guidance note opposite

4. Petitions and Public Address

5. Note of Decisions of Last Meeting (Pages 1 - 8)

To approve the Note of Decisions of the meeting held on 22 March 2012 (**HWB5**) and to receive information arising from it.

6. Amendment to Terms of Reference for the Health & Wellbeing Board

2:05
5 minutes

Person(s) Responsible: Members of the Health & Wellbeing Board
Report presented by: Peter Clark, Monitoring Officer and Head of Law & Culture

Action required: To amend the Shadow Health & Wellbeing Board's Terms of Reference as agreed at the 24 November 2011 meeting, to include a proposal that a senior officer of the Oxfordshire Clinical Commissioning Group be added to the list of officers in attendance at Health & Wellbeing meetings.

7. Joint Strategic Needs Assessment (Pages 9 - 24)

2:10
10 minutes

Person(s) responsible: Members of the respective Partnership Boards
Reports presented by: Director of Public Health

(a) Joint Strategic Needs Assessment (JSNA) – Briefing on the process for revision of JSNA Dr McWilliam will present detailed plans for a thorough revision of the JSNA during 2012 – 13 **(HWB7(a))**. For discussion.

(b) Highlight Report on 2010 – 11 Data Refresh – JSNA. Dr McWilliam will present a report, for the Board's information, on the information used to set the context for Health & Wellbeing priority setting (**HWB7(b**)).

Action required: members of the Board are asked to consider the following questions:

(a) are you content with the vision and governance of the JSNA?

(b) are there any amendments or changes in emphasis that you would like to see?

8. Joint Health & Wellbeing Strategy (Pages 25 - 56)

2:20
30 minutes

Person(s) Responsible: Members of the Health & Wellbeing Board
Reports presented by: Director of Public Health

(a) Report on the consultation and summary of recommended changes
Dr McWilliam will present an overview of the consultation undertaken and a summary of the responses received **(HWB8(a))**

Action Required: to discuss the public consultation results and to debate, decide on and agree on the specific issues raised in this paper.

(b) Approval of final draft Joint Health & Wellbeing Strategy
The post-consultation draft Strategy is attached for consideration **(HWB8(b)(i)).**

As part of the discussion, the Board will need to be mindful of the potential impact on individuals, communities and organisations, including those that share protected characteristics under the Equality Act 2010. To this end, the Service and Community Impact Assessment is attached at **HWB(b)(ii)** for information.

Action Required: to approve the finalised draft Strategy as set out at HWB8(b)(i)).

9. Reports from Partnership Boards

2:50
15 minutes

There will be oral updates from the Chairmen of each Partnership Board in order to provide information on recent progress.

- Children & Young People
- Health Improvement
- Adult Health & Social Care

Action Required: to note the reports.

10. Performance Reports from Partnership Boards (Pages 57 - 66)

3:05
15 minutes

Person(s) Responsible: Members of the Health & Wellbeing Board
Person giving report: Director of Public Health

The following reports will be submitted:

(a) Summary performance report **(HWB10(a))**
(b) Reports on performance issues in relation to:
(1) NHS Health Checks **(HWB10(b)(i))**
(2) Young People not in Education, Employment or Training **(HWB10(b)(ii)**

Action required: Members of the Health & Wellbeing Board are asked to note this information and agree the proposed approach to performance reporting.

11. Themed Discussion - Frail, Older People (Pages 67 - 72)

3:20
25 minutes

There will be a discussion on a range of issues identified in Oxfordshire in relation to frail, older people and how they are being addressed. A background paper, submitted by the Director for Social & Community Services (OCC) and the Interim Director of Planning & Development (OCCG) is attached at **HWB11**.

12. Briefing on the White Paper on Adult Social Care

3:45
20 minutes

Person(s) responsible: Members of the Health & Wellbeing Board
Person giving the report: Director of Social & Community Services

John Jackson will give a presentation on the recently published White Paper on Adult Social Care, highlighting the implications for the work of the Board.

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OXFORDSHIRE COUNTY COUNCIL
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INFORMAL SHADOW OXFORDSHIRE HEALTH & WELLBEING BOARD

OUTCOMES of the meeting held on Thursday, 22 March 2012 commencing at 9.30 am and finishing at 11.30 am

Present:

Board Members: Councillor Keith R. Mitchell CBE – in the Chair

Dr Stephen Richards (Vice-Chairman)
District Councillor Mark Booty
Councillor Val Smith
Dr Jonathan McWilliam
Sue Butterworth
Dr Joe McManners
John Jackson
Councillor Louise Chapman
Dr Mary Keenan
Jim Leivers

Officers:

Whole of meeting — Joanna Simons, Peter Clark and Julie Dean (Oxfordshire County Council)

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

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

	ACTION
1 Welcome by Chairman, Councillor Keith R. Mitchell CBE	
2 Apologies for Absence and Temporary Appointments	
Councillor Arash Fatemian, Chairman of the Adult Health & Social Care Board and Matthew Tait, Chief Executive, Buckinghamshire & Oxfordshire NHS Cluster, extended their apologies.	

3 Declarations of Interest - see guidance note opposite	
There were no declarations of interest.	
4 Petitions and Public Address	
There were no petitions or requests to speak submitted.	
5 Note of Decisions of Last Meeting	
To approve the Note of Decisions of the meeting held on 24 November 2011 (**HWB5**) and to receive information arising from them. The Decision Note was approved and signed as a correct record.	Julie Dean
6 Approval of Terms of Reference for the Partnership Boards	
Peter Clark, County Solicitor & Monitoring Officer, presented the Board with the draft Terms of Reference for the Partnerships listed below, for consideration (HWB6). It was **AGREED** to approve the draft Terms of Reference for the: • Adult Health & Social Care Partnership Board • Oxfordshire Children & Young People's Partnership Board • Health Improvement Partnership Board subject Mr Clark looking further into a possible revision to the Terms of Reference relating to the Children & Young People's Partnership Board, with a view to encompassing a link with the Terms of Reference for the Oxfordshire Children Safeguarding Board.	)))) Peter Clark/ Glenn Watson))))
7 Overview of the new and emerging powers and duties of the Health & Wellbeing Board	
Dr McWilliam gave an overview (HWB7) of new and emerging powers and duties in so far as they relate to member organisations and of the Board itself. It was **AGREED** to note the new powers and duties.	All to note

8 Priorities from the Joint Strategic Needs Assessment for Health and Wellbeing as summarised in the Director of Public Health Annual Report	
Dr McWilliam gave an overview from the fifth Director of Public Health Annual Report (HWB8) which reviewed the Joint Strategic Needs Assessment (JSNA) data from the last four years; with a view to reviewing County priorities for health and wellbeing and to make recommendations for the Health & Wellbeing Board. It was **AGREED** to note the overview and to thank Dr McWilliam for his presentation.	All to note
9 Proposed outcome measures and target indicators for the Adult Health & Social Care Partnership Board	
The Vice-Chairman of the Adult Health & Social Care Partnership Board, Councillor Joe McManners, presented proposals for tackling the highest priorities and outcomes for Adult Health and Social Care as set out in the report HWB9. During the course of the discussion, members of the Board suggested the following for inclusion into the draft Health & Wellbeing Strategy: • The addition of an indicator relating to satisfaction with hospital based care; • A more ambitious target in relation to the identification of dementia; • The inclusion of an outcome on the availability of extra care housing; • When making final decisions on outcomes to be included within the Strategy, to conduct further discussions, as part of the public consultation, on whether outcomes on care home places and re-ablement are too ambitious; • Also in relation to the above, to consider whether the timescales for the Section 75 agreement are realistic; and • The need for signposting across the whole of Adult & Social Care services. It was **AGREED** to **APPROVE** proposals for tackling the highest priorities and outcomes for Adult & Social Care contained within the report HWB9, in principle, and to request the officers to investigate the above for possible inclusion within the consultation paper for the Strategy.	Cllr Arash Fatemian/ Cllr Joe McManners/ John Jackson

10 Proposed outcome measures and target indicators for the Children & Young People's Partnership Board	
The Chairman and Vice - Chairman of the Children & Young People's Partnership Board, Councillor Louise Chapman and Dr Mary Keenan, presented proposals for tackling the highest priorities and outcomes for children and young people, as set out in report HWB10. During the course of the discussion, members of the Board suggested the following for inclusion into the draft Health & Wellbeing Strategy: • The need to benchmark safeguarding outcomes with national comparators; • Geographical focus required for work on attainment, to raise horizons, not simply by deprivation; • The need to continue the County Council's success with regard to Teenage Pregnancy targets; and • The need to ensure that we focus on the gap between conception rates and educational attainment. It was **AGREED** to **APPROVE** proposals for tackling the highest priorities and outcomes for Adult & Social Care contained within the report HWB10 and to request the officers to investigate the above for possible inclusion within the consultation paper for the Strategy.	Cllr Louise Chapman/Dr Mary Keenan/Jim Leivers
11 Proposed outcome measures and target indicators for the Health Improvement Partnership Board	
The Chairman and Vice-Chairman of the Health Improvement Board, Councillors Mark Booty and Val Smith, presented proposals for tackling the highest priorities and outcomes for health improvement, as set out in report HWB11. During the course of the discussion, members of the Board suggested the following for inclusion into the draft Health & Wellbeing Strategy: • A communication programme with groups not accessing services is key; • A need to map key service providers, including large and small voluntary organisations, with a view to ascertain if there is a common approach to support systems; • To report to the Health Improvement Board and subsequently this body, on the work in progress to reduce alcohol related harm;	

• To make the forthcoming workshop on housing issues inclusive of all issues including extra care housing, sheltered housing, housing for the Military and to link it to Supporting People; • To devise a form of reporting on support for homeless people, together with support for their families; and • To increase the target to reflect uptake of bowel screening. It was **AGREED** to **APPROVE** proposals for tackling the highest priorities and outcomes for health improvement contained within the report HWB11 and to request the officers to investigate the above for possible inclusion within the consultation paper for the Strategy.	Cllr Mark Booty/ Cllr Val Smith/ Jonathan McWilliam
12 Progress report on establishment of the Public Involvement Board	
Sue Butterworth briefed members of the Board on the recent national developments with regard to HealthWatch, together with the arrangements for taking it forward locally. The local HealthWatch was to be commissioned from April 2013 and it was hoped that the contract would be awarded by Autumn 2012 to enable arrangements to be put in place. These would be supported by a transition grant to be made available by the Department of Health to all authorities. She also reported orally on progress in relation to the establishment of the Public Involvement Board (PIB). The findings from the local HealthWatch consultation and the consultation undertaken by Oxfordshire Clinical Commissioning Group with regard to engagement in the new Health structures had informed the development of the PIB model. The Steering Group had developed this thinking in a workshop setting which took place on 2 March 2012 at which a wide plethora of organisations, carers and service users were represented. She added that whilst the aims of the PIB had been welcomed by people attending the workshop, there had been considerable confusion about the use of the term 'Board', it being regarded as 'misleading' in terms of its function and powers and its overlapping functions with HealthWatch in relation to public engagement. Accordingly, the Steering Group had met to review the model and now recommended to the Health & Wellbeing Board the following transitional model which included the following features: • To rename the PIB to the Public Involvement Network (PIN); • To establish the PIN for 1 year to April2013 initially,	

pending the establishment of the local HealthWatch and a review of its effectiveness. The PIN would ensure that the opinions and experiences of people in Oxfordshire would underpin the work of this Board and its Partnership Boards; and develop new engagement routes where gaps are identified via active and effective public engagement; • To develop joint Quality Standards for engagement activity across the network as part of the Oxfordshire HealthWatch Kitemark plans; • A small PIN Advisory Group, to include representatives from the County, City and District Councils, OCCG, the voluntary sector, users and carers and the Oxfordshire LINk would manage the transitional year; and • Two expert witnesses, to be identified via the PIN, to attend the Partnerships and workshops. Accountability for the PIN, and indeed the whole of the Health & Wellbeing structure remained with the Oxfordshire Joint Health Overview & Scrutiny Committee. The Vice-Chair brought to the Board's attention the need for clarity of linkage of particular groups based on the six GP Commissioning locations. Members of the Health & Wellbeing Board **AGREED** to: (a) thank Sue Butterworth for her report; (b) approve the above transitional model for the PIN; and (c) to request the officers to bring a report to the next meeting on 26 July on the linkage of particular groups based on the GP Commissioning locations.	) Sue Butterworth/ Dr Stephen Richards)
13 Joint Health & Wellbeing Strategy and Forward Plan	
The Director for Social & Community Services led a discussion on the process and timing for the production of the draft Joint Health & Wellbeing Strategy (HWB13). Members of the Board were reassured that work was underway to ensure that consultation would take place with all interested Groups within Oxfordshire. Members of the Board **AGREED** to note the process and timing for the production of the Strategy, as set out in the report HWB13.	All to note

14 Implications of the Health & Wellbeing Board priorities for the work of partner organisations	
Dr. Stephen Richards and Councillors Keith Mitchell and Mark Booty led some reflections on discussion during the meeting insofar as it related to the day to day work of the Clinical Commissioning Group and the County and District Councils. Points raised included the following: Members of the Board commented that the promotion of the cross cutting nature and integration of different organisations was an exciting concept, albeit challenging; and it was felt that a strong starting point had been made towards the overall goal of improving health and social care outcomes for the population of Oxfordshire. This was a valuable opportunity to set a working model to deliver for the next decade. It was also an opportunity to begin to get upstream towards a prevention agenda – to this end a housing link was of particular importance. Further, it was felt that this was an ideal opportunity to communicate with hard to reach groups and thus, a Communication Strategy was of the utmost importance to realise this. A practical endeavour to ensure that the language used in reports was meaningful to all interested people was therefore also crucial.	

..... in the Chair

Date of signing .....

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Joint Strategic Needs Assessment for Oxfordshire

Briefing for the Oxfordshire Health and Wellbeing Board

26 July 2012

1. This paper sets out the process for revising the Joint Strategic Needs Assessment for Oxfordshire. A companion paper (HWB 7 (b)) gives a highlight report from the refreshed JSNA data for 2010-11 on priority areas for the Health and Wellbeing Board.

Introduction

2. Guidance from the Department of Health, published in October 2011, sets out the following explanation about the link between the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy:

3. *"At the heart of the health and wellbeing board's role in joining up commissioning across health and social care, is the development of a Joint Strategic Needs Assessment (JSNA). The production of a JSNA is an existing statutory duty, which currently rests with local authorities and PCTs. From April 2013, local authorities and CCGs will each have equal and explicit obligations to prepare a JSNA, and this duty will have to be discharged by the health and wellbeing board. The JSNA must consider all the current and future health and social care needs in relation to the area of the responsible authority – needs which are capable of being met, or affected to a significant extent, by the local authority, clinical commissioning group or NHS Commissioning Board functions. In preparing the JSNA, there is a requirement to involve people living or working in the area, as well as the local Healthwatch, and, in the case of county councils, the relevant district councils. Others, such as professionals from outside the area or organisations, may also be involved in or invited to contribute to its development as is considered appropriate."*

4. This paper sets out the process by which the Oxfordshire Joint Strategic Needs Assessment will be revised during 2012-13 in order to make sure the Health and Wellbeing Board has a strong platform for future planning.

5. The existing JSNA was updated in 2011-12 and a highlight report on the issues identified as priorities for the Oxfordshire Health and Wellbeing Board is appended.

Revising the Joint Strategic Needs Assessment for Oxfordshire

Vision

6. A Joint Strategic Needs Assessment that will provide an analysis of need in Oxfordshire to drive decision making across a wide range of areas and which is accessible to all partners.

7. The JSNA will comprise:
   - A new, broader data set to which new indicators have been included to reflect both need and performance and to respond to feedback from partners
   - Trend information on as many indicators as possible, so everyone can see whether things are getting better or worse.
   - A range of appended documents on specific topics or reporting about needs of particular groups of people, contributed by partners including VCS organisations
   - Information at a level of detail which is sufficient to identify inequalities without compromising confidentiality e.g. ward level, super output area, service area (eg GP surgery or school).
   - Information on groups with protected characteristics to ensure all partners can be compliant with the Equalities Act and ensure service planning is responsive to need.

Strategic Decision making

8. This function will be taken on by the H&WB Steering Group which meets twice a month

9. Core membership for the strategic direction of the JSNA revision:
   - Director of Public Health (Jonathan McWilliam)
   - Director of Children, Education and Families (Jim Leivers)
   - Director of Social and Community Services (John Jackson)
   - Clinical Commissioner from CCG (Peter von Eichstorff)
   - District Councils partnerships officer (Val Johnson)
   - Corporate Delivery Manager (Alexandra Bailey)
   - Project manager from OCC (John McLauchlan)
   - Other officers from OCC, Public Health, CCG as appropriate

10. Role:
    - Provide strategic oversight for the project
    - Ensure timely delivery of project plan
    - Engage elected members and Clinical leads
    - Engage with and report to H&WB and partnership boards

Contents of the JSNA

11. A partnership group is being established to
    - Ensure participation by a range of partners, including local authorities, public health, Clinical Commissioning Group, Voluntary and Community Sector organisations, Armed forces, Community Safety Partnership, Local Enterprise Partnership.
    - Draw up and implement detailed action plans,
    - Define the scope of the JSNA, to include H&WB, Economy and Environment, Community Safety, an Asset Register, outcomes for improvement.
    - Commission the products that are needed, including additional data sets, additional analysis by locality or population group.
    - Ensure analysis is complete and accessible
    - Provide expert interpretation of data so that the implications can be understood and acted upon
    - Plan consultation with the public
    - Draft the JSNA report and other outputs

Technical Work

12. Technical experts from a range of organisations will
    - Ensure that existing data is updated and available to all partners
    - Provide or acquire new data as needed
    - Provide new analysis as needed, including trend data for indicators where this is relevant and helpful
    - Add or link to existing data / information from other sources e.g. community safety Information Management System, VCS organisation needs assessments, other completed reports that can be appended to the JSNA
    - Develop the “Data Room” as the home of the new JSNA data

13. **The Health and Wellbeing Board members are asked to consider the following questions**:
    (a) Are you content with the vision and governance of the JSNA?
    (b) Are there any amendments or changes in emphasis that you would like to see?

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Oxfordshire Joint Strategic Needs Assessment

Highlight Report for the Health and Wellbeing Board on the refresh of the JSNA, March 2012

(from JSNA data set versions 4 and 5 - 2010/2011 data)

Introduction

The Joint Strategic Needs Assessment (JSNA) for Oxfordshire brings together a vast range of health and healthcare related data including public health, primary care, social care and hospital services. The data has been refreshed during 2011-12 as a national requirement.

The information underpins strategic planning and priority setting across Oxfordshire. Oxfordshire's Health and Wellbeing Board is accountable for ensuring a high quality JSNA is produced.

This short report draws on the full JSNA data set and highlights particular issues that demand attention. It is not a full report on all the trends or interpretation of every indicator within the data set, but it does provide an overview of important issues for discussion. This will provide the context for discussion and priority setting at the Health and Wellbeing Board and for partner agencies to enable strategic planning.

The data is hosted on the Oxfordshire Local Information System (LIS) and can be found at https://data.oxfordshireobservatory.info/IAS/ . Much of the data is available graphically and on user-defined maps. A user account is required for some levels of data. A wealth of data is available at ward level and finer geographies on the LIS. The ward level data in the annex shows a breakdown on some key indicators. Care should be taken when making comparisons due to small numbers in some of the data.

The data remains available and accessible for further investigation on a wide range of issues throughout the year. Plans are also being implemented for a major revision of the JSNA during 2012-13

Summary

Oxfordshire's JSNA dataset is now in its fifth iteration. Although analysis of the refreshed data shows that health and wellbeing overall in Oxfordshire is generally quite stable, we have now included data trends over time which help to highlight potential priorities. These priorities include:

- More people are living into old age but there are significant differences in life expectancy between particular areas, related to relative disadvantage.
- The population is aging, with the number of people aged over 85 set to double over the next 15 years. This is more apparent in rural areas. The number of informal carers needing support is also rising.
- There has been an increase in the percentage of people with a diagnosis of dementia
- School attainment is improving overall, but some groups of young people still have poor outcomes. These inequalities are related to relative disadvantage
- There is persistent childhood obesity which (though lower than national levels) mirrors upward trends in adult obesity too.
- Several diseases that are considered preventable by adopting healthy lifestyles are a cause for concern in some parts of the county.
- Immunisation rates have been good but there are some signs that coverage is slipping.

1. Oxfordshire - people and place

Oxfordshire remains a comparatively healthy and prosperous place to live.

Life expectancy is above the national average across all districts. However, significant differences do remain between areas within the county.

Fig 1. Male life expectancy, 1998-2010

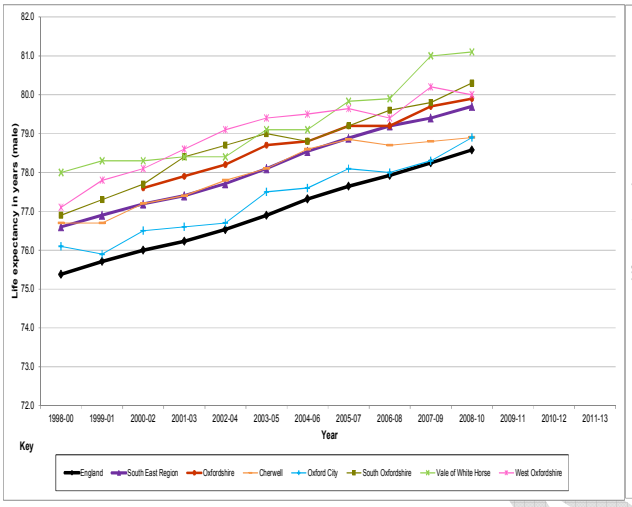
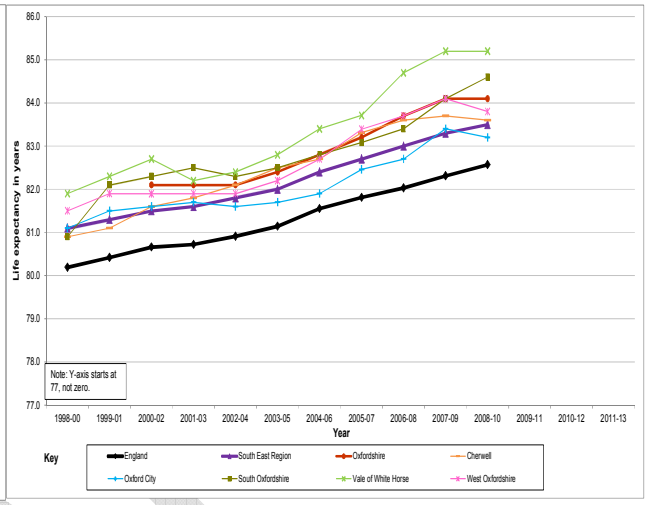


Fig 2. Female life expectancy, 1998-2010



Each year, more people are living into old age. However, these changes to the population are not uniform across the county; with proportionately higher numbers of older people forecast in rural areas, particularly in the west of the county.

Oxford City is has a drastically different demographic profile to the rest of the county. It has a younger population and also a reduced life expectancy in a number of wards.

Population projections suggest that these trends in age structure will continue and associated pressures will therefore intensify over the coming decades.

Fig 3. Population projections for Oxfordshire in 2013

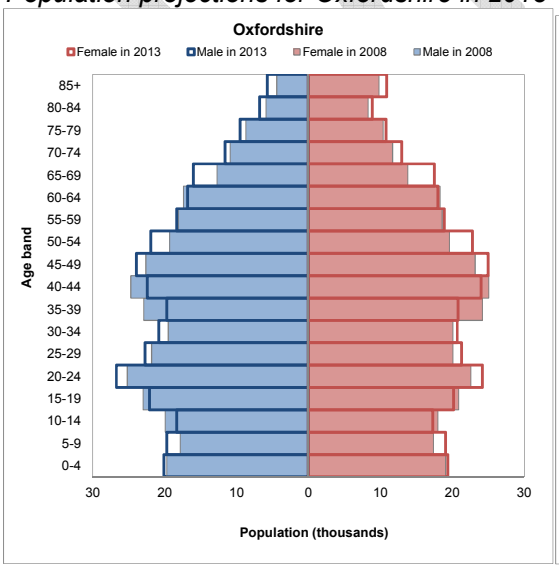
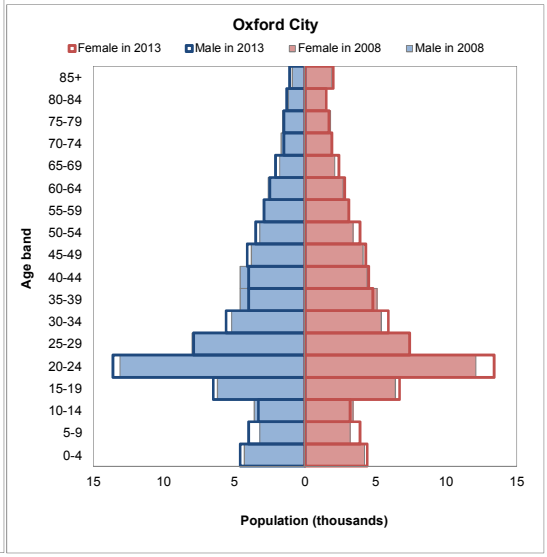
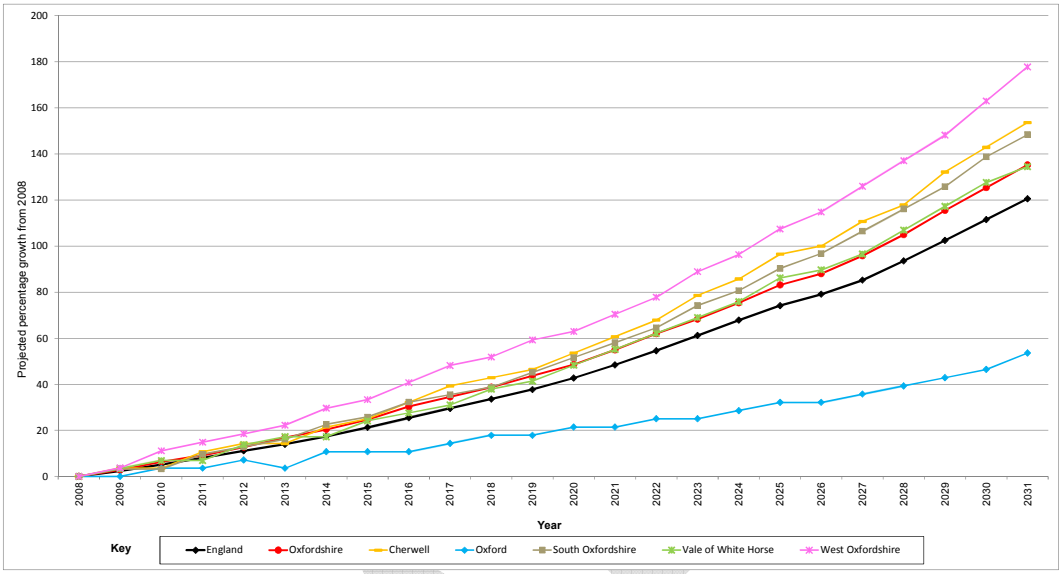


Fig 4. Population projections for Oxford City in 2013



Numbers of people 85+ in particular, are set to double over the next 15 years, with the notable exception of Oxford City. This group traditionally have high health and social care needs associated with aging.

Fig 5. Projected population - Estimated percentage growth from 2008 to 2031 in those aged 85+ years

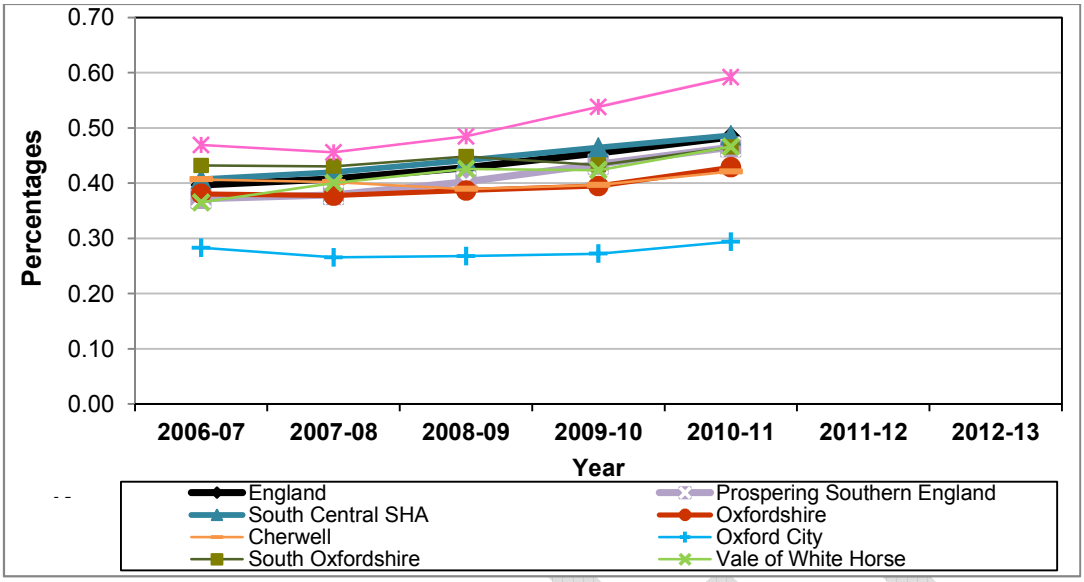


The growing number of older people in Oxfordshire appears to be increasing demand for health and social care services. There are also greater numbers of people with a learning disability surviving into adulthood. Although there has been progress in shifting services from residential to a domiciliary setting in line with policy, the total numbers of people receiving support continue to rise.

Fig 6. Proportion of adult population receiving residential or domiciliary care services

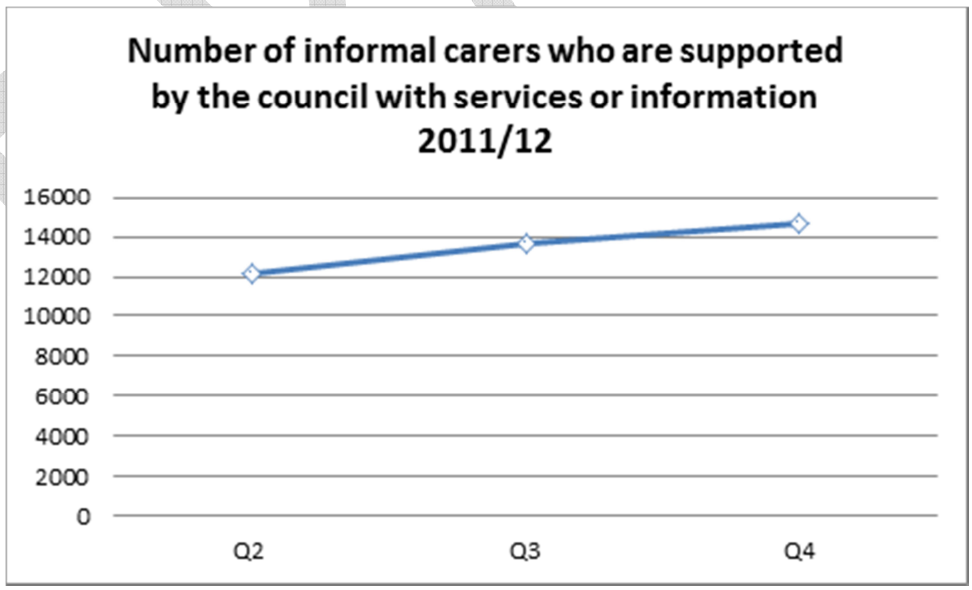
The percentage of patients with a recorded diagnosis of dementia has also increased.

Fig 7. Patients with a recorded diagnosis of dementia in the GP registered population, 2006-2013



As well as increases in the demand for services, recent data show an increase in the number of informal carers given support by Adult Social Care. Whilst carers will be vital in managing increased direct demand for services, this suggests the need to provide adequate support for this group itself.

Fig 8. Number of informal carers in Oxfordshire supported by the council with services or information, 2011-12

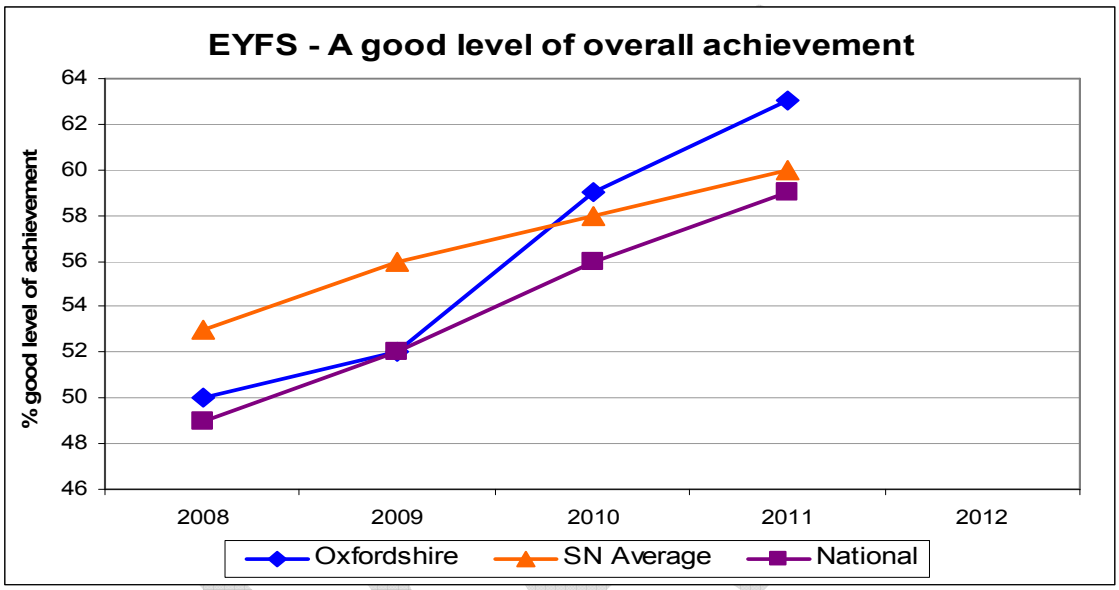


2. Life chances of children and young people

The overall picture of educational attainment is one of strength in early years, but with progressively poorer results at key stages 1 and 4. Early years foundation stage attainment is above both statistical neighbours and national averages, whereas GCSE results this year fell below the national average.

Early Years Foundation Stage

Fig 9. Percentage of pupils receiving a 'good' level of overall achievement[1], 2008-2012



Key Stage One

Fig 10. Percentage of pupils achieving level 2 or above in writing, 2008-2011

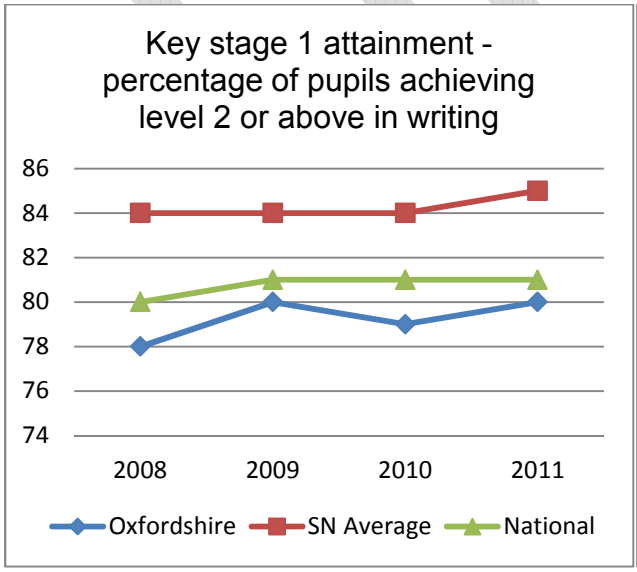
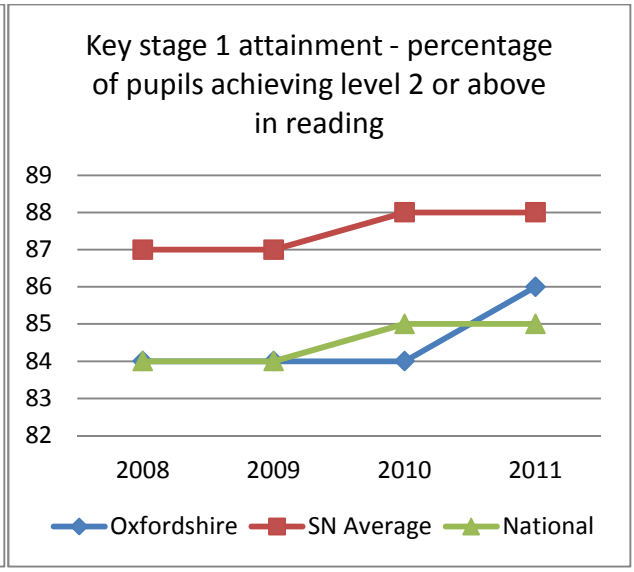


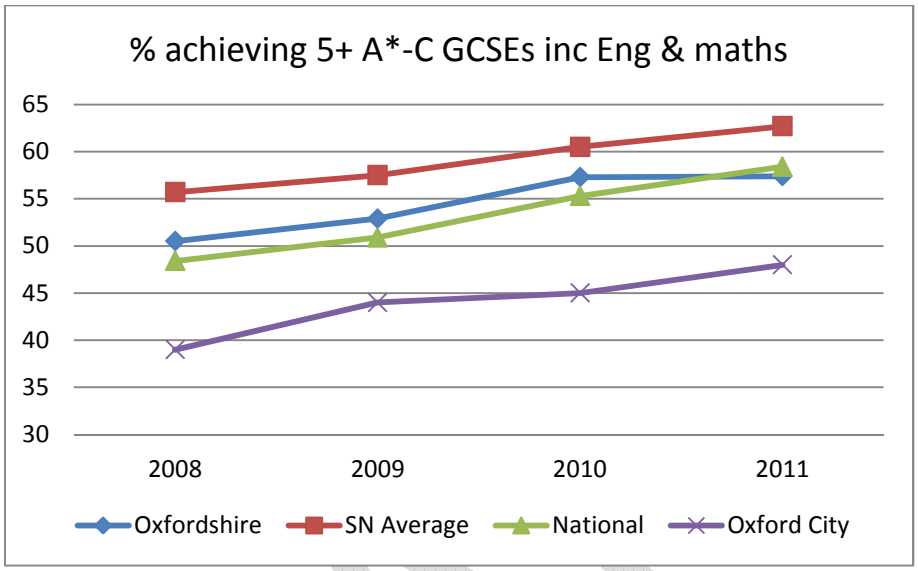
Fig 11. Percentage of pupils achieving level 2 or above in reading, 2008-2011



[1] 78+ points overall and 6+ pointss in Personal, Social & Emotional Development, and Communication, Language & Literacy

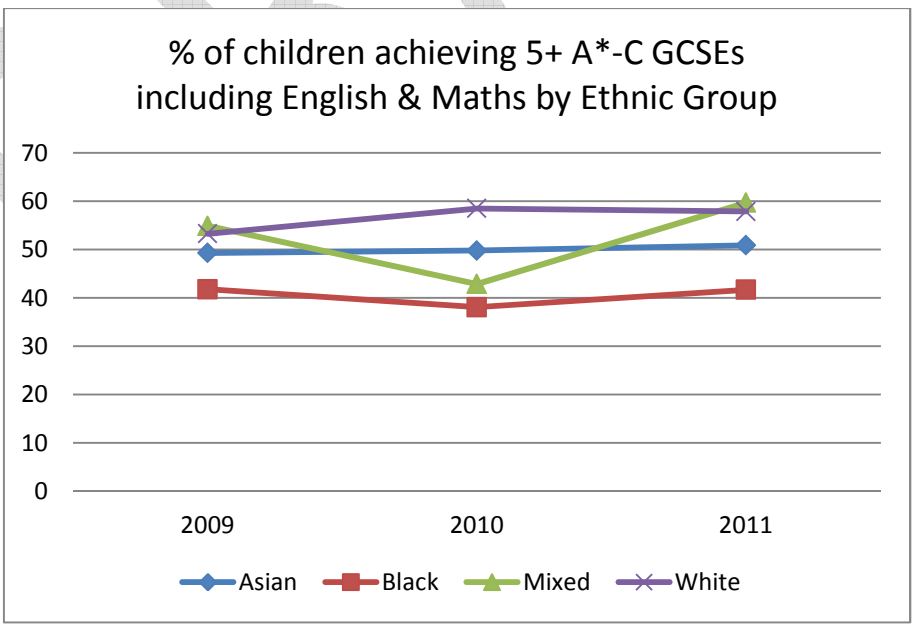
By key stage four, attainment is falling behind Oxfordshire's statistical neighbours. In 2011 GCSE results were particularly disappointing, falling behind the national average. The national trend is towards gradual improvement but there remain significant differences in attainment in Oxfordshire's districts. Oxford City in particular, suffers from poor results.

Fig 12. Percentage of pupils achieving 5 or more A-C GCSEs including English and Maths*



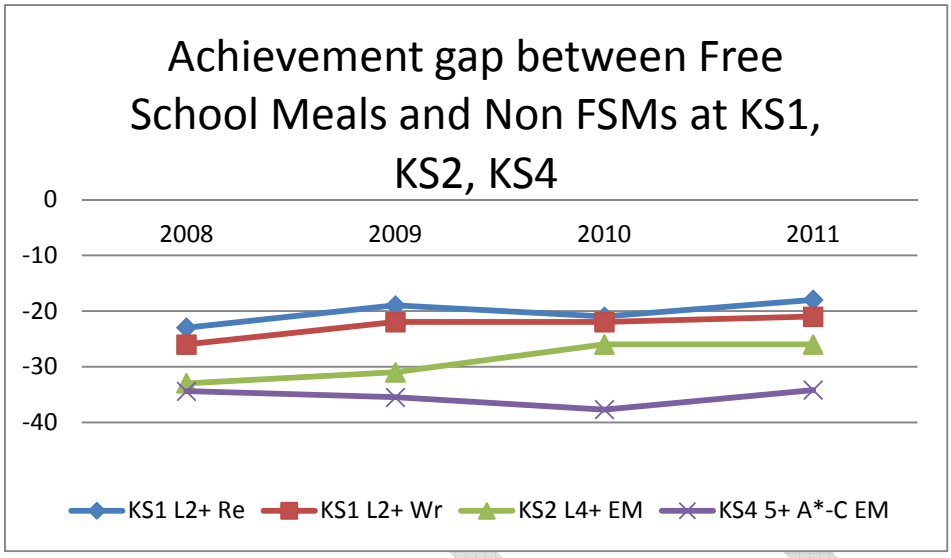
In addition to the geographic inequalities, particular groups are also suffering from poorer educational outcomes. This is an issue for ethnic minorities;

Fig 13. Percentage of children by ethnic group achieving 5 or more A-C GCSEs including English and Maths*



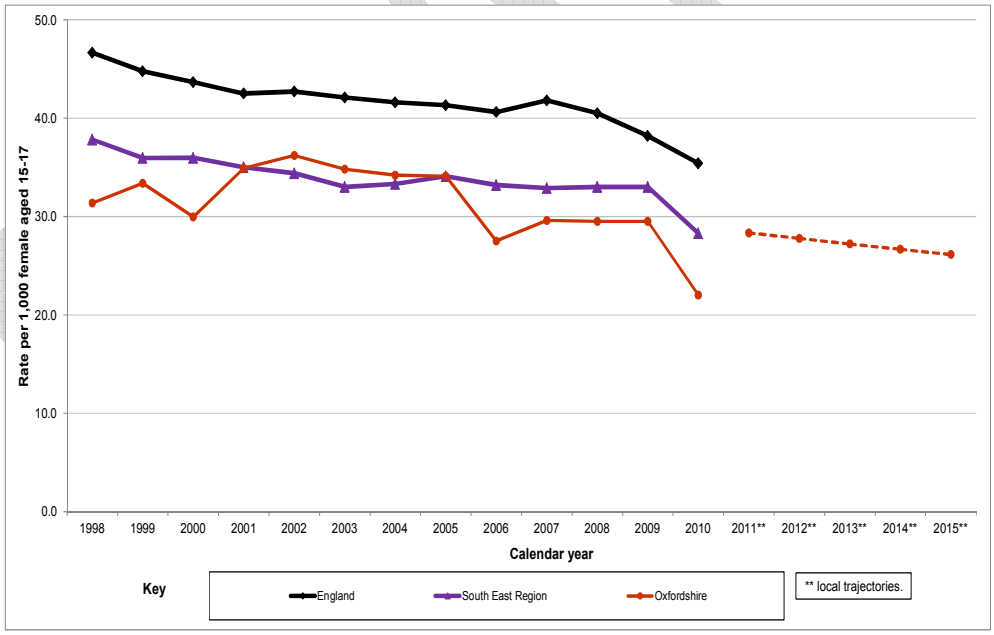
Much of the inequality is rooted in income deprivation and there remains a significant gap in achievement between Children who qualify for free school meals and those who do not. There is some evidence that this is closing but there remains work to do;

Fig 14. Achievement gap between pupils receiving Free School Meals and those who do not at Key Stages 1, 2, and 4, 2008-2011.



One area where targeted intervention has reaped results in improving childhood life chances is in reducing teenage pregnancy

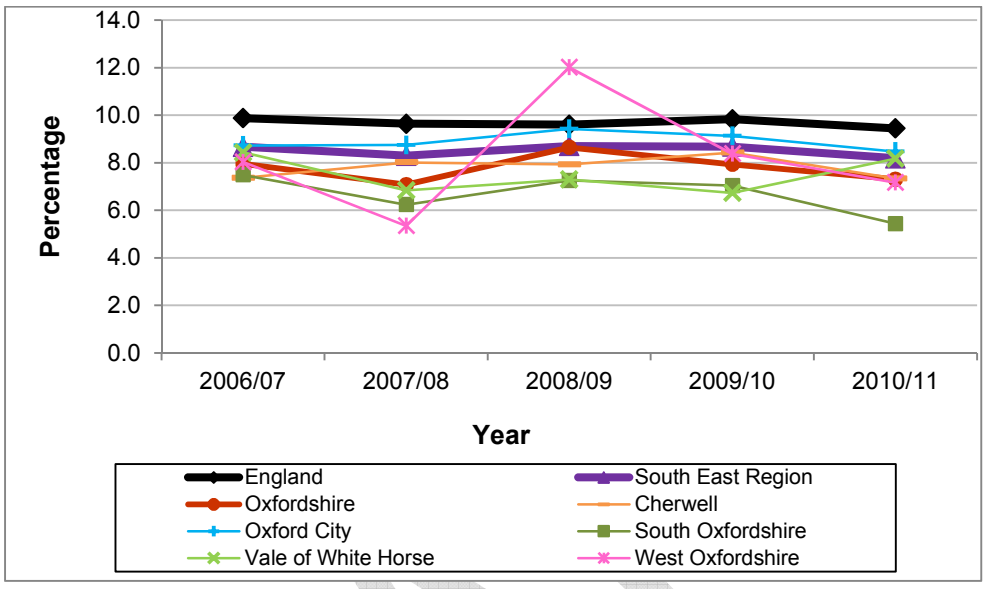
Fig 15. Conception rate per 1,000 female population between 15-17, 1998-2010 (single years)



3. Lifestyle behaviours and prevention of ill health

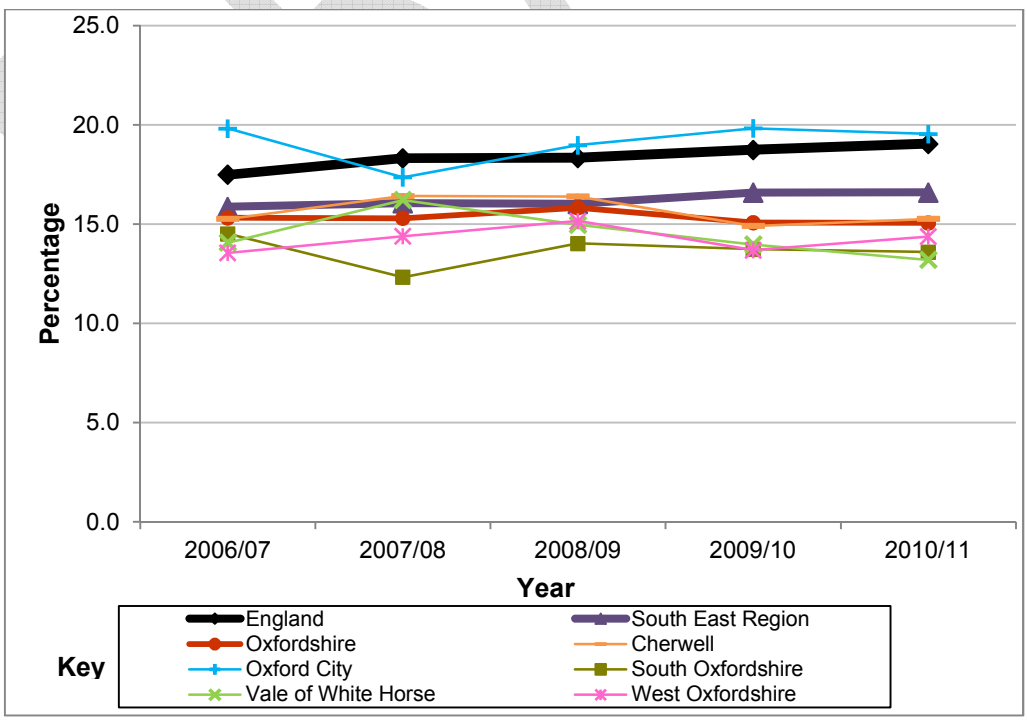
In reception age children there remains a persistent level of obesity (around 8%) which remains below the national average. The level in Oxford city is high for the region however.

Fig 16. Percentage of children in Reception Year who are obese - 2006/07 to 2010/11 (Academic Years)



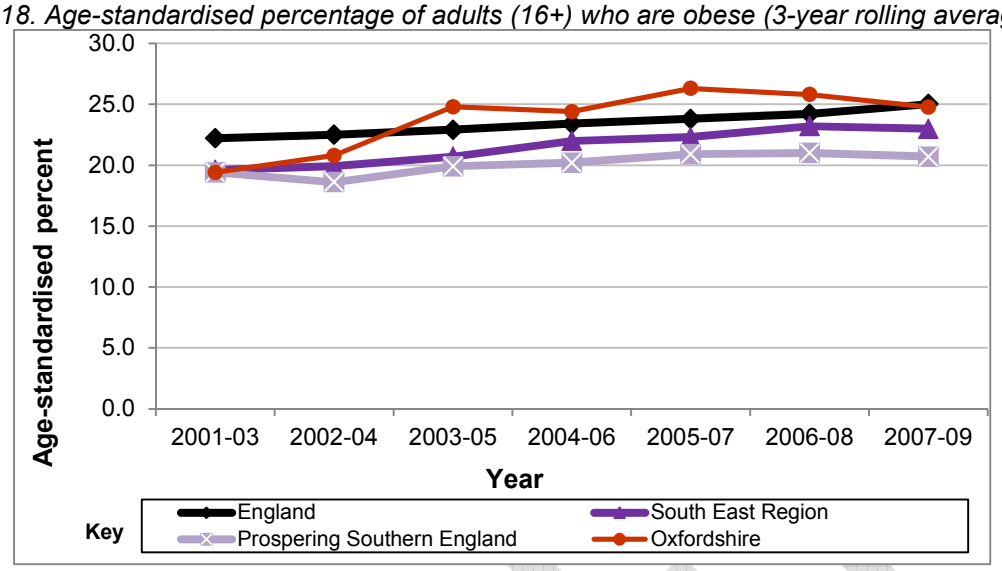
At year 6, 15% of the children weighed are obese. Again this is below national averages, with the exception of Oxford City

Fig 17. Percentage of Year 6 children who are obese: 2006/07 to 2010/11 (Academic Year)



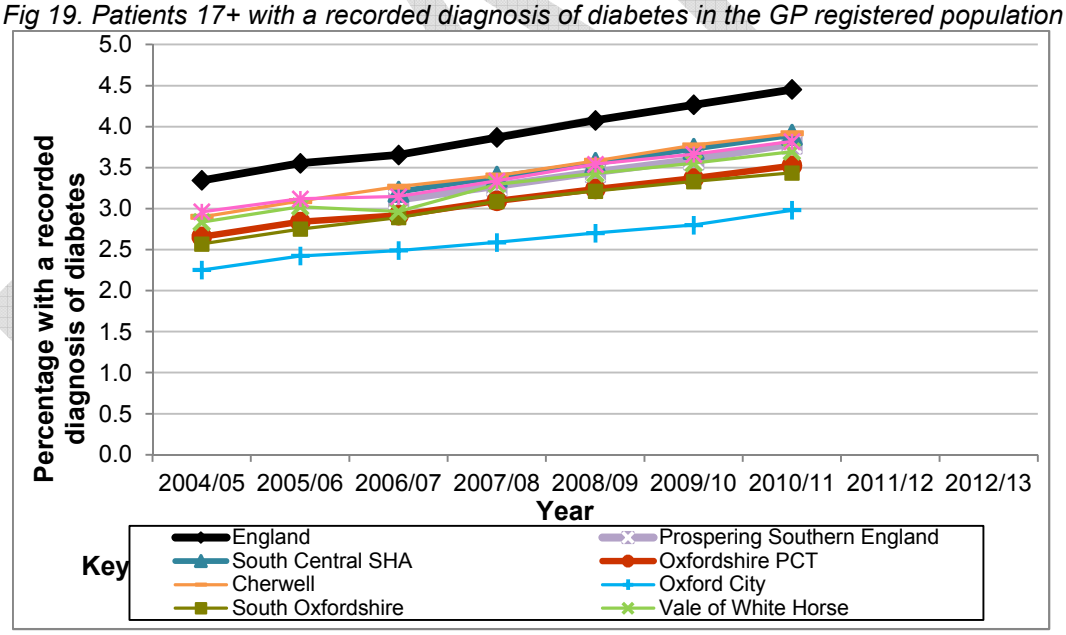
Whilst still slightly below the national level, in adults there is a long-term upward trend in prevalence of obesity in adults in Oxfordshire.

Fig 18. Age-standardised percentage of adults (16+) who are obese (3-year rolling averages)



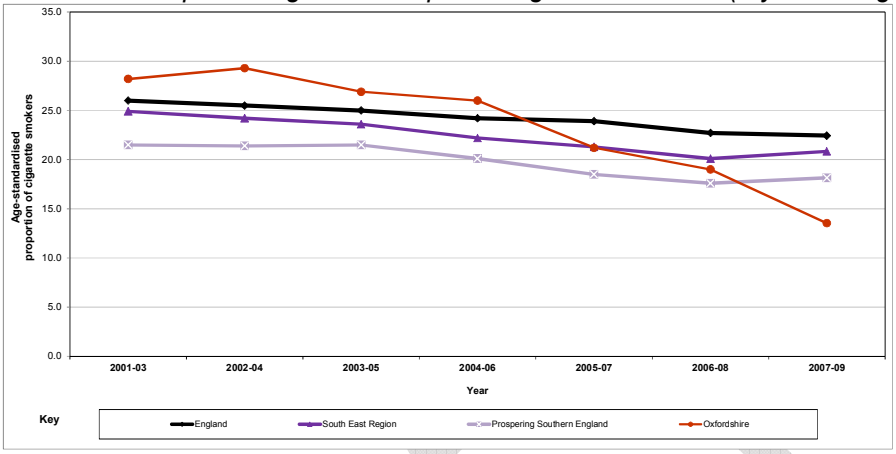
The consistent upward trend in diabetes a chronic disease associated with obesity, perhaps reveals the effects an ongoing increase in obesity will have.

Fig 19. Patients 17+ with a recorded diagnosis of diabetes in the GP registered population



Year on year fewer people are reporting a smoking habit

Fig 20. Age-standardised percentage of self-reported cigarette smokers (3-year rolling averages)



This is a contributory factor to improving lung and heart health (not that the apparent rise in Oxford City lung cancers is not statistically significant).

Fig 21. Directly standardised mortality rate from lung cancers in Males under 75 yrs (3-yr rolling averages)

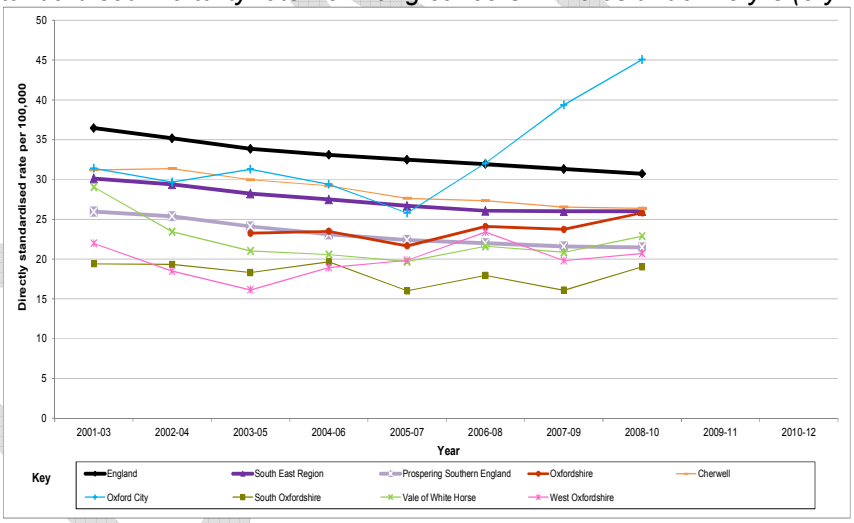
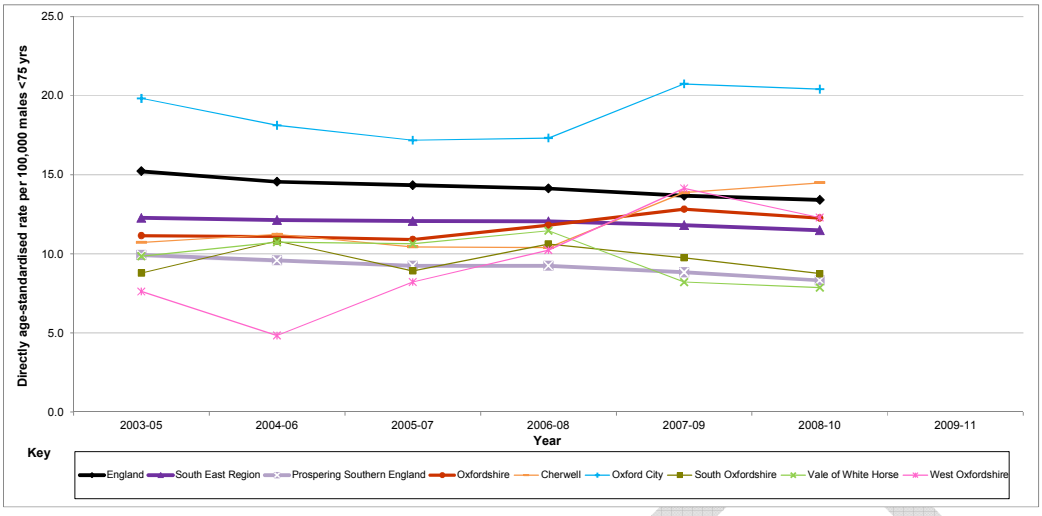
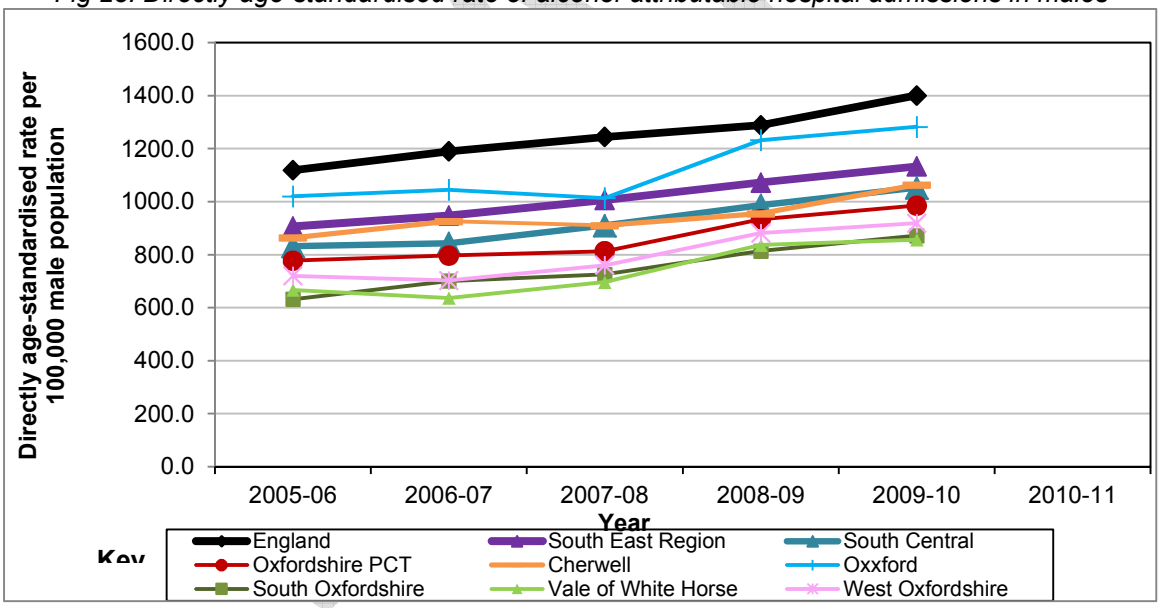


Fig 22. Directly age-standardised mortality rate from chronic obstructive pulmonary disease (COPD) per 100,000 males (under 75 yrs) (3-yr rolling averages)



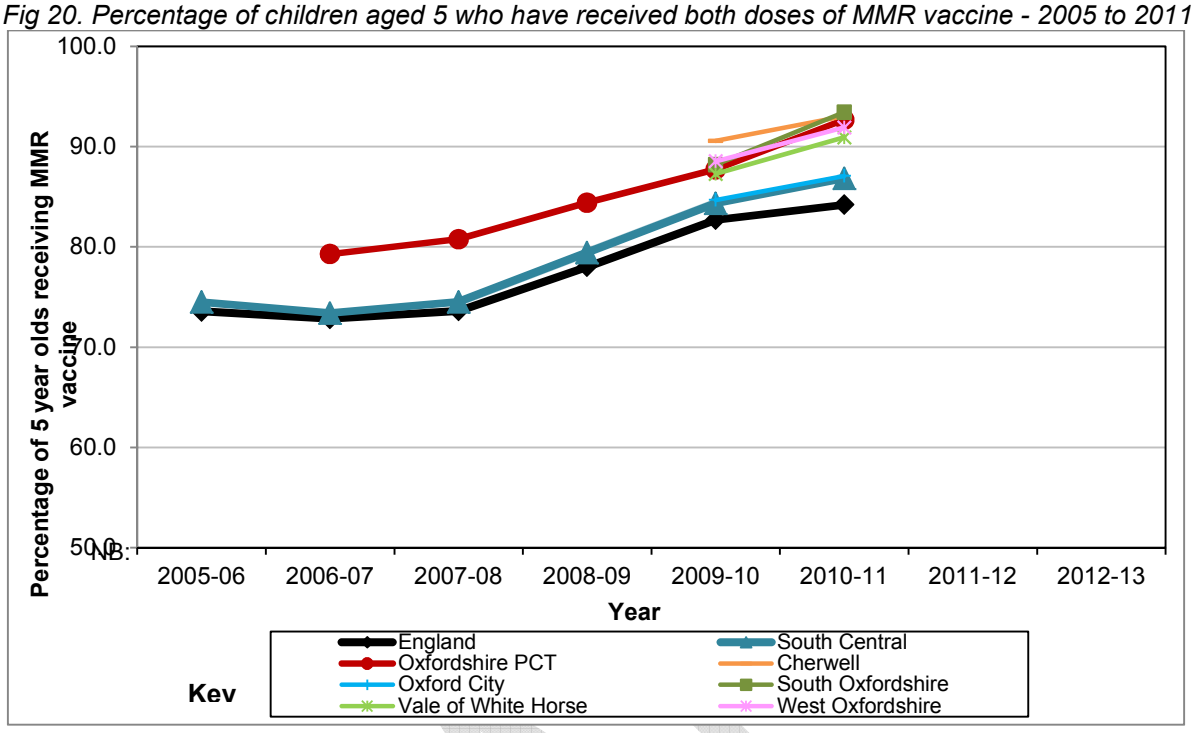
Alcohol consumption however, is a growing challenge with attributable hospital admissions on the rise (twice as high for males and again varying by district).

Fig 23. Directly age-standardised rate of alcohol-attributable hospital admissions in males



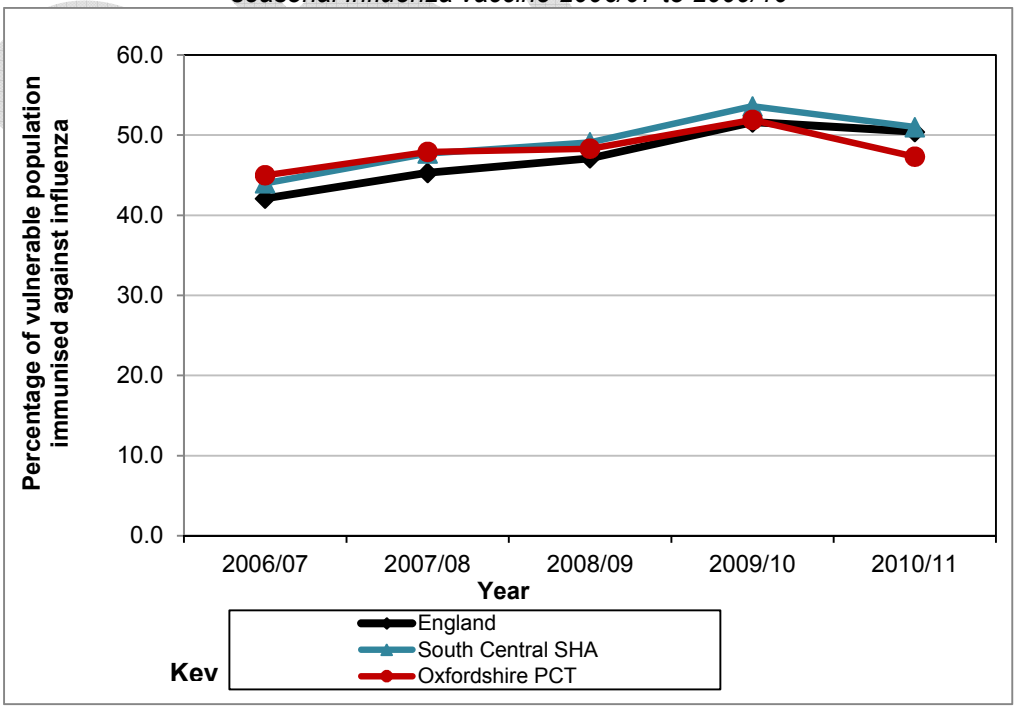
Coverage for immunisation against childhood diseases is good in Oxfordshire.

Fig 20. Percentage of children aged 5 who have received both doses of MMR vaccine - 2005 to 2011



Rates for influenza in under 65's however, indicate a recent slippage in what have previously been good rates compared to the national average.

Fig 21. Percentage of patients in clinical at risk groups, aged 6 months to under 65 years, who have received seasonal Influenza vaccine 2006/07 to 2009/10



The Public Consultation Regarding the Draft Joint Health and Wellbeing Strategy (JHWS): A Report, Summary of Action taken and Decisions for the Board to Make

Introduction

1. Public consultation was undertaken on the Draft Joint Health and Wellbeing Strategy between May 15th and June 30th 2012. The consultation took many forms: public meetings, web-based surveys, and engagement with our many partners, scrutiny committees, Clinical Commissioning Group localities and NHS Trusts.

2. This paper aims to:
   - Give an overview of the findings
   - Say how the opinions expressed have been used
   - Set out the implications for the Health and Wellbeing Board for debate

Overview of the Findings and how the consultation comments are being used

3. A wealth of valuable information and opinion has emerged and this is set out in more detail at https://consult.oxfordshirepct.nhs.uk/consult.ti/hwb.strategy/listdocuments

4. The main themes arising can be summarised as follows:

   4.1 The consultation was very productive and valuable. Views came from a wide range of respondents including our many partners and individuals.

   4.2 There was strong support for the topics chosen as priorities for the County. The Health and Wellbeing Board can take this as confirmation that it has got the priority areas broadly right.

   4.3 The strongest support came for the following priorities:
   - Living & working well - supporting adults with long-term conditions, physical disabilities, learning disabilities or mental health problems to live independently and achieve their full potential
   - Supporting older people to live independently with dignity whilst reducing the need for care and support
   - Narrowing the gap for our most disadvantaged and vulnerable groups

   4.4 A wide range of useful and detailed points were made which have been incorporated into the strategy before us today and will also be referred to other work across the County.

   4.5 Many of these points are on issues which are too 'fine-grained' for inclusion in an overarching strategy of this type, but these are welcomed by individual service managers. These points can also be considered and taken forward by the partnership boards.

   4.6 We will need to keep under close review the input of the voluntary sector, faith communities, carers and service users in the 3 Partnership Boards as this came across loud and clear as a major concern.

   4.7 A number of cross-cutting themes have emerged repeatedly in the consultation which are applicable to all priorities in the strategy, these are:
   - The need to focus on disadvantage in all priorities, whether due to rural issues, urban issues or through being a member of a specific disadvantaged group or an ethnic minority group.
   - The need to find ways to help communities help themselves to combat, for example, loneliness and social isolation
   - The need to make plans locality by locality where the needs of localities differ sharply.

5. These issues have been included in the revised Strategy and the Health and Wellbeing Board will expect them to be taken into account in all implementation plans. In summary

therefore the consultation has been an extremely rich source of useful information and a valuable step forward.

Implications of the Public Consultation for debate

6. The consultation has usefully raised a number of issues on which the Board's views are specifically sought:

   6.1 Does the board support the expectation that issues such as disadvantage, helping communities help themselves and encouraging locality working should be found in all of our plans where appropriate?.

   6.2 Have we got the balance right between debating general themes and setting priorities and targets?

7. So far the Board has been occupied with setting broad priorities and agreeing performance measures. However, many of the factors of major importance to the public are general themes on which general debate might strengthen our collective approach. For example, 'supporting older people to live independently with dignity whilst reducing the need for care and support' is a major public priority. It is easy to say but elusive to achieve. It may profitable to debate this issue formally at a forthcoming meeting, in which case, have we got the balance right between giving our organisations a clear steer on general issues and performance managing specific targets? Will this avoid a 'talking shop' or create one?

8. At today's meeting we are experimenting with our first 'themed discussion'. This experience should help us to get the balance right.

Specific Changes to targets

9. During the consultation, useful comments were made about specific targets or new data has been received which has prompted us to propose a number of detailed changes to the targets. These are:

   9.1 Agree the inclusion of two new targets in priority 2:
   - The ‘Thriving Families’ project will have begun work with the first 100 families by April 2013
   - Reduce persistent absence (15% lost school days or more) from school for children looked after to 4.9% (currently 11.7%)

   9.2 In priority 2 - maintain the recently improved teenage conception rate in the county rather than seeking ‘ a sustainable decrease’

   9.3 Include a third target in priority 3 - collect information to establish a baseline of prevalence and trends of child sexual exploitation in Oxfordshire by March 2013.

   9.4 The alignment of the targets in the ‘Raising Achievement’ Priority 4 have been amended to match the emerging County Education Strategy.

   9.5 The Board are asked to confirm the percentage increase of people with a Learning Disability who are offered a physical health check in priority 5, by choosing between the following options which need to balance ambition with practicality:
   - 50% of people with learning disabilities will have an annual physical health check by their GP (currently 46%)

   Or

   - 60% of people with learning disabilities will have an annual physical health check by their GP (currently 46%)

9.6 Agree the targets in priority 6

- 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 per year to be permanently admitted to a care home from October 2012 (currently 546)
- 50% (or more) of the expected population with dementia will have a recorded diagnosis (currently 37.8%) (*see 9.7 below regarding the need to make a decision on the level of ambition for this target*)

And 2 new targets as follows: -

- maintain the current high standard of supporting people at home with dignity as measured by people themselves (currently 91.6%).
- Review transport in the community to understand the best way of meeting community needs by June 2013

9.7 The Board are asked to confirm the percentage of people with dementia whose diagnosis is recorded by GPs at an appropriate level in Priority 6, thereby agreeing a target which will balance ambition and practicality:

- 50% of the expected population with dementia will have a recorded diagnosis (currently 37.8%)

Or

- More than 50% (*percentage to be agreed e.g. 55% or 60%)* of the expected population with dementia will have a recorded diagnosis (currently 37.8%)

9.9 Agree for priority 7

- A new title i.e. 'Working together to improve quality and value for money in the Health and Social Care System' which replaces 'Integrating health and social care'.
- Create two targets from one
    1) deliver a joint single point of access to health and social care community services, provided by Oxford Health and Oxfordshire County Council by the 1st December 2012
    2) deliver fully functioning, locality based and integrated health and social care services by March 2013 .

9.10 Agree the inclusion of the targets below in priority 7

- 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).

Action to be taken

10. The Health and Wellbeing Board are asked to discuss the public consultation results and to debate, decide on and agree on the specific issues raised in this paper.

Jonathan McWilliam
Director of Public Health for Oxfordshire
July 2012

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Oxfordshire's Joint Health & Wellbeing Strategy

2012 - 2016

Final draft for Health and Wellbeing Board consideration following public consultation

July 2012

CONTENTS

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

We are delighted to launch our first Health and Wellbeing Strategy for Oxfordshire. We believe this strategy is a significant step forward for the health and wellbeing of 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.

Our understanding of the issues facing Oxfordshire has been strengthened by an in depth consultation on this strategy with the public and our many partners.

It is important that we can measure the changes to services we intend to make and the improvements in health outcomes we hope to achieve. We have therefore included targets throughout the document. Many 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 will now go ahead and make the detailed plans needed to make this strategy a reality.

We look forward to continuing to work with the public and our partners to make sure this remains a joint venture.

Cllr Ian Hudspeth, **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 its people. Oxfordshire has a rich history of partnership working which strives to improve the health of Oxfordshire's people and the care they are offered. This 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 this strategy for improving the situation.

This strategy will be the main focus of the Health and Wellbeing Board's work. 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. This sets out our aspiration in broad terms. It is fleshed out in the priorities which follow and the action plans that are now in progress.

By 2016 in Oxfordshire:

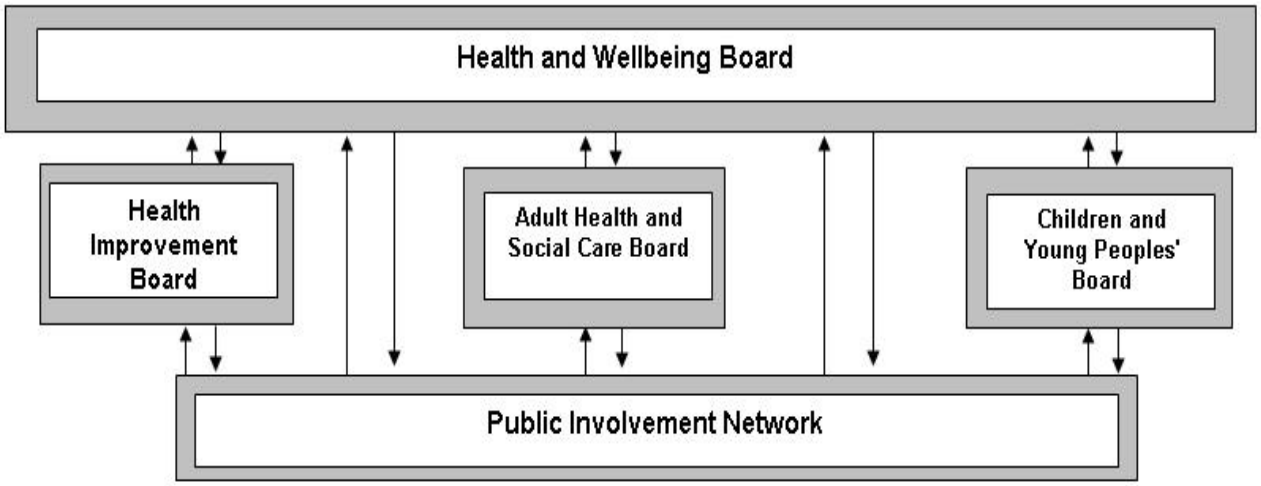
- more children and young people will lead healthy, safe lives and will be given the opportunity to develop the skills, confidence and opportunities they need to achieve their full potential;
- more adults will have the support they need to live their lives as healthily, successfully, independently and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

The priorities set out in this document put flesh on these themes. The priorities are intended to run to 2016 while the measures and targets set out within each priority are for the financial year 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 support and services they need while achieving better value for money, especially through oversight of our pooled budgets.	To keep all children and young people safe; raise achievement for all children and young people and improve the life chances for our most disadvantaged and vulnerable groups	To add life to years and years to life, focusing on the factors underpinning wellbeing, while levelling up differences in the health of different groups in the County	To ensure that the 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 setting a direction for the County in partnership. Its members are committed to working with its three Partnership Boards and its Public Involvement Network to agree that direction. 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 and social care providers, voluntary agencies, carers, faith groups, members of the public and advocacy groups. We will be inviting these partners to formal meetings as 'expert witnesses' and to workshops during the year as a means of engagement. In this way, the decisions of the Health and Wellbeing Board aim to be truly inclusive.

The Health and Wellbeing Board 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, informal/ volunteer carers, faith groups, voluntary sector representatives, the public 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 scientific research, 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 influence its constituent organisations 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

4.3 The Work of Other Partnerships and Cross-Cutting themes

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

- Better Mental Health in Oxfordshire
- Carers Strategy Oxfordshire
- Children's Urgent Care Project Board
- Civilian Military Partnership
- Dementia Plan for Oxfordshire
- Drug and Alcohol Action Team (DAAT) Board and the Drug and Alcohol Strategy
- End of Life Care Strategy
- Joint Management Groups
- Learning Disability Partnership Board and 'The Big Plan – making a difference for adults with Learning Disabilities'
- Maternity Strategy and Commissioning Group
- Oxfordshire Autism Partnership Board
- Oxfordshire County Council's Commissioning Intentions for Older People
- Oxfordshire Safer Communities Partnership
- Oxfordshire Stronger Communities Alliance
- A draft Physical Disability Strategy for Oxfordshire
- Draft Strategic Plan for Education Oxfordshire
- Supporting People Strategy
- Teenage Pregnancy Strategy Group
- Thriving Families Project
- Young Carers' Strategy Oxfordshire

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

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

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

2) Helping communities and individuals to help themselves
As the public purse tightens, we need to find new ways of supporting people to help themselves. It is early days for this approach, but recent examples have included direct

payments to people to buy their own care and the County Council's use of the 'Big Society Fund'.

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

5. 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.

This analysis is the scientific bedrock on which this strategy rests.

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

5.2 What are the specific challenges?

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

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

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

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

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

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

5.4 What criteria have been followed in selecting priorities?

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

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

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

A summary of the priorities can be found in Annex 1 on page 17

A. Priorities for Children and Young People

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

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

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. This is particularly relevant to young people with mental health needs. We are determined to act on this.

Targets for achievement during 2012/13 are:

Having a healthy start in life and staying healthy into adulthood

- Reduce emergency admissions to hospital for episodes of self-harm by 5% year on year. This means reducing admissions by 8 young people in 2012/13 (currently 156)
- Reduce emergency admissions to hospital with infections by 10% year on year. This means reducing emergency admissions by 145 in 2012/13 (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

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

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

Poverty and disadvantage are known to be strongly linked to poor outcomes and so work focused on reducing the gap between the most disadvantaged and most advantaged groups is seen as a key way of improving outcomes for children and families. Reducing the number of teenage pregnancies in the County has proved to be a useful overall focus for this work.

There is a renewed national focus on helping the most disadvantaged and challenged families to turn their lives around. The "Thriving Families" project will work with these families to reduce worklessness, antisocial behaviour, crime and school exclusions and to increase school attendance. A key focus will be on our most resource intensive and vulnerable families with the aim of reducing the numbers on social care thresholds. This will be a vital strand in the ongoing work locally to 'narrow the gap'. Work to date has focused on identifying the families. The project will start working with families in September.

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.

Targets for achievement during 2012/13 are:

Narrowing the gap for our most disadvantaged and vulnerable groups

- Maintain the recently improved rate of teenage conceptions (currently at 22 women aged 15-17 per 1000 - in 2010 this was 251 conceptions)
- The 'Thriving Families' project will have begun work with the first 100 families by April 2013
- Reduce persistent absence (15% lost school days or more) from school for children looked after to 4.9% (currently 11.7%)

Priority 3: Keeping all children and young people safer

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. We know that both nationally and locally there is growing awareness about young people who are victims of sexual exploitation. We need to do more to understand the picture in Oxfordshire and work together as agencies to prevent this happening.

We know nationally that the number of children who have Child Protection Plans has increased and that 0-4 year olds are the largest single age group with Child Protection Plans.

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%. It should be noted that this national indicator is being redefined so this target may change within the year.

In Oxfordshire over the last year we have seen a real improvement in the reduction of repeat plans from 18.2% to 15.3% so the 15% target reflects the need to sustain this improvement. This will be achieved through focusing on improving organisation processes so that in future years all interventions will have a greater impact and there will be higher skill levels amongst the workforce.

To improve this situation, targets for achievement during 2012/13 are:

Keeping all children and young people safer

- Collect information to establish a baseline of prevalence and trends of child sexual exploitation in Oxfordshire by March 2013
- Reduce the number of children who need a subsequent Child Protection Plan (following a previous completed plan) to no more than 15%, which will require full multi-agency commitment (in 2011/12 15.3%)
- A regular pattern of quality assurance audits is undertaken and reviewed through the Oxfordshire's Safeguarding Children Board covering the following agencies: children's social care; youth offending service; education services; children and adult health services; early intervention services; services provided by the police. Over 50% of these audits will show a positive overall impact (baseline to be confirmed in 2012/13)

Priority 4: Raising 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 and to see the gap reduced between the lowest and the highest achievers. We aim for every single school to be rated at least as 'good' and to be moving towards 'outstanding'.

The trend for young people 'Not in Education, Employment or Training (NEET)' in Oxfordshire is downwards, which means young people are finding jobs and training. The trend information masks some concerns with regard to specific groups of young people and levels vary across the county so there will be a continued focus on reducing NEET's.

Targets for achievement are:

Raising achievement for all children and young people

- 76% (5,000) children achieve Level 2b or above in reading at the end of Key Stage 1 of the academic year 2011/12 (currently 74.3% for the academic year 2010/11)
- 80% (4,880) of children achieve Level 4 or above in English and Maths at the end of Key Stage 2 of the academic year 2011/12 (currently 74.8% for the academic year 2010/11)
- 59% (3,500 out of 6,000) of young people achieve 5 GCSEs at A*-C including English and Maths at the end of the academic year 2011/12 (currently 56.8% for the academic year 2010/11)
- 66% (153) primary schools and 70% (24) secondary schools with be judged by Ofsted to be good or outstanding in 2012/13 (currently 61% (142) of primary schools and 65% (21) of secondary schools)
- Reduce the number of young people not in education, employment or training to 5% or 864 young people (currently 5.7% in the financial year 2012/13)

B. Priorities for Adult Health and Social Care

Priority 5: Living and working well: Adults with long-term conditions, physical disabilities, learning disabilities or mental health problems living independently and achieving their full potential

Adults living with 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 so they are 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 quality care for their physical health

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

- 75% of working age adults who use adult social care say that they find information very or fairly easy to find (currently 72.4%)
- 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 46%)*
  Or
  60% of people with learning disabilities will have an annual physical health check by their GP (currently 46%)

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

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

We also 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.

In 2011/12 Oxfordshire had the highest level of delayed transfers of care from hospital 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 and to prevent ill health. These services are called “reablement services”. We are committed to offer these to more people.

For all these reasons our priority is to support older people to live at home whilst reducing the need for care and support. To achieve this some of the areas we would like to focus on jointly are better use of reablement; reducing the number of people permanently admitted to care homes; develop more integrated community services as per priority 7; provide additional extra-care housing units: develop transport options to enable people to get to services that support them and to make sure older people find the information they need more easily.

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

Another key issue is the increase in the number of people with dementia who need access to newly emerging treatments. To enable us to develop high quality care for people with dementia we need to diagnose it earlier. 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 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.

Targets for achievement during 2012/13 are:

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 per year to be permanently admitted to a care home from October 2012 (currently 546)
- *50% (or more) of the expected population with dementia will have a recorded diagnosis (currently 37.8%)*
- 3,140 people will receive a reablement service (currently 1,812)
- Maintain the current high standard of supporting people at home with dignity as measured by people themselves (currently 91.6%).
- 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
- 75% of older people who use adult social care say that they find information very or fairly easy to find (currently 73.8%)
- Review transport in the community to understand the best way of meeting community needs by June 2013

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

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

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

One objective is to deliver integrated community services between Oxford Health NHS Foundation Trust, Social and Community Services and other relevant providers. The first step is to deliver a joint single point of telephone access to be used by health and social care staff seeking to help prevent acute hospital admissions and facilitate hospital discharges. This will be followed by delivery of integrated assessments, integrated care plans and joined up care management by a single lead professional who will remain the main point of contact for the patient.

The County Council and Oxfordshire Clinical Commissioning Group are committed to work together to raise the quality and improve the value of health and social care services, as outlined in the targets below. 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.

Targets for achievement during 2012/13 are:

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

- Deliver a joint single point of access to health and social care community services, provided by Oxford Health and Oxfordshire County Council by the 1st December 2012
- Deliver fully functioning, locality based and integrated health and social care services by March 2013
- A single Section 75 agreement to cover all the pooled budget arrangements by April 2013
- A joint older people's commissioning strategy covering both health and social care by April 2013
- 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%)
- 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).
- Establish a baseline for measuring carer satisfaction of services by May 2013
- 800 carers' breaks jointly funded and accessed via GPs (currently 709)

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.

Targets for achievement during 2012/13 are:

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 (meeting the challenging national target of 60% of 60-69 year olds every 2 years)
- 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 and children 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 ever increasing levels of obesity in young adults. Making parents aware of problems early helps them to take action if they choose to. Healthy eating initiatives are part of the approach. Levels of obesity are also linked to social deprivation, with more deprived parts of the County showing higher rates of obesity, so some targeting of effort is called for here too.

Promoting physical activity in adults
Physical activity is an important component of maintaining a healthy weight for all ages and there is local encouragement here, with Oxfordshire 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. Regular participation in physical activity will also have an impact on mental wellbeing.

Targets for achievement during 2012/13 are:

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

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

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

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

These housing issues all have to be tackled in partnership.

Work to determine the specific focus for this priority and to identify and recommend outcomes and indicators is underway. This work is building on existing initiatives and taking account of changes in national policy and local structures.

It is likely that the process indicators shown in the box below will be agreed through the Health Improvement Board as the focus for this work. By 2013-14 more specific outcome measures will be defined.

Tackling the broader determinants of health through better housing and preventing homelessness. (specific targets for this section are to be set following a forthcoming workshop)

- A reduction in the number of households at risk of fuel poverty though use of improvement grants and enforcement activity
- Action to prevent homelessness and ensure a joint approach in times of change.
- New arrangements for partnership work to ensure vulnerable people are supported to remain in appropriate accommodation e.g. young people, victims of domestic violence, offenders and other adults with complex needs.

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. The leadership for these services will change profoundly during the next year and maintaining our current position will be a real challenge.

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

Targets for achievement during 2012/13 are:

Prevent infectious disease through immunisation

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

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

Children and Young People

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

Adult Health and Social Care

Priority 5: Living and working well: Adults with long term conditions, physical or learning disability or mental health problems living independently and achieving their full potential

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

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

Health Improvement

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

Annex 2: Glossary of Key Terms

Terms

Carer	Someone of any age who looks after a relative, partner, friend or neighbour who has an illness, disability, frailty, or addiction. The help they provide is not paid for as part of their employment.
Child Poverty	Children are said to be living in relative income poverty if their household's income is less than 60 per cent of the median national income.
Child Protection Plan	The plan details how a child will be protected and their health and development promoted.
Commissioning	The process by which the health and social care needs of local people are identified, priorities determined and appropriate services purchased.

Delayed Transfer of Care	The national definition of a delayed transfer of care is that it occurs when a patient is medically fit for transfer from a hospital bed, but is still occupying a hospital bed.
Director of Public Health Annual Report	http://www.oxfordshirepct.nhs.uk/about-us/publications/public-health-annual-report.aspx
Extra Care Housing	A self-contained housing option for older people that has care support on site 24 hours a day.
Fuel Poverty	Households are considered by the Government to be in 'fuel poverty' if they would have to spend more than 10% of their household income on fuel to maintain an adequate level of warmth.
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's Safeguarding Children Board	Representatives from the main statutory agencies who ensure there are suitable robust arrangements for protecting children in Oxfordshire.
Pooled budget	A mechanism by which the partners to the agreement bring money to form a discrete 'fund'. The purpose and scope of the fund is agreed at the outset and then used to pay for the services and activities for the relevant client group.
Quality Assurance Audit	A process that helps to ensure an organisation's systems are in place and are being followed.

Reablement	A service for people to learn or relearn the skills necessary for daily living.
Secondary Mental Health Service	Services for adults with more severe mental health problems and needs requiring the specialist skills and facilities of mental health services.
Section 75 agreement	An agreement made under section 75 of National Health Services Act 2006 between a local authority and PCT(s), NHS trusts or NHS foundation trusts. This can include arrangements for pooling resources and delegating certain functions to the other partners if it would lead to an improvement in the way those functions are exercised.
Thriving Families Programme	A national programme which aims to turn around the lives of 'Troubled' families by 2015.
Transition	This is the process through which a person with special needs transfers from children's services to adults services.

Directorate Name: Chief Executive's Office

Oxfordshire Joint Health and Wellbeing Strategy 2012-2016

Service and Community Impact Assessment

Lead Officer: Jonathan McWilliam

Purpose of the assessment

This is an assessment of the potential impact of the new Oxfordshire Joint Health and Wellbeing Strategy 2012-2016, with particular reference to groups of people who share protected characteristics. This assessment will be kept under review as the strategy and priorities it contains are implemented, and updated as necessary to ensure emerging risks are identified and appropriate mitigating action taken. Separate assessments will be undertaken on specific actions as appropriate, for example where they in themselves constitute a significant change in policy in their own right or are intended to effect specific improvements in outcomes for particular groups.

Summary

The Oxfordshire Joint Health and Wellbeing Strategy 2012-2016 is intended to provide overarching direction in the development of health and social care services. The Strategy focuses on long-term intractable issues (such as delayed transfers of care and low educational attainment), and identifies priorities where working across health and social care can make a real difference in maintaining or improving the health and wellbeing of people in Oxfordshire.

Once agreed the priorities will be the main focus of the Oxfordshire Health and Wellbeing Board. They have been selected as areas where focused work will result in meaningful and measurable improvements whilst ensuring value for money.

The focus in the strategy is on areas that require additional work, new approaches or renewed emphasis. This does not replace the current priorities and arrangements already in place across a number of organisations and partnerships, and is intended to build on and supplement existing good practice rather than seeking to capture it all. As such, there is limited focus on meeting the specific needs of some groups that share protected characteristics where existing arrangements are working well and targets are being achieved (e.g. people with disabilities).

Although the policy is intended to have a positive impact on outcomes for all individuals and groups, including those who share protected characteristics, potential negative impacts are identified on customers, staff and providers. However these are mitigated by a range of actions, including the completion of service and community impact assessments for individual actions and policies, communication, engagement and consultation with a wide range of individuals and communities, and the use and development of the Joint Strategic Needs Assessment to ensure an evidence-based approach to the development of the strategy and the actions by which it will be delivered.

Introduction

Section 149 of the Equalities Act 2010 ("the 2010 Act") imposes a duty on the Council to give due regard to three needs in exercising its functions. This proposal is such a function. The three needs are:

- the need to eliminate any conduct which is prohibited by or under the 2010 Act;
- the need to advance equality of opportunity between persons who
- share any of the protected characteristics listed in section 149(7); and the need to foster good relations between persons who share a relevant protected characteristic and those who do not.

Complying with section 149 may involve treating some people more favourably than others, but only to the extent that that does not amount to conduct which is otherwise unlawful under the new Act.

The need to advance equality of opportunity involves having due regard to the need to:

- remove or minimise disadvantages which are connected to a relevant protected characteristic and which are suffered by persons who share that characteristic,
- take steps to meet the needs of persons who share a relevant protected characteristic and which are different from the needs other people, and encourage those who share a relevant characteristic to take part in public life or in any other activity in which participation by such people is disproportionately low.
- Steps to meet the needs of disabled people which are different from the needs of people who are not disabled include steps to take account of a person's disabilities.

The need to foster good relations between different groups involves having due regard to the need to tackle prejudice and promote understanding.

These protected characteristics are:

- Age (people of different age groups)
- Disability (e.g. physical or sensory impairments, long-term illnesses and conditions, hidden impairments such as a heart condition, frailty, learning disabilities or mental health problems)
- Gender Reassignment
- Marriage/civil partnerships (but only in respect of eliminating unlawful discrimination)
- Pregnancy & Maternity
- Race (including ethnic or national origins, colour or nationality)
- Religion or belief (including lack of belief)
- Sex
- Sexual orientation

In addition to the characteristics above, the Council has also considered the effect of the proposals on particular communities (e.g. urban, rural, deprived).

Consultation

Consultation on a draft of the Strategy with the public and a wide range of organisations took place during May and June 2012. This included individuals, communities and organisations from across the county, including representatives of some of the groups that share protected characteristics and from rural areas and areas of deprivation. The consultation also included staff and providers of services.

The outcomes of this consultation have been used to further refine the Strategy, including the measures and priorities. Overall a wide range of responses were received to the consultation and feedback was gathered from over 750 individuals and organisations across Oxfordshire through surveys, letters, emails, meetings with stakeholder groups / organisations and public workshops.

In response to the consultation, changes have been made to the strategy and the approach to action planning to ensure:

- A greater focus on interdependencies and linkages with other strategies e.g. end of life
- More references to social exclusion and access to services
- More focus on health issues encountered by people from Black, Asian and minority ethnic groups, and people with learning disabilities.
- Inclusion of mental wellbeing and helping communities tackle the impact of isolation/loneliness

- Safeguarding for adults as well as children is reflected
- Inclusion of child sexual exploitation
- More of a focus on children looked after
- Dementia support is an overarching theme across priorities for older people
- Complex needs of individuals and families are included
- Plans reflect the differing needs of different localities, particularly where the needs of localities differ sharply
- A focus on improving quality of services and staff as well as ensuring equity of services and consistently high standards in service delivery

Concerns were raised about the Joint Strategic Needs Assessment (JSNA), the key data source on which the strategy is based. Specific reference was made to Autism and Aspergers, vulnerable children and children in poverty as there is the need for more research into the current needs of these groups, as currently these are not fully covered by the JSNA. In addition, the importance of local knowledge of services was expressed and the need for more data on ethnicity in Oxfordshire and an assessment of whether existing services are adequately addressing current needs. These concerns will be addressed as part of the development of the next iteration of the JSNA by April 2013, which will in turn inform revisions of the strategy as appropriate.

The consultation outcomes will also inform the development of appropriate actions to deliver measurable and meaningful improvements in health and wellbeing. These more detailed actions will give full consideration to the needs of different individuals, communities and organisations, including those that share or represent protected characteristics where appropriate. The development of these actions will be further informed through workshop sessions held by the partnership boards that support the Health and Wellbeing Board (the Adult Health and Social Care Board, Children and Young People's Board, and Health Improvement Board), as well as through the engagement of members of the Public Involvement Network.

Impact on Individuals and Communities

The Oxfordshire Joint Health and Wellbeing Strategy 2012-2016 is intended to provide overarching direction in the development of health and social care services. The strategy itself is a high level document that discusses the key strategic priorities that will be shared between partner agencies. Once agreed, the priorities will be the main focus of the

Oxfordshire Health and Wellbeing Board. They have been selected as areas where focused work will result in meaningful and measurable improvements whilst ensuring value for money.

The Strategy focuses on long-term intractable issues (such as delayed transfers of care and low educational attainment), and identifies priorities where working across health and social care can make a real difference in maintaining or improving the health and wellbeing of people in Oxfordshire.

By definition, the Oxfordshire Joint Health and Wellbeing Strategy 2012-2016 is intended to have a positive impact on outcomes for people who share protected characteristics and in many cases for the wider communities of Oxfordshire as well. Several of the priorities in the strategy have a particular emphasis on improving outcomes for vulnerable groups and/or people who share protected characteristics where particular challenges, issues and under-performance have been identified:

Priority 1: All children have a healthy start in life and stay healthy into adulthood
Priority 2: Narrowing the gap for our most disadvantaged and vulnerable groups
Priority 3: Keeping all children and young people safer
Priority 4: Raising achievement for all children and young people
Priority 5: Living and working well: Adults with long term conditions, physical or learning disability or mental health problems living independently and achieving their full potential
Priority 6: Support older people to live independently with dignity whilst reducing the need for care and support
Priority 7: Working together to improve quality and value for money in the Health and Social Care System
Priority 8: Preventing early death and improving quality of life in later years
Priority 9: Preventing chronic disease through tackling obesity
Priority 10: Tackling the broader determinants of health through better housing and preventing homelessness
Priority 11: Preventing infectious disease through immunisation

The focus in the strategy is on areas that require additional work, new approaches or renewed emphasis. This does not replace the current priorities and arrangements already in place across a number of organisations and partnerships, and is intended to build on and supplement existing good practice rather than seeking to capture it all. As such, there is limited focus on meeting the specific needs of some groups that share protected characteristics where existing arrangements are working well and targets are being achieved (e.g. people with disabilities).

The Strategy highlights where significant differences exist in outcomes for people who share protected characteristics, and people in different parts of the county, without discussing in detail where equally important but less significant differences exist beneath the headline figures. These subtleties will be priorities for the organisations, boards and strategies responsible for the delivering meaningful and measurable improvements against each of the priorities, as part of detailed action and service planning, commissioning activity and so on. These actions will be developed following agreement of the revised strategy (to reflect the outcomes of consultation) by the Health and Wellbeing Board in July.

There is unlikely to be any negative impact on particular groups as a direct result of the strategy itself. However the implementation of specific actions will need to be closely

monitored to ensure that, in positively impacting circumstances for one or more groups, there are not unintended negative impacts on others. Where appropriate a separate Service and Community Impact Assessment will be developed and updated to ensure the needs of all individuals and communities are considered. The Health and Wellbeing Board (in having overall responsibility for the delivery of the Joint Health and Wellbeing Strategy) will continue to reinforce this requirement as part of performance management arrangements.

Risk	**Mitigation**
The needs of different individuals, communities and organisations are not fully understood, meaning inappropriate (or no) action is taken, leading to either no improvement in outcomes or unintended consequences as a result	Consultation with a wide range of individuals, communities and organisations (including those that share or represent those that share protected characteristics) took place during May and June 2012. The draft strategy has been updated to reflect the outcomes of this consultation. In particular, further detail has been added about o health issues encountered by people from Black, Asian and minority ethnic groups, and people with learning disabilities. o mental wellbeing and helping communities tackle the impact of isolation/loneliness o end-of-life care o Safeguarding for adults as well as children o Dementia support as an overarching theme across priorities for older people The Joint Strategic Needs Assessment (JSNA), the shared evidence base for Oxfordshire, has been used to identify the issues, challenges and priorities that the strategy needs to address. This includes identifying where particular groups have different needs that must be addressed to meet the priorities in the strategy – for example specific Black and Minority Ethnic Groups who achieve significantly lower levels of educational attainment at Key Stage 4. The JSNA will also be developed throughout 2012/13, including more detailed consideration of the needs of different groups who share protected characteristics. Where information continues to be limited, appropriate action will be taken to try and address this.
The key priorities for action are not implemented, or do not have the desired positive impact	Progress in implementing the objectives and actions will be monitored reviewed as part of the overall performance and risk management arrangements established for the Health and Wellbeing Board, and appropriate action taken or amendments made as required Service users, individuals and communities who share protected characteristics and representative organisations will be engaged in the development and implementation of actions as appropriate. In particular this will take place through the workshops held by each of the partnership

	boards during the year, focused on particular priorities within the strategy.
Implementing actions to have a positive impact on one or more groups (eg those who share protected characteristics) has an unintended and potentially negative consequence on others	Progress in implementing the objectives and actions will be monitored reviewed as part of the overall performance and risk management arrangements established for the Health and Wellbeing Board, and amended as appropriate / required. Partner organisations (including the Council) will also be encouraged to embed actions they are responsible for within their own performance and risk management arrangements. All actions that represent a significant change in policy or are likely to impact on one or more groups of customers will undergo a Service and Community Impact Assessment, with appropriate mitigating actions identified and implemented. These assessments will be updated on an ongoing basis to ensure they remain current and reflect any learning as a result of developing policy, changes in approach, implementation, new evidence and so on.

Impact on specific individuals and communities

No additional impacts on specific individuals and communities, who share protected characteristics, are from rural or deprived areas and so on have been identified beyond those discussed above.

Impact on staff

The Oxfordshire Joint Health and Wellbeing Strategy 2012-2016 will set the context and priorities within which partner organisations will deliver meaningful and measurable improvements in public health and wellbeing. As such, the priorities and actions identified will need to be embedded in business plans and individual work programmes to ensure that the progress in delivering key outcomes is achieved. Senior officers / employees have been engaged in the development of the draft strategy through involvement in the Health and Wellbeing Board, and council staff and those in partner organisations were encouraged to take part in the consultation. The Strategy has been refined to reflect the outcomes of consultation, and impacts arising during its implementation will be kept under review and responded to appropriately.

Risk	**Mitigation**
Staff are not aware of the new strategy, or their opportunity to comment as part of the consultation	A communications and engagement plan was developed to help raise awareness of the consultation on the draft strategy, utilising a range of methods across partner organisations. Following sign off by the Health and Wellbeing Board, further communications and engagement will be used to raise awareness and help embed the priorities and actions within business plans and individual work programmes.

Staff are not confident in adopting a partnership approach to the development and delivery of actions to achieve meaningful and measurable improvements in health and wellbeing.	There are already strong partnership working arrangements and cultures across the organisations involved in developing and delivering the new strategy, and these will be further encouraged / developed. This includes between the council and NHS (including the new Clinical Commissioning Group), with providers including the voluntary sector, and with District Councils. The consultation showed support for greater emphasis on improving quality of services, and it was identified that an emphasis on culture change in the organisations involved is needed to achieve this. Staff will be supported and encouraged to work across organisational boundaries, by senior managers who are signed up to achieving this and through reinforcement from the Health and Wellbeing and supporting boards in setting direction and expectations and monitoring delivery.

Impact on providers

As above, the Oxfordshire Joint Health and Wellbeing Strategy 2012-2016 will set the context and priorities within which partner organisations will deliver meaningful and measurable improvements in public health and wellbeing. It will therefore help to frame the expectations organisations place on providers, within existing contracts and in developing future commissioning intentions / arrangements.

However, the priorities and actions in the strategy are not necessarily new or a significant diversion from the current situation, reflecting as they do the ongoing, high level issues and challenges facing the county. As such, they are likely to be within a similar broad context, albeit with different actions and approaches where necessary to create meaningful progress against long-term, intractable problems (eg delayed transfers of care, educational attainment, breaking the cycle of deprivation / addressing inequalities). Work will be needed to ensure providers are aware of any changes in approach and / or expectations, and providers were given (and in many cases took) the opportunity to comment as part of the consultation. The outcomes from consultation have been used to inform further development of the strategy, and the action planning that will follow sign off of the strategy by the Health and Wellbeing Board.

Risk	**Mitigation**
Providers are not aware of the new strategy, or their opportunity to comment as part of the consultation	A communications and engagement plan was developed and implemented developed to help raise awareness of the consultation on the draft strategy, utilising a range of methods across partner organisations. Commissioners have also been raising awareness of the new partnership arrangements and emerging priorities as part of regular engagement with providers, and will continue to do so as part of ongoing contract monitoring arrangements and market testing / development. This will include a focus on improving quality of services and staff as well as ensuring equity of services and consistently high standards in service

	delivery (a theme that emerged from the consultation). Following sign off by the Health and Wellbeing Board, further communications and engagement will be used to raise awareness and help embed the priorities and actions within business plans and individual work programmes.

Impact on other council services

No risks specific to other council services have been identified, beyond those already considered above as part of the impact on staff and customers.

Next Steps

The key milestones in the development and implementation of the Oxfordshire Joint Health and Wellbeing Strategy are set out below. This assessment will be updated as appropriate throughout this timeline, to reflect learning as the result of policy development and changes, guidance from the Health and Wellbeing Board, development of the JSNA and development and implementation of action plans..

Action	**Timescale**	**Responsibility**
Sign off of final strategy following consultation	26 July	Health and Wellbeing Board
Implementation of strategy	August 2012 – March 2016	Partner organisations, including council
Performance management and monitoring implementation of strategy	At 3 meetings per year	Health and Wellbeing Board
Development of Joint Strategic Needs Assessment, including action to address any gaps in knowledge of needs of particular groups	March 2013	Alexandra Bailey
Review of Joint Health and Wellbeing Strategy	June 2013	Health and Wellbeing Board

Oxfordshire Shadow Health and Wellbeing Board - 26 July 2012
Summary Performance Report, July 2012

Introduction

1. It is important that Health and Wellbeing Board (H&WB) members are able to monitor progress on the work they have agreed to do. The Joint Health and Wellbeing Strategy sets out a range of ambitious work, with measurable outcomes of success for each priority. Progress towards these outcomes will be reported on a regular basis so that causes of concern can be identified early and rectified.

Proposals for performance reporting

2. A final list of indicators for reporting will be drawn from the Joint Health and Wellbeing Strategy once this is finalised This will form the basis of regular reports to each of the partnership boards and to the H&WB at each meeting.

3. A full list of proposed performance indicators was included in the draft Joint Health and Wellbeing Strategy in May 2012. The extensive public consultation on this draft strategy has resulted in some changes to these proposals. A final performance framework will be drawn up once the priorities of the Board and details of how these are to be measured are agreed and set out in the Strategy. This will then be updated regularly and reported at each meeting.

4. In addition to providing an overview of performance at each meeting, it is proposed that in-depth reports can also be presented to the Board. These are likely to highlight any areas that are causing concern and include information on action being undertaken to improve performance.

Overall performance to date

5. Performance on a range of indicators is already being reported to the Partnership Boards and good progress is being made on a range of indicators. There are, however, some early causes for concern which need to be addressed. Two of these areas are
    a. the number of young people not in education, employment or training
    b. the number of people invited for NHS Health Checks

6. In-depth reports on these two topics are attached to this report at HWB 10 (b)(i) and HWB 10 (b) (ii)).

Recommendation

7. Members of the Health &Wellbeing Board are asked to note this information and agree the proposed approach to performance reporting.

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Oxfordshire Shadow Health and Wellbeing Board
Detailed performance report

OUTCOME MEASURE: 30,000 people invited for Health Checks for the first time in 2012-13

NHS Health Checks are carried out in GP Practices. Individuals aged 40-75 are invited every 5 years. The check covers lifestyle factors such as obesity, exercise, smoking, blood cholesterol levels ,diabetes and blood pressure. From April 2013 it will also include alcohol assessment.

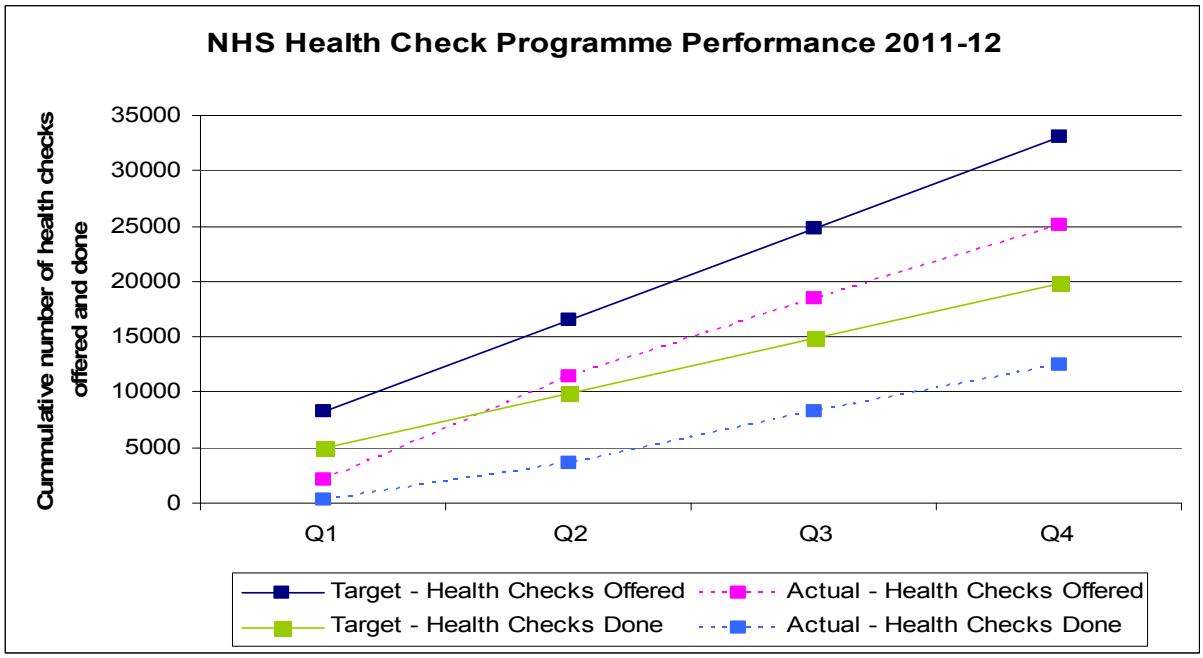
Strategic Priority: 8 Preventing early death and improving quality of life in later years

Strategic Lead: *Paula Jackson, Locum Consultant – Public Health* **Last updated**: June'12

Current indicator RAG Rating Amber

2. Trend Data

This indicator is currently rated "amber" as the target set by the Strategic Health Authority was not met in 2011-12. This report sets of plans to recover this performance and meet the target for 2012-13



3. What is the story behind this trend? - Analysis of Performance

- In October 2010, the Department of Health stipulated that all PCTs should provide free NHS Health Checks to their local population.
- In Oxfordshire, the programme was commissioned by Public Health and launched in April 2011 through a locally enhanced service (LES) as an add-on to existing GP contracts.
- The programme was not fully operational until the end of quarter one in 2011. This was because of a delay in purchase of computer systems to identify and invite eligible patients.
- 76 out of 82 practices signed up to deliver the programme, however only 56 actually invited people to attend and delivered health checks in 2011-12. The key barriers were the availability of clinical staff and space within the practice.
- The performance, both for inviting and carrying out health checks, has progressively improved during the rest of 2011-12 but the target was still not met due to the slow implementation in quarter one.
- The local trajectory for health checks offered and given remained on track throughout the year (see the chart above). The proportion of people receiving a health check has now reached 49% which is significantly better than the national average of approx 35%
- The target is expected to be GREEN by the end of quarter one 2012.

4. What is being done? - Current initiatives and actions

Actions	Commentary
¤ **Maximise coverage of the programme** (work with GPs and locality leads to maximise the number of practices singed up to deliver the health checks LES in 2012/13)	• All 82 practices have now signed up to deliver the service (June'12) • Practical support and training is provided to practices to ensure the programme is implemented i.e. practices starting to invite patients for health check
¤ **Awareness raising/publicity** Increase public awareness of the health checks programme through a local communication plan	• Communication strategy ready • First press release out on June 15th • Training session for GP practices – 25 practice staff attended training on June 22nd
¤ **Practical support to practices with low performance**	• Offer practice visits to any practice who is experiencing practical issues with service delivery

5. What needs to be done now? - New initiatives and actions

Action	By Whom & By When
¤ Analyse data at practice level to identify practices with high uptake and share good practice providing tailored support to improve performance in low uptake practices	Paula Jackson Nisha Sharma July 2012
¤ Analyse outcome data and identify patient groups with low uptake rates and develop tailored plans to improve performance	Paula Jackson Nisha Sharma July – Dec 2012
¤ Continue to offer additional health check training to practice staff to enable the delivery of a high quality service, including individual practice sessions where necessary	Nisha Sharma Sept – Feb 2012
¤ Continue to increase public awareness of the health check programme through agreed communications strategy	Jo Wilks Nisha Sharma Sept-March 2012
¤ Continue to provide support and advice to practice with low performance, offer practice visits where necessary	Nisha Sharma June-March 2012

Oxfordshire Health and Wellbeing Board
Detailed performance report
26 July 2012

1. Details

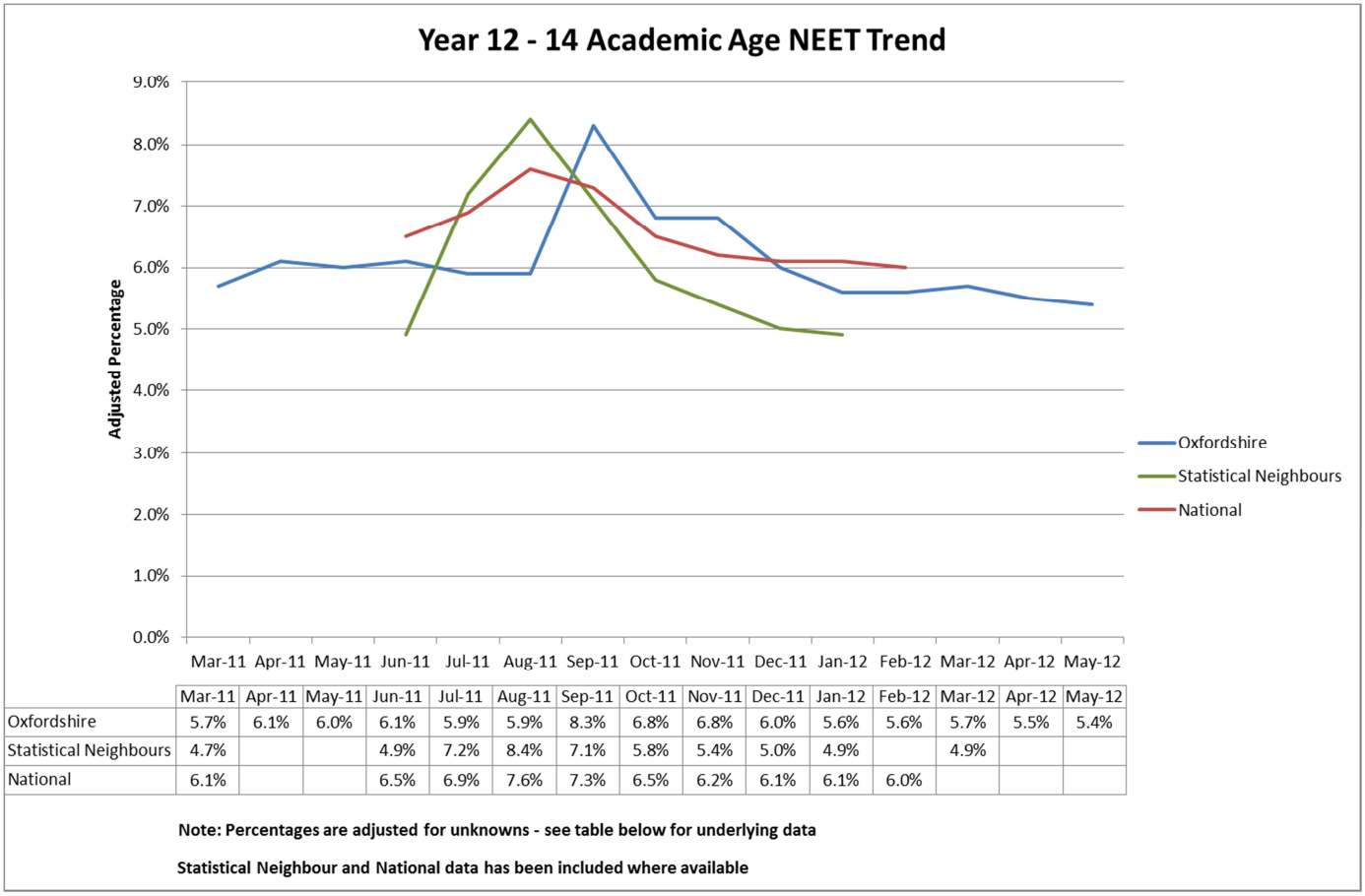
Strategic Priority: *Raising achievement for all children and young people*

Strategic Lead: *Frances Craven, Deputy Director, Education and Early Intervention*

PROGRESS MEASURE: *reduce the number of young people not in education, employment or training (NEET) to 5% or 864 young people (5.7% in March 2012)*

Current indicator RAG Rating: Amber

2. Trend Data



	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12
Oxfordshire	5.7%	6.1%	6.0%	6.1%	5.9%	5.9%	8.3%	6.8%	6.8%	6.0%	5.6%	5.6%	5.7%	5.5%	5.4%
Statistical Neighbours	4.7%			4.9%	7.2%	8.4%	7.1%	5.8%	5.4%	5.0%	4.9%		4.9%		
National	6.1%			6.5%	6.9%	7.6%	7.3%	6.5%	6.2%	6.1%	6.1%	6.0%			

Note: Percentages are adjusted for unknowns - see table below for underlying data

Statistical Neighbour and National data has been included where available

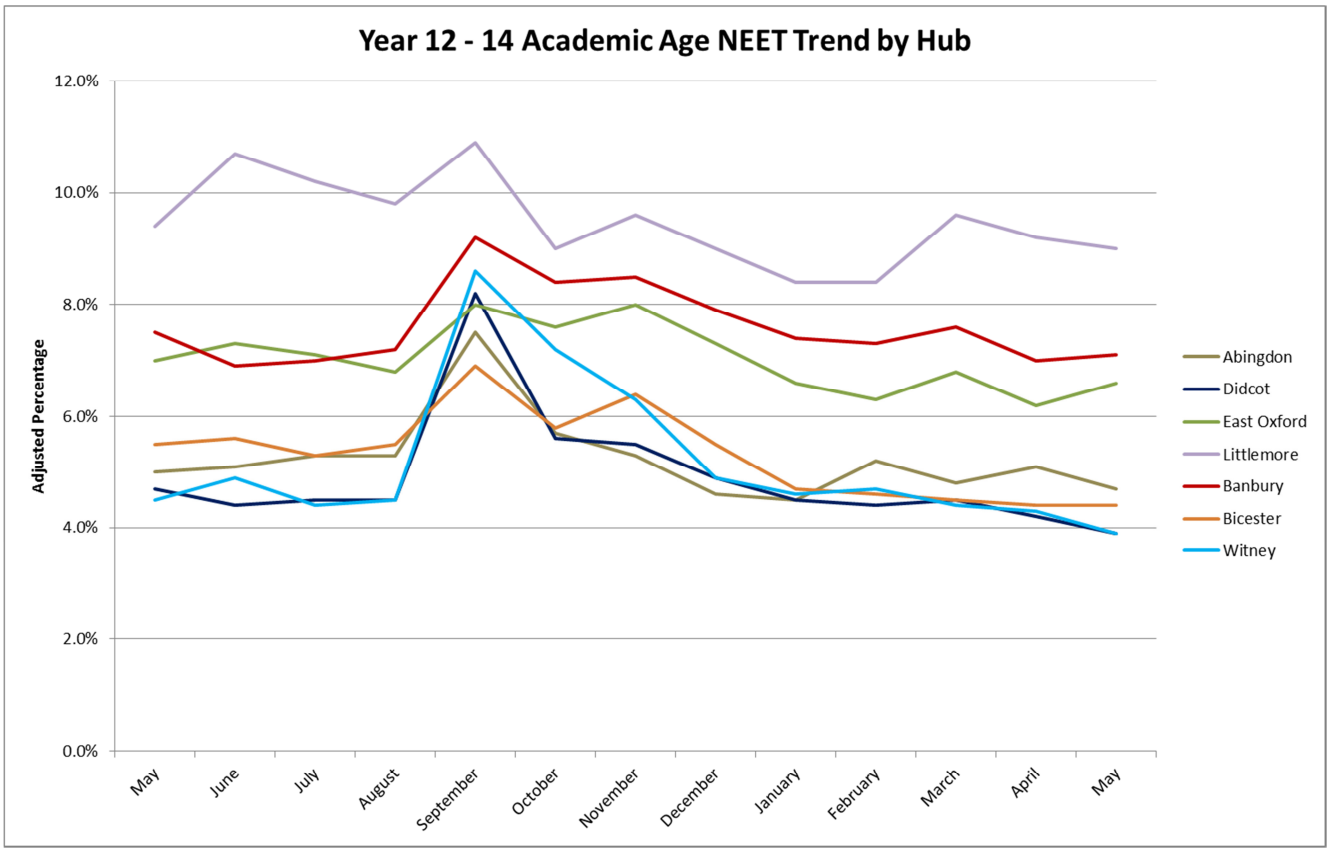
3. What is the story behind this trend? Analysis of Performance

3.1 The NEET trend in Oxfordshire is downwards

- The NEET trend is downwards in Oxfordshire, which means young people are finding jobs and training. This is in line with national and statistical neighbour trends.

- The job market In Oxfordshire is buoyant in relation to young people with over 300 jobs, apprenticeships and learning opportunities consistently advertised.
- Oxfordshire is performing well with 'Looked After' young people, as most of them are participating in Education, Employment or Training - EET (78.5%).
- The trend information masks some concerns with regard to different types of young people and geographic areas of the county.

3.2 NEET is not evenly spread across the county



- Banbury, East Oxford and Oxford Littlemore are NEET hotspots in the county. (Banbury 7.1%, Littlemore 9%, East Oxford 6.6%, Witney 3.9%, Bicester 4.4%, Abingdon 4.7% and Didcot 3.9%)
- The East Oxford hub area is of particular concern as the trend is upward
- Information down to ward level shows the area of highest NEET in Oxford are Northfield Brook, Barton and Sandhills, Blackbird Leys, Littlemore and Rose Hill and Iffley whilst in Banbury the wards are Grimsbury and Castle and Ruscote.

3.3 There are a high number of young people in employment without training

- Oxfordshire is at 5.4% NEET (May 2012), so is doing well, but there are a higher number of young people in employment without training compared to our statistical neighbours
- 23.5% of young people in the county have employment but are not deemed to have learning with their employment (Not in Learning). This is of concern and potentially an issue for the future. Young people who do not continue to receive formal learning are less likely to be economically active throughout their lives and statistically will be paid less.
- The legislation to 'Raise the Participation Age' (RPA) comes into operation in September 2013. Young people in the current Year 10 will be expected to continue

to participate in learning until they are 17 years. By 2015 all young people 16 –18 years will need to be participating in learning. Employers wishing to employ young people will be expected to provide accredited learning or time off for young people to attend. The final statutory guidance is expected soon but this represents a potential risk in Oxfordshire, which is being addressed collaboratively through the Early Intervention Service and the Business and Skills Bureau.

3.4 There are a number of vulnerable groups who need particular attention

Additional Targets	May 2011 %	May 2012 %
Post Compulsory Offenders in EET	41.5%	39.3%
Teen Parent in EET (Age 16-19)	28.2%	17.4%
LDD in NEET	14.7%	8.3%
Young Carers in EET	70.6%	71.7%

- Young people with a Learning Difficulty or Disability (LDD) are numerically the single highest group of NEET young people. Over the last year we have been successful in almost halving the number of LDD young people who are NEET. The current figure of 8.3% is low.
- LDD young people are prone to moving in and out of Education, Employment and Training (EET). These young people are more likely to be involved in low level training than employment. There remains a shortage of suitable employment opportunities for this group. The new Specialist NEET service will target LDD young people to support them to move into EET, sustain their EET position and develop further skills to progress. There are particular challenges in finding employment for this group and work to increase employment options needs action.
- The number of young parents actually in Employment, Education and Training are very low this year compared to last year. There may be an issue with collecting the data but further work is proposed urgently to address this downward trend.

3.5 The length of time Not in Education, Employment or Training (NEET) has an impact on future employment prospects

- In the last year 1059 young people were NEET for more than 4 months, 908 for more than 6 and 476 for more than 12 months.
- The longer young people remain in NEET the more difficult it is to find suitable and sustainable education, employment or training.
- Of NEET young people in the vulnerable groups 77.6% have been NEET for six or more months – these young people will be targeted by the Specialist NEET service.
- Action to target young people who have been NEET for six months or more will also be addressed through the revised area NEET/'Not In Learning' groups.

3.6 A number of young people frequently move in and out of education, employment and training

- It is difficult to quantify numbers in relation to this but data evidences this 'revolving door' effect showing young people in Oxfordshire moving between training providers and/or employment.
- This is most often as a result of young people not being ready for employment, education or training at 16, making ill informed choices about what they want to do or responding to family pressure to take any job.
- Young people in this group are not usually developing skills, knowledge or experience that supports their progress to sustained EET situations for the future

4. What is being done? Current initiatives and actions

There is already a clear set of initiatives underway to address the issues identified. This includes improving the Council's ability to 'track' young people who become NEET, using work from other Local Authorities to develop an indicator for risk of becoming NEET (RONI), and sharing student information with schools where there is a high risk of NEET identified.

Skills UK are working with Hub Teams to target families where substantial familial unemployment is an issue and all Year 11 students at Meadowbrook College (the Pupil Referral Unit) are now automatically referred to their local Early Intervention Hub for targeted support. The Specialist NEET Service has been set up to target the most vulnerable NEET young people with workers located with the Hubs to ensure coherence.

The 'Passport' is a web-based facility for young people to develop employability skills through training – in particular, areas that have been identified as gaps by local employers. There is also a web-chat facility which offers discussion forums for young people struggling with employment issues.

5. What needs to be done now? Initiatives and actions

Action	By Whom & By When
• To carry out an option appraisal on tracking mechanisms and agree way forward.	Youth Engagement and Opportunities Team (Sept 2012)
• Continue to develop and implement the Passport, to support young people into employment.	Business and Skills team (Sept 2012)
• Re-focus the NEET Area meetings to Early Intervention areas and assertively address hot spots, in particular length of time in NEET.	Early Intervention Service (July 2012)
• Target employers to take on young people particularly developing employers understanding of disabled young people.	Business and Skills Team (Sept 2012)
• Continue to work with employers to build suitable training opportunities within their employment.	Business and Skills Team (Sept 2012)
• To ensure every school knows their students who are at risk of becoming NEET and has an action plan to intervene.	Youth Engagement and Opportunities Team (Sept 2012)
• To work with maternity services, Family Nurse Partnership team and primary care to ensure the issue of teenage parents is addressed.	Early Intervention Service (2012)

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Shadow Oxfordshire Health and Wellbeing Board
26 July 2012
Themed discussion: frail older people

Introduction

1. Most of the spending of health and social care is focused on supporting frail older people often with several long term conditions such as heart problems, breathing difficulties, dementia or diabetes. Up to £500m is spent each year on this in Oxfordshire. Demands are likely to grow as the general population ages although these pressures can be reduced if people have healthier lifestyles (the **prevention agenda**) or there are **early interventions** as individuals become more frail which limit or delay the need for more intensive forms of care.

2. Supporting older people to live independently with dignity whilst reducing the need for care and support was identified as one of the priorities in the draft Health and Wellbeing Strategy. This priority has been supported strongly in the consultation. The strategy set out the challenges that we face in this area.

3. It is clear that we have not yet got all the right services in place, the right approach to commissioning those services or the right practices on the ground. This is despite the relatively high levels of spending in this area whether measured by the amount spent by adult social care or the number of community hospital beds.

4. These problems are most obviously reflected in the level of delayed transfers of care (where patients are delayed in one hospital setting due to the unavailability of the next proposed placement – whether elsewhere in the health system or at home with support from health and social care) This is a problem that has featured in Oxfordshire for many years. All partners are agreed that this problem is a reflection of wider system wide issues about how we support frail older people.

5. If we can tackle the broader system wide issues then we will reduce delays and also address the much more underlying issues which will become even more challenging if nothing happens as demographic pressures increase at a time of limited financial resources. This short paper provides more details about the analysis of the problems and then sets out what is happening in response. It is worth pointing out that a number of the issues set out in this paper are also reflected in the Government's White Paper "Caring for our future: reforming care and support" which was published on 11 July.

6. Our conclusion is that there has been considerable analysis of the issues which has helped improve understanding. Commissioners and providers now need to focus on implementing the changes that are required to improve personal experiences and to provide more timely and more effective services.

Analysis of the issues

7. Most (although not all) frail older people are over 85 years of age. There were **14,200** people in Oxfordshire **aged 85 or over** in **2008**. This is expected to increase to **37,600** by **2033** – an increase of **165%** (or over two and half times as many). The percentage increase in those aged over 90 is even greater.

8. **Levels of spending are relatively high**. Oxfordshire County Council spends **20%** more than comparable local authorities on adult social care for older people. The number of **community hospital beds** (which are almost entirely occupied by frail older people) is relatively high especially when compared with more urban areas.

9. Outcomes for older people in Oxfordshire are not as good as they should be. Life expectancy is high which one would expect with one of the most prosperous areas in the country (although there are significant differences within Oxfordshire which generally reflect the incidence of deprivation). However, the **number of older people who end up in care homes after being admitted to hospital** is about **twice** the national average. The **average length of stay in a care home in Oxfordshire** for those people who are known to social services is **nearly 3 years** (2.84) – possibly twice as long as in other areas. We suspect that those making their own arrangements are spending even longer in care homes when their care needs might be supported in the community.

10. The Institute of Public Care (based at Oxford Brookes University) carried out research with the County Council into the reasons why people were admitted into a care home. The five most important reasons were incontinence, falls, dementia, stroke and depression.

11. **Diagnosis of dementia is relatively low**. **Last year, only 38%** of people with dementia had a diagnosis compared with a national average of 42% and the performance in the **best performing area of 59%.** Early diagnosis of dementia means that the person and their family carer(s) are able to access services which help delay the onset of the dementia so that they are on average able to be supported at home for 18 months longer rather than being admitted into a care home.

12. Every survey of older people has confirmed that **older people want to be able to carry on living in the community for as long as possible**. We are not meeting their expectations. Consultation with older people always identifies that there is more that the NHS and local authorities (at all levels) can do to help support people living in the community with their personal and health care needs including addressing the issue of loneliness. If we can do more then this will improve outcomes for older people and will reduce some of the financial pressures because support in the community is normally much less expensive than bed based care - in a hospital or in a care home and whoever pays for it. We will need to work closely with the voluntary and community sectors to address this.

13. More recently, there are signs of increasing pressures within the system. The **numbers of referrals for ongoing care from the acute hospitals** has increased by **34%** over the last year. There is a lack of understanding as to why this is happening. The **number of placements from hospital into care homes** has increased by **28%** over the last year. This is despite the increase in the number of hours of home care (up from 74,000 hours a week in 2010 to 90,000 hours a week in 2011 – an increase of 21%). There have also been new community services developed such as Hospital at Home, the Crisis Response Service, the end of life care service (known as RISE), the Supported Discharge Service provided by the Oxford University Hospitals Trust and an expansion of the reablement service provided by Oxford Health Foundation Trust.

14. The increase in the number and diversity of services is creating some further issues as GPs struggle to work their way through the different services available.

What is happening in response?

15. There is **collective recognition** that this can not continue and things need to change (for all the reasons set out above). This is reflected in the **Appropriate Care for Everyone (ACE) Programme** led by Dr Stephen Richards, Vice Chairman of this Board which brings together health and social care commissioners and clinicians from the County Council and the Clinical Commissioning Group and the key providers namely Oxford University Hospitals Trust, Oxford Health Foundation Trust and the operational side of adult social care. In addition, the **providers** are working together on issues which are within their direct control. This is led personally by the Chief Executives of those organisations.

16. Some progress has been made on providing support to frail older people to live in their communities. In 2009, there were only 20 **extra care housing** units in Oxfordshire. This had increased to 276 last year and will increase to 407 by next March. Plans are well advanced to increase the number still further to 930 by March 2015. This reflects close working between the District/City Councils (who are responsible for housing and planning) and the County Council (responsible for social care). However, there is more work to be done: planned provision is still too patchy; there are few developments for those who want to continue to own their own properties; there are other areas of housing need for older people which need to be considered. Further work is underway to consider these issues.

17. **Reablement and rehabilitation** are essential if frail older people are to be given a chance to “get back on their feet” (literally as well as metaphorically) when they become unwell or have a fall. Reablement services were introduced relatively early in Oxfordshire but the services provided have not been operating at the level of capacity required or been as effective as they might be. Oxford Health Foundation Trust (who

provide these services) are committed to increasing significantly the number of people supported by the reablement service and improving the number of people who do not need ongoing care after their period of reablement has been completed. Additional funding is going into this service using the additional funding provided by the Department of Health to the Clinical Commissioning Group for this purpose.

18. The PCT and the County Council have worked closely together to improve the services available to **carers**. This is recognised by the Oxfordshire Carers Forum. Resources for carers have been protected by both organisations. However, it is likely that further improvements can be made which will provide further support to the invaluable work provided by carers.

19. Older people (and their relatives) need much better **information and advice** so that they can make decisions about how they live their lives to reduce the chance of them needing care. This is a clear gap at the moment which is in the process of being addressed. In particular it is important that those who fund their own care (and may not receive any advice from social care) have the right information and advice before they decide what to do.

20. Both health and social care leaders recognise that there are improvements that need to be made in the way that professionals (whether hospital consultants, nurses, therapists, GPs or social workers) support frail older people in hospital, at risk of admission or when they are discharged home. This means improving **assessment** arrangements and **discharge planning**. There is strong support to the principle that we should "**discharge to assess**" rather than assess people in a hospital environment. (The hospital environment is the wrong place to make an assessment of people's long term care needs). We have not yet delivered on this aspiration. Work is currently underway to move to this as the overriding principle in the autumn. Professionals will be supported to change the way that they carry out their duties.

21. To help guide GPs (and other health and social care professionals) through the services available a **single point of access** to community services is being developed which will speed up discharge, help avoid admissions to hospital, simplify pathways and improve patients' experience of care. This has been rolled out within Oxford Health's community health services and will be extended to adult social care by the end of this year. This is part of the work to deliver integrated community services.

22. It is also important to review the **efficiency and effectiveness** of all the **community services** commissioned by health and social care. Immediate work (which will be concluded over the summer) will focus on **community personal care services** notably the Crisis Response service and the Supported Discharge Service and their links with the Reablement Service and mainstream home care services. Issues already identified

which need to be addressed include developing a Rapid Response service (which supports people when they are discharged home to be assessed), to improve night care and to ensure that services do not duplicate other services or make recruitment of care workers more difficult.

23. This review needs to be extended more widely to review all relevant health and social care services. It will be guided by the development of a **joint health and social care Older People's commissioning strategy**. This will build on the existing overarching strategy, Ageing Successfully, and the work that adult social care has done recently on its commissioning intentions for older people. The strategy will come forward for agreement by this Board next March.

24. There is widespread support for the idea that **health and social care must work more closely together** so that that the patient/service user experiences no gaps. At the operational level this is reflected in the integrated community service teams (which underpin the single point of access – see paragraph 21 above) as well as the joint work on discharge and assessment arrangements and changing the way that professionals work (paragraph 20). It is reflected on the commissioning side from the joint strategy which builds on established good practice in Oxfordshire for other groups. This needs to be supported by developing a **genuine pooled budget for older people** which incorporates all appropriate budgets for older people and enables resources to be moved around in reflection of changing needs and an understanding of which services most effectively and efficiently meet those needs. The intention is to introduce major changes from 1 April 2013.

Conclusion

25. A great deal of time has been devoted to analysing these complex problems. Work must now focus on delivering the changes suggested by the analysis to build on work that has already been done. Health and Wellbeing Board will be able to monitor the results through performance reports that come to future meetings.

John Jackson
Director for Social & Community Services
Oxfordshire County Council

Alan Webb
Interim Director Planning & Development
Oxfordshire Clinical Commissioning Group

July 2012

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