Proposed Outcome Measures and Target Indicators for Adult Health and Social Care Partnership Board

The overall goal of the Adult Health and Social Care Partnership Board is to:

- Ensure people can access the health and social care they need as simply as possible
- Support people to live independently and with dignity to reach their full potential
- Improve outcomes for adults who are most likely to need support
- Promote better financial management and greater efficiency

Priority 1 – Integration of health and social care

Closer integration of health and social care has been a recurrent goal of public policy for at least the past 40 years. Different solutions have been proposed including full structural integration into a single system. Other models are geared to overcome barriers and facilitate closer joint working and sharing of resources to give a seamless service. The successful integration of health and social care offers three potential benefits[1]:

- Better outcomes for people, e.g. living independently at home with maximum choice and control
- More efficient use of existing resources and a reduction in the demand on expensive health and social care services by avoiding duplication and ensuring people receive the right care, in the right place at the right time
- Improve access to, experience of, and satisfaction with, health and social care services

Politicians and the Oxfordshire Clinical Commissioning group have made clear their commitment to the integration of health and social care and it's what the public want.[2] In the context of intense financial and demographic challenges facing both services integration offers opportunities to improve outcomes for people and use of resources for organisations.

A key priority is to support carers to have a high quality of life and enable them to continue to care for their family and friends for as long as possible as this is important to them. In 2009 we surveyed 1500 carers, 80% of who said their quality of life was good or acceptable. In 2012/13 there will be a national survey of carers. This will give us a useful benchmark and in future years we will look to improve quality of life. Carers tell us that having a break from their caring role is key to enabling them to continue caring. As such we have initiated a joint health and social care funded scheme which provides direct payments for carers from GPs.

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[1] The Kings Fund – Integrating Health and Social Care

[2] "achieving integrated care would be the biggest contribution that health and social care services could make to improving quality and safety" (National Voices 2011)

This suggests that outcomes for Priority 1 should be:

Outcomes for Priority 1	Key Indicator definitions for Priority 1
• Single point of access to fully functioning integrated health and social care community services • Ensure overall satisfaction of people and their carers across health and social care system • Increase the number of carers breaks funded jointly and accessed via the GP • Clinical Commissioning Group formally established	• Fully functioning integrated health and social care community services teams established with a single point of access • Older peoples commissioning strategy agreed • Section 75 pooled budget agreement • Satisfaction of people who use services with their care and support • Patient experience of primary care • Establish a baseline for measuring carer satisfaction • Carers breaks jointly funded and accessed via the GP through a direct payment • Clinical Commissioning Group authorised

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If we accept these priorities, the Health and Wellbeing Board in 2012/13 should aim to achieve:

- **a single point of access to fully functioning integrated health and social care community services provided by Oxfordshire County Council and Oxford Health NHS Foundation Trust by 31st August 2012**
- **a single Section 75 agreement to cover all the pooled budget arrangements by September 2012**
- **an interim older peoples commissioning strategy will be implemented by the County Council in April 2012. The intention is to develop a joint older peoples commissioning strategy and joint commissioning arrangements by December 2012 – joint strategy / pooled budget arrangements / lead commissioner**
- **Clinical Commissioning Group 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**
- **a baseline for measuring carer satisfaction**
- **More than 51% of people are 'very satisfied' with their GP surgery**
- **800 more carers breaks jointly funded and accessed via GPs**

Priority 2 – Support older people to live independently with dignity by reducing the need for care and support

Ensuing that people can live independently in their own homes is key to the quality of life they can enjoy and it's what people say they want. A key concern raised by older people is that they are "supported to access a range of networks, relationships and activities to maximise independence, health and well-being and community connections (including public health)."[3]

[3] http://www.thinklocalactpersonal.org.uk/_library/Resources/Personalisation/TLAP/MakingItReal.pdf Page 7

The issue of dignity in care is high on the national and local agenda. The NHS Confederation states that the overarching commitment to dignity in care is to help keep us physically and mentally well, to involve us in decisions about our care, to help us get better when we are ill and, when we cannot fully recover, to stay as well as we can and live as independently as we can until the end of our lives. [4]

In 2011/12 we have the highest level of delayed transfers of care in the country. The last published figure for delayed transfers of care in Oxfordshire was 176 (January 2012). A key priority is to improve performance significantly through the work overseen by the 'Appropriate Care for Everyone' programme which brings together the Clinical Commissioning Group, the County Council and the two key NHS providers – Oxfordshire University Hospitals Trust and Oxford Health.

In part, due to the pressures of delayed transfers of care, in the first 10 months of 2011/12, 437 people have been placed in permanent care home placements. This is 15% higher than the corresponding period in 2010/1, and includes a 45% increase in admissions direct from hospitals. In line with its demographic profile Oxfordshire admits relatively few people into care homes; however people who are admitted live in care homes for longer. The Oxfordshire Director of Public Health in his annual report said that the proportion of older people in the population continues to increase, which means that every pound spent from the public purse has further to go. Therefore we wish to support people in the community for longer and ensure that the number of people admitted to care homes does not increase.

A key demographic issue is the growth of people with dementia. This group of people need services provided by appropriately skilled staff, delivered in the right environment. To enable us to develop better services we need to increase the rate of diagnosis of dementia which currently stands at 37.8% (South Central SHA 2011 average is 41.4%) of the expected rate. We would look to increase this to 50%; this would take us above the national average.

To reduce delayed transfers of care and ensure people achieve greater independence and need less expensive care and support or no care at all, we will offer more people a reablement service and look to improve the efficiency of the service. In the first 10 months of 2011/12 1561 people started reablement and 44% of those who completed the service needed no on-going long term care. Local analysis of demand identifies that over 3000 people per year, and national evidence from the department of health indicates that over 50% should need no on-going care. Reablement is defined as "services for people with poor physical or mental health to help them accommodate their illness (or condition) by learning or re-learning the skills necessary for daily living" [5]

A key way people are supported to remain independent is through good quality information and advice. In an national survey 55% of social care service users said that they found information 'very' or 'fairly' easy to find. In Oxfordshire this figure was 53%, and amongst older people 52%.

The outcomes we have chosen to measure our progress are as follows:

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[4] http://www.nhsconfed.org/Documents/dignity.pdf page 10

[5] http://www.csed.dh.gov.uk/homeCareReablement/Toolkit/vision/#item2

Outcomes for priority 2	Key Indicator definitions for priority 2
• Reduce people who are in a hospital bed who are medically fit for discharge • Ensure the number of older people permanently admitted to care homes does not increase • Increase our knowledge of who has dementia and what services they are receiving • Increase the number of people receiving a reablement service and increase the proportion of them who need no on-going care at the end of the service • Increase the proportion of people, including carers, who say that they find information easy to find.	• Average number of Oxfordshire residents who are in a hospital bed who are medically fit for transfer • Number of older people permanently admitted to care homes • % of people diagnosed with dementia • Number of people who start the reablement service • % of people who leave the reablement service who need no on-going care. • % of older people who use services who find information easy to find.

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If we accept these priorities, the Health and Wellbeing Board in 2012/13 should aim to achieve:

- **a reduction in delayed transfers of care so that Oxfordshire's performance is out of the bottom quarter**
- **No more than 400 older people permanently admitted to a care home**
- **50% of the expected population with dementia will have a recorded diagnosis**
- **3250 people will receive a reablement service**
- **55% of the people completing the reablement service will be completely reabled and need no on-going care**
- **55% of older people who use adult social care say that they find information very or fairly easy to find**

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

Adults living with physical disability, learning disability, severe mental illness or another disabling long-term condition consistently tell us that they want to be independent, to have choice and control, and to be able to live "ordinary lives" as fully participating members of the wider community.

Consistently national and local strategy development tells us that people define the ability to live ordinary lives in terms of:[6]

- Improved access to information that supports choice and control
- improved access to responsive housing and support
- Improved access to employment, study, meaningful activity and involvement in the community and wider public life

[6] *No Health without Mental Health,* the *Sayce Review*; *Better Mental Health in Oxfordshire, Promoting Independence, a commissioning strategy for people with a physical Disability 2010-15*

- Responsive, coherent services that help people self-manage their care, but flex to provide support as people's needs vary
- Improved support for carers, to help them help the people they care for live as independently as possible

The closer we get to meeting these aspirations the more people will meet their full potential and move towards independence. The outcomes we have chosen to measure our progress are as follows:

Outcomes for priority 3	Key Indicator definitions for priority 3
• Increase the proportion of adults of working age who use services who find it easy to find information • Increase employment of people in contact with secondary mental health services • Increase the proportion of people with a long-term condition who feel able to manage their condition • Increase the proportion of people with learning disabilities and severe mental illness receiving annual health checks	• Number of service users (adults of working age) who find information easily • Number of people receiving mental health service in paid employment at the time of their most recent assessment/review • % of people with a long-term condition who have sufficient support from local services to manage their condition • % of people diagnosed with severe mental illness or a learning disability having an annual health check from their GP

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If we accept these priorities, the Health and Wellbeing Board in 2012/13 should aim to achieve:

- **55% of working age adults who use adult social care say that they find information very or fairly easy to find**
- **15% of people with severe mental illness using secondary mental health services are in employment**
- **95% of people with a long-term condition will feel able to manage their condition**
- **95% of people living with severe mental illness will have an annual physical health check by their GP**
- **50% of people with learning disabilities will have an annual physical health check by their GP**

Annex 1 Adult Health and Social Care Partnership Board full list of measures

This report identifies the key measures that health and social care can work on together to improve outcomes for people. The list below identifies all of the measures that the Adult Health and Social Care Board would like to monitor to deliver its key priorities –

Priority 1

- Achievement of key milestones for the delivery of integrated community services teams closer to home

- Milestones for joint commissioning arrangements and Clinical Commissioning Group will be met
- (maintain) the overall satisfaction of people who use services with their care and support
- (maintain) overall satisfaction of carers with social services
- (maintain) patient experience of primary care

Priority 2
- (reduce) emergency admissions for acute conditions that should not usually require hospital admission broken down by GP
- (improve) recovery from stroke
- (reduce) emergency admissions within 30 days of discharge from hospital
- (reduce) permanent admissions to care homes
- (reduce) delayed transfers of care
- (increase) the proportion of people who use services and carers who find it easy to find information
- (increase) carer reported quality of life
- (increase) the amount of spending on personal budgets which supports people in their own home
- (improve) Older people's perception of community safety
- (reduce) Falls and injuries in the over 65's
- (reduce) Hip fractures in over 65's
- (reduce) Excess winter deaths
- (reduce) the impacts of dementia
- (increase) efficiency & effectiveness of the reablement service
- (improve) the experience of health care for people at the end of their lives

Priority 3
- (increase) the proportion of people who use services or who care for them who find it easy to find information about support
- (increase) proportion of people feeling supported to manage their own condition
- (increase) proportion of adults with learning disabilities who live in their own home or with their family
- (increase) proportion of adults in contact with acute mental health services who live independently with or without support
- (increase) employment of people with long term conditions, learning disabilities or in contact with secondary mental health services
- (increase) the proportion of people receiving talking therapies
- (reduce) unplanned hospitalisation for chronic conditions
- (increase) the number of acute mental health inpatient admissions that have been gate kept by the Crisis team
- (increase) proportion of people using social care who receive self directed support and those receiving direct payments
- (increase) the proportion of people who use services who feel safe
- (increase) carer reported quality of life
- (increase) the proportion of people with learning disabilities and severe mental illness receiving annual health checks