Public Document Pack

To: Members of the Oxfordshire Health & Wellbeing Board

Notice of a Meeting of the Oxfordshire Health & Wellbeing Board

Thursday, 5 November 2015 at 2.00 pm
County Hall, New Road, Oxford

Peter G. Clark
Head of Paid Service

October 2015

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

Membership

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

Board Members:

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

In Attendance: Peter Clark, Head of Paid Service, OCC
David Smith, Chief Executive, OCCG

Notes:•Date of next meeting: 3 March 2016

Declarations of Interest

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

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

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

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

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

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

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

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

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

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

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

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

AGENDA

1. Welcome by Chairman, Councillor Ian Hudspeth

2. Apologies for Absence and Temporary Appointments

3. Declarations of Interest - see guidance note opposite

4. Petitions and Public Address

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

To approve the Note of Decisions of the meeting held on 16 July 2015 (**HBW5**) and to receive information arising from them.

6. Performance Report for Quarters 1 & 2 2015/16 (Pages 11 - 30)

2:05
15 Minutes

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

There will be a review of current performance during quarters 1 and 2, 2015/16 against the outcomes as set out in the Health & Wellbeing Strategy **(HWB6).**

Action Required: to note the report.

7. Health Inequalities Commission (Pages 31 - 32)

2:20
5 minutes

Persons Responsible:	OCCG
Person giving report:	Clinical Chair, OCCG

Dr Joe McManners will give an update **(HWB7)** on the appointment of a Chair for the Health Inequalities Commission and the next steps.

Action Required: to note the report.

8. Healthwatch Oxfordshire - Update (Pages 33 - 36)

2:25
10 minutes

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

There will be a general update on HWO activities by Eddie Duller, OBE, Chairman of HWO **(HWB8).**

Action Required: to note the report.

9. Children & Adolescent Mental Health Services (CAMHS) - Transformation Plan (Pages 37 - 58)

2.35
20 minutes

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

In August 2015 the Department of Health announced new funding for Child and Adolescent Mental Health Services (CAMHS). This equates to £1.1m recurrently for Oxfordshire, including £320,000 for a dedicated Community Eating Disorder Team. In order to access the funding, Clinical Commissioning Groups were required to submit a CAMHS Transformation Plan by 16 October 2015.

The Oxfordshire CAMHS Transformation Plan is attached at **HWB9.** It was signed off by the Chair of the Children's Trust on behalf of this Board.

If approved, the proposal is for the additional investment to come into the mental health pooled budget. This will increase the CAMHS element of the mental health pooled budget from £6,727,000 to £7,927,000 from 2016-17. The Clinical Commissioning Group will then be required to publish a Local CAMHS Offer, which will identify spending, workforce, waiting times and services available.

Following the CAMHS Review earlier this year, the CCG has already agreed to conduct a Most Capable Provider process with Oxford Health NHS Foundation Trust in order to secure a new model of CAMHS by 1 April 2016. This process will now include the new funding and will result in new contractual arrangements for CAMHS.

Action Required: The Board are asked to comment on and endorse the report.

10. Oxfordshire Safeguarding Adult Board (OSAB) Annual Report 2014/15 and OSAB Peer Review (June 2015) (Pages 59 - 116)

2:55
10 minutes

Persons responsible:	Independent Chair of OSAB & Director of Adult Social Care
Persons giving reports:	Independent Chair of OSAB and Deputy Director of Adult Social Care

The OSAB is required to report annually on the work of the Board and of its partners, assessing the position of the partnerships in relation to the safeguarding adults at risk within Oxfordshire. Sarah Mitchell, Chair of the Board, will present the report **(HWB10)**.

A Peer Review of the OSAB, which was carried out in June 2015, has also been included at **HWB10**, together with an Action Plan culminating from the Review**.** This will be presented by Seona Douglas, Deputy Director, Adult Social Care.

Action Required:

In relation to the OSAB Annual Report 2014/15, this Board is RECOMMENDED to note the Report and to:

(a) ensure the report is discussed within member agency Governance meetings;

(b) note the increased pressure on Adult Social Care with the rising number of safeguarding alerts;

(c) challenge the progress of the Care Act implementation within the member agencies; and

(d) consider how the HWBB can satisfy itself that members agencies are carrying out their duties with due regard for the safeguarding of vulnerable people.

and, in respect of the Peer Review (June 2015), to note the Action Plan currently being implemented as a result of the recommendations of the Peer Review.

11. Oxfordshire Safeguarding Children Board (OSCB) - Annual Report 2014/15 (Pages 117 - 186)

3:05
10 minutes

Persons Responsible: Independent Chair of OSCB
Person giving report: Independent Chair of OSCB

The OSCB is required to report annually on the work of the Board and of its partners, assessing the position of the partnerships in relation to the safeguarding of children at risk within Oxfordshire **(HWB11).** Maggie Blyth, Chair of the OCSB will present the Annual Report.

Action Required: to

(a) note that the child protection partnership is working effectively across Oxfordshire but there are severe pressure points in relation to the increased complexity of cases and activity in the system;

(b) consider the implications for the partnership in relation to the deficits in appropriate provision for those adults that disclose abuse or exploitation from childhood; and

(c) ensure that the OSCB Annual Report is submitted to all governing bodies of member organisations represented on the Health & Wellbeing Board.

12. Increase in Child Protection Cases - Report Card (Pages 187 - 212)

3:15
10 minutes

Person responsible: OCC
Person giving report: Director for Children's Services.

A report card is before the Board **(HWB12)** which sets out the growth in activity in the Child Protection system and its impact across the partnership. This issue has been previously discussed at the Children's Trust and the Oxfordshire Safeguarding Children Board in September**.**

Action Required: The Health and Wellbeing Board is recommended to consider any additional measures to mitigate against the risks set out in the report card.

13. Reports from Sub-Groups (Pages 213 - 218)

3:25
10 minutes

Written reports on activities since the last full Board meeting in July **(HWB13)** from**:**

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

Action Required: to receive the reports.

14. Oxfordshire's Health & Social Care Transformation Plan (Pages 219 - 232)

3:35
30 minutes

Persons responsible:	OCCG and OCC
Persons giving report:	Chief Executive, OCCG and Director for Adult Social Services, OCC

The paper at **HWB14** briefs the Board on the emerging system-wide plans for transformation of the way in which Oxfordshire's health and social care will be delivered to address population growth, demographic demands and pressures on available resources now and in future years.

The paper also provides an overview of the governance arrangements for the system wide transformation programme and indicative development and implementation timescales.

A presentation on the Plans will be given at the meeting by David Smith, Chief Executive, OCCG.

Action Required: to receive the report and to comment on the proposed approach and emerging vision.

15. OCCG 2016/17 Commissioning Intentions (Pages 233 - 280)

4:05
10 minutes

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

A report outlining the OCCG Commissioning Intentions for 2016/17 is attached at **HWB15.**

Action Required: to note the report.

16. OCC Budget Savings Options 2016/17 - Consultation (Pages 281 - 282)

4:15
10 minutes

Persons responsible:	OCC
Persons giving report:	Head of Paid Service, Director for Children's Services, Director for Adult Social Services, Director of Public Health

A paper is submitted outlining the options being consulted upon to deliver savings plans in the County Council **(HWB16).**

Action Required: to consider the impact of the savings options and provide comments as part of the consultation process.

17. Devolution

4:25
5 minutes

Persons responsible:	OCC, District Councils, OCCG
Person giving report:	Director of Public Health

There will be a verbal update on the recently submitted expression of interest in devolution of particular powers to Oxfordshire.

Action Required: to note the report.

18. PAPERS FOR INFORMATION ONLY (Pages 283 - 288)

The following papers are attached for information at **HWB18:**

- A summary of correspondence with the Chairman is attached for information**.**
- Mental Health Crisis Concordat – Update on progress and next steps in implementation**.**

4:30 Close of Meeting.

OXFORDSHIRE HEALTH & WELLBEING BOARD

OUTCOMES of the meeting held on Thursday, 16 July 2015 commencing at 2.00 pm and finishing at 4.25 pm

Present:

Board Members:	Councillor Ian Hudspeth – in the Chair Dr Joe McManners (Vice-Chairman) Councillor Anna Badcock Eddie Duller Councillor Mrs Judith Heathcoat John Jackson Dr Jonathan McWilliam Dr Paul Park Councillor Melinda Tilley City Councillor Ed Turner Hannah Farncombe (In place of Jim Leivers) James Drury (In place of Rachel Pearce)
Other Persons in Attendance:	Diane Hedges, CCG
Officers:	
Whole of meeting	Julie Dean, OCC
Part of meeting	Peter Clark, OCC

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

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

	ACTION
1 Welcome by Chairman, Councillor Ian Hudspeth (Agenda No. 1)	
The Chairman extended a welcome to new members of the Board, Cllr Anna Badcock and Mr Eddie Duller. He also	

welcomed Rosie Rowe and Julie Dandridge (CCG) who attended for Agenda Item 11 and Sula Wiltshire (CCG) and Seona Douglas (OCC) who attended for Agenda Item 13.	
2 Apologies for Absence and Temporary Appointments (Agenda No. 2)	
Apologies were received from Joanna Simons, Cllr Hilary Hibbert – Biles (OCC) and Dr Matthew Gaw (CCG). Diane Hedges attended for David Smith (CCG), James Drury for Rachel Pearce (NHS England) and Hannah Farncombe for Jim Leivers (OCC).	Andrea Newman
3 Declarations of Interest - see guidance note opposite (Agenda No. 3)	
There were no declarations of interest.	Andrea Newman
4 Petitions and Public Address (Agenda No. 4)	
There were no requests to submit a petition or to make an address.	Andrea Newman
5 Note of Decisions of Last Meeting (Agenda No. 5)	
The note of the meeting held on 5 March 2015 was approved and signed as a correct record. In response to a query from a member of the Board, it was reported that the Primary Care Strategy on the expansion of practices and the joining up of the workforce element would be brought to the next meeting on 5 November for discussion. In relation to Item 10 – 'Healthwatch Oxfordshire Report – Summary of Outcomes/Responses' - Healthwatch Oxfordshire had reported at the last meeting that the CCG had agreed to meet with My Life My Choice to progress improvement on the take up of health checks for people with a learning disability. Eddie Duller reported that the meeting had taken place and My Life My Choice were awaiting confirmation from the CCG of the next steps.	Julie Dean Julie Dean David Smith

6 Implications of the Chancellor's Budget (Agenda No. 6)	
John Jackson made the following observations on the 8 July Chancellor's Budget Statement, commenting that it would be the spending review expected in October/early November which would be of the utmost importance: • No details were yet known on the announcement made that there would be a reduction in funding for Public Health. • The announced increases in the national living wage would have a minimal impact on employees in Oxfordshire as most health care providers were already paying more than the minimum wage. • There could be a significant impact on the Oxfordshire health care sector workforce if employees in the retail sector were to be paid more as a result of the changes in tax credits. Dr McManners commented that the CCG would find it very useful if the Board was to have a round table discussion on the subject of key worker housing. Cllr Turner reported that the Health Improvement Partnership Board had already taken on an oversight of the challenges to be faced by the Government's withdrawal of Housing Benefit for 18 – 21 year olds and for larger families, including the impact it would have on the homeless pathways. He also asked Dr McManners whether the announcement of more public sector pay restraints would cause significant challenges for the recruitment and retention of staff. He responded that it was difficult to know at this stage and the CCG were planning forward in order to understand the scale of the problem. It was **AGREED** to thank John Jackson for the report and to ask for a full report on workforce issues to be presented to the 5 November meeting.	John Jackson
7 Director of Public Health's Annual Report (Agenda No. 7)	
The Director of Public Health gave a presentation on his independent report (HWB7) which was for all organisations and individuals. It summarised the key issues associated with public health in the county and included details of progress over the past year, as well as recommendations for future work.	

The Board also had before them, included on the Addenda to the meeting, the comments of the Oxfordshire Health Overview & Scrutiny Committee from their meeting on 2 July. The Board discussed the need for organisations to accept a collective responsibility to promote the need to plan early for the proper inclusion of health services in individually planned developments within the district councils. Due consideration would also have to be made to the limited financial pot however. John Jackson undertook to lead on this, in his capacity as the CCG's Director of Strategy & Transformation. In addition, the Board agreed that there was also a role for other organisations such as the Local Enterprise Partnership and the Growth Board to play in this. The Board therefore **AGREED** that all organisations should take a collective responsibility to ensure that appropriate Health provision was included into housing developments where possible and appropriate and that there should be regular updates on action taken to address this.	John Jackson
In addition, the Board **AGREED** to **RECOMMEND** that the Oxfordshire Joint Health Overview & Scrutiny Committee scrutinise the role of prevention of obesity, focusing on the collective roles of the district councils, the clinicians and on public health.	Jonathan McWilliam/Claire Phillips/Julie Dean
It was **AGREED** to thank Dr McWilliam for his excellent report and to agree all the recommendations contained within the report which were for the Board.	Jonathan McWilliam
8 Healthwatch Oxfordshire Report and Summary of Responses to Quality Accounts (Agenda No. 8)	
Eddie Duller and Rachel Coney (Chair and Chief Executive of Healthwatch Oxfordshire (HWO), respectively) introduced the Healthwatch Oxfordshire update (HWB8) which also summarised the responses made by HWO to the Quality Accounts produced by providers in Oxfordshire for 2015/16. It also provided the Board with an overview, from the HWO perspective, of the quality issues that need to be addressed in the local health economy in the year ahead. Members of the Board welcomed the summary as prepared by HWO much of which was a useful addition the draft Health & Wellbeing Strategy. Diane Hedges commented that this was a fair representation of the challenges facing Health in Oxfordshire, adding that there had	

been a recognition that some improvements had been made in Quality issues but that there was no complacency on the part of the CCG. Cllr Tilley asked if HWO were going to be focusing on children's issues during the latter half of this year. Rachel Coney responded that the HWO Board was due to consider their forward plan at the end of July. She also informed the Board that the fieldwork for their project on national dignity of care standards was due to end by the end of July and that they would be sharing their findings in early September. It was **AGREED** to note the report.	Eddie Duller/Rachel Coney
9 Performance Report for 2014 - 15 - final report on last year's outcomes (Agenda No. 9)	
The Board reviewed the final report of performance against last year's outcomes as set out in the Health & Wellbeing Strategy 2014/15 (HWB9). Dr McWilliam pointed out that revised outcomes had been included within the draft revised Strategy at Agenda Item 10. He reported an error in 5.7 'Increase the employment rate amongst people with mental illness from a baseline of 9.9% in 2013/14 ' – the 'Actual' statistic was corrected from 16% to 9.6% thus turning the colour from green to amber. It was **AGREED** to note the report.	Jonathan McWilliam/Ben Threadgold
10 Revised Joint Health & Wellbeing Strategy and proposed Performance Framework for 2015-16 (Agenda No. 10)	
Dr McWilliam introduced the revised Joint Health & Wellbeing Strategy and proposed Performance Framework for 2015/16 (HWB10) for consideration by the Board. Dr McWilliam directed the Board's attention to the comments of the Oxfordshire Joint Health & Overview Scrutiny Committee on 2 July which had been included on the Addenda. The following points were raised by members of the Board during the discussion: - the strong focus on the provision of sport in schools in relation to priority1 was welcomed;	

- In response to a query in relation to priority 4.1 - 'improving the free school meals gap at all key stages and aim to be in line with the national average by 2015', Hannah Farncombe explained that the Deputy Director for Children's Services had devised a new strategy for working with schools, with the aim of driving up achievement and attainment and refreshing the school improvement programme; - In response to a request that a target be included to identify child carers within the county, John Jackson responded that the new Care Act had introduced a statutory requirement for the identification of carers; - In relation to the stated need for a focus on the development of clinical support to patients, it was explained that the structure predated the recent CCG's structural organisations. It was noted that the inclusion of Health issues would be welcomed as soon as it was possible to do so; - The CCG would be undertaking a piece of work for public engagement on supporting people with management of long term health conditions; - Performance on targets may mask variations in outcomes for different groups of people or locations, and a hope that the Children's Trust and the Older People JMG would keep it in mind. The draft Strategy was a large, overarching document and there was an inevitable tendency to consult on specific pieces of it. - Reassurance was given that the budgetary component would be picked up in a slightly different format in future to take into account monies coming in from the Prime Minister's Challenge Fund, for example. Taking all of the above into account, it was **AGREED** to approve the revised Health & Wellbeing Strategy for 2015/16.	Jonathan McWilliam/Jackie Wilderspin
11 Primary Care - Implications for Services following award of funding from the Prime Minister's Challenge Fund (Agenda No. 11)	
In September 2014, the Prime Minister announced a second wave of funding amounting to £100m for a Challenge Fund for	

2015/16 to help improve access to general practice and stimulate innovative ways of improving primary care services. There was a pan-Oxfordshire submission by the three GP Federations covering the County's population. It comprised three complementary sets of interventions to address a patchwork of local need. The aim of the schemes was to enhance patient access to Primary Care (physically and digitally). At the end of March 2015 it was announced that Oxfordshire Federations were successful in securing funding to the sum of £4.9m. A summary of the schemes approved was set out in the report HWB11 and further information was also available at Appendix A. Rosie Rowe and Julie Dandridge (CCG) presented the report and made themselves available for questions from the Board. When asked if there had been a noticeable difference in respect of those schemes which started in June, Dr Park responded that to date they were running very successfully and were freeing up time for GPs to see their patients with more complex conditions. Rose Rowe pointed out that the CCG were currently designing an independent evaluation plan for Oxford University to deliver to ensure that investment was concentrating on the key issues. Rosie Rowe was asked what would happen after the one year funding ran out. She explained that that the reason for conducting the independent evaluation of the outcomes was to know about the overall impact the scheme had on individual parts of the system and what was successful and what was not. It would also enable GPs to try working in different ways using new models of care. Rose Rowe was asked about progress in Oxford City. She reported that progress had been good, particularly within the new GP Federation. The early visiting scheme had been provided using practice nurses. The Federation was also working with Oxford Health and the GP Out of Hours Scheme to enable full patient records to be seen in order to assess risk more accurately. They were also looking to roll out an online website. Eddie Duller asked if the evaluation of the pilot schemes would include public opinion on whether the new systems were an improvement or not. Rose Rowe responded that the CCG would be asking patients to comment on their experiences and that Oxford University would be discussing that with HWO. The Board hoped that any savings could be evaluated and then used to enable the pilot services to run on after the funds had run out.	

It was **AGREED** to: (a) note the progress in mobilisation; and (b) note the plans to evaluate the schemes.	) David Smith/ Rosie Rowe)
12 Better Care Fund plans - Update (Agenda No. 12)	
The Better Care Fund (BCF) plan for Oxfordshire was submitted in January 2015 to NHS England, supported by Swindon CCG, Aylesbury CCG, Oxfordshire County Council and the Chair of the Oxfordshire Health & Wellbeing Board and the main providers in Oxfordshire including the Oxford University Hospitals NHS Trust and the Oxford Health Foundation Trust. The plan commits to protecting adult social care with an investment of £8m and £1.35m to support implementation of the Care Act 2014. Attached at HWB12 was information in relation to the performance element of the plans, together with information on the various initiatives. More comment on future work to be done would be submitted to the 5 November meeting. John Jackson presented the report. Eddie Duller reported that at a recent workshop held by HWO many voluntary organisations had reported that the self - assessment process was not working as well as it could do. John Jackson thanked Mr Duller for this information which would be taken on board, but he had found that 70% of older people had filled in the self - assessment form which was a higher number than expected. Dr McManners commented that there were areas where progress was slower than others. Diane Hedges responded that this tended to appear in areas where one service crossed over into other. She added that there would be a meeting on 29 July to establish whether there was alignment or whether there were issues which needed to be ironed out, for example, in EMU ambulatory care. Information on this would be reported to the next meeting of the Board. It was **AGREED** to: (a) note the report and that a further progress report would be submitted to the next meeting of this Board on 5 November; and	)))

(b) support the 2% calculation figures as set out above, as part of the Better Care Fund submission to NHS England. This would mean that a further submission would not be required.	John Jackson/Ben Threadgold)
13 Oxfordshire Safeguarding Adults Board (OSAB) - Annual Report 2013/14 (Agenda No. 13)	
The Oxfordshire Safeguarding Adults Board (OSAB) 2013/14 is required to report annually on the work of the Board and of its partners, assessing the position of the partnership in relation to the safeguarding of adults at risk within Oxfordshire. Sula Wiltshire, Vice Chairman of the OSAB and Seona Douglas, Deputy Director for Adult Social Services presented the report on behalf of the Chair of OSAB. It outlined the work of the Board and its partners to safeguard adults at risk within Oxfordshire for the financial year 2013/14. It also covered the main national and local policy changes that occurred in that period (HWB13). Sula Wiltshire apologised for the delay in reporting activities for 2013/14 and undertook to ensure that the 2014/15 report would be presented to the Board by the end of the financial year. She reported that the Board now had a new Chair, Sarah Mitchell, who was due to start in September. She was also the Chair of the Buckinghamshire Board. Sula Wiltshire observed that now that the Board was on a statutory footing, this would assist the Board to strengthen its processes going forward. A joint business unit was also in place to give dedicated office and governance support to the Children's Safeguarding Services and also to the Adult Services. The first steps would be to work out up to 5 priorities for next year which would be subject to proper performance targets and delivery. It was **AGREED** to note the OSAB report for 2013/14.	Sula Wiltshire/Seona Douglas
14 Reports from Sub-Groups (Agenda No. 14)	
The Board had before them written reports on activities since the last full Board meeting from the Children's Trust, the Older People Joint Management Group and the Health Improvement Partnership Board (HWB14). It was **AGREED** to note the reports.	All to note

15 The Children & Young People's Plan (Agenda No. 15)	
Members of the Board were given a presentation on the draft Children & Young People's Plan (HWB15) aided by three young people who had had some involvement in its production. The Board thanked the young people for their part in giving both theirs and other young people's very valuable viewpoints in relation to a wide number of issues, and for all their hard work in the production of the Plan. Hannah Farncombe spoke of the importance of building good relationships of trust between children and young people and partner organisations such as the Police, social workers, health workers, teachers etc, adding that this leads to a sense of safety, security, receiving a better education and better health. It was **AGREED** to accept the Children & Young People's Plan.	Jim Leivers/Hannah Farncombe
16 PAPERS FOR INFORMATION ONLY (Agenda No. 16)	
The Board received a summary of correspondence with the Chairman (HWB16).	

..... in the Chair

Date of signing

Health & Wellbeing Board
Performance Report
2015/16 Quarter 1

Introduction

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

2. Priority 4 - raising achievement for all children and young people is monitored annually once the national results are known.

Summary

3. The table below summarises performance on each priority. In total 65 measures are reported, with 41 rated. 17 (just over 40%) are on target, with 11 (just over a quarter) rated amber and 13 (just under a third) rated red. Looking across all the measures performance is good on priorities 3, 5, 10 and 11, whereas in the following priorities most measures are rated red:
    a. Narrowing the gap for our most disadvantaged and vulnerable groups
    b. Support older people to live independently with dignity whilst reducing the need for care and support
    c. Preventing early death and improving quality of life in later years

	Red	Amber	Green	Not Rated	Total
1. Ensuring children have a healthy start in life and stay healthy into adulthood	0	0	0	2	2
2. Narrowing the gap for our most disadvantaged and vulnerable groups	3	0	2	3	8
3. Keeping children and young people safe	1	1	4	2	8
5. Working together to improve quality and value for money in the Health and Social Care System	1	3	5	2	11
6 Adults with long term conditions living independently and achieving their full potential	1	1	2	4	8
7. Support older people to live independently with dignity whilst reducing the need for care &support	4	3	0	2	9
8 Preventing early death and improving quality of life in later years	3	2	2	0	7
9. Preventing chronic disease through tackling obesity	0	1	0	2	3
10. Tackling the broader determinants of health through better housing and preventing homelessness	0	0	1	5	6
11. Preventing infectious disease through immunisation	0	1	1	2	4
Total	13	11	17	24	65

4. The individual indicators rated as red are:
    a. Ensuring children have a healthy start in life and stay healthy into adulthood (none)
    b. Narrowing the gap for our most disadvantaged and vulnerable groups

   i. 2.2 Reduce the number of children and young people placed out of county and not in neighbouring authorities from 74 to 70
   ii. 2.5 Reduce the number of children with SEN with at least one fixed term exclusion in the academic year.
   iii. 2.7 Reduce the number of young people convicted of a violence against a person offence excluding common assault
c. Keeping children and young people safe
   i. 3.4 Reduce the number of hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24)
d. Working together to improve quality and value for money in the Health and Social Care System
   i. 5.2 Reduce the number of avoidable emergency admissions to hospital for older people per 100,000 population
e. Living and working well: Adults with long term conditions, physical or learning disability or mental health problems living independently and achieving their full potential
   i. 6.5 Reduce the number of emergency admissions for acute conditions that should not usually require hospital admission for people of all ages
f. Support older people to live independently with dignity whilst reducing the need for care and support
   i. 7.1 Reduce the number of people delayed in hospital
   ii. 7.2 Reduce the number of older people placed in a care home
   iii. Increasing the number of people accessing reablement from the community.
   iv. 7.8 Increase the number of people supported through home care by social care in extra care housing by 10%
g. Preventing early death and improving quality of life in later years
   i. At least 3650 people will quit smoking for at least 4 weeks
   ii. The target for opiate users by end 2015/16 should be at least 7.6% successfully leaving treatment and not representing within 6 months
   iii. At least 39% of non-opiate users by 2015/16 should successfully leave treatment and not represent within 6 months
h. Preventing chronic disease through tackling obesity/ Tackling the broader determinants of health through better housing and preventing homelessness/ Preventing infectious disease through immunisation all have no red indicators

Steve Thomas
Performance & Information Manager, Joint Commissioning
October 2015

Annex 1

Oxfordshire Health and Wellbeing Board
Performance Report

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

	Target	Q1		Q2		Q3		Q4		Comment
		Fig	RAG	Fig	RAG	Fig	RAG	Fig	RAG	
1.1 Waiting times for first appointment CAHMS. 75% of children will receive their first appointment within 8 weeks of referral by the end 2016/16	75%	Not yet available								Awaiting data from the service
1.2 Support secondary schools to have a school health improvement plan which includes smoking, drug and alcohol initiatives.	100%									Annual measure only

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

	Target	Q1		Q2		Q3		Q4		Comment
		Fig	RAG	Fig	RAG	Fig	RAG	Fig	RAG	
2.1 Reducing inequalities as measured by Public Health measure 1.01i - Children in poverty (all dependent children under 20)	<10.9									Annual measure
2.2 Reduce the number of children and young people placed out of county and not in neighbouring authorities from 74 to 70	70	83	R							The growth in numbers placed out of county is a factor of the increase in overall looked after numbers.
2.3 Reduce the level of care leavers not in employment, education or training	< 47%									Annual measure
2.4 Increase the number of young carers identified and worked with by 20% from 1825 at April 1, 2015 to 2190.	2190	1945 - 120 new	G							365 new young carers need to be identified by March 2016. In the first quarter 120 or 33%
2.5 Reduce the number of children with SEN with at least one fixed term exclusion in the academic year. (Measured on an academic year)	5.1%	5.8%	R							747/12989
2.6 Increase the proportion of children with a disability who are accessing short breaks services who are eligible for school meals	24%	39.5%	G							38 children receiving short breaks, 15 eligible for FSM, 13 receiving pupil premium
2.7 Reduce the number of first time entrants to Youth Justice Service from 208 in the calendar year 2014	< 208									Annual measure
2.8 Reduce the number of young people convicted of a violence against a person offence excluding common assault (defined as a gravity score of 4 and above)	< 18	6	R							

Priority Three: Keeping children and young people safe

	Target	Q1		Q2		Q3		Q4		Comment
		Fig	RAG	Fig	RAG	Fig	RAG	Fig	RAG	
3.1 Set a baseline for and then increase the amount of times the Independent Chair is satisfied that the core group minutes show that the objectives of the CP Plan are being progressed by the Core Group. Baseline 48.6%	48.6%	72.8%	G							New measure. Will be examined going forward
3.2 Set a baseline for and then increase the proportion of specified outcomes that have been achieved in the child protection plan. Baseline 39%.	39%	42%	G							Overall there has been a small increase in the number of outcomes that have been achieved
3.3 Increase the proportion of neglect cases where the neglect tool is used.	13.3%	14.2%	A							127 new CPP for neglect. 18 neglect tools recorded. Figures are for neglect tools recorded on social care system only. Tools used in other organisations but may not be recorded on social care systems. Report card on use of neglect tool being drawn up.
3.4 Reduce the number of hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24) (PH OF 2.07ii)	135.4	145.0	R							Covered in report on the growth in demand for services across agencies
3.5 More than 70 schools receive direct support to implement effective Anti-Bullying strategies as evidenced by school action plans to tackle and reduce bullying through increased membership of Anti-Bullying Ambassador scheme, individual support from Anti-Bullying Co-ordinator and provision of training	70	46	G							28 primary & 18 secondary schools supported
3.6 Reduce the assessed level of risk for high risk domestic violence victims managed through the MARAC (Multi-Agency Referral Risk Assessment Conference)	< 80%	75%	G							

3.7 Female Genital Mutilation (measure to be confirmed)	tbc	tbc								Specific measure to be agreed
3.8 Monitor the proportion of MASH enquiries leading to a referral where information was shared with partner agencies.	32%	33.5% 557/ 1663								

Priority Four: Raising achievement for all children and young people

As these results are annual these will be provided by an annual report in February 2016 when both Oxfordshire's figures and other local authority figures will be available

Monitoring Education Strategy measures:	
4.1 Early Years, including: • *62% of children in early years & foundation stage reaching a good level of development*	
4.2 Levels of attainment and quality across all primary and secondary schools	
4.3 Closing the attainment gap, including: • *Children eligible for Free School Meals* • *Special schools* • *Children with Special Educational Needs*	
Monitoring Oxfordshire Skills Board measures:	
4.4 Creating seamless services to support young people through their learning –from school and into training, further education, employment or business	
4.5 Up-skilling and improving the chances of young people marginalised or disadvantaged from work	
4.6 Increasing the number of apprenticeship opportunities	

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

	Target	Q1		Q2		Q3		Q4		Comment
		Fig	RAG	Fig	RAG	Fig	RAG	Fig	RAG	
5.1 Deliver the 6 Better Care Fund national requirements for closer working of health and social care			G							All are on track
5.2 Reduce the number of avoidable emergency admissions to hospital for older people per 100,000 population from a baseline of 15,849 in 13/14	15,849	16,782	R							
5.3 Increase the number of carers known to social care from 16,265 (March 2015) to 17,000 by March 2016	17,000	16,546	G							On track
5.4 Increase the number of carers receiving a social care assessment from 6,042 in 2014/15 to 7,000 in 2015/16	7,000	1,131	G							Target requires just under 600 assessments per month. Currently below target but performance is increasing month on month. In June & July 1380 assessments were completed. At this rate the target will be exceeded
5.5 Increase the number of carers receiving a service from 2,226 in 2014/15 to 2,450 in 2015/16	2,450	304								The current level of service recipients is half the target. This is primarily an unforeseen consequence the Care Act. National guidance is such that only carers with a personal budget or direct payment should be counted as receiving a service. Carers now have to be assessed to receive these, whereas previously they could directly access direct payments from GPs, The figure excludes most services that provide support for carers e.g. over 4000 people receive the Alert service, which provides an alarm to a call centre. A recent review of such

										services showed that in 88% of cases these reduced carers levels of stress and anxiety
5.6 Increase the percentage of people waiting a total time of less than 4 hours in A&E. Target 95% based on an average from the first three quarters of 2014/15 which is 91.3%	95%	96.2%	A							
5.7 Increase the percentage of people waiting less than 18 weeks for treatment following a referral:										
• Admitted patients target 90%	90%	89.0%	A							
• Non-admitted patients target 95%	95%	95.9%	G							On track
• Of patients who do not complete the pathway target 92%	92%	94.2%	G							On track
5.8 Monitor complaints and compliments people raise about health and social care with the Clinical Commissioning Group and the County Council. Set a target to increase next year as a measure of transparency and openness to learning										Information not yet available

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

	Target	Q1		Q2		Q3		Q4		Comment
		Fig	RAG	Fig	RAG	Fig	RAG	Fig	RAG	
6.1 20,000 people to receive information and advice about areas of support as part of community information networks	20,000	9078	**G**							On track
6.2 15% of patients with common mental health disorders, primarily anxiety and depression will access treatment	15%	Not yet available								
6.3 Improve access to psychological therapies so that more than 50% of people who have completed treatment having attended at least 2 treatment contacts are moving to recovery	50%	Not yet available								
6.4 At least 60% of people with learning disabilities will have an annual physical health check by their GP	60%	Not yet available								
6.5 Reduce the number of emergency admissions for acute conditions that should not usually require hospital admission for people of all ages (2013/14 baseline: 951.4 per 100,000 population)	< 951.4	986	**R**							
6.6 Increase the employment rate amongst people with mental illness from a baseline of 9.9% in 2013/14	9.9%	Not yet available								
6.7 Reduce the number of assessment and treatment hospital admissions for adults with a learning disability to 8 in 2015/16 from 20 in 2014/15	8		**A**							Figures are currently below the level reported last year, but higher than the expected position for 8 in the year.
6.8 Reduce the length of stay of hospital episodes for adults with a learning disability so that by March 2016 no one has been in a NHS Assessment & Treatment Unit for more than 2 years. It is acknowledged that 2 years remains an unacceptable length of stay and are working to develop a new approach which will improve the pathway.	0		**G**							On track to be at zero by the end of the year.

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

	Target	Q1		Q2		Q3		Q4		Comment
		Fig	RAG	Fig	RAG	Fig	RAG	Fig	RAG	
7.1 Reduce the number of people delayed in hospital from an average of 145 per day in 2014/15.to an average of 96 for 2015/16	96	154	R							
7.2 Reduce the number of older people placed in a care home from 11.5 per week in 2014/15 to 10.5 per week for 2015/16	10.5	12.8	R							166 people were placed in a care homes in quarter 1 or 12.8 people per week. This includes individuals coming from hospital or their own home, or who were previously self-funding but their savings have fallen below the threshold for local authority funding. The rate is above target and higher than the same period last year. This is in part due to general increasing demand for services, as more people are living longer. It is also a symptom of the capacity issue within the market for home care provision, as care homes are used as an alternative to home care. However, relative to other authorities, Oxfordshire tends to perform well on this measure and it is expected that it will be in the top quartile nationally when figures are published later in the year.
7.3 Increase the proportion of older people with an on-going care package supported to live at home from 62.7% in April 2015 to 63.0% in April 2016	63%	62.6%	A							More people than planned have been supported in care homes with the increase in admissions described above
7.4 Over 67% of the expected population (5081 out of 7641) with dementia will have a recorded diagnosis (provisional baseline 59.5% or 4948 people)	67%									Not yet available

7.5 Increase the number of people accessing the reablement pathway including										
• Increasing the number of people accessing the reablement pathway from a hospital pathway to at least the national average.	1945	420	A							1945 people accessed reablement from hospital last year. This is marginally above the national average. To maintain this level would require just fewer than 490 new episodes a quarter. In quarter 1 there have been just fewer than this, but episodes traditionally increase over winter
• Increasing the number of people accessing reablement from the community. Our target for the year is 1875.	1875	412	R							A multi-agency project has been set up to improve access to reablement and the performance of the whole reablement pathway. Work streams include developing a commissioning pathway, and improving the interface between the different parts of the reablement pathway. The recommendation for a single provider service from hospital delivered by a combined service from both current providers was agreed and the providers are developing a plan to implement this change.
7.6 Reduce the proportion of people who do not complete their reablement episode from 20.3% in 2014/15 to 17% in 2015/16	17%	18.4%	A							Significant improvement in year
7.7 Monitor the number of providers described as outstanding, good, requires improvement and inadequate by CQC and take appropriate action where required.										See below
7.8 Increase the number of people supported through home care by social care in extra care housing by 10% (from 114 to 125)	125	107	R							The number has dropped in the first quarter, but has subsequently risen again. Further work is in hand to better understand how people are supported.

7.9 Increase the proportion of people on the end of life pathway who die in their preferred place.									Not yet available

Provider CQC Ratings (as reported 7/9/2014) of providers inspected so far

	Care Homes			Clinics[1]			Community Services			Doctors/GPs			Hospitals			Mental health services			Social Care Support at home		
	Oxon No	Oxon %	National %	Oxon No	Oxon %	National %	Oxon No	Oxon %	National %	Oxon No	Oxon %	National %	Oxon No	Oxon %	National %	Oxon No	Oxon %	National %	Oxon No	Oxon %	National %
Outstanding	0	0%	0%	0	0%	4%	0	0%	1%	0	0%	4%	0	0%	2%	0	0%	2%	0	0%	1%
Good	19	58%	61%	7	70%	75%	1	50%	34%	5	71%	80%	3	75%	32%	3	60%	43%	5	38%	68%
Requires Improvement	13	39%	33%	2	20%	17%	1	50%	57%	1	14%	12%	1	25%	58%	2	40%	47%	8	62%	27%
Inadequate	1	3%	5%	1	10%	3%	0	0%	8%	1	14%	3%	0	0%	8%	0	0%	7%	0	0%	4%

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

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

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

[1] There are a range of different types of healthcare clinics in England in addition to GPs, which offer services such as IVF, cosmetic surgery and advice or treatment to help with family planning or losing weight.

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

No	Indicator	Q1 Apr-Jun	RAG	Q2 Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Locality spread	Notes
8.1	At least 60% of those sent bowel screening packs will complete and return them (ages 60-74 years)	**Expected** 60%	A	**Expected** 60%		**Expected** 60%		**Expected** 60%			
NHS England		**Actual** 59.2%		**Actual**		**Actual**		**Actual**			
8.2	Of people aged 40-74 who are eligible for health checks once every 5 years, at least 15% are invited to attend during the year. No CCG locality should record less than 15% and all should aspire to 20%	**Expected** 3.75%	G	**Expected** 7.5%		**Expected** 11.25%		**Expected** 15%		West Oxfordshire locality has fairly small proportion invited to attend (1.8%) this quarter.	
OCC		**Actual** 5%		**Actual**		**Actual**		**Actual**			
8.3	At least 66% of those invited for NHS Health Checks will attend (ages 40-74) and no CCG locality should record less than 50% with all aspiring to 66% (Baseline 46% Apr 2014)	**Expected** 46%	A	**Expected** 50%		**Expected** 58%		**Expected** 66%		North East Oxfordshire has a lower proportion attending (26.7%) whilst West Oxfordshire has had more attending than invited (150%)	
OCC		**Actual** 42.2%		**Actual**		**Actual**		**Actual**			
8.4	At least 3650 people will quit smoking for at least 4 weeks (Achievement in 2014/15 = 1955)	**Expected** 913	R	**Expected** 1825		**Expected** 2738		**Expected** 3650			
OCC		**Actual** 477		**Actual**		**Actual**		**Actual**			

8.5	The number of women smoking in pregnancy should decrease to below 8% (recorded at time of delivery). (Baseline 2014/15 = 8.1%)	**Expected** <8%	G	**Expected** <8%		**Expected** <8%		**Expected** <8%			
OCC G		**Actual** 7.8%		**Actual**		**Actual**		**Actual**			
8.6	The target for opiate users by end 2015/16 should be at least 7.6% successfully leaving treatment and not representing within 6 months (baseline 7.8%)	**Expected** 7.6%	R	**Expected** 7.6%		**Expected** 7.6%		**Expected** 7.6%			Please note that the completion data is from 1/10/14 to 31/12/14 and representations are up to 30/06/2015.
OCC		**Actual** 6.2%		**Actual**		**Actual**		**Actual**			
8.7	At least 39% of non-opiate users by 2015/16 should successfully leave treatment and not represent within 6 months (baseline 37.8%)	**Expected** **39%**	R	**Expected** **%**		**Expected** **%**		**Expected** **%**			
OCC		**Actual** 29%		**Actual** %		**Actual**		**Actual**			

Priority 9: Preventing chronic disease through tackling obesity

No	Indicator	Q1 Apr-Jun	RAG	Q2 Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Locality spread	Notes
9.1	Ensure that the obesity level in Year 6 children is held at no more than 16% (in 2013/14 this was 16.9%). No district population should record more than 19%					**Expected** 16% or less					
OCC						**Actual**					
9.2	Reduce by 1% the proportion of people who are NOT physically active for at least 30 minutes a week (Baseline for Oxfordshire 23% against 28.9% nationally, 2014-15 Active People Survey)							**Expected** 22% or less			
District council								**Actual**			
9.3	63% of babies are breastfed at 6-8 weeks of age (currently 60.4%) and no individual CCG locality should have a rate of less than 50%	**Expected** 63%		**Expected** 63%		**Expected** 63%		**Expected** 63%		For CCG localities in Q1 all are over 50%	
NHS England & CCG		**Actual** 60.9%	**A**	**Actual** %		**Actual** **%**		**Actual**			

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

No	Indicator	Q1 Apr-Jun	RAG	Q2 Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Locality spread	Notes
10.1	The number of households in temporary accommodation as at 31 March 2016 should be no greater than the level reported in March 2015 (192 households in Oxfordshire in 2014/15)			**Expected** 192 or less				**Expected** 192 or less			
District Councils				**Actual**				**Actual**			
10.2	At least 75% of people receiving housing related support will depart services to take up independent living (baseline 91% in 14/15)	**Expected** 75%	**G**	**Expected** 75%		**Expected** 75%		**Expected** 75%			
OCC		**Actual** 84.8%		**Actual** %		**Actual** **%**		**Actual**			
10.3	At least 80% of households presenting at risk of being homeless and known to District Housing services or District funded advice agencies will be prevented from becoming homeless (baseline 83% in 2014/15 when there were 2454 households known to services). Reported 6-monthly			**Expected** 80%				**Expected** 80%			
District Councils				**Actual** %				**Actual**			
10.4	More than 700 households in Oxfordshire will receive information or services to enable significant increases in the			**Expected** >700				**Expected** >700			.

Affordable Warmth	energy efficiency of their homes or their ability to afford adequate heating, as a result of the activity of the Affordable Warmth Network and their partners.			**Actual**				**Actual**			
10.5	Ensure that the number of people estimated to be sleeping rough in Oxfordshire does not exceed the baseline figure of 70 (2014/15)					**Target** < 70					
District Councils						**Actual**					
10.6	A measure will be included in the performance framework to monitor the success of supporting vulnerable young people in appropriate housing following monitoring to establish a baseline.										Baseline to be established and outcome to be discussed in March 2016
OCC											

Priority 11: Preventing infectious disease through immunisation

No	Indicator	Q1 Apr-Jun	RAG	Q2 Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Locality spread	Notes
11.1	At least 95% children receive dose 1 of MMR (measles, mumps, rubella) vaccination by age 2 (currently 95.2%) and no CCG locality should perform below 94%	**Expected** 95%	G	**Expected** 95%		**Expected** 95%		**Expected** 95%		Oxford City is almost at the target (93.3%). All others are achieving over 95%	
NHS England		**Actual** 95.1%		**Actual** %		**Actual** **%**		**Actual**			
11.2	At least 95% children receive dose 2 of MMR vaccination by age 5 (currently 92.5%) and no CCG locality should perform below 94%	**Expected** 95%	A	**Expected** 95%		**Expected** 95%		**Expected** 95%		North Oxfordshire and Oxford City have lower rates this quarter – below 92%. All other CCG localities are achieving 94% or higher	
NHS England		**Actual** 92%		**Actual**		**Actual** **%**		**Actual**			
11.3	At least 60% of people aged under 65 in "risk groups" receive flu vaccination (2014/15 =)							**Expected** 55%			
NHS England								**Actual**			
11.4	At least 90% of young women will receive both doses of HPV vaccination. (2014/15 =)							**Expected** Over 90%			
NHS Englan								**Actual**			

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NHS
Oxfordshire
Clinical Commissioning Group

Oxfordshire Health & Wellbeing Board – 5 November 2015

Health Inequalities Commission

Presented by Joe McManners, GP, Clinical Chair, OCCG

Purpose of this paper

To inform the Health & Wellbeing Board as to the status of the Health Inequalities Commission.

Background

1. Earlier this year, Dr Joe McManners, Oxfordshire Clinical Commissioning Group (OCCG) Clinical Chair announced his intention to the Health & Wellbeing Board to launch a multi-agency Health Inequalities Commission for Oxfordshire, to answer the question: 'What does Oxfordshire need to do over the next 5 years to reduce health inequalities?' with the specific objectives of:
   a) Undertaking work with local community groups to improve understanding of barriers to accessing health services, and the causes for poor health outcomes;
   b) Reviewing existing initiatives across the UK, and assessing their impact, evidence base and cost;
   c) Improving shared understanding of mutual objectives for reducing health inequalities across Oxfordshire;
   d) Recommending a tightly defined programme of work to be jointly delivered by health, local government and third sector partners over the next 2-5 years.

The Health & Well Being Board, Health Improvement Board, Oxford Strategic Partnership, Cherwell District Council and OCCG Executive Board endorsed this approach.

Objectives of the Commission

The Commission will be a 'task and finish' group with specific objectives:

a) To review existing initiatives and best practice in addressing inequalities across the UK, assess their impact, evidence base and cost. The scope is to look broadly across health and society to determine what best evidence is to address the determinants of poor health;
b) To review current programmes in Oxfordshire to support and learn from successes and to recommend next steps;
c) To take evidence and views from stakeholders and patients/public to tackle the problem;
d) To produce a report based on findings with recommendations.

Expected Outcomes

a) Final report to be presented to the Health & Wellbeing Board (H&WBB);
b) Report and H&WBB recommendations to be presented to local partners;
c) Report to be presented at a large scale, high profile event consisting of key stakeholders, for opportunities to comment on the report;
d) Relevant organisations to incorporate recommendations and actions into their programmes and projects for delivery and evaluation;
e) Actions and outcomes to be reported via the refreshed Health & Wellbeing Strategy.

Current Status

A Steering Group, which has a Terms of Reference, is already in situ and comprises members from OCCG, including GPs; Central Southern Commissioning Support Unit (CSCSU); Oxford Health; Oxford University Hospitals Trust (OUHT); Oxfordshire County Council Public Health and OCC Children's Services; Public Health England; Oxford City Council; Cherwell District Council and Healthwatch.

Joe McManners and Ian Hudspeth, Leader of Oxfordshire County Council, appointed an independent Chair to the Commission. Sian Griffiths is an ex Director of Public Health in Oxfordshire and also an academic and is familiar with the geography and inequality issues in Oxfordshire.

The Steering Group has developed a proposed framework for the Commission to work to, which has been verified by the Chair. The framework includes proposed membership of the Commission and members' roles; the reporting and governance structure; the inequalities themes to be in scope; communication and engagement with patients, public, voluntary and community groups and a mechanism for receiving their contributions.

A project manager will be recruited on a short term basis to assist with the research, which will be national as well as local, and will review current services and identify gaps and needs. The project manager will also provide administration to the Commission and assist with the report writing.

Progress of the Commission work will be reported to the Health & Wellbeing Board, with the final report being presented to members.

Healthwatch Oxfordshire

1 Introduction

This report summarises the key areas dealt with by Healthwatch Oxfordshire in the first six months of this year. In addition to this report,we would like to update the board verbally about the key findings from our Dignity in Care Report, which is due to be published on November 4th.

2 Improving Discharges from Hospital in Oxfordshire.

Healthwatch published its report into how the hospital discharge process in Oxfordshire could be improved in September. This made 14 recommendations that were based on the feedback received from over 200 patients and nearly 90 professionals, mainly GPs and pharmacists. The report was warmly accepted by Health Overview and Scrutiny Committee (HOSC) and from some other organisations but was initially received with reservations by Oxford University Hospitals Trust (OUHT), Oxford Health Foundation Trust (OHFT), Oxfordshire County Council (OCC) and Oxfordshire Clinical Commissioning Group (OCCG). A meeting took place with these organisations, who have subsequently committed to publishing an action plan setting out how they will respond to our recommendations before Christmas.

3 The Big Plan

Healthwatch raised concerns with OCC during the summer of 2015 about the proposed implementation of the Big Plan to improve learning disability services in Oxfordshire. These focused on the planned speed of transition and the risks associated with that. We have subsequently shared the statement, made by OCC at the September HOSC meeting, which announced a much slower transition of services from Southern Health to Oxford Health with all those who had contacted us to express a concern. The revised plans have been positively received by those who raised their concerns with us.

4 Campsfield House

Healthwatch relayed concerns raised by local volunteers about healthcare in Campsfield House to OCC and NHS England earlier in the year. As a result the procedures for volunteers to raise safeguarding alerts have been clarified, and NHS England announced at the last Thames Valley Quality Surveillance Group meeting that it was bringing forward its plans to do a full day site visit to the facility. This is now scheduled for the first half of 2016, and Healthwatch has been assured that it will include a confidential focus group for inmates, who will be invited to participate on the day so that the managers of the facility cannot influence who takes part. Meanwhile the provider is due to give NHS England a completed Patient Experience Survey at the end of the current financial year, and Healthwatch has been assured that it will receive a copy.

5 Community Hospital Provision

Healthwatch has been actively seeking to help mediate discussions between local communities, commissioners and providers about planned changes to local community hospital and intermediate care provision in Chipping Norton, Henley and Witney. We will continue to try and ensure that future consultations meet the public's expectations in terms of the openness and transparency with which they

are conducted and in the extent to which they provide a clear explanation of the data about need on which decisions are being based.

6 Healthwatch Project Fund reports

In the first half of 2015/16 Healthwatch funded and published the following reports in partnership with local organisations in Oxfordshire:

6.1 **Alice's Report** – This report, undertaken in partnership with Restore, recommends supporting the creation of a new organisation led by people who use the service to ensure Oxfordshire is delivering best practice in involving mental health service users in service redesign. The OCCG has agreed to work with the partners to the MH Outcomes Based Contract to set up a conference to explore how service user involvement needs to develop in the context of this new contract. OCCG has also pledged to involve the service user who researched and wrote the report in planning that event, and to ensure her proposals are debated as one of the possible ways forward.

6.2 **Sustaining Dementia Friendly Communities** – This report, published in partnership with Oxfordshire Rural Community Council recommended three main actions to OCCG and OCC required to sustain dementia friendly communities. These were:

- To provide some ongoing professional community development support, training, and funding for volunteer recruitment and incidental costs to organisations that have undertaken dementia awareness training and are committed to providing support to dementia patients and their families.
- To support these groups to make their services known to local GPs.
- To encourage GP practices to have a named dementia lead, who drives the adoption in the practice of social prescribing to these local groups as part of the care prescribed to dementia patients and their carers.

6.3 **Carers in Oxfordshire** – This report, researched and written by Guideposts Trust, set out to identify gaps in services for carers of people with learning disabilities, people with mental health issues and young carers. The main gaps it identified were:

- Insufficient access to holidays for the carer and the cared for.
- Insufficient provision of social activities for the cared for, which provide a break for the carer.
- Insufficient access to care provided by others, outside the home, on a regular basis.
- Demand for access to professional care at home, during the day and overnight, is highly valued and people would like more of it – particularly for people with dementia.
- Access to information for carers of people with mental health issues is still not meeting their needs.

The report has been passed on to the lead commissioners for carers in OCCG and OCC , and we will seek feedback on the action they have taken as a result when we compile our annual "We Said, they Did (or Didn't)" Report.

6.4 **Families' experiences of ante and post natal community services** – This report, researched and written by Homestart, recommended to OCCG, OHFT and OCC that:

- GP practices consider parents of very young children a priority when offering appointments.
- Midwives and Health Visitors be required to incorporate basic parenting and baby care as part of their routine support to all new parents.
- Service providers prioritise continuity of care between individual staff and families, so that parents can develop productive and trusting relationships with those providing them with support.

The report has been passed on to relevant commissioning leads and service managers and we will seek feedback on the action they have taken as a result when we compile our annual "We Said, they Did (or Didn't)" Report.

6.5 SEAP (Support, Empowerment, Advocacy, Promotion) is currently undertaking research into the gypsy and traveller communities experiences of accessing services, and OxPIP (The Oxford Parent Infant Project) is looking at the extent to which the needs of families from the point of conception until their children are two years old are being met locally by health and social care providers. Further grants will have been awarded by the time the Board meets.

7 Outreach Programme

Our staff are now running at least one event somewhere in the county every week, with 27 events held between the end of May and the end of September, and a further 17 planned before Christmas. This programme enables us to canvas people in regard to their experience of health and social care services. Our first report on the information gathered through this programme during the first two quarters of this year has been shared with trusts and commissioners through our regular meeting with Quality and Patient Experience leads.

8 Listening events

8.1 Healthwatch held a series of Hearsay! listening events for users of adult social care in the early summer. Four main areas of concern were raised:

- The need for a joined up health and social care system that offers appropriate and adequate information, advice and communication, to offer a much more coordinated and integrated experience of health and social care.
- The need for a personalised, holistic approach to care with an emphasis on maintaining a person's quality of life.
- There are gaps in age appropriate services for younger people and working age adults.
- There is not enough support for family members who are carers.

OCC has published an action plan setting out how it will address these concerns, and a follow up event is scheduled for January 18th 2016, at which services users will hear directly from Oxfordshire County Council about the progress they have made on delivering this plan for improvement.

8.2 On July 8th we held a conference attended by 40 voluntary organisations and charities, as well as key staff from OCC and OCCG. The event was designed:

- To update members of the voluntary sector on Healthwatch Oxfordshire's role, priorities and work programme.

- To provide information on Healthwatch Oxfordshire's Project Fund and get feedback from the voluntary sector on possible barriers to accessing the fund.
- To enable a discussion on children and young people's health and social care needs with relevant commissioners present.
- To enable a discussion on the Care Act 2014 and its implication on carers in Oxfordshire with the relevant commissioners.
- To provide voluntary sector colleagues with the opportunity to hear about the health and social care commissioning priorities for Oxfordshire from the Director of Adult Social care at Oxfordshire County Council and the Chief Executive of the Oxfordshire Clinical Commissioning Group.

We have passed a full report of the event to OCCG and OCC. This sets out the concerns raised by those present about:

- The vital role played by children's centres and the impact of closure
- Difficulties in transition from children to adult services
- Female genital mutilation
- Access to child and adolescent mental health services
- The barriers facing young people who have to act as interpreters for family members
- The need for better definitions locally of "prevention" and "carer" in the context of the Care Act.
- Getting carers to identify themselves.
- The online carers assessment tool
- Support to carers
- The commissioning of voluntary sector organisations by statutory bodies
- The quality of consultations undertaken in Oxfordshire.

The event report also summarises the actions that will be taken forward by Healthwatch, Carers Oxfordshire and OCC as a result. We will continue to monitor progress on delivery of these actions, and a follow up event is planned for January28th 2016.

9 OCC budget cuts

Healthwatch has received formal notification that OCC is considering making a cut of £100k to its budget from April 2016. This equates to almost 1/3rd of our income. We will give the Board our initial assessment of the impact that this proposed cut would have on our ability to continue to provide it with sound evidence about the concerns raised by those using health and social services in the county.

10 Conclusion

The Health and Wellbeing Board is asked to note:

- **The matters and concerns of those that have been raised by Healthwatch in the first half of 2015/16**
- **That Healthwatch will bring its annual update on actions taken by the system in response to its recommendations to the March meeting.**

NHS
Oxfordshire
Clinical Commissioning Group

Oxfordshire Clinical Commissioning Group

Oxfordshire CAMHS Transformation Plan

October 2015

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1 Introduction

Oxfordshire has a long and proud history of working together to improve children and young people's mental health. There has been a Joint Commissioning Team for Children and Young People in place since 2006. There has been a pooled budget for mental health of, which CAMHS is a part, since 2012. Over the last 10 years local schools have championed whole school approaches to mental health and emotional resilience through programmes such as Social and Emotional Aspects of Learning (SEAL) and more recently targeted programmes such as Values Versus Violence. Public Health in the local authority has re-commissioned school nursing services to explicitly include their role in mental health promotion and early intervention with joint initiatives around self-harm, eating disorders and more recently sexual exploitation.

In Oxfordshire however, leaders recognised there is no room for complacency. As demand increases and resources become more thinly stretched the Clinical Commissioning Group proposed a strategic review of the CAMHS service in order to inform the commissioning of services for the next five years. Following a detailed review process involving parents' groups, children and young people, more than fifty schools, all six GP Locality Groups, Social Work Teams, Children's Centres and every CAMHS Team, the final review was published in April 2015.

The review concluded that radical change is essential if changing profile of needs were to be met in a way children, young people and families wanted over the next five years. It was clear that 'no change was not an option'. Increased capacity was important ,but so too was cultural change to move from a service with thresholds and tiers to a tier less service that addresses needs as they present.

Future in Mind sets out a national blueprint to achieve this. The new funding for CAMHS is a real game changer in terms of the scale and pace of that change. With big ambitions, strong partnership, backed by the new investment we are in a strong position to deliver the transformation that is required.

2 Oxfordshire ambitions and how they align with Future in Mind

Oxfordshire is a place where every child and young person can achieve their full potential. This commitment is the 'golden thread' that binds together our citizens and our services. It is about giving every child the best start in life, keeping them safe through childhood and enabling them to develop into secure and resilient adults and a commitment to promote equality and addressing health inequalities.

We all recognise and value the importance of promoting good mental health and building resilience in children, young people and families. A child's mental health and wellbeing is everybody's business so that collective resilience in our communities is seen as our counties strength and is something of, which our leaders are proud.

Schools, colleges and early years' settings (including those in the independent sector) are enabled to develop 'whole setting' approach to mental wellbeing. We all recognise the pivotal role universal services play in promoting mental health, building resilience and spotting problems early, but we acknowledge that they can't do this all on their own. We invest time and resources in supporting our universal communities.

Everyone knows where to get help when they need it and is clear about what's on offer. There is a published offer that is updated annually so that everyone can see what is provided and how taxpayers' money is spent. The latest developments in digital technology are used to support self-help, self-referral, recovery and independence.

No child or young person should be left without help when they are experiencing mental distress or trauma. Services for children in crisis will continue to be available 24/7. Any child or young person who is in distress will be considered in need of assessment and support quickly. For many this will be same day, but we aspire to ensuring that no child is left waiting more than two weeks for routine referrals. Every child will have access to a named 'supporter' to help them navigate their way around the CAMHS system.

Children and young people should keep getting help until they are confident that they are well enough not to need it any more. And if they then feel they need help again within a year, they will be able to refer themselves back into the services using simple online requests.

Every child and young person is treated as an individual, setting their own targets and goals and being able to influence how services develop in the future. There is easy access to information about mental health and mental health problems – if and when people want it. Children and young people are able to develop their own plan with professionals they trust and who take time to get to know them as individuals. The service will routinely collect, record and report clinical and experience outcomes in collaboration with service users. Parents are recognised as experts in care of their children and can be offered the tools and resources to promote their own child's recovery and independence.

Everyone who works with children will have the skills, capacity and time to deliver the best care for every child and young person. We have a skill mixed workforce integrated across Oxfordshire with processes and structures in place to encourage joint working, risk management and service development. Our local Voluntary and Community Sector are equal partners in service delivery.

2.1 Oxfordshire priorities for transformation

The review[1] of CAMHS made a series of recommendation for the design of a new CAMHS model. These recommendations very much align themselves with the Future in Mind report.

It was clear from the local review that that a radical redesign was necessary. With that in mind the multi-agency project board set about designing a new model for CAMHS, which is underpinned by our stated ambitions. Our key priorities for the future of CAMHS in Oxfordshire therefore are:

Approach

- A service model that is focussed on building resilience, capacity, prevention and capabilities.
- A Consultation and liaison model
- Improved communication to families and delivery partners
- Improved information (published pathways, service offer and self-help options)
- Introducing a tier less model where nobody gets turned away
- Prevention – earlier help, on-line info, self help
- Better support to families and young people whilst waiting for first appointment and beyond (support worker)

Service delivery

- Reducing waiting times and improving access
- Prioritising support to some our most vulnerable children (Looked After Children (LAC), Edge of Care[2], Learning Disability, Autistic Spectrum Disorder, fostered and adopted children)
- Improve Transitions to adult services
- An Evidenced Based Service; providing evidence-based, NICE-approved and Young People Improved Access To Psychological Therapies (CYP IAPT) standard therapies such as Cognitive Behavioural Therapy, Inter Personal Therapy, Systemic Family Therapy and Family Therapy.
- Self-referral
- Increase capacity
- Better use of data for service improvement and development
- Use technology to improve access and self help
- Collection and monitoring of Outcome Measures/Children and CYP IAPT Collaborative

Partnership working

[1] http://www.oxfordshireccg.nhs.uk/your-health/childrens-health/
[2] Definition of Edge of Care: *Children/young people who will without concerted intervention become LAC within 3 months. Services use a RAG rating to assess risk.*

- Partnership working with key stakeholders
- Integration with the Council's Children's Services
- Third Sector to work in partnership to deliver new model with NHS provider as main contractor
- Improve information and consultation
- Explore the possibility of developing a one stop shop with partners

2.2 New delivery model

The new CAMHS model will be an outcome based tier less service model based on the new emerging Thrive Model as endorsed by the *Future in Mind* report. The service will use an outward facing and collaborative approach, which emphasises consultation, capacity and capability building of partner organisations. This is to ensure that children and young people can get support at an early stage before problems become severe and will need the intervention of more specialist services such as CAMHS. The approach will be to offer help early and build on children and young people's own resilience and encourage self-help techniques where possible and to help give them the skills they need for moving into adulthood. Key emphasis will be on delivering speedy access to support and ensuring our most vulnerable children have access to mental health services. The CAMH Service will need to undertake a cultural shift from being a diagnostic service only to being a service, which can support and offer advice to those who have concerns about children and young people's emotional and mental health.

The model will use evidence based interventions supported by NICE, CYPIAPT, SCIE and emerging research, which has been evaluated as effective. For further details of the model please see Appendix 1

3 Engagement and partnership approach

3.1 Local Stakeholder engagement and partnership

The review of CAMHS and the development of a new model have been achieved through using a partnership approach and it is Oxfordshire Clinical Commissioning Group (CCG) intention to continue to use this approach in the development of the CAMHS Transformation plan (see Appendix 2 for details of Engagement Report).

The Oxfordshire CAMHS Transformation Plan is intended to be a 'live' document, ,which will be developed over time with the involvement of our stakeholders. This plan has been developed in partnership with:

- NHS England Specialist commissioners
- Health Youth Justice Board
- Oxford Health NHS Foundation Trust
- Oxfordshire County Council

- Parents (and parents groups)
- Children and young people
- GPs and primary care
- Community Paediatricians

- Schools and colleges
- Oxfordshire Public health Team
- Adult mental health commissioners
- Third sector representatives
- Oxfordshire Healthwatch

On 1st October the draft Transformation Plan was shared with Oxfordshire Schools at a special seminar. There was resounding support for the Plan ("*what's not to like?" Deputy Head, Banbury School)*. There was also helpful challenge around shared language (such as vulnerable learners), shared outcomes (such as pupil progress) and shared resources (such as Pastoral Teams). This was the first phase of engaging with all schools around the development of our Transformation Plans and CAMHS in- reach into Schools. Further plans will involve having regular workshops with stakeholders including young people and their families to continue to develop our plan. This is in addition to a more formal delivery group (please see point 4.1 for details of delivery group).

During our review phase we have had good engagement with key partners and intend to use our existing routes of engagement.

It was clear in the review that the CAMHS services could not deliver effectively if all the other partners within the system were not delivering their part of the pathway effectively. We are therefore looking at new partnership arrangements across the new model including:

- New opportunities for integration with the Council Children's Services – this would include co-location and integrated teams
- Schools and colleges – this would include support to whole school approaches, training for school staff and direct work with identified groups of young people.
- Primary Care – especially with GPs where there would be a clear 'service offer' between CAMHS and GPs that reduces the need for reprioritisation of referrals and enables speedy re-referral if required.
- Paediatricians – with joint operational protocols for key vulnerable groups such as Looked After Children and those with Special Educational Needs.

3.1.1 NHS England Specialist Commissioning partnership

Appropriate access to inpatient beds for young people and those with a severe learning disability and mental illness continues to be a challenge nationally and locally. For Oxfordshire the challenges are exacerbated for those most complex

young people who present typically with a severe learning disability and comorbid autism/emerging mental illness.

These young people challenge the whole system from education to social care and health from puberty onwards. In Oxfordshire the County Council has supported the setting up of a local Autism School called the Endeavour Academy School, specifically for these young people. It provides 52 and 33 week placements as well as day provision and weekly provision for up to 26 young people with learning disability and autism. The aim is to provide an education setting that is integrated with local services and close to home so that the young person can remain part of their local community in a safe environment. It supports the Transforming Care recommendations.

In addition the CCG commissions an integrated CAMHS/Learning Disability Team (CAMHS/LD) that provides care management, assessment and intervention for all young people with a learning disability and mental health problem. They provide support into special schools, the home and other setting and are part of the wider Endeavour Academy School Team. They support discharge planning for any young person who is an inpatient and provide continuity of care where possible. The CAMHS/LD Team also delivers a crisis service, which is operates 24/7, 365 days a year. The crisis service is part of the overall crisis service within CAMHS. The service works in close partnerships with the Local Authority's Childrens' Disability Service and provide joint care packages to avoid hospital admissions when a child or young person is experiencing a mental health crisis.

The crisis team in the core CAMHS also operates 24/7 365 days a year and supports young people in mental health crisis in the community. The service has since its inception in 2007 been highly effective in reducing the need for in-patient care. The core CAMHS works closely with in-patient services to support discharge back to the community.

NHS England Specialist Commissioners have also commissioned a Community Forensic Child & Adolescent Mental Health Services (CFCAMHS) with Oxford Health NHS Foundation Trust Foundation Trust as the provider. The service acts as a tertiary referral service for CAMHS teams (including CAMHS/Youth Offending Team (YOT) link workers and learning disability services for young people). In addition, the team is accessible to all agencies (e.g. social services, YOTs, prisons, courts, solicitors, education, health commissioners etc.) that may have contact with young people exhibiting risky behaviours or young people in the youth justice system who have mental health difficulties. The service provides a highly specialist forensic mental health triage, advice and signposting and formal consultation to a variety of agencies regarding cases of concern. It offers support for local services to enhance delivery of responsive child-centred care in high risk cases through multiagency care-planning and promotion of user engagement.

3.1.2 Health and Justice Commissioning partnership

It is now well established that young people in the youth justice system are far more likely to have specific vulnerabilities around learning disabilities and mental health problems. The existing provider, Oxford Health NHS Foundation Trust Foundation

Trust therefore offers three closely-coordinated services for young people who have high-risk behaviours, or who come into contact with the youth justice system.

These come under the general heading of the Thames Valley Young People's Forensic Service, and consist of:

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

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

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

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

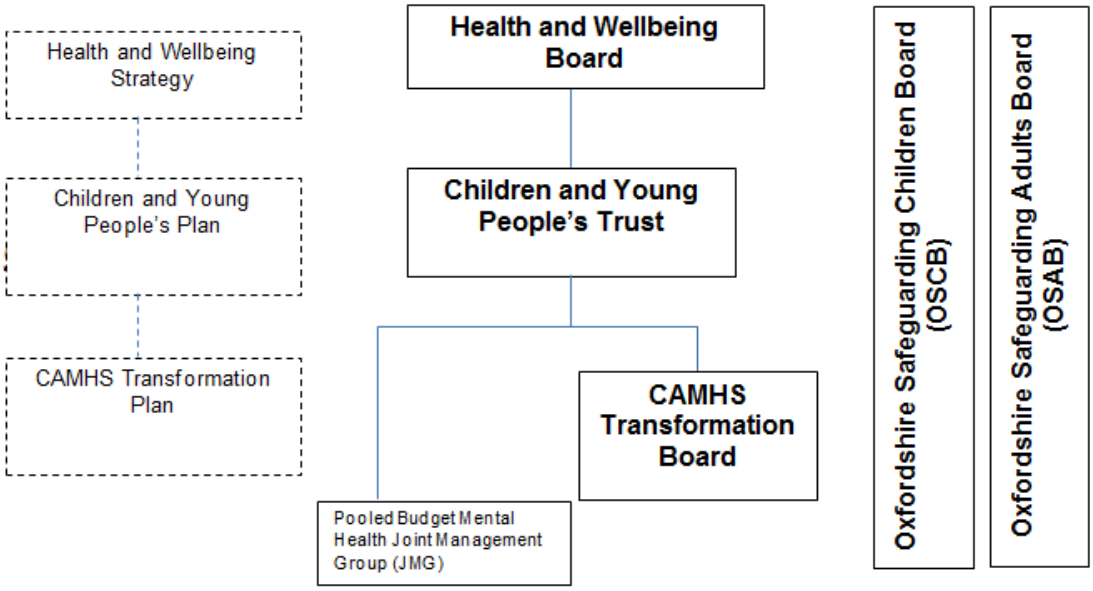
From January 2016 they will also provide single point of access, assessment and intervention for children and young people who have been sexually abused commissioned by the CCG. This is a multi-disciplinary team that will be co-located with children's social care teams. It will have close links with the SARC, general paediatric services and CAHBS. It will also link to the Oxfordshire Kingfisher Team in order to provide a single therapeutic pathway for victims of child sexual exploitation. This acknowledges the complex link between victims and perpetrators (as victims) evident in much sexual abuse and sexual offending. It is also integrated with the Police and Crime Commissioner plans for new services for victims of crimes (counselling hubs) and with the Sexual Abuse Referral Centre commissioned by NHS England.

4 Governance

Oxfordshire Clinical Commissioning Group is the lead commissioning organisation for CAMHS in Oxfordshire and as lead commissioner, the CCG will be responsible for final sign off of the Plan before submission in October. The Director of Deliveries and Localities will be responsible for ensuring sign-off. Development of the Plan requires a partnership approach and therefore the developmental phase has been driven through the Health and Wellbeing Board infrastructure, reporting to the Children's Trust and with sign off delegated to the Chair of the Children's Trust by the Chair of the Health and Wellbeing Board. This will ensure coherence with the Oxfordshire Children and Young People's Plan and the Oxfordshire Health and Wellbeing Strategy.

A multi-agency CAMHS Project Board has been responsible for the initial review of CAMHS and the subsequent development of this Plan. That Project Board has reported to the Children's Trust throughout the review and development phase. The Chair of that Project Board is the Strategic Commissioner for Children, working across the CCG and the Local Authority.

In the next phase of the programme the Project Board will be chaired by the Clinical Director with responsibility for CAMHS at the CCG.



4.1 Oversight of the delivery of the Oxfordshire Transformation Plan

The CCG currently has a multi-agency project board for the CAMHS development and it is intended that this board will take over the function of overseeing the implementation of our plan. The CCG will organise and chair the meetings. This board will meet four times a year to oversee the implementation of the plan. Board members will include initially (this may expand or change over time as plans develop):

- CCG
- Oxford Health NHS Foundation Trust Foundation Trust
- Parent rep
- Article 12 rep (young people engagement group in CAMHS)
- Children's Services (including Education and Youth Offending Service)
- Primary Care
- Paediatric services
- Public Health
- Schools and colleges
- Third sector
- Adult Mental Health Commissioners

In addition Oxford Health NHS Foundation Trust will build additional management capacity in the short-term to provide programme management to the delivery of the plans in 15/16 and 16/17.

5 Publishing our Transformation Plan

The Oxfordshire CAMHS Transformation Plan is by necessity a long and complex document, but the CCG is committed to making it easy to read for professionals and young people alike. The commitment is to publish the Plan in an easy to read version on the CCG website by 1st December. The CCG will then use the Oxfordshire Talking Health webpages to seek views on the Plan over the next year. The reviewed and refreshed Plan will be published in an easy to read version each December. This will be accompanied by a "You said; We did." report that will detail the outcomes of that consultation.

6 Investment and spend

6.1 CAMHS Investment

The budget for CAMHS in Oxfordshire is managed through a S.75 pooled mental health budget with the CCG as the lead commissioners and the investment for 2014/15 financial year is as follows:

CAMHS Budget 2014-15	
Oxfordshire Clinical Group Investment in CAMHS	
CAMHS including PCAMHS	£5,293,014
Oxfordshire County Council Investment	£754,000
Total Investment	**£6,047,014**

During the financial year 2015/16 Oxfordshire CCG took the decision to allocated over 25% of the new Parity of Esteem funding to CAMHS. In addition the new national money for a Young People's Eating Disorder Service was added to the pooled budget September 2015. Therefore the funding for 15/16 show an increase in budgets as well as the Specialist Commissioning investment for Tier4 in-patient services:

CAMHS Budget 2015-16	
Oxfordshire Clinical Group Investment in CAMHS	
CAMHS including PCAMHS	£5,226,322
Parity of Esteem investment	£680,000
Sub Total	**£5,906,322**
Oxfordshire County Council Investment	£754,000
Total Investment	**£6,660,322**

Other CAMHS additional Funding 2015-16	
Eating Disorder Funding (already received)	£322,090
Transformation funding (subject to approval of Transformation Plan)	£806,222
Liaison and Diversion	231,299
CYP IAPT	£75,000
NHSE Specialist commissioning - Tier4	£1,781,884
Total Investment	**£3,216,495**

The total funding for CAMHS 2015-16 from all funding sources is therefore:

Total CAMHS funding from all funding sources 2015-16	
Oxfordshire CAMHS funding (CCG&LA)	£6,660,322
CAMHS additional funding	£3,216,495
Total	**£9,876,817**

6.2 CAMHS Staffing (benchmark)

The current Oxford Health NHS Foundation Trust staffing establishment for the CAMHS service is attached as Appendix 3. This provides a baseline of current staff in post (excluding vacancies). It demonstrates a staffing structure that has evolved over time, increasing or changing as new services are commissioned.

The CAMHS Transformation Plan gives the opportunity to build a staffing structure that will meet the service needs as they change. This will include more use of staff from the third sector and more focus on clinical leadership at different levels. The aim will be to develop a local Workforce Tracker, alongside the Finance Tracker so that we can clearly identify the significant increase in capacity required by the new model. Further work on this will be discussed.

6.3 Performance data

The referral and waiting time's baseline data for 2014/15 are the following:

Oxon CAMHS (All Services) 14-15	Number
Referrals Received	5318
Referrals Accepted[3]	4634
Direct Contacts (Attended)	31,672
Indirect Contacts (Attended)	10,150
Waits-% seen within 12 weeks	YTD
Tier 2 PCAMHS	45%
Tier 3 CAMHS	76%

There is further baseline data including comparison with neighbouring counties outlined in the CAMHS Review. It should be noted that data about CAMHS services

[3] *Those not accepted would have been signposted elsewhere, or advice would have been given

is difficult to benchmark and analyse ,but this will be addressed by the introduction of the new CAMHS Minimum Dataset in January 2016.

7 Needs assessment

7.1 Overview

Oxfordshire's Joint Strategic Needs Assessment and the Children and Young People's Needs Assessment can be found on the Insight webpages at: www.oxfordshire.gov.uk/insight

A CAMHS specific needs assessment can be found in the CAMHS Review and evidence of consultation in the Engagement report (Appendix 2).

7.2 Targeting of vulnerable groups to improve access

A number of projects have been run concurrently as sub projects of the CAMHS review to specifically improve access to our most vulnerable children. The projects include:

- Developing the Autistic Spectrum Disorder (ASD) diagnostic Pathway to improve diagnosis of non- comorbid children with suspected ASD (0-18) and improved support to families post diagnosis.
- Sexual Abuse Pathway – Improving support for those children and young people who have experienced sexual abuse including Child Sexual Exploitation.
- Working with Oxfordshire County Council on their Placement Strategy[4] for children in and on the edge of care. This is to ensure that CAMHS is able to deliver accessible mental health service in a timely manner to Looked After Children and those on the Edge of Care. The strategy is primarily about keeping our riskiest and most vulnerable children in Oxfordshire.
- In-reach into schools pilot –The pilot has over the past year built links with initially nine secondary schools. CAMHS have started to deliver services in schools including expanding the use of group work to increase access. This has proven successful and efficient use of resources and this autumn this will be rolled out to more secondary and primary schools. The CCG submitted a bid the national schools pilot[5], but were unfortunately not successful.

These new development will form part of the new CAMHS overall model and are already in the initial implementation phase.

4 http://mycouncil.oxfordshire.gov.uk/documents/s21493/CA_JUL1613R20%20Placement%20Strategy.pdf

5 http://www.england.nhs.uk/wp-content/uploads/2015/06/joint-mh-train-plts-eoi.pdf

8 Phased Approach

It is clear from the sheer amount of change that is required that a phased approach is necessary. We are therefore intending to phase changes over the next five years and this is reflected in our plan. We intend to front load the change programme so that we address the key issues of improving access and an improved front door though engagement with voluntary sector provider(s). We are also committed to reducing waiting times through sustained waiting list initiatives until capacity is increased to meet waiting list pressures in a sustainable way. We are clear that this cannot be sustained until the service is remodelled and there is a cultural shift in staff and services. This will take much longer.

9 Implementation

9.1 Most Capable Provider process

At the end of October the CCG will issue an outline proposal (including service specification), inviting Oxford Health NHS Foundation Trust to respond in the form of a service bid. This is the procurement route chosen by the CCG to ensure that the provider is clear about what is required and can demonstrate the capacity to deliver the change required. It gives the CCG the option to look at a different contracting approach and a more incentivised management of the change. As a negotiated approach it also gives Oxford Health NHS Foundation Trust the mandate to look at how they can deliver the change by engaging with a wide range of partner organisations including one or more voluntary sector partners. By April 2016 a new contract will have been awarded. A draft timetable is attached as Appendix 4.

9.2 Crisis Concordat

Work on the crisis concordat has been underway for some time and our response to under 18's is very much part of the delivery of the new CAMHs model and indeed of our existing model. In Oxfordshire the is an action plan for under 18's incorporated into the overall plan and commissioners and providers including the Local Authority are working together to deliver the outcomes. For more details of Oxfordshire Crisis Concordat please follow this link:
http://www.crisiscareconcordat.org.uk/areas/oxfordshire/#action-plans-content

9.3 Special Educational Needs and Disability

The Children and Families Act 2014 requires health providers to work with a new framework of assessment based on the single plan (Education, Health and Care Plan). Work has been underway for the past 18 months to re-align processes in Oxfordshire to deliver against the new statutory duties and these will be reflected in the remodelling of the CAMHS service. Oxford Health NHS Foundation Trust will be required to update and maintain the CAMHS offer to the Local Offer through the online webpages found at: https://www.oxfordshire.gov.uk/cms/public-site/special-educational-needs-and-disability-local-offer

9.4 CYP IAPT/Routine Outcome Measures

Our current CAMHS service was one of the first providers to start to undertake training in children's IAPT and over the past three years a substantial number of staff

have received training in evidence based practices, measuring outcomes, participation and leadership. This work will continue with the new model and there is a commitment to continue to release staff to undertake training and deliver a CAMHS using the IAPT approach.

The service will continue to collect, monitor and submit routine outcome measures to support continual service delivery and development and to evidence positive outcomes of the service users. The service will use outcome measures to monitor clinical progression and their experiences of service and interventions received pre, during and post episodes of care. The service will use Goal Based Outcomes, allowing individuals to set personalised goals in partnership with the CAMHS worker; use session-by-session satisfaction ratings and feedback regarding intervention relationship and care plan involvement; use Specific Symptom trackers to follow changes in presentation and complexities; use measures to monitor users' views and the effectiveness of each intervention and event. Using the outcome measures allows continual assessment of the individual and their needs and views, facilitating change where required.

10 Plans for 15-16

10.1 Develop Local Model for Eating Disorder Service

A costed model has been developed with our current provider. The modelling has included:

- Needs analysis and projection of future need
- Base line data of who is using the services and demand
- Current Service model and gap analysis
- Current staffing structure, skill mix and competencies
- Identified Training needs
- How additional funding will be deployed to meet the Access and Waiting time Standard
- Is compliant with National Collaborating Centre for Mental Health/NHS England (NCCMH/NHSE) Guidelines

10.1.1 Overview of Model

There is currently a 'mini team' within CAMHS that delivers an Eating Disorder Service. It is the intention to build on this and make it compliant with NCCM/NHSE Guidelines. Additional staff will need to be recruited to meet the Access and Waiting Times Standard. The service will be commissioned for Oxfordshire alone as there is a sufficiently large population to make it financially viable. For details of the model please see Appendix 5.

10.1.2 Staffing Structure Currently and for the New Service and Costing

Please see Appendix 6 for details.

10.1.3 Recruitment and Retention

The Trust will develop a workforce development plan that will build on the Trust wide recruitment and retention policy. It will identify future staffing requirements as well as strategies to retain current staff.

10.2 Implement ASD Diagnostic Pathway

A project team consisting of OHFT, CCG, Paediatricians, and Council Children's Services has been involved in developing a diagnostic and pathway for 0-18 year olds. The pathway will not only describe the process for diagnosis, but will also have post diagnostic support embedded in the pathway. The post diagnostic support was developed as a response to what families told us they wanted. The model has recently been agreed and will be operational by 1st November 2015.

10.3 Implement new Sexual Abuse Pathway

A project team consisting of OHFT, CCG, Paediatricians, Council's Children's Services and the third sector have been involved in developing the Sexual Abuse Pathway. This redesign was done in response to concerns from professionals that children and families were falling through service gaps and the pathway was not sufficiently robust. Subsequently Serious Case Reviews[6] added weight to the need for a revised model.

The project is now entering the implementation phase and the new service will be part of the CAMHS service. Recruitment is currently underway and the service will be operational for all new referrals from 1st November 2015.

10.4 Schools In-Reach Project

As mentioned a pilot has taken place over the past year for nine secondary schools. The emphases in on building links with schools and have a named link worker protocol in place and to use evidenced based school based interventions. This is aimed at improving access, early intervention and preventing the onset of crisis and severity of presentations. This pilot has been very successful and has improved access to treatment, communication and consultation. It has reduced stigma and normalised getting support for mental health concerns. The schools involved in the pilot have been supported to build capabilities to support pupils within the school environment stopping unnecessary referrals coming to CAMHS. Group work is one of the new interventions and this has proven successful and meant that capacity has been expanded and waiting times are improving.

Learning from the pilots and feedback from the Schools Seminar will be incorporated into the roll out of the schools offer starting in autumn term 2015.

8.5 Adult Mental Health IAPT

[6] http://www.oscb.org.uk/case-reviews/

Adult Mental Health Commissioners have been part of the project group to review and develop the new CAMHS model. We have through discussions agreed with Adult Mental Health Commissioners that they will commission an extended IAPT service to include 16-18 year olds utilising the portion of the Parity of Esteem Funding[7] that was allocated to CCGs this financial year. This will be commissioned and commence December 2015.

10.6 Early Intervention in Psychosis Service

Additional Parity of Esteem Funding has been made available to develop the service and to meet new Waiting Times Standards. Adult Mental Health Commissioners are currently working with the existing provider, OHFT, to develop the service to meet the new standards.

During this year pathways will be developed between the Early Intervention in Psychosis Service and CAMHS. This is to ensure that appropriate links are made and that young people have access to a service that is most appropriate to their needs and under 18's with psychosis have access to the specialist service to improve their outcomes. Currently there are fewer young people accessing the Early Intervention in Psychosis Service than we would expect compared with our neighbouring comparative CCGs in Bucks.

CAMHS and the Early Intervention in Psychosis Service will work together during this year to improve access to treatment for psychosis through the new role CAMHS will have in schools. There will be joint agreement between the services regarding raising awareness of psychosis and how to identify the early signs in young people.

10.7 Psychiatric Liaison

Commissioners will work with Adult Mental Health Commissioners to develop an all age 24/7 psychiatric liaison service in Oxfordshire.

11 Plans for 16-17

11.6 Implement new CAMHS Model during 16-17

During 16-17 will be the first year of implementing the new model and it is anticipated that for all elements to be implemented this will take approximately 18 months as the service model is such a radical departure from our existing CAMHS.

11.7 Publishing Pathways

During 16-17 the most common pathways will be defined and published. Communication about the pathways to all stakeholders will be developed and published. The pathways will be developed with young people and parents and will be written so they are accessible to the public.

11.8 Implement Phase One of the Eating Disorder Service

The new Eating Disorder Model will commence from April 2016. Recruitment to all new posts will take place at the beginning of 2016. Protocols between the Eating Disorder Service and in-patient and paediatric service will be developed. Awareness raising to primary care and schools/colleges will take place to ensure early detection and referrals to the service.

From January 2017 work will commence to start the evaluation of the first months of the new service.

11.9 Developing the Workforce

Training plan for staff will be implemented to deliver the new service as set out in the Most Capable Provider Bid including the Eating disorder Service.
Specific training plan to support the roll out of IAPT to all relevant staff will be developed as a subset of the overall plan.

Analysis will be undertaken to identify further training needs to deliver plans for 2018-20.

11.10 Working with Schools

This work strand will build in the aforementioned schools pilot and of course the development of the School Health Nurse Service (commissioned by Public Health).

11.11 Working with Council Children's Services

Integration with the Council's Children's Services was a key recommendation from the CAMHS Review and will be a key part of the Transformation agenda.

11.12 Working with Primary Care and Paediatricians

A specific offer to primary care and Paediatricians has been developed with GPs and paediatricians. This will be implemented by March 2017

11.13 IAPT for 16-18 year olds

A new Service will be implemented from April 16 onwards. Pathways will be developed this year between the IAPT service (Talking Space) and CAMHS to ensure that young people have access to the right service.

11.14 Early Intervention in Psychosis Service

CAMHS and the Early Intervention in Psychosis Service will work together during this year to improve access to treatment for psychosis through the new role CAMHS

will have in schools. There will be joint agreement between the services regarding raising awareness of psychosis and how to identify the early signs in young people.

11.15 Implementing New National Dataset

The new National dataset for CAMHS will come into force in January 2016. This comprehensive data set will for the first time start to support commissioner to get evidence of service effectiveness and improved outcomes for children and young people. It is also our intention to get a much improved dataset to analyse access to CAMHS and areas we need to improve in terms of equality and health inequality.

12 Plans for 17-18, 18-19 and 19-20

Given the intention to front load the transformation process in the first 18 months, there will be a need for consolidation across the partnership and reviewing the effectiveness of the changes. There will need to be evaluation as well as consolidation and then the plans for 2017/8 onwards can be agreed.

13 Appendices

Appendix 1

New Oxfordshire CAMHS Model

Appendix 2

CAMHS Review Engagement Report

Engagement report
for Children and Adol

Appendix 3
CAMHS Staffing

Oxfordshire CAMHS
staffing 2015 Final.xl

Appendix 4

Draft Timetable for the Most Capable Provider Process

Copy of Procurement
Timetable_CAMHS_V4

Appendix 5

Oxfordshire's Eating Disorder Service Model

ED model across
Oxon and Bucks FINA

Appendix 6
Eating Disorder Service Staffing current and for the new service and costing

Eating disorder staffing _costs Final.›

OXFORDSHIRE HEALTH & WELLBEING BOARD – 5 NOVEMBER 2015

Oxfordshire Safeguarding Adults Board – Annual Report 2014-15 Executive Summary

The Oxfordshire Safeguarding Adults Board (OSAB) annual report for 2014-15 covers the work of the Board and its partners during the last financial year. It outlines the local and national context in which we were operating last year and the issues and challenges facing the Board and social care going forward. The report will be presented at the Health & Wellbeing Board meeting by Sarah Mitchell, Independent Chair of the Oxfordshire Safeguarding Adults Board, who assumed the role in September 2015. A copy is being dispatched to HWBB Members on the 29 October as it contains embargoed national data that cannot be released until that day.

The key challenges are noted as the implementation of the Care Act (both by the Board and its partner agencies) and resourcing the Board so it can operate effectively.

Priorities for 2015-16

The report contains four priorities for the Board for the current year

1. Ensure that people who use health and social care services and their families are at the centre of any decisions about their care and support.
2. Develop a multi-agency protocol on Provider mergers and significant changes which will ensure agencies manage provider change safely.
3. Implementation of the Peer Review Action Plan which covers governance arrangements, quality assurance and good practice issues, so that the Board is compliant with the Care Act.
4. Ensure that the Board is sufficiently resourced to deliver its ambition.

These are draft proposals pending the OSAB's development day on 30 November and the new Chair will be pleased to return to the HWBB to present the Strategic Plan once it has been written.

Recommendations

The Health & Wellbeing Board is **RECOMMENDED** to:

(a) ensure the report is discussed within member agency Governance meetings;

(b) note the increased pressure on Adult Social Care with the rising number of safeguarding alerts;

(c) challenge the progress of the Care Act implementation within the member agencies; and

(d) consider how the HWBB can satisfy itself that members agencies are carrying out their duties with due regard for the safeguarding of vulnerable people.

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OSAB

Oxfordshire Safeguarding Adults Board

Annual Report

2014/15

Contents

1. Foreword

Statement from Sarah Mitchell, Independent Chair of the OSAB

"I am pleased to be taking over the Chair of the Oxfordshire Safeguarding Adults Board at this important time. The importance of Safeguarding Adults has been recognised in the Care Act 2014 and makes it clear to us all that we have a responsibility to be proactive in identifying those who may be at risk of abuse and to take a personalised approach in how we deal with such abuse. People experience abuse in different ways and so our response has to be sensitive to that individual experience.

The new statutory roles for Local Government, the NHS and the Police will provide clear strategic leadership for the OSAB and as Chair of the Board I am strongly committed to delivering their vision and make Oxfordshire a safe and inclusive place to live.

The increase in domestic abuse, hate crime, radicalisation and self-neglect are all a cause of concern for the Board alongside the need to ensure that standards of care in health and social care settings are of the highest quality. The Board is determined to listen to the views of people who use the services in Oxfordshire and ensure that their voice is heard through appropriate application of the Mental Capacity Act. We also want to hear from families, carers and the wider community, working with them to design the support and care which is needed.

A very welcome requirement is for the Board to produce a strategic plan which the OSAB is currently doing for the period 2015 to 2018, building on the outcome of the peer review and the development work being done with the Board.

We are publishing this annual report knowing that we can achieve so much more over the next three years, with a clear focus on delivery and engagement from each member of the Board.

Confronting abuse where and when we think it might be happening is the first step to preventing it becoming more widespread and it is a responsibility we all share."

Statement from Rachel Coney, Chief Executive, Healthwatch Oxfordshire

"Healthwatch Oxfordshire has been pleased to be able to establish a good relationship with the safeguarding team over the last year. We have started to make referrals when we uncover safeguarding issues in the course of our work with patients and service users, and have been able to raise awareness with other voluntary sector organisations about how safeguarding works, and when and how their volunteers should be reporting issues. We look forward to building on this initial partnership working next year"

2. Introduction & Local Context

Oxfordshire is home to some 666,100 people. The population grew by 400 people per month in the decade to 2011 and is predicted to grow 14% in the next 15 years. The population is growing older. The number of people aged 65 and over increased by almost 30% since 2001, compared with a total population growth of around 10% and the numbers of people aged over 90 is forecast to increase 90% by 2026. In addition to the growth of older people there are increasing numbers of people with a learning disability, living for longer and with increased complexity of need. This changing population is placing more pressure on services.

The population is also becoming more diverse. Between the 2001 and 2011 census surveys, the proportion of people identifying as black and ethnic minorities almost doubled, from 4.9% to 9.2% of the population. 22% of Oxford's population are of non-white ethnicity.

Oxfordshire is the most rural county in the South East - with 33.4% of our residents live in what is considered to be a rural area and is generally prosperous, but with pockets of social deprivation. There is a very high employment rate – 78% of adults in work and only 1% of working age adults claiming Job Seekers Allowance. The workforce is amongst the most highly-qualified nationally. Oxfordshire is the second most expensive place outside London to live, and least affordable in relation to earnings. The average house price is nine times higher than median annual earnings, despite a median salary of £29,400, being well above the national average. This has significant implications on the number of people who are willing to work in the caring professions locally, leading to issue of both work force capacity and capability. Wages are not high and latest estimates are that an extra 750 jobs each year are needed in Oxfordshire just to keep pace with increased demand for care and support.

The council has a duty to safeguard 'vulnerable adults' defined as people who

- have needs for care and support (whether or not they are being met by the council);
- are experiencing, or at risk of, abuse or neglect;
- and who as a result of their care and support needs, are unable to protect themselves from this.

Most people in Oxfordshire meet their needs for care and support with help from family and friends, or through the private care market – not via the council. Some people with care needs, both locally in Oxfordshire, and nationally do not have services and their needs are not met.

In the 2011 census approximately 24,000 older people in Oxfordshire said they were having problems with 3 or more activities of daily living (washing, getting up, making food etc.). Also around 7,700 people identified themselves as carers of older people providing over 20 hours. The council currently provides long term services for 4,150 people and estimate around 5,500 self fund care. We therefore know a significant number of people with care needs are not having them met.

This is reflected in safeguarding alerts received by the council – in 2014/15, 47% of safeguarding alerts were from people who were not receiving services commissioned by Adult Social Care at the point of the alert.

Safeguarding vulnerable adults cannot therefore be seen as the sole responsibility of social care or statutory services. It can only be delivered in partnership with the local community of family, friends and neighbours and the private care market.

The creation of a local multi-agency management committee (safeguarding adults) as a means of achieving effective inter-agency working was recommended in the Department of Health report, *No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse* (2000). This guidance, issued under Section 7 of the Local Authority Social Services Act 1970, requires local authorities in their social services functions to play a coordinating role in the development of local policies and procedures for the protection of vulnerable adults from abuse.

A multi-agency working group was established in Oxfordshire in 2001, which led to the development of the Oxfordshire Codes of Practice for the Protection of All Vulnerable Adults from Abuse, Exploitation and Mistreatment in May 2002 and the development of the Oxfordshire Adult Protection Committee.

The publication of *Safeguarding Adults – A national framework of standards for good practice and outcomes in adult protection work* (ADSS, 2005) led the committee to re-evaluate its existing title and terms of reference and become the Oxfordshire Safeguarding Adults Board.

The purpose of the Oxfordshire Safeguarding Adults Board is to create a framework within which all responsible agencies work together to ensure a coherent policy for the protection of vulnerable adults at risk of abuse and a consistent and effective response to any circumstances giving ground for concern or formal complaints or expressions of anxiety.

Case Study – Mr Bishop

Mr Bishop was admitted to hospital in November 2014. A few days later the social work team at the hospital received an alert from a member of the ward staff.

On admission to hospital Jean, a friend of Mr Bishop's, was recorded as Mr Bishop's next-of-kin. However, ward staff started to be concerned when Mr Bishop gave them, for safe-keeping, written instructions from Jean for a solicitor, instructing them to grant her power of attorney for both financial and health and welfare decisions. The instructions also concerned a change to his Will granting a further £50,000 to this acquaintance.

When an occupational therapist subsequently reported to the nurse that Joan was 'almost angry' that Mr Bishop had received a pacemaker, the ward staff spoke to Mr Bishop about their concerns. He said he was not happy about the situation and agreed to referral to the social work team for help.

The social worker, Anne, immediately visited Mr Bishop in the ward. Mr Bishop was angry about what had happened and said:

- He wants to be in control of his own affairs and have support and protection in doing this.
- He wants to continue to live independently at home.
- He wants to review his Will.
- He wants to appoint a Power of Attorney of his own choosing.

Anne subsequently contacted the police because of her concerns but Mr Bishop, although he was angry did not want any criminal action taken.

Mr Bishop was subsequently assessed for a direct payment and, with support from Age Concern, he was able to identify a personal assistant to support him and he returned home. Anne supported him to find a suitable solicitor who could act as his Power of Attorney and help him with his will. Finally a referral was made, with Mr Bishop, to Circles of Support, a joint project between Age UK Oxfordshire, Oxfordshire County Council and Oxford Health NHS Trust. Mr Bishop has now settled back at home and is increasingly involved in his local community.

3. National Policy and Context

The Care Act came into force in April 2014 and brought important new responsibilities for the agencies involved in Safeguarding Adults. It requires the Local Authority to establish a Safeguarding Adults Board and specifies the key membership of the Board to be the NHS and the Police and it asks that these key agencies help to contribute to the cost of the Board and its operation.

The Act recognised that there has been much learning already from case reviews showing that poor communication and information sharing can create more situations where people are at increased risk of abuse. There is a requirement for agencies to provide and share information and we are actively developing a multi-agency protocol to achieve that.

The Act sets out six principles which underpin a new safeguarding adults approach:

- Empowerment - listening to individuals and their families and carers
- Prevention - doing all we can to reduce the levels of abuse
- Proportionality - making sure we get the balance right in all that we do
- Protection - making sure we act quickly and appropriately when we need to take action
- Partnership - working together on behalf of the people in Oxfordshire
- Accountability - being clear where the responsibility lies and being transparent when something goes wrong

The aim of the Act is to prevent harm from happening and to reduce the risk of abuse or neglect and that requires sensitive, skilled intervention by staff and local communities. Developing an open and supportive culture in organisations creates the climate needed to enable staff and members of the public to report concerns or talk to someone whom they think might be suffering abuse. The role of the Board is to know they are supported when they do speak out and to ensure they know how to alert people to the possibility of abuse.

But we must ensure we safeguard adults in such a way that enables people to exercise choice and maintain control - not to do so can feel abusive for people who are already feeling vulnerable. Going at someone's own pace, listening to what they want to happen and ensuring that the decisions made are their decisions are all key to achieving a successful outcome from a safeguarding investigation. The Making Safeguarding Personal programme which was developed by ADASS and the LGA has now become part of the Care Act and sets out how taking a truly personalised approach in safeguarding approach produces very different outcomes for people. The Board has an important role in promoting that approach as well as in publicising the leadership role of the Board to raise public awareness and create communities who will not tolerate unacceptable levels of abuse.

Some types of abuse are more familiar to us than others, the Act does require Boards to consider their role in domestic abuse and self-neglect, learning from cases which showed that we can do more to support people in these distressing situations. The importance of making appropriate links to other Boards - the OSCB and the Safer Communities Board are key to the effective governance of such cases - making sure communication and partnership is strong between the relevant Boards.

Training and support for carers is an essential part of developing a preventative approach to safeguarding adults. Ensuring that we provide the advice, information and support which enables carers to get the right support at the right time for them and for any support to be personally tailored to their needs.

The Board will build the community awareness of safeguarding in Oxfordshire and ensure agencies are proactive and responsive in their approach, taking an evidence based approach to developing best practice.

In transparently holding the system to account, the Board will ensure there are clear arrangements in place to make sure appropriate enquires are made to identify people at risk from abuse, timely and safe action is taken and outcomes are monitored. To do this we need a skilled workforce across all agencies and providers of health and social care and we must be sure that the care being provided is of the highest quality possible.

There is much for the Board to do in 2015 but the work we have done in 2014 builds a strong and secure platform for the future.

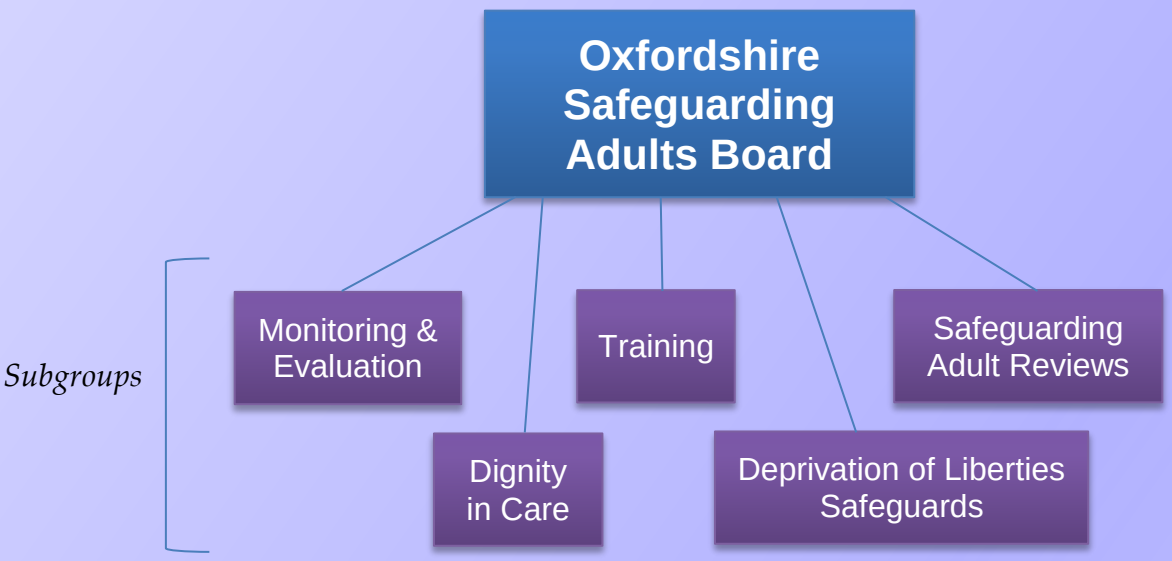
4. Governance and Accountability

The Board is well established as a partnership and has good representation from the main statutory and non-statutory agencies including local providers and the Care Quality Commission. The Board will be reviewing the level of its membership to ensure that decision makers are represented and that the board is able to operate at a sufficiently strategic level and to hold partners to account. A new chair has been appointed and the vision and strategic direction of the board will be refreshed. Roles and responsibilities will also be reviewed as well as the best way to include carers, service users, private care and the voluntary sector more systematically. Links with Healthwatch will also be agreed so that its learning can inform the Board's decision making.

The current sub-group structure will also be reviewed and strengthened with clear reporting mechanisms into the Board. The Training Sub-Group will become a combined OSCB and OSAB group from the autumn 2015.

There is a protocol in place between the OSAB and the Oxfordshire Safeguarding Children Board (OSCB) and it is planned to extend the new protocol between OSCB and the Oxfordshire Safer Communities Partnership and the district Community Safety Partnerships to include OSAB and the Health and Well Being Board in the new year so that the partnership geography in relation to safeguarding is clear.

OSAB Structure



The Board has a new Independent Chair who has overall responsibility for overseeing the safeguarding arrangements in Oxfordshire and for ensuring the Board operates in accordance with statutory requirements and the Care Act 2014.

In 2015 a new combined Business Unit for both OSAB and OSCB was created to ensure that the safeguarding agenda is efficiently managed and that where appropriate processes and policies are aligned, key joint strategic themes are addressed effectively and that both boards are sighted on the right priorities and there is no duplication. This included the appointment of a Strategic Safeguarding Partnerships Manager for both Boards and a new Business Manager for OSAB.

Currently the OSAB business is largely funded by Oxfordshire County Council with a contribution from health partners. Contributions from partner agencies will be reviewed over the coming year to ensure that the business of the board is effectively resourced and delivered and a Financial Plan is in place in accordance with the Care Act 2014.

The Board met four times during the reporting period (April 2014, July 2014, October 2014 and January 2015). Oxfordshire County Council, The Clinical Commissioning Group and Thames Valley Police were represented at every meeting.

5. Safeguarding Board Effectiveness

2014/15 has been a transitional year for the Board during which time it has strengthened its infrastructure in order to improve its effectiveness and to comply with the requirements of the Care Act 2014.

To assist with this process a peer review of the Board was undertaken in June 2015 and a clear action plan is in place to implement the findings of the review.

The reviewers were very positive about the culture and capacity and energy to deliver change across the board and the workforce, the transparency and recognition of the areas to be addressed, evidence of innovation and practice and a commitment to continuous improvement. An example of innovative work that they cited is the preventative work embedded across safeguarding services led by the Fire and Rescue Service.

Key areas for improvement relate to governance arrangements, the Board vision, strategic plan and work programme, the evidence base for identifying key safeguarding issues, assuring consistent practice and capacity issues to deliver the Board work programme. These areas will be top priorities for the Board to address in 2015/16.

6. Safeguarding training

The board is assured that individual providers/agencies have been providing training to their staff and that this has been of sufficient quality to ensure a continued flow of alerts into the safeguarding teams.

Many providers have worked in partnership with the Children's Board to combine training providing a lifespan safeguarding provision.

The CCG and Public Health have clear monitoring arrangements for the update of training within those providers they commission as they are required to provide figures as part of contract monitoring arrangements on a quarterly basis.

In year, there was some training delivered to a multi-agency audience by providers. Locally, Oxfordshire have also hosted a Department of Health (DoH) learning event on Female Genital Mutilation (FGM).

Excellent examples from partners include:

- Deprivation of Liberties Safeguards (DoLS) – The County Council have trained a large number of their own staff in regards to Deprivation of Liberties Safeguards, delivered by the DOLS Manager.
- Mental Capacity Act and Mental Health Act training forms a core part of the induction process for Health Professionals.
- The Fire & Rescue Service deliver an in-house *Safeguarding Everyone* course, covering the safeguarding agenda for both Children's and Adults.
- Oxford University Hospitals NHS Trust also provide staff with joint safeguarding training at induction covering both children's and adults.

The energy, appetite and drive by individual organisations around training and maintaining knowledge is commendable.

The workplan for the Training subgroup in 2015-16 will focus on building on the energy and drive of the partners to:

- Develop a clear Safeguarding Training Strategy
- Create a basic awareness course and materials/resources for agencies to use in-house
- Refresh the previously written multi-agency alerter level safeguarding training
- Work to join together of children and adults training subgroups
- Integrate content of the Mental Capacity Act training with safeguarding training
- Introduce multi-agency learning events

A number of these will be dependent on the outcome of the training review, the funding for the Board going forward, the Board's agreed priorities which will come out of the development day later in the year.

7. Monitoring the effectiveness of local work to safeguard and promote welfare

a. Performance, audit and quality assurance

The data for this report was extracted from the Oxfordshire County Council social care system (SWIFT). In most cases, the data included in this report is consistent with the Department of Health (DH) statutory returns: Abuse of Vulnerable Adults (AVA) for 2012-13 and the Safeguarding Adults Return (SAR) for 2013-14 & 2014-15.

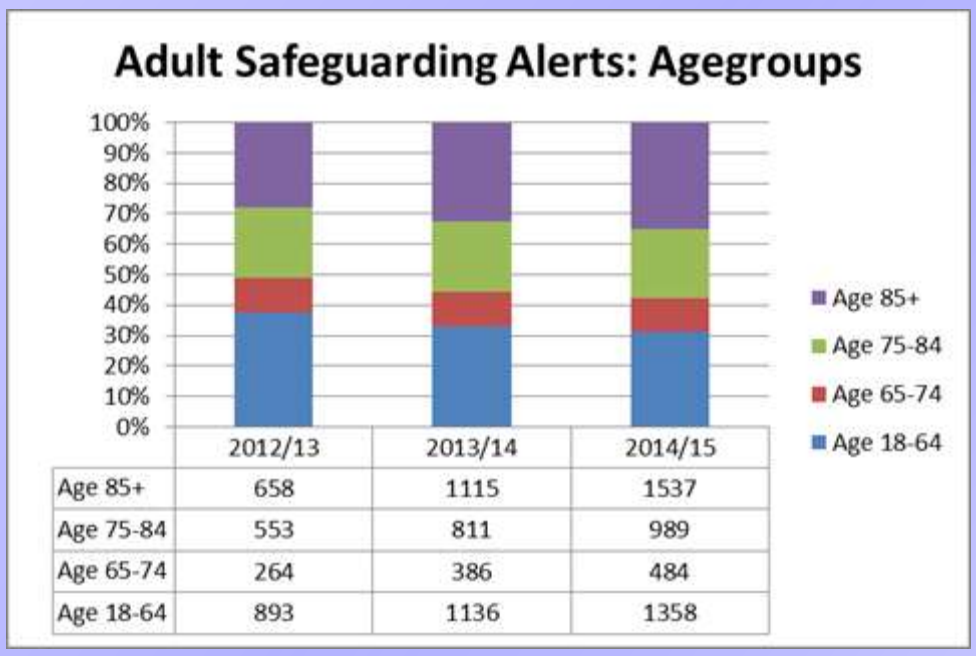
New Safeguarding Alerts

There was a 24% increase in safeguarding alerts[1] in 2014/15, increasing from 3,518 last year to 4,372. This continued the consistent increase in adult safeguarding activity over the last 4 years.

[1] The terminology used in this report is not in line with the changed process described by the Care Act. This is because the data in this report refers primarily to 2014/15 which is pre Care Act. An alert is when someone contacts social services with a safeguarding concern over an adult.

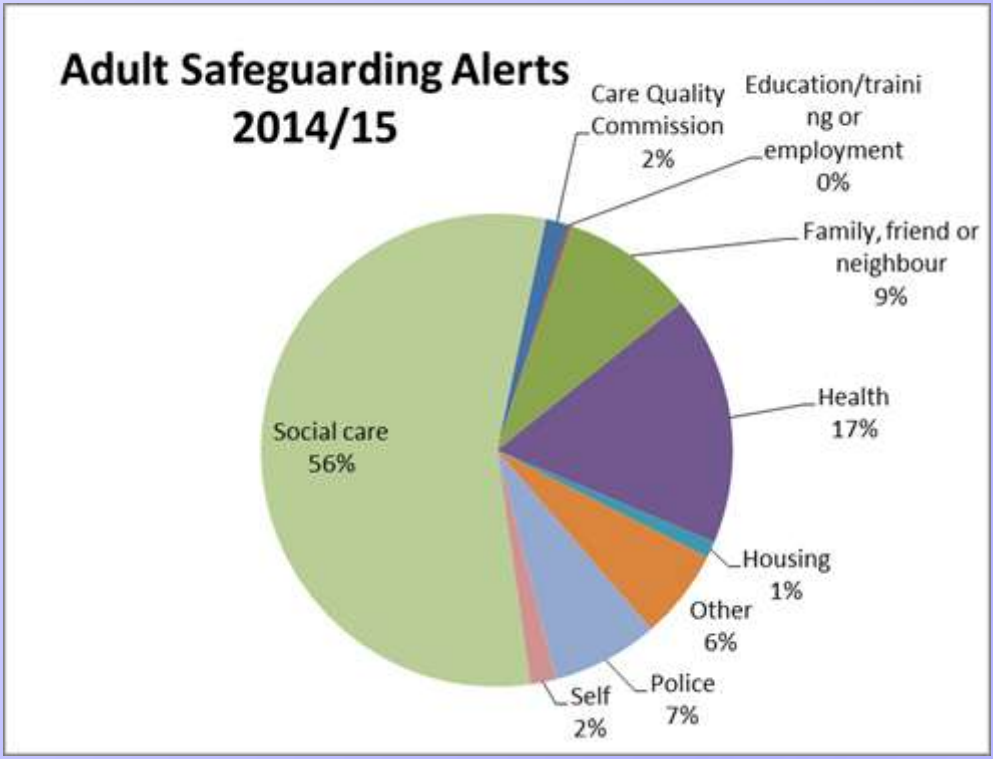
	2010-11	2011-12	2012-13	2013-14	2014-15
No. of Alerts	1086	1467	2170	3518	4372

While there has been an increase in the number of alerts for all age groups, there has been a particularly large increase in the alerts on people aged 85 and over. 35% of alerts were for people aged 85+.



	2012/13	2013/14	2014/15
Age 85+	658	1115	1537
Age 75-84	553	811	989
Age 65-74	264	386	484
Age 18-64	893	1136	1358

In 2014/15, over half the alerts were raised by social care providers or staff, and one in six alerts by Health.



In the last 2 years the number of alerts raised by each group of people or organisations has increased. Alerts from the Care Quality Commission have increased nearly 6 fold, but remain relatively low. Alerts raised by social care providers have more than doubled; alerts from the police have doubled and alerts from members of the public have increased by 50%. Alerts from health staff have increased by a third.

Source of Safeguarding Alerts	2012/13	2013/14	2014/15	Change in last 2 years
Social care (service providers/council)	1097	1623	2431	222%
Health	557	740	746	134%
Family, friend or neighbour	266	343	402	151%
Police	162	260	320	198%
Other	238	342	270	113%
Self	52	70	77	148%
Care Quality Commission	12	20	68	567%
Housing	31	48	49	158%
Education/training or employment	6	8	9	150%

Referrals / investigations

A referral is where an alert is taken beyond an initial consideration, and is investigated. Comparative data is available on referrals but not alerts. In Oxfordshire we have recently revised our interpretation of a referral more accurately reflect the number of cases where further

enquiries/investigation were undertaken at an early stage in the safeguarding process[2], hence the 44% increase between 2013-14 and 2014-15 in the table below. The rate of safeguarding referrals in Oxfordshire is now much more in line with other authorities.

In 2014/15 there were 936 people referred for safeguarding in Oxfordshire or 178 for every 100,000 adults in the population. Nationally there were just over 100,000 referrals or 245 per 100,000 population and just over 21,000 in authorities most similar to Oxfordshire[3] or 214 per 100,000 of the population. Of the 152 local authorities in England, Oxfordshire had the 92 highest levels of referrals and the 9th highest out of the 16 authorities most similar to us. Levels of referrals are therefore in line with what we would expect.

Adult Safeguarding Referrals per 100,000 Population

	Oxon rate	National average	Oxon as a % of national rate	Similar Authority average	Oxon as a % of similar authority rate
2013-14 comparison	124	246	50%	208	60%
2014-15 comparison	178	245	73%	214	83%
Change	44%	0%		3%	

During 2014/15, 3.84% of people supported within the safeguarding adults procedures were from minority ethnic communities. According to the 2011 Census, 9.15% of Oxfordshire's residents come from non-white backgrounds. This discrepancy is largely explained by the difference between age groups. Whereas the proportion of adults under 65 from non-white backgrounds is 9.44% the proportion of adults over 65 from non-white backgrounds is 2.25%.

Ethnicity of people with Adult Safeguarding Referrals 2014/15

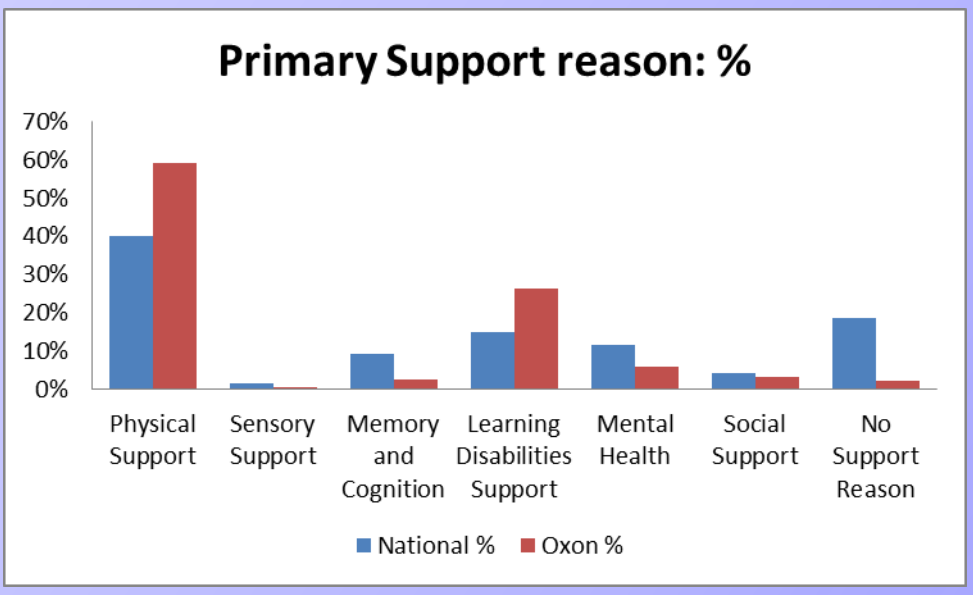
	White	Mixed/ Multiple Groups	Asian/Asian British	Black or Black British	Chinese	Other Ethnic Group
2012/13	96.15%	0.53%	1.06%	1.44%	0.38%	0.43%
2013/14	96.25%	0.50%	1.21%	1.55%	0.15%	0.34%
2014/15	96.16%	0.70%	1.16%	1.28%	0.00%	0.70%

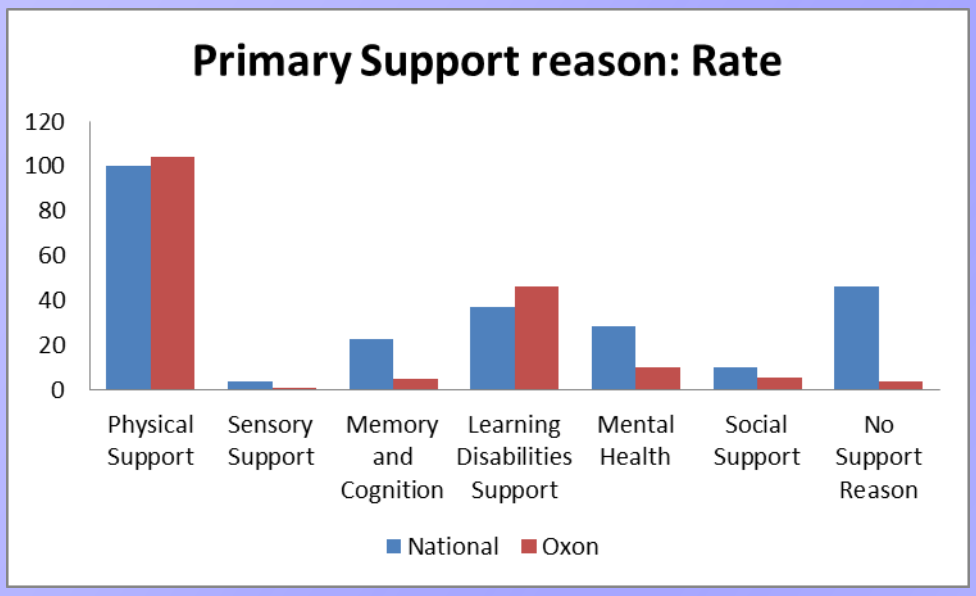
The following graphs look at the primary support reason of the person referred. The first looks at this in terms of the percentage of all people referred for Oxfordshire and nationally while the second looks at the level of referrals per 100,000 of the population. Oxfordshire has more referrals on adults with a physical disability and a learning disability than elsewhere, but fewer on adults with mental health problems including support with memory and cognition. This may reflect

[2] Previously we had defined any case which could be dealt with in 24 hours as an alert only. We now define a referral as any case which is investigated.

[3] These authorities are: North Yorkshire, Warwickshire, Worcestershire, Northamptonshire, Leicestershire, Hertfordshire, Suffolk, Buckinghamshire, Essex, Cambridgeshire, Surrey, West Sussex, Hampshire, Gloucestershire, Somerset

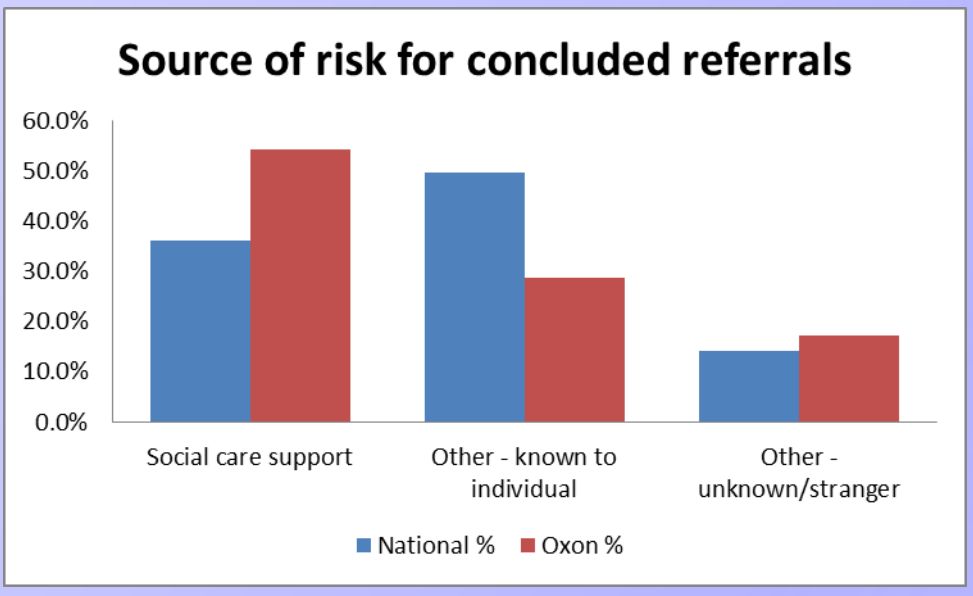
recording practices in Oxfordshire and is an area we need to explore more fully over the coming year. Oxfordshire also has a low rate of people with 'no support reasons'. This is in line with the care act definition of a vulnerable person being someone with support needs.



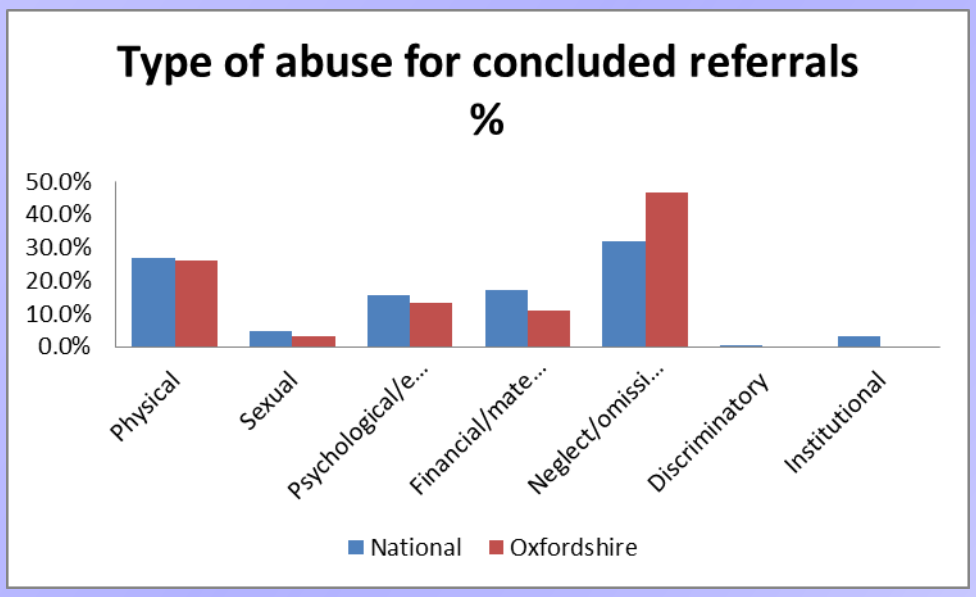


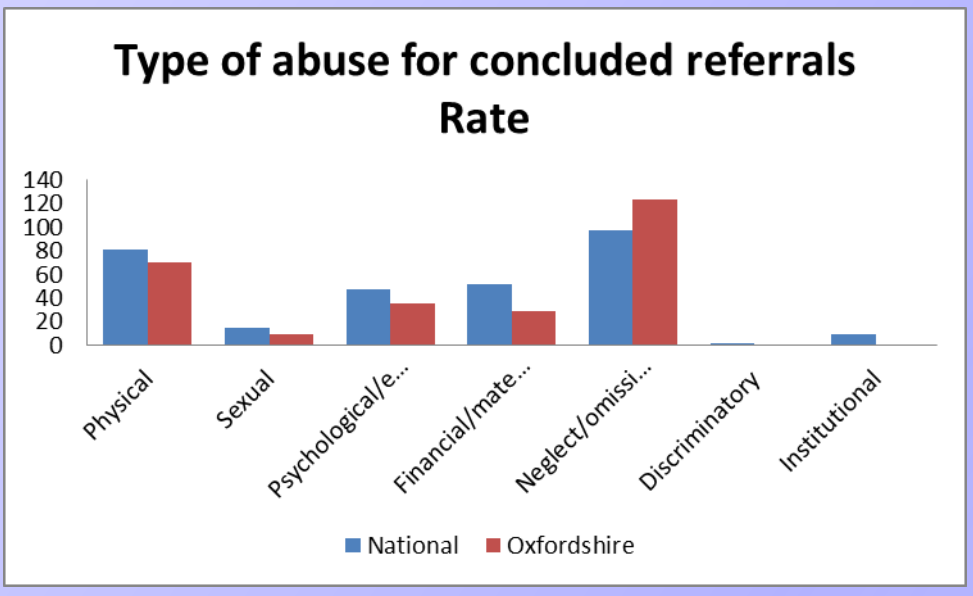
Source of Risk, Type of Abuse and Location of Alleged Abuse

The source of risk is grouped into whether the risk comes from commissioned/ paid for services or not. In Oxfordshire, over half the risk is associated with commissioned care. This reflects the fact that most alerts (c60%) are raised by providers who are very aware of the need to alert the local authority of any safeguarding concern. Alerts raised in relation to each individual provider are regularly reviewed and action taken where serious concerns arise.

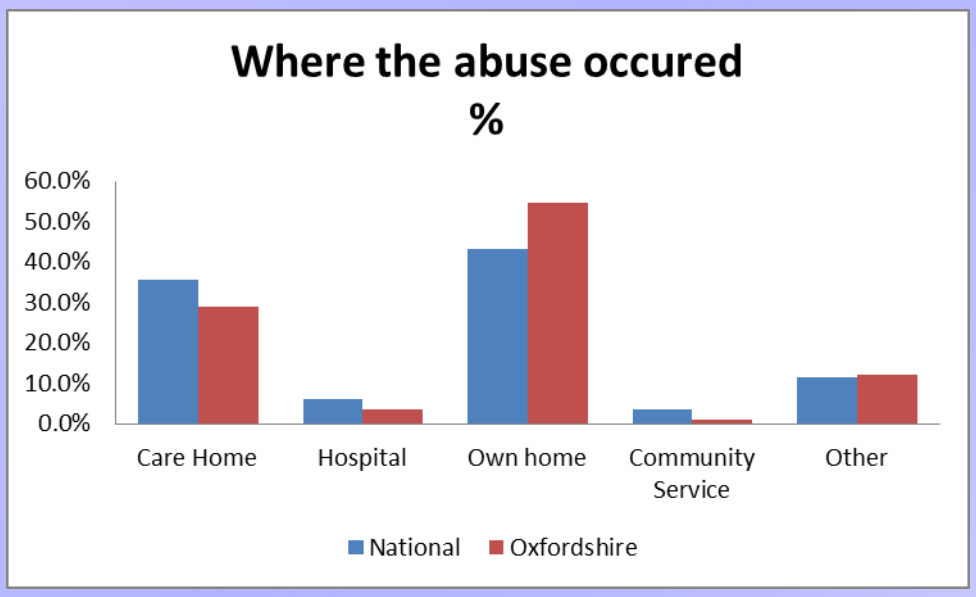


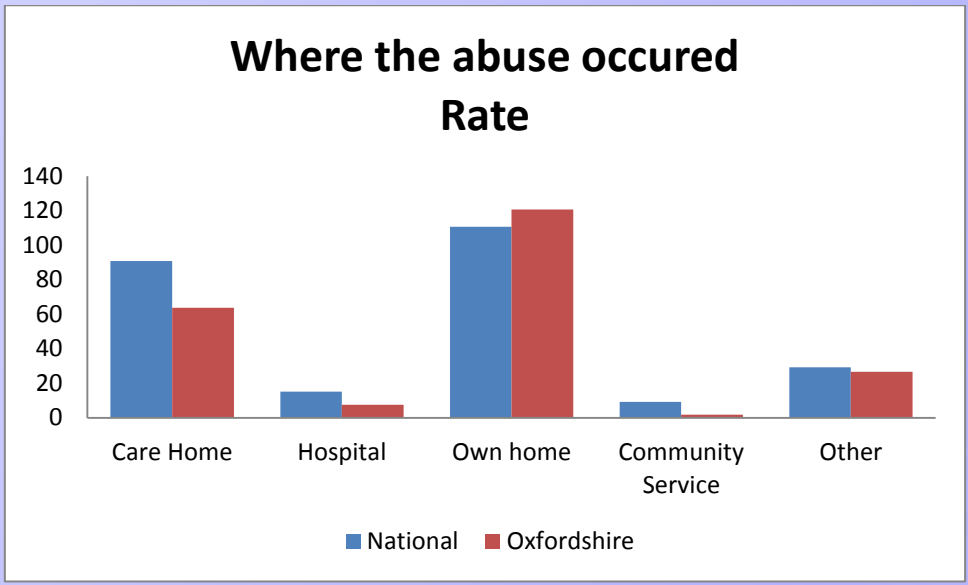
The most common type of abuse was neglect and acts of omission, followed by physical abuse. This is the same pattern as nationally, however Oxfordshire has a higher rate of referrals for neglect and acts of omission than elsewhere due to high rates of alerts from adult social care provider services, particularly residential services. This is the only category where this is the case.





Most abuse occurred in the individuals own home - with the rate of abuse higher than the national figures. There is less recorded abuse in other services (such as a care home, or community services).





National data is reported on actions and results of safeguarding investigations. This has not been included in this report as it is clearly reported differently in different authorities and not in line with the guidance.

The new Performance Information and Quality Assurance Sub-Group of the board is developing a new performance and quality assurance framework so that robust processes are in place to inform the board's planning.

What adults who have experienced the process say and the extent to which the outcomes they wanted (their wishes) have been realised

Adult Social Care's current processes did not capture this information during 2014-15. However, ASC will be considering how to capture this information as part of Making Safeguarding Personal for 2015-16. Making Safeguarding Personal means that safeguarding work should be person-led and outcome-focused. It engages the person in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety.

New safeguarding forms that capture each person's wishes and views about what they want have been developed and will be implemented in 2015 so will be reported against this next year.

In Oxford Health NHS Foundation Trust the outcomes for people who have experienced the safeguarding adults process have not been monitored centrally, however patient survey information has asked the person about their overall experience.

What front line practitioners say about outcomes for adults and about their ability to work in a personalised way with those adults

The Oxford Health NHS Foundation Trust Staff Survey in 2014 showed that 90% of staff agreed that their role makes a difference to patient/service users. 69% of staff were satisfied with the quality of work and patient care they were able to deliver.

b. Policy, procedures and practice developments

The OSAB currently have the following in place:

- Oxfordshire Safeguarding Adults Policy
- Oxfordshire Safeguarding Adults Procedures
- Oxfordshire Safeguarding Adults Confidentiality & Information Sharing Agreement

In the light of the Care Act 2014 and Care and Support Statutory Guidance these policies and procedures are all subject to review and will be completed in 2015/16.

The Oxfordshire Safeguarding Adults Safeguarding Adult Review Protocol was finalised in February 2015.

In June 2014 following the death of an adult at risk of abuse or neglect we undertook an immediate review of the Oxfordshire Safeguarding Adults Procedures (2008, reviewed 2012). We subsequently amended and strengthened the Safeguarding Adults procedures to the effect that:
In any case where the provision of care services is terminated by the person, someone reporting to be acting on behalf of the person, the council or any other agency for whatever reason a review involving all relevant partner agencies (e.g. police, GP, district nursing service) and risk assessment will be completed.

The person and/or their representative must be formally notified informed in writing of the concerns. However, consideration must also be given to person's communication needs or other issues (e.g. interception of post) and where necessary the person should be seen in person.
Following a number of deaths occurring as a result of home fires in Oxfordshire we are developing robust protocols between board members and particularly fire and rescue to enhance communication between agencies where there is perceived to be a fire risk. We anticipate being able to report more fully on this next year.

Priority 1: Improve information sharing between partner agencies to strengthen joint working to safeguard adults from abuse/harm.

An Information sharing agreement is in place to be reviewed in 2015/16.

Information is central to effective inter-agency working aimed at safeguarding people at risk of harm and abuse. Over the last year we have continued work on the development of the Oxfordshire Adult MASH which will provide invaluable early information sharing between

partner agencies. Unfortunately the implementation of the MASH has been delayed but we anticipate that this will be in place in 2015/16.

We are currently working on developing robust protocols between board members and particularly fire and rescue to enhance communication between agencies where there is perceived to be a fire risk.

Priority 2: Develop methods for engaging service users and carers to capture their views and experience.

Single agency work has progressed to ensure that service users and carers experience is captured e.g. patient experience survey in the Oxfordshire University Hospitals trust and the introduction of a new adult social care recording system that will enable us to capture this information.

Priority 3: Ensure there is a strong multi-agency approach to prevent adult abuse/harm.

A strong multi-agency approach to prevent adult abuse/harm is reflected in a number of ways.

1. Partnership awareness:
   During the last year we have continued to see a rise in the number of safeguarding contacts made with the council by 22%. An increase 3454 to 4424 with a notable increase in contacts from the police, ambulance service and adult social care providers.

2. Joint operational work:
   During the year Thames Valley Police, Community Safety and Adult Social Care, with support from health, housing and non-statutory agencies, have been involved in a joint operation in relation to the criminal exploitation of adults some of whom had care and support needs. We anticipate being able to report on the outcomes of this operation next year.

   In addition board partners and other non-statutory partners have established a vulnerable adult missing persons panel to coordinate the management of risk to people at risk of abuse and exploitation who are reported missing.

Priority 4: Ensure there are robust processes and procedures in place to respond to national and local safeguarding developments by risk assessing the impact of developments and risk assess response.

Case Study – Sam Joseph

Mr Sam Joseph, a 69-year-old gentleman with a mild learning disability, was referred to social services by the police.

A woman had come to Sam's house with her young daughter on a number of occasions to ask for money. Believing that her intention was to pay him back and her need for money was genuine he gave her small amounts of money (£10 or £20 at a time). The money was not returned.

The social worker, Claire, visited Sam who said he thought the situation was better and that he now knew to contact the police if she called on him again. However, he was worried about his money and about financial scams. He said that what he wanted:

- financial assistance from his brother to continue as before, and
- help with dealing with cold callers and dealing with financial scams.

Mr Joseph agreed to Claire contacting the social worker working with Trading Standards.

Claire & Sarah, from the trading standards team, visited Sam. Sam agreed to have a call blocker fitted to his phone and a sticker put on the front door indicating that cold callers weren't welcome. Sarah also provided a book of approved tradesmen in Oxfordshire. Sam's brother was happy to carry on helping Sam with managing his finances.

Sarah visited Sam again a few weeks later. He was pleased with the call blocker and wanted to keep it. He said a couple of sales calls had got through but he knew how to use the red button to stop them calling again.

No further concerns have been raised.

c. Safeguarding Adults Review (SAR)

There was a SCR agreed in June 2014 that has not yet progressed regarding a lady placed in a nursing home. This will be a lesson learnt approach with the agencies involved with this lady. Due to the timeline of when the lady died, the scope of the lessons learnt meeting will be limited to addressing what happened prior and just after her death and what has subsequently changed as part of the multi - agency working practices.

A previous SCR commissioned in April 2013 came to the board in October 2014 for signing off and an action plan was agreed - this has been monitored through the SAR sub group - the lessons learnt SAR template was circulated to SAR group members for circulation to their agencies.

d. Partner agency safeguarding reports

Oxfordshire County Council, Adult Social Care
As the lead agency responsible for coordinating adult safeguarding enquiries in Oxfordshire, Adult Social Care has continued to manage an increasing number of alerts and referrals relating to concerns about adult abuse. This continues to be managed despite increasing demands on adult social care.

Early in 2014/15 a series of random case audits were conducted with adult social care operational teams across the county during which a number of consistent themes emerged. There were clear differences in teams understanding of safeguarding processes and procedures: in many cases teams were undertaking quite extensive preliminary enquiries into concerns but not recording this work as referral activity. As a consequence the number of referrals reported in Oxfordshire fell below national comparators and targets e.g. one day from alert to referral were not being achieved. There was also some degree of variation in the quality of enquiries undertaken.

Since then OCC has made significant steps in relation to the governance of safeguarding within the local authority. A monthly performance board chaired by the Deputy Director for adult social care has been introduced to monitor and review operational activities including time-scales for safeguarding cases. Minimum standards requiring adult social care teams to ensure that all safeguarding concerns are assessed within one working day of day of receipt; a safeguarding strategy is developed within a further 5 working days and subsequent enquiries/investigations are completed within a further 20 working days. In each case a current target has been set at 75% and we will be looking to achieve and stretch this target over 2015/16.

A new supervision policy has been introduced requiring that all team managers conduct a minimum of three case audits per month, again to be reported to the monthly performance board.

Adult Social Care has also established a bi-monthly Care Governance & Quality Provider Board to oversee themes, issues and concerns relating to service providers across Oxfordshire. This draws on a range of information including the number of alerts relating to individual providers and any themes emerging from these; the outcomes of quality monitoring visits undertaken by our joint commissioning teams; complaints about services; emerging health and safety issues and Care Quality Commission reports are all used to develop a much broader picture of the adult social care provision in Oxfordshire and. where required, work with the provider in a pro-active and supportive way where required to address any issues.

To support this institutional procedures for adult safeguarding are being reviewed and we are developing a serious concerns framework that draws on the information above to identify providers or areas of concern that need to be supported to develop and improve.

In the light of the new requirements of the Care Act 2014 adult social care has been reviewing its internal adult safeguarding procedures in conjunction with the introduction a new recording systems and structures for operational teams. The requirements of the Care Act and in particular Making Safeguarding Personal are being integrated into the new system which is due to be introduced in 2014/15.

Oxfordshire Clinical Commissioning Group (OCCG)

OCCG welcomes the increased focus on adult safeguarding brought about by the Care Act. Awareness of the needs of vulnerable adults is increasing as is awareness of abuse and preparedness to address it. As commissioners the role of OCCG is to ensure that providers of NHS services are carrying out their responsibilities to safeguard vulnerable adults. This includes their use of the Mental Capacity act and Deprivation of Liberty Safeguards (DoLs), as well as the number of safeguarding referrals made. As commissioners we require assurance that providers are appropriately training their staff to safeguard vulnerable adults.

The safeguarding function at OCCG sits within the Quality function, which has a responsibility to ensure that providers are delivering safe, effective care with a positive patient experience. This means that they have an overview of where care may fall below expected standards as well as where there are instances of alleged or proven abuse. The CCG takes contractual action where standards fall below what we would expect.

In 2014-15 the CCG took part in 2 Domestic Homicide Reviews (DHR) and 1 adult serious case review. Following these reviews, the CCG oversees the providers' implementation of the recommendations. The CCG has also used the new rights set out in the 2015 Serious Incidents Framework to commission and independent review into a serious incident.

In addition to our role as commissioners the safeguarding team at the CCG supports General Practitioners (GPs) and other primary care providers to deliver high quality care. This includes providing safeguarding training. In 2014-15 the CCG provided training to 125 Gps and well as other primary care staff.

OCCG has a role in coordinating PREVENT reporting by our providers and in ensuring that health care professionals have received the appropriate training to identify where vulnerable adults are at risk of being exploited by terrorist groups.

In 2014-15 the CCG was successful in bidding for funds to support the use of the Mental Capacity Act within health services. The funds have used for a joint with Chilterns CCG to develop an app for smartphones.

OCCG is a part of the adult Multi-agency Safeguarding Hub (MASH) development and looks forward to the improved safeguarding which the increased sharing of information and colocation will bring about.

OCCG welcomes the finding of the OSAB peer review and looks forward to working within a strengthened safeguarding board in the future.

Thames Valley Police (TVP)

In light of the new requirements of the Care Act 2014, TVP have reviewed representation at LSAB meetings across the region and agreed these will be at Local Police Area (LPA) Commander (Superintendent) level. In Oxfordshire TVP have reviewed and identified a structure for attendance of senior managers at OSAB subgroup meetings.

The force holds quarterly meetings chaired by the Superintendent for Protecting Vulnerable People (PVP) for all Directors of Adult Safeguarding in Oxfordshire, Berkshire and Buckinghamshire. These are well attended and cover a variety of Police issues in relation to Adult Safeguarding.

TVP are currently creating a training package for all LPA Commanders in relation to (PVP) matters. Adult safeguarding will be central to this when it is rolled out in early 2016.
A pilot is currently underway in the Cherwell & West Oxfordshire LPA to identify and train front line patrol officers as champions in Domestic Abuse and Adult Safeguarding matters. If successful, this will be rolled out across Oxfordshire.

The Domestic Abuse Investigation Unit (DAIU) Detective Inspectors have been nominated as the Designated Adult Safeguarding Manager for each LSAB area.

Previously, info-sharing by police of Adult Protection incidents only took place if assessed as HIGH-risk or if explicit consent had been obtained. Despite attending officers being more aware of the need to obtain consent, the number of incidents info-shared was quite limited. However, greater use of professional judgement is being made in deciding whether there are grounds to info-share in the absence of HIGH-risk or explicit consent.

The MASH Detective Inspector is currently writing the Multi-Agency Information Sharing

Agreement for Adult MASH on behalf of the partnership.

Thames Valley Police's Safeguarding, Vulnerability and Exploitation (SaVE) Programme is being developed to increase awareness amongst front-line staff of safeguarding issues generally. Provisionally, the plan is to roll-out SaVE training from January 2016.

A new computer system called Niche RMS, introduced on 29th April, incorporates a qualifier (flag) for 'vulnerable adult' and has an occurrence classification of 'Adult Protection' for recording safeguarding concerns which is a significant improvement on our old system. Niche RMS also includes a bespoke Missing Person module for missing person investigations, which has been supported by training packages to assist staff to proactively manage missing persons, including vulnerable adults.

Several Standard Operating Procedures (e.g. Missing Persons, Domestic Abuse) have been revised and now specifically state that a Niche occurrence must be created if safeguarding concerns in respect of a child or a vulnerable adult are identified.

TVP have instigated a cross-partnership Adults Missing Person Panel. The Missing Person Panel has been running since March 2015 as a pilot in Oxford City. TVP normally chair this panel where the intention is to problem solve, specifically, those adults who have been reported missing three times in a ninety day period – absents are included at the discretion of the chair.

The panel is reasonably well attended by partner agencies including: Adult Social Care, Learning disability Team, MH Community and Wards, Connections, Elmore Team and the John Radcliffe, although the list of attendees has been discussed and the following agencies have been identified as required for some involvement: Leaving Care, NHPT, Drug & Alcohol, Probation and Luther Street (Homelessness). All parties are signatories to the joint information sharing agreement/ confidentiality agreement. At the initial set up Police solely chaired the meeting but there is now a gradual handover to Adult Social Care to take the lead, although the Police Vulnerable Adult Co-ordinator will continue to take the minutes.

Each person discussed at the meeting is allocated an Risk Management Owner. There is currently still some discussion over who should own these and the proposal is that the Neighbourhood Police teams take them on in the spirit of demand reduction; In addition this runs well alongside the protocol for the child panel.

Although, the panel is currently for Adult missing persons, there has been discussion internally in TVP with the Protecting Vulnerable People strategy unit whether a general 'Vulnerable Adults at risk' panel would be more effective. This was discussed at the last meeting and was a well received idea by the panel members. It is felt that there are a sufficient amount of adults at risk

that would benefit from discussion at the panel but wouldn't currently fit the criteria. Therefore, in order to progress this aspect, Adult Social Care, are intending to write some terms of reference to ensure that the panel would not get too many referrals that would become unmanageable.

At this time it is difficult to monitor how successful the panel has been in the last 6 months as a lot of the cases that have been discussed have focussed more on education of other agencies about when to report persons missing, rather than risk reduction. However, it is felt that in the future the success of the panel could be measured on the amount of repeat missing cases of each individual and how often they return to the panel. The opportunity to sit down each month with fellow professionals has been invaluable in several ways and by inviting the newly identified agencies and widening the criteria for cases, TVP feel that it will greatly improve the risk management of Vulnerable Adults.

As this is proving to be very successful in Oxfordshire, the force are looking to roll out similar to Safeguarding Boards across Buckinghamshire and Berkshire going forward.

TVP have also conducted a force-wide review of safeguarding training for their officers and come up with an agreed training programme for all Officers, including PCSOs.

Oxford Health NHS Foundation Trust

During 2014-15 OHFT has been working with the engagement of its staff to help them improve the quality of care provided, which encompasses the protection of adults at risk. A framework called Improving Care through 5 Questions (IC:5) is being used. The main focus of which is to encourage staff to think about what they are doing well and where they are working to improve and deliver the best possible high quality of care to patients, service users and clients now and in the future. IC:5 encourages staff to ask themselves the key questions that are known to matter most to patients, which also reflect the national quality standards (fundamental standards) applied by the Care Quality Commission to assess the quality of services.

Are we:

- Safe?
- Caring?
- Effective to ensure good patient outcomes?
- Responsive to patients' needs?
- Well lead?

More specifically, work is being implemented to integrate physical health and mental health services for older people. Work has been embedded into practice to ensure patients are assessed for their risk of falling on admission, after each fall and after 28 days. There is a project in place to eliminate the use of prone restraint. Work continues to reduce the number of suicides of people who have contact with OHFT services. The introduction of the Street Triage service has reduced

the number of people taken to a place of safety when it was not necessary, which has released resources to be more readily available for those who need them most.

8. Issues and challenges facing safeguarding

There are a number of significant external national changes that have influenced the safeguarding agenda in 2014/15, most notably the Care Act 2014 and the Cheshire West ruling in March 2014.

The Care Act has brought in key changes which include the ethos of safeguarding, so that work is person centred and makes safeguarding personal, that human rights are respected and responses are proportionate, timely, professional and ethical. The language of safeguarding has also changed and there are notable changes in representation and advocacy, changes to the categories to include modern slavery and self-neglect and changes to the duty to investigate. The key principles of prevention, protection, empowerment, partnership, proportionality and accountability now govern our practice.

In addition there is clear guidance on the core duties of the Safeguarding Adults Board to publish its strategic plan for each financial year, to publish an annual report and to conduct any Safeguarding Adult Reviews in accordance with section 44 of the Care Act 2014.

Locally these changes are being introduced across the workforce and led to the peer review of OSAB and a new action plan to implement the findings.

The Cheshire West ruling resulted in a revised test for deprivation of liberty and how deprivation of liberty can be assessed in 'domestic' settings, which has implications for resources and volume of Deprivation of Liberty Assessments undertaken locally which have risen from 232 in 2013/14 to 1,424 in 2014/15. There are local plans in place to integrate health and social care services which are anticipated to improve safeguarding arrangements.

The board's priorities for 2014-2015 were:
- Priority 1: Improve information sharing between partner agencies to strengthen joint working to safeguard adults from abuse/harm.
- Priority 2: Develop methods for engaging service users and carers to capture their views and experience.
- Priority 3: Ensure there is a strong multi-agency approach to prevent adult abuse/harm.
- Priority 4: Ensure there are robust processes and procedures in place to respond to national and local safeguarding developments by risk assessing the impact of developments and risk assess response.

Work is in hand in relation to all four priorities and there is a strong commitment by the board to further enhance these through the implementation of the findings of the peer review, which provides a comprehensive programme of change for the board. In addition the infrastructure to support the board has been strengthened with further plans being introduced to enhance its capacity and to ensure that key priorities are fully realised.

9. Planned future developments and key priorities

It is recognised that 2014/15 has been a developmental year for the board and priorities for 2015/16 must reflect the commitment to change. We will strengthen the role and strategic functioning of the board, its governance arrangements, its strategic vision and overall grip on the safeguarding agenda from a multi-agency perspective. We need to ensure that quality assurance and performance management processes are in place so that the board can assess need and clearly identify gaps in services and address current and emerging safeguarding themes. We are committed to ensuring that service users, carers, care providers and the voluntary sector are able to inform the board about key safeguarding concerns and influence and shape our agenda.

We will be raising the profile of the board and its role at the heart of safeguarding vulnerable adults in Oxfordshire and to support the multi-agency workforce to improve practice and learn from findings from Safeguarding Adults Reviews and quality assurance processes.

We are committed to working closely across the key safeguarding partnerships in Oxfordshire and in particular to work closely with OSCB, Oxfordshire Safer Communities Partnership and district Community Safety Partnerships

Key Priorities for 2015/16

1. Ensure that people who use health and social care services and their families are at the centre of any decisions about their care and support.
2. Develop a multi-agency protocol on Provider mergers and significant changes which will ensure agencies manage provider change safely.
3. Implementation of the Peer Review Action Plan which covers governance arrangements, quality assurance and good practice issues, so that the Board is compliant with the Care Act.
4. Ensure that the Board is sufficiently resourced to deliver its ambition.

OXFORDSHIRE HEALTH & WELLBEING BOARD – 5 NOVEMBER 2015

Oxfordshire Safeguarding Adult Board (OSAB) Peer Review – Executive Summary

Purpose
To inform the Health and Well Being Board about the Peer Review undertaken during June 2015, in relation to the Oxfordshire Adult Safeguarding Board (OSAB).

Context
The Local Government Association set out a new approach in 2011 following the changes to the nationally imposed inspection and assessment regime (under the Care Quality Commission) to a new system referred to as "Sector Led Improvement".

This approach has received high levels of support as Councils have endorsed the key principles, in that they see themselves as responsible for, their own performance and improvement, working with partners as part of a whole system to deliver services and ensure there is transparency and accountability locally.

In Adult Social Care Sector Led improvement has been implemented to oversee and improve standards, and are a key aspect of driving forward both strategic and operational improvements. It is therefore critical that in order to take maximum advantage of the opportunity.

The local authority can choose both the area for review and the scope of that review. By the very nature of the review it is expected that an area is selected where there can be significant opportunity for service improvement, where there are proven challenges and where it would be difficult for a single agency to effect the necessary change alone.

Oxfordshire Peer Review
As part of the South East Directors of Adult Social Services (SE ADASS) sector led improvement initiative, Oxfordshire requested a Peer Review of the Oxfordshire Adults Safeguarding Board (OSAB). The review is intended to support Adult Social Care and partners to improve the services and performance, whilst not straying into regulatory territory.

The OSAB was selected for a number of reasons:

- Safeguarding Adult Boards became a statutory requirement in the Care Act 2014 for implementation in April 2015.
- Whilst OSAB had been in place for a number of years it was widely recognised that it would benefit from a review of its overall leadership and governance and to test whether it was Care Act compliant.
- It was also recognised that there were a number of shortcomings and capacity issues as a consequence of the lack of a Business Manager for a significant period.
- A formal review would assist in whole partnership change given that the responsibilities are broader than those for Adult Social Care alone.

- The review would give all partners and governing bodies a clear mandate and roadmap for change.

Discussion also took place with other local authorities who had selected their Safeguarding Adult Board for a Peer Review, who confirmed that the review had been a key catalyst for change, in generating a common ownership of the new agenda and in galvanising all partners to renew their energies and responsibilities in relation to the Board and the delivery of its core functions.

In addition the Board and Adult Social Care had instituted a number of changes over the spring and summer 2015, during the time of the Peer Review, in order to ensure that there was sufficient capacity for change, so that the Board would be in a position to take a robust strategic leadership role in relation to safeguarding locally, and deliver the anticipated actions from the review to ensure Care Act compliance.

These included:

- The appointment of a new chair.
- The development of a joint Safeguarding Business Unit for adults and children.
- The appointment of a new Business Manager.
- The appointment of a new post of Strategic Safeguarding Partnerships Manager to work across the adult and children's boards.

The outcome of the review was broadly in line with expectations and gives a clear mandate to all partners to take a strong leadership role and implement the key actions from the review, as well as repositioning the Board at the heart of the partnership geography for safeguarding adults with care and support needs in Oxfordshire.

Recommendation

To note the Action Plan currently being implemented as a result of the Recommendations.

South East Region

Peer Review - Oxfordshire

24th - 26th June 2015

1. Introduction and background

1.1 As part of the South East Directors of Adult Social Services (SE ADASS) sector led improvement initiative, Oxfordshire requested an external view of the Oxfordshire Adults Safeguarding Board (OSAB). These reviews are intended to support Adult Social Care and partners - supporting the improvement of services and performance, whilst not straying into regulatory territory.

1.2 Following discussions with the Oxfordshire County Council (OCC), the Director (DASS) and Deputy Director of Adult Social Care, it was agreed that the review would address the following key lines of enquiry:

- Is the Board Care Act compliant?
- How do partners work together to ensure adults at risk are protected?

The agreed outcomes:

- To provide a report for the Board that details what could make the Safeguarding Adult Board more effective.

1.3 The review team comprised:

- Keith Hinkley, Director of Adult Social Care and Health, East Sussex County Council
- Angie Turner, Head of Adult Safeguarding, East Sussex County Council
- Nick Sherlock, Head of Safeguarding, Kent County Council
- Jane Simmons, SE ADASS Programme Lead, Sector Led Improvement

1.4 Steve Turner, Oxfordshire Safeguarding Adults Board (OSAB) Business Manager, Jo Taylor-Palmer, OCC Interim Area Service Manager, Safeguarding, Diane Dillon, OCC Senior Administrator and Steve Thomas, OCC Performance and Information Manager provided excellent support prior to and during the review. The OCC Engagement Team provided support to service users attending focus groups.

1.5 The team held a number of interviews and focus groups with:

- Commercial and voluntary sector care service providers
- Healthwatch
- NHS providers and commissioners
- Oxfordshire Safeguarding Adults Board:
  - Chair
  - Some sub-group chairs
  - Board members
  - Business Manager
  - Strategic Safeguarding Partnership Manager
- Oxfordshire Safer Communities Partnership
- Oxfordshire County Council:
  - Leader, Lead Member for Adult Social Care and Chair of Scrutiny
  - Adult Social Care (ASC) staff, including the Director of Adult Social Services (DASS), managers, operational and finance staff
- Safeguarding leads from across partner organisations
- Service Users
- Voluntary sector organisations

1.6 Prior to the fieldwork, questionnaires were sent to Board and non Board members. Five questionnaires were received from Board members and 43 from non members.

1.7 The review team were provided with a range of information about the Board. This included:
- Governance arrangements (e.g. Terms of Reference for the Board and sub-groups; Draft Constitution)
- Minutes of the meetings
- Reports to Scrutiny Committee (OCC)
- Policies and procedures
- Performance returns and evaluation reports

1.8 At the start of the visit the review team met with the Lead Councillor, Director of Adult Social Services, current Board Chair and managers and safeguarding leads from OCC. They provided an overview of Oxfordshire, including broad information about demographics and particular issues facing the County. The Board chair also spoke about what the OSAB does well; doesn't do well; areas for development and challenges.

1.9 The Review Team would like to thank all those people who gave their time to attend focus groups and interviews and hope that their comments and insights are reflected in the report. As part of these discussions, as agreed, the Review Team confirmed that the OSAB would ensure that they received feedback on issues and actions.

2. The Oxfordshire Safeguarding Adults Board:

2.1 The peer review took place during a period of change for the Board:
- The current chair was due to leave and a new chair had not been appointed
- A new Joint Safeguarding Business Unit (adults and children) has been formed and includes:
- OSAB Business Support Manager providing support for the Board (the previous post holder left in July 2014 and has only recently been replaced)
  - Strategic Safeguarding Partnership Manager, appointed in mid May, to work across both adult and children's Safeguarding Boards
- Board Administrator (to be appointed)

This Unit, employed by OCC will provide support to the OSAB and the Local Safeguarding Children's Board, ensuring that any synergies are exploited to the full.

2.2 The current OSAB has membership from a range of partner organisations:
- Bullingdon Prison
- District Council representative
- Health:
  - Clinical Commissioning Group (CCG)
  - NHS England (NHSE)
  - Oxford Health NHS Trust (OHNHST)
  - Oxford Universities Hospitals Trust (OUHNHST)
  - South Central Ambulance Service (SCAT)
- Southern Health NHS Trust (SHNHST)
- Oxfordshire County Council (OCC):
- Adult Social Care (ASC)
- Safer Communities Unit
- Trading Standards
- Drug & Alcohol Team
- General Litigation Team

- Oxfordshire Age UK
- Probation
- Thames Valley Police

2.3 The Board has a number of subgroups:
- Deprivation of Liberty Safeguards (DOLS)
- Dignity in Care
- Learning and Development
- Monitoring and Evaluation
- Policies and Procedures
- Serious Case Reviews (SCRs)

All sub-groups are chaired by Board members or their representatives.

The Business Support Manager has recently met with sub-group chairs to ascertain meeting schedules, Terms of Reference and proposals about how meetings could be managed in the future. A report recommending a reconfiguration of the groups is to be discussed at the next OSAB.

2.4 One Serious Case Review was undertaken in 2014 and the review team were provided with notes and the action plans. The Review Team were also informed about OSABs involvement in other high profile cases impacting on adult safeguarding.

3. Good practice:

3.1 The Review Team were struck by the positive and openly constructive discussions that took place during the review. People seen were clear about the deficits and enthusiastic about taking the Board forward.

3.2 Political leadership for safeguarding was seen to be high, and those politicians who met the team demonstrated a clear commitment to safeguarding. The Safeguarding Annual Report was discussed at the Council's Scrutiny Committee during the visit and the high level of engagement undoubtedly sets the scene for safeguarding across the County. Scrutiny Councillors assure themselves through this and had clear expectations about how their work could be enhanced.

3.3 OCC teams were motivated to provide a good safeguarding service and saw the Safeguarding Team as key to supporting this. The Safeguarding Team and particularly the Manager were seen as the leaders of safeguarding within the Council.

Staff were very receptive to receiving multi agency training and saw positive outcomes from this approach. There were also good relationships reported at a "grass roots" operational level, which encouraged some innovative local initiatives. Generally staff were positive about safeguarding work in Oxfordshire.

3.4 The new Joint Safeguarding Business Unit was welcomed and it was thought to be a good opportunity to look at synergies across adult and children safeguarding, learning from each other and where appropriate working together on issues. The OSAB and the Business Unit will however need to guard against a focus on children's safeguarding to the detriment of adults.

A Board Business Support Group will also aid the development of the OSAB and will lead on the development of web based information, a newsletter (from information generated by training) and will look at how the public can be better informed about adult safeguarding.

3.5 Care service providers and partners wanted more involvement in developing a coherent approach to safeguarding, ensuring that the Board takes a leadership role in the development of a vision for safeguarding across the County and that service users are at the heart of determining how they wish to be supported (in line with Making Safeguarding Personal) at the start.

3.6 The Service user group were pleased to have the opportunity to comment on safeguarding and were very keen to be involved in understanding and sharing key messages from the OSAB. There were suggestions from the group on engagement such as " advertising contact numbers in GP surgeries, hospitals and pubs", as well as having a lay person on the OSAB and the use of " Sting Radio[1]" for OSAB members to have a slot. There was also the suggestion that the OSAB ought to have a public meeting to which key service user groups would be invited to.

3.7 Voluntary Sector members were positive about safeguarding arrangements in Oxford. Although at times staff did find it difficult in accessing the correct staff around complex matters. This was an issue raised by the Housing sector members of the Group. They felt that the SAB could do more to engage the Voluntary sector in its work and given the opportunity were enthusiastic about working with SAB to promote safeguarding.

Some felt the SAB was a bit remote. Age UK did not share this view as they have a representative on the SAB. A significant criticism of the Oxfordshire was the way they implemented the decision to dissolve Partnership Boards without discussion with those involved. This issue was raised at both the service users group and the voluntary sector group by different organisations.

3.8 Commercial Care Providers demonstrated a commitment to be seen as part of the solution when concerns were raised and wanted to work alongside safeguarding teams. They understood their overall responsibilities for ensuring the care and support services they run meet the required standards of care, and for responding to these issues effectively as they arise.

4. Areas for development

The Review Team identified five specific areas for development:

1. Governance arrangements
2. Board vision, strategic plan and work programme
3. Evidence
4. Assuring consistent practice
5. Capacity

4.1 Governance

The Peer Review Team identified the following key issues that should be addressed:

- Review the role of the board and subgroups:
- statutory responsibilities

[1] Sting Radio - this is a radio station run by and for people who have a learning disability. See www.stingradio.org

- agree the role of the Board in the context of other Boards, partnerships and governance arrangements
- confirm accountabilities
- Review membership of the Board and agree expectations of members
- Agree how membership and accountability works
- Ownership of the Board

4.1.1 Ensuring that the OSAB is Care Act compliant has been one of the priorities for the new Business Support Manager. A draft Constitution (undated) had been written for discussion at the OSAB. Until this time the 'Terms of Reference & Responsibilities for Member Organisations' dated June 2014 is still in place and understandably not Care Act compliant.

4.1.2 A new Board chair will be appointed by partners shortly. The draft Constitution makes a number of proposals about how this role will be managed including that accountability will through the Chief Executive Officer (CEO) of OCC to the Leader. 'The ultimate responsibility for the effectiveness of the OSAB rests with the leader of Oxfordshire County Council. The Head of Paid Service of the Council is answerable to the Leader' (of the Council).

The OSAB might wish to consider how this will operate in practice and how the relationship between the Chief Executives (or equivalent) of Thames Valley Police and Oxfordshire Clinical Commissioning Group (CCG) as the statutory partners will operate within current arrangements.

It is intended that the chair is appointed for a three year term. The Review Team did not see the proposed contract, but OCC Head of Paid Service, Director of Adult Social Services and statutory partners might want to consider including reviews at three and six months to ensure that any issues relating to the performance of the Board or the individual are addressed in a timely manner.

4.1.3 Membership - The shape and seniority of partners, able to speak on behalf of their organisations or act as representatives of membership organisations; the voice of the public and carers and how the wider partnerships are involved in the Board needs to be considered. This should include discussing how the Board can balance making the OSAB sufficiently lean to deliver its strategic vision and being inclusive.

- Voice of the public - There is recognition that this is an area that requires further development and a recognition that the OSAB 'need to…seek the views of service users…linking with other bodies…go to them'. There is some confusion about this currently:
  - Two people interviewed were clear that Healthwatch provided this and were involved with the OSAB, a representative from Healthwatch however said that the organisation had not been invited to take part in the Board.
  - Another person mentioned that the Dignity in Care sub-group (chaired by a voluntary sector organisation) provided the formal route to links with the public.
- Service users involved in the focus group were keen that engagement with service users and public should not solely focus on Healthwatch.
- Voluntary sector - The role of voluntary sector organisations, as either providers of care or representative organisations for patients and service users, needs further debate and clarification.
- Acting as representatives - The Chair and the Board will need to ensure representatives are clear about their roles and consider wider engagement with those not directly represented. Safeguarding Adult Boards are considering a range of methods to ensure that there are opportunities for wider engagement e.g. annual safeguarding summits

- There is a growing Personal Assistant market and as an unregulated part of the care system, the OSAB might wish to consider how it engages these providers of care.

4.1.4 Ensuring transparency to how Board members link to their own governance arrangements is crucial. It was not always clear how partners report the work of the OSAB or raise specific issues with their own organisations. When determining accountabilities for Board members, some thought should be given to how these are developed and evidenced.

4.1.5 The Care Act sets out the requisite skills and experience necessary for SABs to act effectively. Members should be able to:

- speak for their organisations with authority
- commit their organisation on policy and practice matters
- hold their organisation to account
- influence the development of their agency's to account
- influence the development of the agency's practice
- contribute to the development of robust and effective monitoring and performance functions

The Review Team was not able to judge whether the current Board members had the the skills and experience necessary. One person did however express concerns about the seniority of people attending the Board and whether they had sufficient influence in their own organisations. Given the Boards new statutory footing, the new chair will wish to meet with the CEOs of all partner organisations to establish whether the OSAB member meets the above requirements and has sufficient influence to effect any changes required.

4.1.6 The draft Constitution proposes that the newly invigorated Board should ensure that the synergies are exploited between partnerships. This was seen as a positive initiative and one that needed urgent attention. The review team noted some confusion about the responsibilities of different partnerships and the impact this could have e.g Domestic Homicide Reviews and the links between these and Safeguarding Adults Reviews (previously Serious Case Reviews). Although the information provided to the team suggested that this was the Local Children's Safeguarding Boards responsibility, most people spoken to seemed unaware of this. Making clear these links would ensure that there is clarity about the role and function of each group in relation to the OSAB.

4.1.7 Current Terms of Reference for subgroups are in the main undated and not written in a consistent style. Discussions between the Business Support Manager and current chairs of the subgroups, looking at the focus, meeting schedules, membership and proposal for the future have now taken place and the number and scope of the sub-groups will be discussed at the OSAB. This will include that accountabilities are clear and Terms of Reference are written in a consistent style. As part of this discussion the OSAB might also consider how it will ensure that sub-groups are supporting the OSABs overall vision and work programme. In order to do this there needs to be a discussion about ensuring that realistic expectations are set and sufficient resources provided to meet these expectations. The Learning and Development sub-group for example will need resources from partners to focus on training for Care Act compliant multi-agency procedures and to ensure that all partners are aware of Making Safeguarding Personal.

4.1.8 As part of the visit, the Review Team were provided with the minutes of OSAB meetings. Comments about the meetings were included in questionnaire responses and a number of people discussed agenda setting, minutes and conduct at meetings. Agenda setting and in one case minutes provided to Board members was seen as a weakness. In part it was suggested that this was

due to the lack of support provided to the Board (the Review Team were told that there had been no formal support for 14 months) and the over reliance on Adult Social Care staff.

The new Business Support Team will be able to provide support to this process and together with the new chair will be able to ensure that meetings have forward plans, actions are noted and followed up, sub-groups are clear about expectations and a work programme (for the OSAB and individual sub-groups) agreed.

4.1.9 The Review Team were provide with copies of the Safeguarding Adults Review Group minutes (previously Serious Case Review) and noted that some actions did not appear to be dealt with between meetings, or feedback provided. Agreeing and following up actions (whether they are outstanding or have been dealt with) would ensure that this group and the OSAB does not leave itself open to criticism. A Serious Case Review (MC) had the appropriate action plan and this format could be replicated for the wider OSAB.

Some concern was expressed by OSAB members and OCC staff that the current chair of the OSAB also chairs the Serious Case Review Group, largely the Review Team understood, because partners had not offered to do this. Whilst it is commendable that these meeting were able to take place, who chairs this meeting needs to be addressed with some urgency.

Also noted was that the SAR Group met with prison team in Huntercombe to discuss lessons learnt from a Serious Case Review. Again whilst this was seen as a supportive action, the role of the OSAB in relation to prisons of this type needs to be clarified for all Board members. (see note from NOMS that clarifies safeguarding in prisons).

4.2 Vision, strategic plan and work programme

It was felt by the Review Team that the Care Act, changes to the OSAB and improved support arrangements could provide the catalyst to develop a clear vision and plan. The Team believed that there are three key activities for focus:

- Develop a vision, strategic plan and outcomes
- Engagement on the plan and sign off
- Work programme to include:
  - priorities and evidence
  - Peer Review
  - Annual Report and feedback (learning)
  - allocate the work and timescales (sub-groups)

4.2.1 The Review Team were told that the current OSAB lacked an overall vision or strategic plan, weaknesses include ‘Lack of scrutiny and challenge’ and one person wanted to see ‘…stronger leadership, leading toward (consistent) agenda setting, priority setting, action planning’ and that the Board had ‘struggled with scope and focus’; ’lack of discussion of strategic issues’ ; ‘lack of leadership from the chair’. The Review Team thought that the lack of direction from the whole Board and the lack of a Business Manager for 14 months has not helped to ensure it has had a strategic direction or aided the smooth running of the Board. As a result the Board has not focused on the Care Act as much as it could have.

People interviewed were however very positive about the future and one person said the OSAB and sub-groups have 'some gaps.and challenges, but changes will help to deliver a new way of working',

4.2.2. Developing the Board as a statutory body, ensuring that members have ownership is key to ensuring that the Board focuses on developing its vision for the County and agrees a strategic plan.

4.2.3 Getting the basic management arrangements right, being clear about what support is available was seen as key. The Peer Review Team suggested using the result of the review and the requirements of the Care Act as a basis for the development of a work programme for both the Board and sub-groups.

4.2.4 Having an oversight of the data available to Board members was highlighted as a priority and would ensure that the Board was able to make decisions about its future direction. Some members also wanted there to be a gear shift towards proactively looking at key safeguarding and associated issues including:

- Modern slavery and human trafficking
- Comparison and benchmarking with national SAB
- Learning from homicide reviews

One Board member would like further discussion about Female Genital Mutilation (the responsibility of the Children's Safeguarding Board) and the Prevent Strategy (part of the UKs counter-terrorism strategy and primarily the responsibility of the Community Safety Partnership).

Board and sub-group members were also keen to understand the impact on safeguarding to any changes to organisations (general activity; re-structures etc) and to factor this into any work programme.

4.2.5 The work programme needs to engage the wider community of interest. It requires sign off by Board members and their members organisations or constituents before final agreement which will then need to be endorsed by Healthwatch. Timescales to do this are tight and the OSAB might wish to agree what is going to be achievable for 2015/16 and how it can engage more widely with the public and partners to develop a plan for 2016/17.

4.3 Evidence

The Team saw some good data about safeguarding, but this was limited to Adult Social Care. There did not appear to be an agreement about what data partners would provide to enable the Board to understand and make decisions about safeguarding strategy across the County.

4.3.1 Given the wide range of data collected by OSAB partners the Peer Review Team proposed that the OSAB:

- Agree a core data set:
  - purpose of the data to be collected
  - national reporting requirements
  - local priorities
  - accepting that information collection will be a challenge

- Qualitative information:
  - case file audits
  - customer and stakeholder feedback
  - complaints
- Benchmarking

4.3.2 One person talked about the need for the Board to 'Develop a framework, measuring (us) against a set of standards', another that the Board does not focus on data across all partner organisations and that data is primarily from ASC. There is '….insufficient data analysis….insufficient detail in relation to outcomes and service changes…'. There was also concern that the partners were not looking at information from all organisations. There had been for example 'no collaborative presentations regarding issues facing vulnerable people. e.g. the Learning Disability presentations were a series of verbal presentations by individual organisations rather than a synthesis and debate about how well services were working across boundaries to safeguard'.

4.3.3 It became clear from discussion that this was an area of concern for a number of Board members and partners. All Safeguarding Adult Boards appear to be struggling with the plethora of data collected and there needs to be some acknowledgement that there is not the 'perfect' data set.

4.3.4 Some Board members talked about the use of 'heat maps' looking at where safeguarding is occurring, or at systems to identify particular addresses where there are issues. Initiatives such as these can provide a focus for partner's performance and data leads.

4.3.5 A number of people noted that some data leads are linked into regional and national groups and have opportunities to examine what data is collected in other areas. Given, as one person suggested, this will be key to ensuring that the Board is 'focused on the right things'. This area of work will require urgent commitment from all partners.

4.3.6 The Review Team discussed the need to ensure that qualitative information, particularly feedback, is provided to the Board. There were examples of this in Board papers, but a more systematic approach in both the collation and reporting from partners could be valuable. This could include complaints and plaudits and undertaking or commissioning customer and stakeholder feedback surveys.

Making stronger, formal links with established organisations, Healthwatch in its statutory role, and other patient, service user and carers organisations would provide information about the impact of safeguarding arrangements and changes that may be required.

4.3.7 Alongside the development of a data set and agreements about how the voices of those people using services are gained, thought needs to be given to ensuring that OSAB can benchmark safeguarding activity against other OSABs. Some organisations (e.g. Adult Social Care) have clear ways to do this but it is suggested that data from all other partners is explored to see what information currently collected and benchmarked could be used.

4.4 Assuring consistent practice

From discussions, the Review Team identified a number of areas where there were gaps in consistent practice. These broadly fell into the following areas:

- Review policies, procedures and practice guidance
- Care Act (Making Safeguarding Personal)
  - self-funders
  - thresholds
- Communication
- Learning and development
    - opportunities for multi-agency training
- Multi-agency audit

4.4.1 In April 2015 the OSAB Policy and Procedures Group set up a Task & Finish Group to review all current procedures and ensure they are in line with the Care Act. A number of policies and procedures have already been through a re-drafting process (e.g. Safeguarding Adult Review, Confidentiality Protocol and Information Sharing Protocol). Others are reported to be on target for completion shortly. These will be discussed and agreed at the OSAB in August.

The Review Team were not clear proposed policies and procedures will have been agreed by partners organisations and how the OSAB can assure themselves that where necessary they have been through the appropriate governance structures. It was also unclear to what extent representatives from all partner organisations have been involved in developing new policies and procedures.

Commercial care providers were concerned about new policies and procedures being written without any discussion with them. This was a particular issue when changes require providers to amend or re-write their own policies. As many providers are relatively small this can be time-consuming and onerous. They have asked that this be acknowledged and appropriate timescales set at the outset.

4.4.2 Self-funders - A key area requiring further examination is how self-funders are dealt with. The Review Team were told that if safeguarding issues were reported by, or on behalf of self-funders, in some cases OCC staff referred people back to individuals relatives to deal with. This is a major area of risk for OCC as the decision to carry out a safeguarding enquiry does not depend on the persons eligibility to receive local authority services but should be taken wherever there is reasonable cause to think that the person is experiencing, or is at risk of, abuse or neglect.

4.4.3 Threshold documents - The local authority has a duty to make enquiries if the three key tests [2]in the Care Act appear to be met. There was a lack of clarity across stakeholders and operational teams regarding the thresholds for responding to individual safeguarding concerns. There was also confusion when information should be treated as a safeguarding concern, what is an enquiry and who can carry out an enquiry. OCC and the OSAB may wish to assure themselves that all staff are fully aware of this.

4.4.4 The OSAB did not appear to have visibility outside of the members of the Board and subgroups. Questionnaires received from non-members of the Board and focus group members were not aware of the Board or its activity. Given the importance of its work, the OSAB might want to

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[2] Where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there) -
(a) has needs for care and support (whether or not the authority is meeting any of those needs),
(b) is experiencing, or is at risk of, abuse or neglect, and
(c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

consider developing a communication and marketing plan. This could include discussions about how partners might work together to ensure that the public are aware of adult safeguarding and where to obtain support. It was suggested that ideally partner organisations Communications Teams they could be tasked with working together to ensure that messages are consistent and co-ordinated. There was a plea that the OSAB 'develop an simple guide for (adult) safeguarding … what to do/where to go'.

4.4.5 Training, particularly from the OSAB about the Care Act and the implications for safeguarding had apparently been scarce. Information and training about the Care Act for the OSAB took place before the draft regulations and guidance had been published and Board members had not received any training on the implications for safeguarding. Commercial care providers also reported that they had received no information about the Care Act or its implications for safeguarding. Larger care providers had accessed their national teams, but smaller providers had struggled to find information pertinent to them.

4.4.6 Support for the Learning and Development Sub-Group stopped when the person supporting the OSAB left in 2014. A new chair has recently been agreed and support is now provided by the Business Support Manager. The new chair also chairs the Learning and Development Group for Children's Safeguarding and it has been agreed that where there are linkages training will be across adult and children's safeguarding.

This re-invigorated group and more particularly the combination of the new chair and Business Support Manager have:

- held one meeting
- agreed a new ToR
- provided support for partner organisations to run safeguarding training and learning events from Serious Case Reviews (multi-agency briefing event about Bullfinch and a joint learning event about domestic abuse)

The sub-group is currently developing a work programme particularly focusing on multi-agency training, which has had not taken place for some months.

4.4.7 There were particular areas of concern for both the voluntary sector and commercial providers about how safeguarding is managed across the County. One person talked about needing to be 'part of the dialogue….solving the problem'. They appear to have good communication with the OCC Safeguarding Team - 'strong, responsive team….not threatening…just right' but most were not aware of the Board or sub-groups, did not know if they were represented and had no way of ensuring that any specific practice or other issues were picked up. They were also unclear what standards were required and how these are benchmarked across the County.

4.4.8 Commercial care sector providers are invited to OCC wide commissioning and contract meetings but there appeared to be no or limited opportunities for them to discuss safeguarding practice issues, with each other or with OCC, the NHS and CQC. Many would welcome this opportunity as they felt they could be in a position to learn from each other and provide useful feedback to agencies. In particular providers were not aware that they could report any safeguarding issues about OCC and the NHS … 'you can't safeguard against the Council…'. The review team were given a number of examples where providers had asked for service users to be moved as they

were abusive, but this has not been actioned and as a result the care provider had then been involved in a safeguarding investigation. This area of practice will need further review.

4.4.9 Ensuring that providers are aware when poorly performing staff move on is crucial to the success of their businesses. Care providers in Oxfordshire have an informal network but are often prevented from knowing about potential employees as some care providers refuse to provide references, just stating that X has worked for them. OCC and the CCG might wish to look at this as part of their contract for service.

4.5 Capacity

In order for the OSAB to be effective, the Review Team determined that the Board need to:

- Assess resources required for delivery:
    - existing capacity
    - Board budget
    - core organisational responsibilities
- Action plan (from Peer Review) and Board work programme

4.5.1 'The County Council is the principal provider of both financial and staffing resources to the Board'. This includes payment to the OSAB chair, salaries and on costs for the Business Manager, Strategic Safeguarding Partnership Manager and the yet to be appointed Administrator. Adult Social Care also fund room hire for meetings and support events associated with adult safeguarding. There have been discussions in the past with OSAB partners about resourcing the Board, but this issue has not been resolved. Arrangements for supporting the LSCB are well established, and there were comments about the inequity between the resources provided for the two Boards (£40k against £350k).

4.5.2 Other partners commit resources in kind to sub groups (attendance at the Serious Case Review, Policy and Procedure and Training sub groups) and the CCG support an experienced and skilled training manager to chair and lead on training activity associated with the Board.

It was acknowledged during the review that for some partners (e.g. Police, Fire and Rescue, Ambulance) cover large geographical areas and are expected to attend and provide resources for numerous adult and children's safeguarding boards. One person wanted to see the OSAB 'Promoting a shared responsibility'.

These will need to be factored into any discussions about resourcing the Board and its work programme.

4.5.3 The OCC lead safeguarding manager and performance lead also appear to provide a significant amount of information for the Board. Whilst partners are clearly active in addressing risks and ensuring safety in their own services, this inevitably leads to meetings and agendas being dominated by the ASC '..primarily still ASC reporting to the Board', and in the past months when there appeared to be a disconnect between OCC and the activity of the Board which had led to a "gap in support to the Board'. The reduction in Board resources has led, it appears, to a diminution of Board effectiveness, leading to gaps being filled by the Board chair and ASC.

4.5.4 Partners need to become more active contributors in cash and kind if the OSAB is to meet the new duties in the Care Act and to better reflect that Adult Safeguarding is everyone's business.

As part of the new Chairs role it is suggested that there are discussions about what all agencies are doing in respect of the OSAB.

5. Is the OSAB Care Act ready?

5.1 The statutory objective of SABs is to "help and protect adults in its area in cases of the kind described in s42(1)" This section "applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)
(a) has needs for care and support (whether or not the authority is meeting any of those needs),
(b) is experiencing, or is at risk of, abuse or neglect, and
(c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.
(2) The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case (whether under this Part or otherwise) and, if so, what and by whom.
(3)"Abuse" includes financial abuse; and for that purpose "financial abuse" includes—
(a) having money or other property stolen,
(b) being defrauded,
(c) being put under pressure in relation to money or other property, and
(d) having money or other property misused".

5.2 The Care Act and Support Statutory Guidance requires each Local Authority to set up a Safeguarding Adults Board which has three core duties:

- To publish a strategic plan for each financial year:
  - developed with local community involvement and consulting the local Healthwatch
  - is evidence based, making use of 'all available evidence and intelligence from partners'.
- To publish an annual report during the year to achieve its main objective and implement its strategic plan detailing:
  - what each member has done to implement the strategy
  - detail findings of any Safeguarding Adults Reviews and subsequent actions
- Conduct any Safeguarding Adults Reviews in accordance to s44 of the Act

5.3 In addition the guidance includes a range of specific actions about the running of Boards, including roles and responsibilities, holding partners to account, developing strategies and training. The following table sets out these specific areas, identifies areas of good practice and where changes could be considered.

5.4 As the team were on site for three days, there may be gaps in information or interpretation:

Is there a Safeguarding Adults Board in place and providing support?	The Care Act requires that a Safeguarding Adults Board is established in each Local Authority areas. The OSAB has been in place for a number of years, attended by a a range of partner organisations and independently chaired. The current chair is leaving and a new chair is to be appointed by partners in early July. A Joint Strategic Partnership Safeguarding Manager (adults and children) and Business Support Manager have been appointed recently. These arrangements however continue to be principally resourced through Adult Social Care services.	The new chair, with statutory partners need to consider how OSAB arrangements are supported in the future. This should include how partner organisations provide support. The OSAB was seen as the poor relation to children's safeguarding, differently funded and supported. There was a general view that some consideration should be given to balancing the resources provided by the statutory partners. A review of sub-groups, including how they are resourced needs to be reviewed urgently. In particular in order to ensure that practitioners are aware of new multi-agency procedures are embedded into practice, training need to be adequately resourced.
Membership and skills	The Care Act states that the Local Authority which set up the SAB, CCGs and the Police in the Local Authority area are statutory partners. These three organisations are represented on the OSAB and sub-groups. The Care Act suggests a number of other partners can be invited to join the Board. The OSAB includes a range of other partners from across the County. The Care Act also sets out the requisite skills for SABs to act efficiently and effectively. Members should be able to: • speak for their organisation • commit their organisation on policy and practice matters • hold their organisation to account • influence the development of their agency's practice • contribute to the development of robust and effective monitoring and performance functions.	When the new chair is appointed, it is suggested that there is a review of Board members and expectations. This could include: • discussion about right level of decision makers • distinction between Board members and people who are dealing with specific issues or reporting on agreed actions • the inclusion of the carers and service user voice should be reviewed to ensure that it is directly linked to the Board (Healthwatch). Consideration needs to be given to how the: • commercial care and health sectors • service users • voluntary sector will be engaged in the OSAB, ensuring that membership organisations are able to be representative and feedback loops are well established.

Strategic Plan	This is the first time that SABs are required to publish a Strategic Plan each financial year. Many Boards are therefore in the same position as the OSAB.	The Review Team were provided throughout with information and ideas that could be form basis for strategic planning. OSAB and incoming chair to consider business planning identifying priorities for action.
Annual report	SABs are now required to publish a report about Board activity on a yearly basis. This should be achieved by working in partnership and should be agreed with Healthwatch.	Develop a mechanism through the OSAB structures for formal consultation. Consultation needs to be wider than present and thought needs to be given to how the voluntary sector and patient/service user groups are engaged.
Identifying key roles and responsibilities	SABS need to assure themselves that all members, including those on sub-groups understand their roles and responsibilities.	The draft Constitution sets out responsibilities of OSAB members. Included is that members who represent other organisations will conduct themselves. Further work might be required to ensure that there is a written agreement about how this relationship will operate. This would be of particular importance to membership organisations (e.g. commercial care providers and voluntary sector organisations).
Challenge between partners/ holding partners to account	This is key to ensuring that the OSAB works effectively and although is primarily the role of the chair, clarity about arrangements could be included in the Constitution.	A Draft Constitution has been developed for discussion at the Board. It was unclear how partners will conduct themselves and conflict managed. A proposal that the chair of the Board holds CEOs of partner organisations to account has been suggested. A discussion with CEOs of the statutory partners about how business is currently dealt with may ensure that issues can be resolved quickly and appropriately.
Effective links with key partnerships	The OSAB has developed a map of partnerships they work with.	Consideration needs to be given to the full list of potential partnerships and an agreement made about how links to the OSAB will be made. Crucially there needs to be an agreement about which partnerships deal with specific issues e.g. Domestic Homicide Reviews.
Analysing and interrogating data	Partners need to provide data to support making strategic decisions about safeguarding.	The OSAB need to review and agree a data set. The OSAB need to identify and agree key indicators that will be regularly analysed and considered by the Board. It is suggested that a small group of meaningful indicators could be used to start with.

Arrangements for Peer Review and Audit	All SABs are now required to have in place arrangements for Peer Review and Audit.	The current peer review should enable the OSAB to look at issues it might want to address and the Board could consider how it might wish to review whether it has completed all actions agreed. An area for further work might be the development of a self audit for partners, and Board arrangements. There was a suggestion that additional resources would be required for this activity. The OSAB might wish to discuss what arrangements other Regional SABs have put in place to undertake this. A number are led by operational safeguarding leads from across the partnership.
Developing policies and procedures with other agencies and taking into account views of adults who have care and support needs	The development of the Multi Agency Policy and supporting documentation needs to consider how it can engage with all partner organisations including commercial and voluntary sector care providers and the public.	Work has begun to look at all policies and procedures and it is proposed that these are discussed at the OSAB in August. Some consideration needs to be given to ensuring that these procedures have been widely considered, and discussions about how the policy will operate in practice both across the workforce and with partner agencies/ stakeholders. Engagement, public participation and communication staff from partner agencies could provide the necessary skills and support.
Preventative strategies - aiming to reduce instances of abuse and neglect	The OSAB need to be aware of how current preventative strategies are being undertaken and, using data available, develop a clear co-ordinated strategy.	Self-neglect was highlighted by a number of practitioners as needing addressing. The OSAB could consider developing a multi-agency self-neglect policy to complement the revised safeguarding procedures.
Strategies to deal with grievances; complaints; professional and administrative malpractice in relation to safeguarding	Procedures and policies for contracted, commissioned and directly provided services should include safeguarding.	The review team were not able to review the relevant policies and procedures. Partners might wish to consider whether their policies and procedures include safeguarding vulnerable adults and commissioners/contract managers might wish to ensure that contract for service includes a reference to safeguarding. There was no specific reference for dealing with complaints about the OSAB or the Chair. This might be something that the partners would wish to consider.

Making enquiries	New duties have been placed on partners to carry out s42 enquiries and more broadly Making Safeguarding Personal and the need to ensure that the individual is engaged in the safeguarding process from the start - managing risks through family networks, neighbours etc. All partners are required to have a Dedicated Adult Safeguarding Manager (DASM)	The revised Safeguarding procedures should incorporate the MSP approach to help embed this in the work of practitioners. The procedures should also provide clarity on thresholds as well as an enhanced menu of responses. Multi agency training will assist in translating this approach to an outcomes way of working within the new legal framework. An update on which partners have established a DASM role may be an area that the OSAB should explore.
Strategies to deal with impact of race; ethnicity; religion; gender; gender orientation;	The OSAB did not have a strategy to address this.	Consideration could be given to including this as a specific aim/function of one of the groups. The OSAB will also need to ensure that this is included in all strategies and that these are linked to human trafficking, modern slavery and discrimination.
Confidentiality	Each SAB needs to have a confidentiality agreement setting out when and what to share.	The OSAB have a draft Confidentiality Agreement in place. This needs to be formally agreed and a communication plan agreed and actioned in order that all practitioners are aware of its contents.
Identify types of circumstances giving grounds for concern and when they should be considered as a referral to social services	SABs and ASC must work with partners to ensure that multi agency policy and procedures are clear to all agencies, not solely statutory partners but voluntary and commercial care organisations.	This is included in the multi-agency procedures. Links between commercial care organisations and the OSAB needs to be strengthened in order to ensure that there is clarity about how and when care providers should refer to social care.

Information - accessible to partner organisations and the public	Each SAB should ensure that information is available to the wider public about what safeguarding is and where people can get help. Partners need to have available all necessary information to work together and keep updated about policy development.	Some concerns were expressed about the difficulties of accessing information about safeguarding, although it was acknowledged that the proposal to develop an adult safeguarding site would help this. OCC publish information about how to access ASC services, but the OSAB have no public facing information. Healthwatch and other public and patient participation groups are crucial to ensuring that this information is culturally sensitive and reaches all parts of the Counties communities. The Joint Safeguarding Business Unit are developing web based information for partner organisations, including updated policies and procedures, updates on initiatives and activity across the County. The Business Unit might want to consult with operational colleagues about what information they may wish to have access to. They might also want to consider including links to national organisations that focus on safeguarding (e.g. SCIE).
Mechanisms for monitoring and reviewing the implementation of policy and training	The OSAB need to agree how it will assure itself that all OSAB policies are fit for purpose and meet the requirement of the Care Act and other legislation. Training for partners needs to follow any changes to policy or procedures.	The OSAB might wish to include this in any forward work plans.
Promote multi-agency training	This training is based on multi-agency policies and procedures and needs to occur across all partner organisations.	The OSAB multi-agency policy and procedures are out of date and multi-agency training has not taken place for some months. The L&D group have responsibility for this but it was reported to run on *'goodwill and is not sustainable'.* Following the agreement of the multi-agency safeguarding policy a programme of training all partner organisations needs to be resourced and agreed.

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Oxfordshire Safeguarding Adults Board Peer Review: Action Plan

Context for Peer Reviews

The Local Government Association set out a new approach in 2011 following the changes to the nationally imposed inspection and assessment regime (under the Care Quality Commission) to a new system referred to as "Sector Led Improvement". This approach has received high levels of support as Councils have endorsed the key principles, in that they see themselves as responsible for, their own performance and improvement, working with partners as part of a whole system to deliver services and ensure there is transparency and accountability locally. In Adult Social Care, Sector Led improvement has been implemented to oversee and improve standards, and are a key aspect of driving forward both strategic and operational improvements. It is therefore critical to take maximum advantage of the opportunity.

The local authority can choose both the area for review and the scope of that review. By the very nature of the review it is expected that an area is selected where there can be significant opportunity for service improvement, where there are proven challenges and where it would be difficult for a single agency to effect the necessary change alone.

Oxfordshire Peer Review

As part of the South East Directors of Adult Social Services (SE ADASS) sector led improvement initiative, Oxfordshire requested a Peer Review of the Oxfordshire Adults Safeguarding Board (OSAB). The review is intended to support Adult Social Care and partners to improve the services and performance, whilst not straying into regulatory territory.

The OSAB was selected for a number of reasons:

- Safeguarding Adult Boards became a statutory requirement in the Care Act 2014 for implementation in April 2015.
- Whilst a Safeguarding Adult Board had been in place in Oxfordshire for a number of years it was widely recognised that it would benefit from a review of its overall leadership and governance and to test whether it was Care Act compliant.
- It was also recognised that there were a number of shortcomings and capacity issues as a consequence of the lack of a Business Manager for a significant period.
- A formal review would assist in whole partnership change, given that the responsibilities are broader than those for Adult Social Care alone.
- The review would give all partners and governing bodies a clear mandate and roadmap for change.

Discussion also took place with other local authorities who had selected their Safeguarding Adult Board for a Peer Review, who confirmed that the review had been a key catalyst for change, in generating a common ownership of the new agenda, and in galvanising all partners to renew their energies and responsibilities in relation to the Board and the delivery of its core functions.

In addition, the Board and Adult Social Care had instituted a number of changes over the spring and summer 2015, during the time of the Peer Review, in order to ensure that there was sufficient capacity for change and so that the Board would be in a position to take a robust strategic leadership role in relation to safeguarding locally, and deliver the anticipated actions from the review and ensure Care Act compliance.

These included:

- The appointment of a new chair, a new Business Manager and a new post of Strategic Safeguarding Partnerships Manager to work across the adult and children's boards.
- The development of a joint Safeguarding Business Unit for adults and children.

The Peer Review team found high levels of motivation for change and transparency in relation to the key areas for development. Political leadership for safeguarding was seen to be high and there was a positive response to the work of safeguarding in Oxfordshire overall. Areas for development included governance arrangements, the Board vision and strategic plan, the evidence base for safeguarding, assuring consistent practice and the capacity of the board. The outcomes of the review were broadly in line with expectations and give a clear mandate to all partners to take a strong leadership role and implement the key actions from the review, as well as repositioning the Board at the heart of the partnership geography for safeguarding adults with care and support needs in Oxfordshire.

The following Action Plan draws out the key findings, action to be taken and progress already made against the key actions. The rating is blue/complete, green/on target, amber/progress being made with some concerns, red/risk area and/or lack of progress.

Peer Review Action Plan

1. Governance: The Care Act requires that a Safeguarding Adults Board is established in each local authority area with three core duties: the publication of an annual strategic plan, an annual report and duty to arrange Safeguarding Adults Reviews. The Board is responsible for protecting and helping adults who need care and support. In order to achieve this aim there needs to be healthy, effective relationships between the organisations who make up the Board within a clearly accountable Board structure, a Board membership of the right people at the right level and sufficient resources and capacity to deliver these functions.

Aim	Action	Lead & Timeframe	Measure/Evidence	Progress & RAG Rating
1.1 To ensure that the Board has the capacity to function effectively and that **members are clear about their roles and responsibilities**, have the right skills and can provide effective leadership of safeguarding issues. (Peer Review Recommendation (PRR) 1, 2, 5, 6, 12, 13,15)	To agree a Financial Plan.	OSAB Chair/ Strategic SG Partnerships Manager/ Business Manager. **Timescale: Dec 2015**	Minutes of OSAB confirm ratification of Financial Plan and adequate resources in place.	Financial Plan in place and partners to report back on contributions by 6/11/15. RED
	To write an up to date members handbook with up-to-date terms of reference; constitution; confidentiality agreement for members; roles of members; role of Dedicated Adult Safeguarding Manager (DASM), information sharing protocol; links to own agency governance; clear roles and duties for representative of other agencies; escalation processes, complaints including relating to the chair; and performance review of board members and chair. To ensure the constitution includes conduct, conflict resolution and a process for holding partners to account.		Members Handbook published. agreed	Members Handbook to go to the December Board for agreement. GREEN
			All Board members at a strategic level.	Board Development Day set for 30/11/15 with all partners at a strategic level. GREEN
			DASM appointed in each agency	DASM identified in all key statutory agencies. BLUE
	To meet with Chief Executives (CEOs) of statutory partners to agree management of core business.		Joint CEO Summit in place.	Agreement in place to combine existing Oxfordshire Safeguarding Children Board (OSCB) annual Summit with CEOs with OSAB. GREEN
1.2 To ensure all sub-groups are fully functioning with clear reporting to the Board and develop area-based Practitioner Forums. (PRR 1)	Sub-Group structures reviewed and all terms of reference updated.	OSAB Development Day/ Business Manager **Timescale: Dec 2015**	New sub-group structures in place with published Terms of Reference and clear work plans. Forums in place for service users, carers and providers.	Safeguarding Adult Review (SAR) Sub-Group, Performance Information and Quality Assurance (PIQA) Sub-Group and Training Sub-Group now covering adults and children in place with updated Terms of Reference. GREEN
				November Board Development Day to establish Executive Group and final sub-group structures. GREEN

Aim	Action	Lead & Timeframe	Measure/Evidence	Progress & RAG Rating
1.3 To develop strong and effective partnerships with adults who use services in Oxfordshire, carers and other key stakeholders so that their views and issues can inform board policy development, planning.	Facilitate Service User, Carer and Provider Forums.	OSAB Chair/ Strategic Partnerships Manager/ Business Manager **Timescale: March 2016**	All partners across the workforce including commercial and voluntary sector providers and the public are engaged in policy development and how they operate in practice.	Review mechanisms with joint commissioning. GREEN
	Publish Easy Read version of Peer Review to share with key stakeholders.		Easy read version published and disseminated	Easy Read version of Peer Review being commissioned to share with stakeholder groups who participated in Peer Review and plan to engage them in next steps. AMBER
1.4 To engage with carers and service users using new or existing mechanisms. (PRR 2, 10)	To agree links with Healthwatch. To develop provider forum.	Strategic Partnerships Manager/ Business Manager **Timescale: March 2016**	Consultation mechanisms in place including service user groups, voluntary sector and Healthwatch.	Review Mechanisms with Joint Commissioning GREEN
1.5 To ensure links and accountabilities to all key strategic and statutory partnerships are clarified including lead for key issues and workstreams. (PRR 7)	Agree a protocol across the Health and Well Being Board, Oxfordshire Safer Communities Partnership and area Community Safety Partnerships and OSCB.		Protocol in place and accountabilities clear.	Content of draft protocol agreed and first draft to be completed by mid-November. GREEN
1.6 To establish a clear vision, agree a Strategic Plan and Business Plan with clear priorities and a proactive approach to current and emerging safeguarding priorities. (PRR 3)	To agree Strategic Plan and Business Plan which provides clarity regarding the board role in relation to key safeguarding issues	Chair/ Strategic Partnerships Manager/ Business Manager **Timescale: Dec 2015**	Strategic Plan and Business Plan in place.	Strategic Plan and Business Plan will be an output from the Board Development Day. GREEN
1.7 To publish an Annual Report in relation to Board activity by working in partnership with key stakeholders. (PRR 4)	To agree annual report for 2014/15 within OSAB. To agree 15/16 annual report with wider partnerships.	Business Manager **Timescale: Nov 2015** **Timescale: June 2016**	14/15 Annual Report published and taken to Health and Well Being Board. Annual Report Published	14/15 Annual Report to be reported to Health and Well Being Board on 5/11/15 and Full Members' Briefing on 8/12/15. GREEN

2. Quality Assurance: The Board needs to ensure that services are delivered to the highest standards and that quality of work is audited and monitored as part of supporting and protecting adults in need of care and support. Robust data should be used to support strategic decision making and arrangements should be in place for Peer Review, audit and self-assessment of safeguarding by all key partners. This will be led and monitored by the PIQA Subgroup of the Board linking closely with other sub-groups and in particular the Training Sub-Group and the SAR Subgroup.

Aim	Action	Lead & Timeframe	Measure/Evidence	Progress & RAG Rating
2.1 To regularly analyse and consider data and qualitative information to support strategic decision making. (PRR 2)	To agree a simple core multi-agency dataset which includes national comparison and benchmarking measures.	Performance Information and Quality Assurance Sub Group (PIQA) **Timescale: June 2016**	Dataset in place and informing strategic direction and priorities.	PIQA sub group set up and draft dataset being revised. GREEN
	To analyse qualitative information from multi-agency and single-agency case file audits; service user, practitioner and stakeholder feedback, compliments and complaints.		Multi-agency and single agency audits in place and informing practice improvement and learning and link to training. Mechanisms for practitioner and stakeholder feedback in place. PIQA Annual Report in place for June 2015.	Programme for multi-agency and single agency audits in place for agreement at December meeting. GREEN
2.2 To ensure all key agencies assess their safeguarding compliance on an annual basis across children's and adults' services through a single process, supported and challenged by a peer review. (PRR 9)	Consider a single annual self-assessment of safeguarding compliance across adults' and children's services.	PIQA and OSCB **Timescale: March 2016**	Single self-assessment tool in place for reporting in December 2016.	Agreement to single self-assessment tool in place through both OSAB and OSCB and Task and Finish Group set up. GREEN
	To set up an annual joint peer review process,	**Feb 2017**	Effective peer review process in place.	First draft to be produced 12/11/15 and Task and Finish Group from both sub-groups being set up. GREEN

3. Driving Good Practice: A comprehensive range of policies, procedures and strategies need to be in place to ensure operational practice is fully supported so that the highest standards of practice are achieved. This includes clarity across the partnership in relation to safeguarding thresholds, making enquiries, wider communication strategies and training plans. This work will be supported by all Board sub-groups but led in particular by the Procedures Sub Group and the Training Sub Group.

Aim	Action	Lead	Measure/Evidence	Progress & RAG Rating
3.1 To ensure that equalities strategies are developed, included in all strategies and linked to human trafficking, modern slavery and discrimination. (PRR 14)	To develop equalities strategies and to update all existing strategies to ensure they address existing and emerging equalities themes.	Procedures Sub Group **Timescale: March 2016**	Equalities strategies in place and addressing key emerging and existing themes.	To be built into Procedures Sub-Group work programme. GREEN

Aim	Action	Lead	Measure/Evidence	Progress & RAG Rating
3.2 To ensure that a comprehensive set of multi-agency policies and procedures including a Safeguarding Strategy aiming to reduce instances of abuse and neglect. (PRR 1, 10, 11, 12) .	To update and publish multi-agency policies and procedures. To ensure practitioners are aware of new multi-agency procedures. Ensure procedures and policies for contracted, commissioned and directly provided services include safeguarding and sharing information	Procedures Sub Group **Timescale: Dec 2015**	Multi-Agency Procedures approved and published. Multi-Agency Safeguarding Strategy in place which will include prevention and informed by performance data. Staff across all agencies are aware of and using policies and procedures and they are well publicised and include safeguarding and sharing information. Evidence of this to be obtained through audit and data analysis by the PIQA Sub-Group Fewer complaints and an increase in compliments.	Core procedures in draft for agreement in November. GREEN Core procedures to be signed off by OSAB in December. GREEN Thematic procedures e.g. self-neglect are part of next phase of procedure development for completion by March 2016. GREEN
3.3 Ensure s42 enquiries and the Making Safeguarding Personal approach are incorporated in the revised Safeguarding procedures including clarity on thresholds and an enhanced menu of responses. This should include engaging the individual from the outset and in risk management processes. (PRR 13, 16, 18)	To update procedure including thresholds guidance in line with the Care Act and include issues for self-funders. Agree and publish threshold guidance with all partners including commercial/private care sector providers. Develop mechanisms for monitoring and reviewing the implementation of policy and training. Embed outcome based approach in multi-agency training. Develop web-based enquiry form.	Procedures Sub Group **Timescale: Dec 2015** Business Manager **Timescale: Jan 2016** Procedures Sub-Group and Training Sub- Group **Timescale: March 2016** Training Sub-Group **Timescale: Dec 2015** Business Manager **Timescale: Nov 2015**	Procedures updated and decisions about enquiries are followed up appropriately. All providers clear regarding what is an enquiry, what are the types of circumstances giving rise to a concern, when a concern should be treated as an enquiry and who can undertake this. This will be tested through the provider forum and audit. Training programme, learning outcomes and training materials reflects updated procedures. Web-based enquiry form well used and evidenced by data analysis .	Update on thresholds and Care Act compliance complete and awaiting sign off. GREEN Communication plan to be developed. AMBER Training offered will depend on capacity of Board. RED Web based enquiry form in development. GREEN

Aim	Action	Lead	Measure/Evidence	Progress & RAG Rating
	Issue a practice note to all Adult Social Care staff to clarify responsibilities in relation to Self-Funders and Safeguarding.	Deputy Director of Adult Social Care **Timescale: Oct 2015**	Practice note implemented.	Practice Note issued 30/9/15 BLUE
3.4 Ensure information is available to the wider public about what safeguarding is and where people can get help and work with Healthwatch and other public and patient participation groups to ensure information is culturally sensitive and accessible to all parts of every community. (PRR 17)	Develop Communication strategy. Improve OSAB website Consult with operational colleagues regarding relevant information and include in website links to national organisations that focus on safeguarding	Chair/Strategic SG Partnerships Manager/Business Manager **Timescale: March 2016**	Profile of OSAB is high demonstrated by its influence on policy and practice and key strategic priorities and messages are widely disseminated through use of a range of social and other media. Public and partners can access necessary information easily as evidenced by website hits and feedback.	Communications Plan to be developed. AMBER Website to be launched by end October. AMBER
3.5 Following the agreement of the multi-agency Safeguarding Strategy a **programme of training for all partner organisations** needs to be resourced and agreed and training should be responsive to future changes in policy and procedures. (PRR 19)	To develop a comprehensive multi-agency training programme. To develop joint OSAB/OSCB training strategy.	Training Sub Group **Timescale: Dec 2015** **Timescale: Sept 2016**	Training programme in place and sessions delivered. Compliance data collected showing attendance at multi-agency training events. Joint training strategy in place.	Training Strategy in place but multi-agency programme will depend on capacity and resourcing to board. RED Joint Training Sub-Group in place. GREEN

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Key to acronyms/initialism

Acronym/Initialism	Full Wording
ADASS	Association of Directors of Adult Social Services
CEO	Chief Executive Officer
DASM	Designated Adult Safeguarding Manager
HWBB	Health & Wellbeing Board
OSAB	Oxfordshire Safeguarding Adults Board
OSCB	Oxfordshire Safeguarding Childrens Board
PAQA	Performance, Audit and Quality Assurance
PIQA	Performance Information and Quality Assurance
PRR	Peer Review Recommendation
SG	Safeguarding

Oxfordshire Health and Wellbeing Board – 5 November 2015

OSCB Annual Report for 2014-15

Report by OSCB Independent Chair, Maggie Blyth

1. Summary

1.1 The attached annual report from the Oxfordshire Safeguarding Children Board provides an independent analysis of the safeguarding services provided to the County's children over 2014/15, and outlines the challenges ahead over the next year.

2. Introduction

2.1 This report presents the 2014/15 Annual Report endorsed by the Oxfordshire Safeguarding Children Board (OSCB) in July 2015.

2.2 This report identifies the progress made by the County Council's Children's Services Department and partners across the NHS, Thames Valley Police, Probation organisations, district councils, schools, and the voluntary sector during 2014/15 in improving the child protection system. It also identifies areas of vulnerabilities and outlines what action is being taken to address challenges where they remain.

2.3 The Annual Report includes lessons from management reviews, serious case reviews and child deaths, as well as findings from multi-agency audits and staff surveys within the reporting period.

2.4 It is important to note that over the reporting period and before, the number of referrals into children's services has continued to increase and the overall activity within the child protection system continues to rise. There are increasingly larger numbers of older children on child protection plans. As the report indicates this places pressure on front line services across all sectors and has required a shift in focus to the needs of adolescents. Multi Agency Safeguarding Hub (MASH) continues to play an important feature of integrated front line working and receives all referrals through its systems. MASH were able to resolve a significant number of initial contacts by providing advice and signposting to other agencies but this still leaves an increasing number which are further progressed to referrals, assessment and investigation where appropriate within the child protection system.

2.5 The Annual Report also outlines in detail the number of activities and work streams to increase understanding and identification of children at risk of sexual exploitation. This area of work has remained a priority for the OSCB during 2014 /15 and members will be aware of the CSE Stocktake report published in July 2015. The number of children vulnerable to CSE has continued to increase over previous years and is a reflection of greater

understanding, and strategic approaches to tackling crimes across the partnership.

2.6 Indeed, the Stocktake report reflects the progress made in Oxfordshire in tackling CSE and other underlying problems that exacerbate the vulnerability of older children. There is evidence that other challenges such as FGM, the increase in the numbers of children self - harming and facing neglect have been addressed through more effective partnership working across policing, social care, education and health.

2.7 Specific challenges are highlighted in the Annual Report around action taken to learn lessons from cases when things go wrong and where children are the subject of neglect, harm or abuse from their carers or other adults around them.

2.8 OSCB is committed to publishing the findings from all Serious Case Reviews (SCRs). There has been a significant increase in the numbers of SCRs commissioned across Oxfordshire in line with new government guidance and during this reporting year 3 SCRs have been published including the high profile case of Children A-F.

2.9 The lessons from all of these cases have influenced the focus of OSCB's multi-agency training programme and a series of Learning Lessons workshops were implemented in 2014/15, resulting in the training of nearly 3,000 front line professionals from all partner agencies. The feedback from front line staff has indicated these multi agency events are well received. OSCB has also started a more in-depth evaluation process to fully ascertain the value of training provided and what positive impact it has on professional understanding and practice over a longer period. This work is in its early stages and will be reported on in more detail next year.

2.10 During the reporting period OSCB completed a number of multi agency audits. The results of these audits have informed the Board's priorities for 2015/16.

2.11 The numbers of child deaths considered by the Child Death Overview Panel in Oxfordshire for the year was 40. The OSCB through the Child Death Overview Panel is required to ensure that a proportionate review is undertaken of each death of a child under 18 irrespective of the cause of the death. The purpose is to understand if there are any lessons to be learnt, and whether there are any wider public health or safety concerns to prevent further deaths. If abuse or neglect is suspected then a serious case review must be undertaken and the findings from this about how agencies worked together to safeguard children must be published.

2.12 Engagement with Education in relation to safeguarding across all schools has been a strong focus. OSCB, in conjunction with the County Council has engaged with all state sector schools and Independent settings requiring completion of an annual s175 or s157 safeguarding assessment. 100% of Schools responded to the self-assessment which is a significant achievement based on previous years. The more worrying concern during the reporting year

has been the number of language schools, including pop up schools that do not comply with safeguarding policies and procedures. The Independent Chair has escalated this issue to the Children's Minister as it may be indicative of a trend in other towns or cities where language schools are common.

2.13 During 2014 the Independent Chair met with the chief executives of the different NHS Trusts and OCCG and seeks assurance from the HWB that a focus on safeguarding children will remain a priority for all of the health economy. Ensuring engagement at the OSCB from the appropriate senior executive from all health commissioners and providers across Oxfordshire is essential and this must include public health involvement. Concerns remain about the availability and waiting lists to access appropriate support for children with mental health needs and the absence of therapeutic provision for adults disclosing child abuse or exploitation was outlined in the CSE Stocktake report. Whilst the overall picture in Oxfordshire reflects the position nationally, CAMHS have seen a significant increase in the number of urgent and crisis presentations requiring immediate assessment. CAMHS have extended their specialist services in order to meet this demand, adult social care/OCCG are to trial a pilot approach to supporting victims of child sexual abuse/exploitation. The OSCB will monitor and review this in next year's report.

3. Financial and Staff Implications

None

4. Equalities Implications

There are no additional equalities implications that are not covered in the report

5. Conclusions

5.1 Oxfordshire agencies are working hard to ensure that the child protection system is working. This Annual Report outlines the achievements of OSCB 2014/15 and provides assurance that the child protection partnership across the County is effective. However, challenges remain to ensure that there is a multi-agency strategic response to the increased activity and complexity of cases within the child protection system; that all schools, including language settings are fully compliant with their safeguarding duties including awareness of how to tackle risks relating to children missing and CSE; and health organisations across Oxfordshire are fully engaged with adult services at an executive level to provide maximum assurance that there are appropriate interventions in Oxfordshire for adult victims of child abuse/exploitation.

6. Recommendations

6.1 Members of the Health and Wellbeing Board are recommended to:

- Note that the child protection partnership is working effectively across Oxfordshire but there are severe pressure points in relation to the increased complexity of cases and activity in the system
- Consider the implications for the partnership in relation to the deficits in appropriate provision for those adults that disclose abuse or exploitation from childhood
- Ensure that the OSCB Annual Report is submitted to all governing bodies of member organisations represented on the HWBB

Maggie Blyth, Independent Chair OSCB

Background papers: Annual report 2014-15

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October 2015

OSCB ANNUAL REPORT 2014-2015

Oxfordshire Safeguarding Children Board

Annual Report Introduction:

I am pleased to introduce the Annual Report for Oxfordshire Safeguarding Children Board 2014/15. I have now been in post just over a year and would like to thank all organisations represented on the OSCB for their commitment; grip and engagement in making sure improvements continue to be made in protecting all children from harm in Oxfordshire. The standard set remains high.

The findings from audits, data, serious case reviews and reporting schedules provided to the OSCB during 2014/15 have given me a clear view of how well child protection work is being managed. The findings give me a clear picture of the pressure points across children's social care services, across NHS organisations, within schools and from policing. The OSCB has examined carefully the work that is being done to improve services and how best to ensure that those working on the front line, as social workers, police officers, health visitors, teachers and any part of the children's workforce are part of the key learning and development. This has included actively listening to the voices of children, families, and the welfare of disabled children, and to the most vulnerable children. In particular, there has been a focus on older children in the child protection system and systems and practice have been strengthened to ensure that this group of children are being supported appropriately and not disadvantaged in the transition into adulthood. Children who go missing from their care, school or home are much better responded to so as to better mitigate their vulnerability.

Oxfordshire maintains a focus on children leaving care. All these issues remain priorities within next year's Business Plan.

Furthermore, during 2014/15 the OSCB has worked with the wider community through engagement with faith groups, community groups and the voluntary sector to raise awareness of child protection matters and this is recognised as an ongoing priority. This has also led to a greater understanding of new challenges facing the child protection system linked to safer transportation of children across the County.

There have been many and varied examples of working, innovative approaches to service delivery and commitment in Oxfordshire that I have seen. I have reported very recently on the progress made to tackling CSE and it seems to me that this has led to progression in tackling other problems facing children across Oxfordshire. Everyone knows the part they have to play in keeping children safe.

As this Annual Report is published there are clearly increased pressures for the child protection partnership across the County as the activity in the system continues to increase with the numbers of children on child protection plans and coming into care, continuing to rise. There are also implications for the extent to which partner agencies are able to maintain existing approaches to early intervention and the OSCB will be monitoring carefully the outcome of any changes to child protection arrangements in Oxfordshire during 2016.

by **Maggie Blyth**
the Chair of the Board

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CHAPTER 1: LOCAL SAFEGUARDING CONTEXT

Oxfordshire demographics

Oxfordshire is the most rural county in the south east. It has a population of approximately 635,000 of which 140,000 are children aged under-18. The number of children has grown approximately 6% in the last ten years – mainly in urban areas such as Oxford, Didcot, Witney, Bicester, and Carterton. The percentage of the county's population from minority ethnic backgrounds is 9.2%, although this figure more than doubles in Oxford City. In the next ten years there is likely to be significant population growth among children born to first generation migrants, particularly those from Middle Eastern, Asian, and new EU countries.

According to the IDACI rankings, Oxfordshire's more deprived areas tend to be in the urban centres of Oxford and Banbury, with further pockets in Abingdon and Didcot. Overall, Oxfordshire is ranked twelfth lowest on IDACI measure.

Oxfordshire performs above both national and statistical neighbour averages for the proportion of both primary and secondary schools judged as good or outstanding. Despite this the proportion of outstanding schools in Oxfordshire remains low. In addition persistent absence rates, permanent exclusions and fixed term exclusions in secondary schools are a concern.

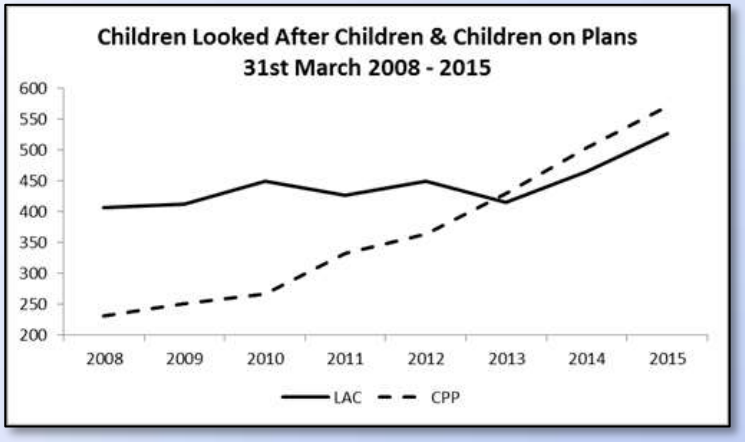
Vulnerable groups

The OSCB focuses on those children who are most vulnerable or at risk of suffering harm. We know that there are many reasons why children can become vulnerable or at increased risk of harm. For example children living in households where there is domestic abuse, substance misuse or their parents are mentally ill are known to be at a greater risk. Children whose family life is neglectful will struggle to get a good start in life. Children who go missing from school or missing from home are placed in greater danger of harm. The needs of these children, and other vulnerable groups, are outlined below to provide an understanding of the local context. The impact of the work done to support these children is outlined extensively later in this report in chapter 3.

The OSCB is aware that it is not always possible to know the complete picture of the children whose safety is at risk. Some abuse or neglect may be hidden and it is important to understand that the local context is a changing one and that new concerns should be escalated as they emerge.

Children with a child protection plan

Children who have a child protection plan are considered to be in need of protection from either neglect, physical, sexual or emotional abuse; or a combination of two or more of these. The plan details the main areas of concern, what action will be taken to reduce those concerns and by whom, and how we will know when progress is being made.



At the end of March 2015 there were 572 children subject to a plan compared with 504 children the previous year. There were an additional 24 children who were the responsibility of another local authority living within Oxfordshire. This is the highest level for many years. Nationally there has been a rise in the number of children subject to a Child Protection Plan though not to the extent seen in Oxfordshire. OSCB has analysed this increase in general activity and concluded that it reflects greater identification, recognition and response to signs of abuse and neglect as well as sensitivity to risk.

The biggest increase has been in older girls. In four years the number of children over 10 on a plan rose by 115% compared to 65% for the under 10s. Despite this most children on plans (71%) remain under 10 years old. A higher proportion of children under 10 are on a plan in Oxfordshire than elsewhere.

When Oxfordshire's rate of increase in child protection numbers is compared against the rates in other local authorities which have been through high profile CSE cases, a common trend is detected. We looked at Derby, Rochdale, Blackpool, Rotherham, Oldham, Torbay, Peterborough, and Manchester. All areas have seen steep rises in their numbers of a CP plan, which is not reflected across the whole country. Oxfordshire's rate of growth is slightly below the group average, increasing by 124% compared with 134% for the whole group. Oxfordshire also has the lowest rate of children on a plan of any of these areas.

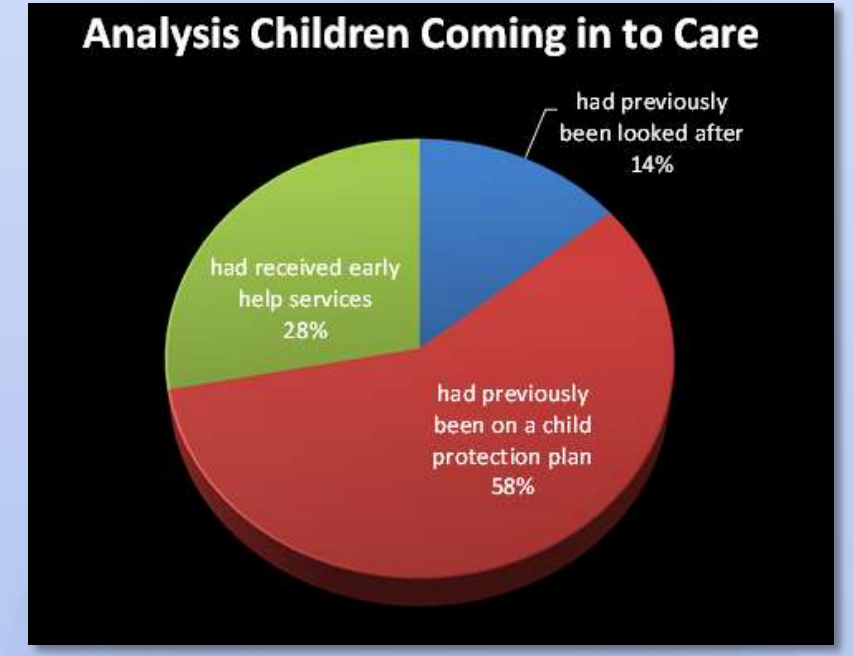
In Oxfordshire this has not led to significantly more referrals; it has led to more referrals converting into assessments and CP plans. This would indicate more in-depth appreciation of risk and responsibility. There is a better recognition of the combined accountability of professionals to identify and protect children.

Children are staying on plans for longer and also having a new plan when risk is deemed to have increased. We know that the majority of children are subject to a plan due to neglect. Addressing neglect is a strategic priority for the Board in 2015.

Children in Care

Children in care are those looked after by the local authority. Only after exploring every possibility of protecting a child at home will the local authority seek a parent's consent or a court decision to move a child away from his or her family. Such decisions, whilst incredibly difficult, are made when it is in the best interest of the child.

There were 527 children in care at the end of March 2015, compared with 463 at the end of March 2014. There has been a consequential increase in the rate of children in care per 10,000 of the child population which has risen from 30.0 in 2013 to 38.1 in 2015. This compares to 40 per 10,000 for Oxfordshire's statistical neighbours. Work has started to review the reasons behind the growth. To some extent it appears to be responsive to perceived risk. We know that 14% of children becoming looked after had previously been in care, over half had been on a children protection plan, 28% had been subject of a children in need plan and a third had received early help. However, even with the increase in numbers there are relatively few children looked after in Oxfordshire.

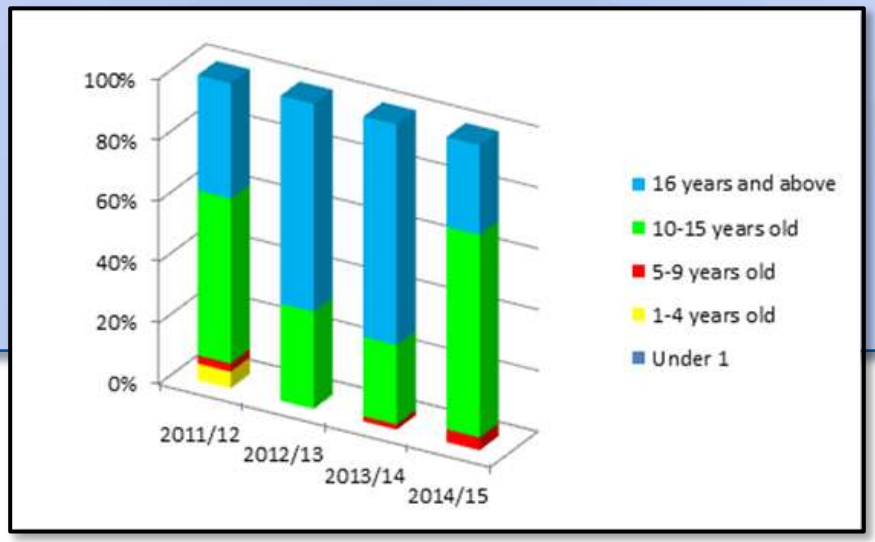


The majority of children (355) were living with foster families.

Children who are privately fostered

Parents may make their own arrangements for their children to live away from home. These are privately fostered children. The local authority must be notified of these arrangements. At the end of March 2015 the local authority were aware of 46 children living in a privately arranged foster placement which is an increase from 34 at the end of March 2014 (a snapshot figure). The number of new arrangements which began over the course of the whole year was 119. This increase is due to the innovative work undertaken by the local authority's private fostering team (1.5 f/t workers) who raise awareness of the need to notify the local authority and ensure the arrangements are visited and checked so that children are safe. This year they have targeted teams working with vulnerable children and had new referrals from the assessment teams and the multi-agency safeguarding hub.

International students have made up the majority of referrals. There has been an increase this year in the number of international students who are attending UK schools rather than specialist language colleges or international schools. Over the last year there has been an increase in the number of 5-9 year olds and also the 10-15 year olds. This reflects language school students coming over to the UK to study at a younger age.



Graph: age breakdown of children privately fostered 2011-12 to 2014-15.

Disabled children

At the end of March 2015 there were 17 disabled children with a Child Protection Plan; this is a small rise on the previous

Children who offend

The children who are involved with Oxfordshire Youth Offending Service (YOS) often present with complex needs requiring significant support both in and out of custody.

The YOS has continued to see the number of children they work with decrease from previous years. In 2014-15, 246 children received a substantive outcome (a caution or above) compared with 282 in 2013-14. The proportion of children receiving a custodial sentence reduced from 4.2% in 2013-14 to 0.6% in 2014-15. The proportion of children receiving a remand to custody also fell from 4.8% in 2013-14 to 0.9% in 2014-15.

Children who are at risk of sexual exploitation

It is estimated that in the period from 1999 to 2014 approximately 370 children have been identified as at risk of abuse through Child Sexual Exploitation. Since 2012 we have had a systematic data collection. We know that there are barriers to children coming forward and reporting this type of abuse which means that children from minority ethnic groups and boys are likely to be significantly under reported.

From 2012 when the Kingfisher Team was established to February 2015 287 children have been identified as suspected to have been at risk of this form of abuse. Of these 238 (83%) were girls and 49 (17%) boys. 215 of these children were identified as of white British or other white origin (90%), 31(10.8%) were described as Asian, black or mixed origin with 7 children where their ethnic origin was not given or recorded.

The use of the CSE Screening Tool enables data to be collected and collated and by March 2015 287 completed screening tools have been sent to the Kingfisher Team.

The predominant age profile for girls starting to be groomed is 13 – 15 years. The predominant age for concerns being raised about boys tends to be older with a peak of boys aged 14 -17 years. Figures for boys are also more complex because they include boys who may be both victims and perpetrators.

Of the 287 children 4 (1.4%) have a statement of Special Educational Needs and a further 116 (40.4%) are recorded as being on some form of additional support in school ranging from School Action to additional SEN support.

Children with mental health issues

Along with many areas across the country there has been a significant increase in referrals to Oxford Health FT Child and Adolescent Mental Health Services (CAMHS). 5308 referrals received and 3407 children assessed by CAMHS during 2014-15. Like last year, along with an increase in the numbers of cases there is an increase in the complexity of mental health issues. This is an on-going concern. As noted in the recent DH report "Future in Mind" there has been an increase nationally on the number and complexity of cases of children being referred to CAMHS. This is also what is happening locally across Oxfordshire, with an increase in accepted referrals. Although Oxford Health FT CAMHS meet the target of seeing children who need to be seen urgently or as an emergency they are working hard to reduce the waiting times for those children who are referred for a routine or non-urgent assessment. A partnership review of the service, which has included key stakeholders e.g. children, parents, social care, schools, GPs etc. has been undertaken in year and a new model which is in line with all the recommendations from the Future in Mind report has been developed. There are strong working relationships between CAMHS and others in respect of working together to safeguard children from harm.

Local transformation plans are currently in development which will enable children and parents to have easier access to targeted and specialist mental health services when needed.

Oxford Health NHS FT continues to see children in an emergency or who are urgently requiring CAMHS within agreed time frames but there has been an increase in waiting times for routine referrals. Oxford Health NHS FT is working hard with partners across the system to reduce waiting times and to ensure that children are seen as quickly as possible.

Children who self-harm

Schools, parents and professionals have expressed concern that there is a rise in the numbers of cases they are seeing. In the last year the numbers presenting at accident and emergency departments has increased (in particular in the north of the county) but we know that the problem is often hidden as children can be worried about talking to their parents or others about self-harming.

Oxford Health FT, which provides mental health services, is working with children social services, schools, GPs, and others to increase awareness of self-harm and the issues that may lead to it. A pilot has taken place which has involved a mental health worker placed in a small number of secondary schools, working with teachers, children social services and the School Health Nurse to increase awareness of mental health issues and support children quickly in familiar surroundings.

A North Oxfordshire network has been set up to identify those children at risk, assess them for support and provide them with the help that they need to manage this issue.

Children missing from home

The number of children who have gone missing from home has risen from last year (694 children compared with 636 last year). The number who went missing three or more times rose from 97 to 132, meaning the proportion of children who repeatedly went missing from home rose from 15.3% to 19%. There are now better processes in place for monitoring children going missing with a rigorous follow up action: a welfare check by the Police as well as return interview to ascertain why the child went missing, where they have been, what they were doing and what support should be put in place to prevent this happening. Deadlines are set to ensure that this takes place in a timely manner and agencies failing to work to this standard are challenged. All of which is reported to key partners, including the OSCB. Whilst the numbers of children going missing have increased, this has provided some initial assurance that children's whereabouts are being monitored and the safe return home pursued. The OSCB partners are analysing responses from interviews to improve prevention work and

Chapter 2: Governance and accountability arrangements

What is the OSCB?

We are a partnership set up to ensure that local agencies co-operate and work well to safeguard and promote the welfare of children. We are responsible, collectively as a Board, for the strategic oversight of child protection arrangements across Oxfordshire. This means that we lead, co- ordinate, develop, challenge and monitor the delivery of effective safeguarding practice by all agencies. The impact should be evidenced in front line practice.

The Board's remit is set out in the government guidance, Working Together 2015 and is to co-ordinate and ensure the effectiveness of what is done by each agency on the Board for the purposes of safeguarding and promoting the welfare of children in Oxfordshire. We aim to do this in two ways:

To co-ordinate local work by:

- Developing robust policies and procedures.
- Participating in the planning of services for children in Oxfordshire.
- Communicating the need to safeguard and promote the welfare of children and explaining how this can be done.

To ensure the effectiveness of that work:

- Monitoring what is done by partner agencies to safeguard and promote the welfare of children.
- Undertaking Serious Case Reviews and other multi-agency case reviews and sharing learning opportunities.
- Collecting and analysing information about child deaths.
- Publishing an annual report on the effectiveness of local arrangements to safeguard and promote the welfare of children in Oxfordshire.

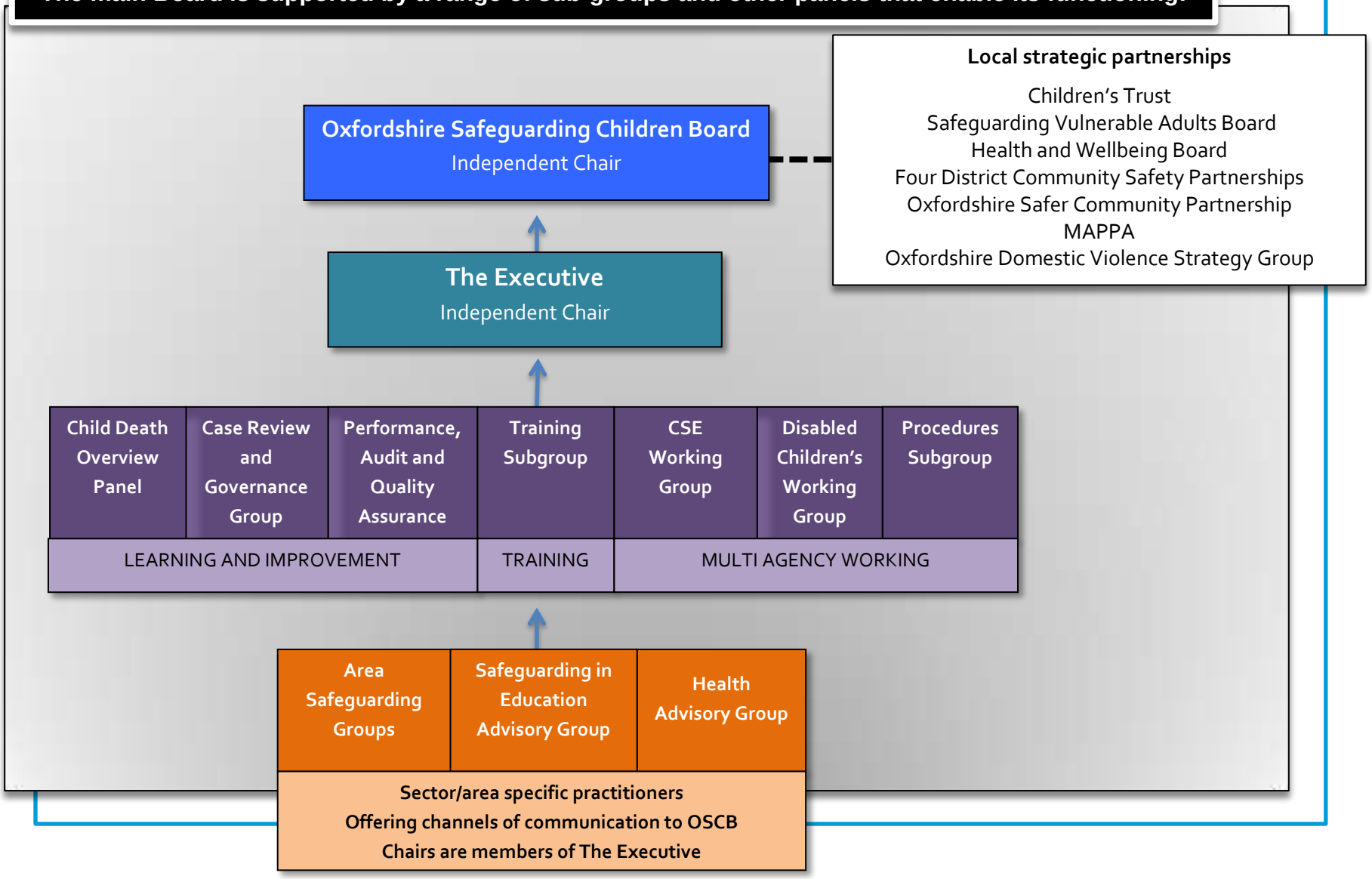
Board Membership:

➢ Independent Chair	➢ West Oxfordshire District Council
➢ Oxfordshire County Council including Children's Services, Adult Services and Public Health	➢ Children and Family Courts Advisory and Support Service
➢ Oxford University Hospitals NHS Trust	➢ Thames Valley Police
➢ Oxfordshire Clinical Commissioning Group	➢ Oxfordshire Fire and Rescue Service
➢ Oxford Health NHS Foundation Trust	➢ Community Rehabilitation Company
➢ 2 Lay Members	➢ National Probation Service
➢ NHS England Area Team	➢ Oxfordshire Youth Offending Service
➢ Cherwell District Council	➢ Representation from schools and colleges
➢ Oxford City Council	➢ Representation from the voluntary sector
➢ South Oxfordshire and Vale of White Horse District Council	➢ Representation from the military

Attendance at the Board and its subgroups continues to be good.

OSCB Structure

The main Board is supported by a range of sub-groups and other panels that enable its functioning:



How the Board works

Statutory body

We are a partnership set up under the Children Act 2004 to co-operate with each other in order to safeguard children and promote their welfare. The Board's job is to make sure services are delivered, in the right way, at the right time, so that children are safe and we make a positive difference to the lives of them and their family. We are not responsible or accountable, as a Board for delivering child protection services. That is the responsibility of each of our agencies separately and collectively but we do need to know whether the system is working.

Local Authority

Oxfordshire County Council is responsible for establishing an LSCB in their area and ensuring that it is run effectively. The Lead Member for Children's Services is the Councillor elected locally with responsibility for making sure that the local authority fulfils its legal responsibilities to safeguard children and children. The Lead Member contributes to OSCB as a participating observer and is not part of the decision-making process. During this period Councillor Tilley fulfilled this role.

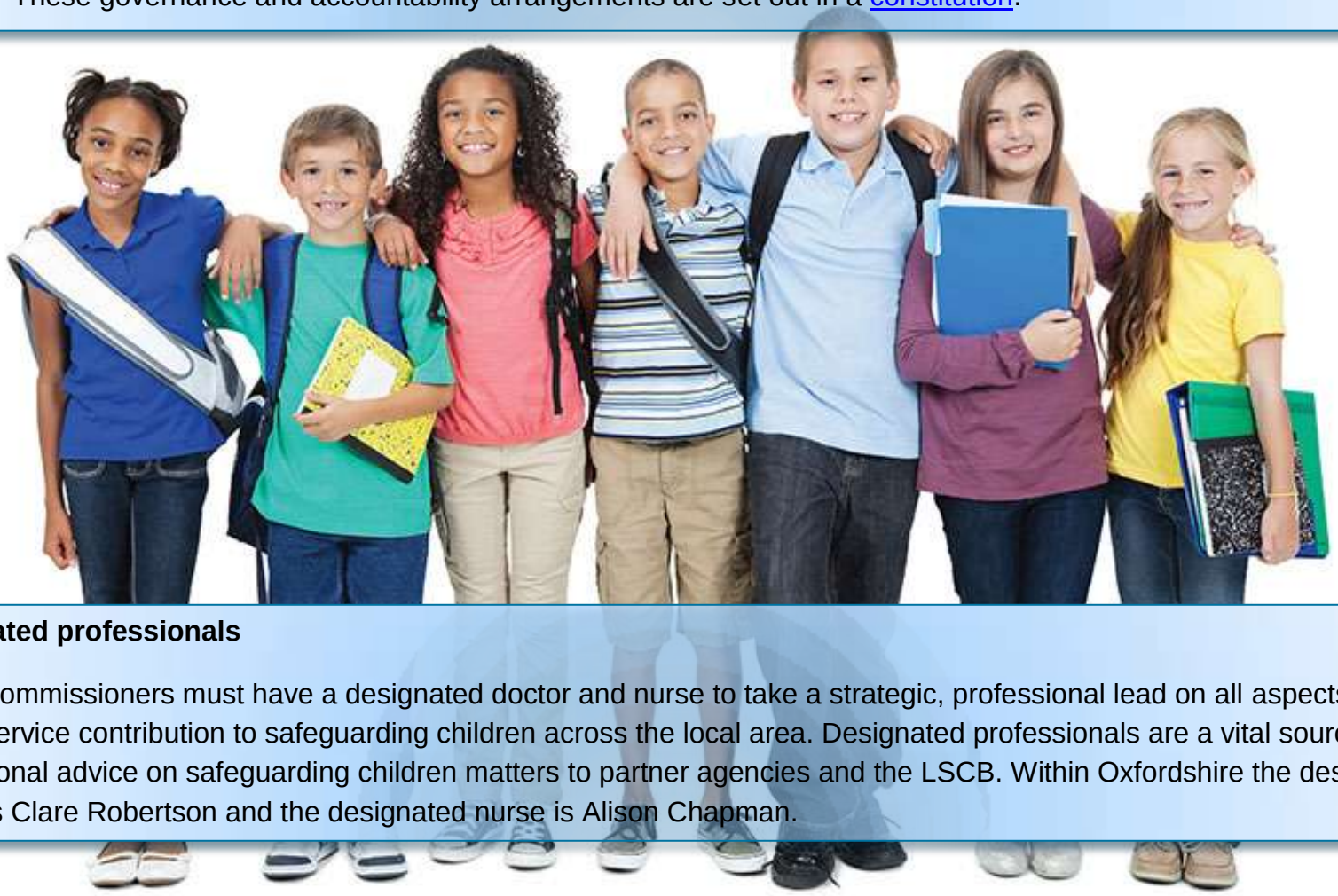
Independence

As an independent Board we hold each other and our respective governance bodies to account for how they are working together. The Board's Independent Chair, Maggie Blyth is directly accountable to the Head of Paid Service at the County Council and works very closely with the Director of Children's Services.

The Independent Chair also liaises regularly with Thames Valley Police and the Police and Crime Commissioner, the Council's executive member for children's services and the Chair of the Health and Wellbeing Board in driving forward improvement in practice. Moreover, the Independent Chair maintains a close relationship with the Oxfordshire Clinical Commissioning Group and NHS Trusts. The OSCB is pleased to have strengthened representation from the military and local schools during 2014-15, and to have positive discussion with the Oxfordshire Community and Voluntary Action (OCVA) about nominating voluntary sector representatives with a clear mandate across the third sector.

Individual partners

Member agencies retain their own lines of accountability for safeguarding practice. Members of the Board hold a strategic role within their organisation and are able to speak for their organisation with authority and commit their organisation on policy and practice matters. On the Board we share responsibility collectively for the whole system, not just for our own agency. These governance and accountability arrangements are set out in a constitution.



Designated professionals

Health commissioners must have a designated doctor and nurse to take a strategic, professional lead on all aspects of the health service contribution to safeguarding children across the local area. Designated professionals are a vital source of professional advice on safeguarding children matters to partner agencies and the LSCB. Within Oxfordshire the designated doctor is Clare Robertson and the designated nurse is Alison Chapman.

Key Relationships

The Board is part of a set of strategic partnerships in Oxfordshire which exist to provide oversight of the planning, commissioning and delivery of services to children. The Board has the specific oversight of safeguarding children within this partnership structure. Protocols are in place to maintain healthy working relationships with the Children's Trust; the Safeguarding Vulnerable Adults Board; the Oxfordshire Safety Communities Partnership and the districts' Community Safety Partnerships in particular. In 2014-5 the OSCB created an additional 'Strategic Partnerships' post within the Business Unit to develop these working relationships and strengthen, in particular, the shared oversight of the children and vulnerable adults board.

'This is an exciting opportunity to ensure that both boards are each channeling their efforts on the key safeguarding issues for vulnerable adults and children and also to ensure that areas of commonality across both boards are addressed effectively in order to improve our safeguarding services and outcomes for vulnerable adults and children.'

Oxfordshire Children's Trust

The OSCB has strengthened its relationship with the Oxfordshire Children's Trust, which is responsible for developing and promoting integrated frontline delivery of services which serve to safeguard children. The chair of OSCB is a member of the Children's Trust and the Chair of the Children's Trust sits on OSCB. The Children's Trust has produced a Children and Young People's Plan which sets out its priorities, including a focus upon early help, and how these will be achieved. The Children's Trust and the OSCB share performance monitoring arrangements to ensure a cohesive approach and collective oversight.

The OSCB is formally consulted as part of any commissioning proposals regarding safeguarding children made by Children's Trust. OSCB presents its annual report to the Children's Trust outlining key safeguarding challenges and any action required from the Children's Trust.

The Health and Wellbeing Board (HWB)

The HWB, set up in 2012, brings together leaders from the County Council, NHS and District Councils to develop a shared understanding of local needs, priorities and service developments. The OSCB is formally consulted as part of any commissioning proposals regarding safeguarding children made by the HWB. OSCB reports annually to the HWB and will hold it to account to ensure that it too tackles the key safeguarding issues for children in Oxfordshire.

Police and Crime Commissioner

The Police and Crime Commissioner (PCC) is an elected official charged with securing efficient and effective policing in the area. OSCB presents its annual report to the PCC outlining key safeguarding challenges and any action required of policing in the area. During 2014/15 the Independent Chair has met with the PCC to discuss key priorities for children and outline respective priorities in relation to tackling child sexual exploitation and female genital mutilation in particular. The PCC's second strategic objective is to protect vulnerable people.

Health Economy

Oxfordshire's Clinical Commissioning Group (OCCG) is an important contributor to the OSCB. The OCCG and local health providers work together to lead a health advisory group to engage health professionals in the safeguarding work of the board. The local area team (NHS England) supports this. The Oxford University Hospital Trust and Oxford Health NHS Foundation Trust are key partners on the Board and important providers within the Oxfordshire safeguarding system.

Oxfordshire Safer Community Partnership (OxSCP)

The Partnership Board identifies and agrees the community safety risks, opportunities and priorities for partners to address on a county-wide basis. Partners include the Police, probation services, fire and rescue services, the county and district councils, the health sector and voluntary sector. The Police and Crime Commissioner attends at least one meeting each year. The OxSCP has priorities in 15-16 to reduce the risk domestic abuse and human exploitation as well as reduce the risk of harm caused by alcohol and drugs misuse, which the OSCB endorses and supports.

Community Safety Partnerships

The community safety partnerships deliver projects that aim to cut crime and the fear of crime. Based in each district or city council area partners from the local authority, police, probation services, housing, fire and rescues services, the environment agency, the health sector and voluntary sector jointly tackle crime and safety issues. The OSCB partners have worked hard this year to align our safeguarding work. District colleagues are integral to the safeguarding work on child sexual exploitation; engagement with the community and voluntary sector and safer transport. Arrangements have been made for better representation on the Board of these key partners.

The Safeguarding Adults Board

The Board leads on arrangements for safeguarding adults across Oxfordshire. It oversees and coordinates the effectiveness of the safeguarding work of its member and partner agencies. As a strategic forum it has three core duties: to develop a strategic plan; publish an annual report and commission safeguarding adults reviews (SARs) for any cases which meet the criteria for these. Partners include adult social care, trading standards, the Police, probation services, fire and rescue services, health commissioners and providers, the voluntary sector and Bullingdon Prison.

Financial arrangements

Board partners contribute to the OSCB's joint budget as well as providing resources in kind. Funding for 2014-15 was £425,951. This includes partner contributions and funding for specific training, the play "Chelsea's Choice" as well as the joint serious case review / domestic homicide review. It does not include the funding the Oxfordshire Child Death Overview Panel which is funded through Oxfordshire Clinical Commissioning Group. 2014-15 has been an exceptional year for the OSCB. Over the course of the year the Board has worked on seven serious case reviews and channelled a lot of resources in to addressing child sexual exploitation. As a result planned expenditure was higher than income and required the use of £189,742 from the reserves.

As set out in last year's annual report, the biggest pressure on the budget has been serious case reviews. The Board worked on seven serious case reviews, one executive summary was updated and published and three full reviews were completed and published. This work included the publication of the A-F SCR, which followed Operation Bullfinch - an investigation which resulted in seven men being jailed for serious offences relating to child sexual exploitation for an extensive period of time. The serious case review included six victims and was unprecedented in terms of scale, format and profile as well as the level of involvement of victims. This review led to additional spend as it impacted on chair's time; reviewer time; practitioner learning events and communications costs to ensure that Oxfordshire's community understood the learning and what work has taken place in the county to address child sexual exploitation. It was determined to cover this spend through the reserves rather than requesting additional contributions from partners.

The Board has agreed to carry forward the reserves from 2014-15 to the 2016-17 budget and is revising its forward plan.

	Revised annual projection - 2014/15	2014/15 - Actuals	Variation from revised projection - 2014/15
Funding streams	£	£	£
CSP funding for DHR / SCR	0	-10,000	10,000
OCC Chelsea's Choice funding	0	-15,326	15,326
OCC Early Years funding	-14,465	-14,465	0
Public Health Risky behaviours	-31,625	-31,625	0
Contributions			
OCC Children, Education &	-196,535	-196,535	0
OCC Dedicated schools grant	-64,000	-64,000	0
Oxfordshire CCCG	-60,000	-60,000	0
Thames Valley Police	-16,000	-16,000	0
Probation Service	-5,000	-5,000	0
Oxford City Council	-4,000	-4,000	0
Cherwell DC	-2,500	-2,500	0
South Oxfordshire DC	-2,000	-2,000	0
West Oxfordshire DC	-2,000	-2,000	0
Vale of White Horse DC	-2,000	-2,000	0
Cafcass	-500	-500	0
Public Health	0	0	0
Total income	**-400,625**	**-425,951**	**0**
Expenditure			
Independent Chair	39,856	39,856	0
Independent Chair SCR costs	0	24,630	24,630
CRAG chair	6,600	6,875	275
Business unit	270,000	278,227	8,227
Comms	15,000	15,000	0
Training & learning	50,000	67,352	17,352
Subgroups	12,000	12,000	0
Chelsea's Choice	0	15,326	15,326
Serious case reviews	94,000	156,427	62,427
	487,456	**615,693**	**128,237**
Overspend:	**86,831**	**189,742**	**102,911**
Reserves	221,431	221,431	0
Drawdown	86,831	189,742	102,911
Reserves Balance	**134,600**	**31,689**	0

CHAPTER 3: PROGRESS AGAINST THE BUSINESS PLAN IN 2014-15

Key priorities:

The OSCB had 5 priorities which were to ensure:

1. there is effective safeguarding practice from early help to very high need

…and to improve…

2. our quality assurance work
3. how we capture the engagement of children and children & practitioners
4. the inter-agency focus on safeguarding-risk groups
5. our effectiveness as a Board.

Priority 1: there is effective safeguarding practice in the child's journey from early help to very high need

The OSCB has a role in ensuring that the child's journey through the safeguarding system works well. This means effective assessment, shared threshold points and plans which are good quality, responsive and well-co-ordinated.

Identifying need

The OSCB has a 'threshold of needs matrix' which supports practitioners to make the right referral to the right service. All OSCB core training includes the use of this matrix. There are a wide range of services providing early help to families in Oxfordshire. This includes the early intervention service's hubs and children's centres, health partners, schools, the voluntary sector, local and district borough councils and social care.

Early help

Early help assessments (CAFs) are completed and families are then supported by regular 'team around the child' (TACs) meetings to monitor progress. Support includes help for children where parents or carers misuse substances and help for those families when social care intervention ends. In the academic year 2013/14 this work increased. There were 821 recorded CAFs and 716 recorded TACs; with schools predominantly taking the lead in this work.

The number of under 5s reached in Oxfordshire i.e. seen at least once at an event or activity at any Oxfordshire children's centre was 18,564 or 44.5% of the population of under 5s. In the recent inspection of Oxfordshire Children's Services Ofsted commented that there was *'evidence that early help is making a difference and improving outcomes for children'.*

The Thriving Families initiative is working with the most vulnerable families. The initiative has identified 493 families with 219 having a named worker from a County Council service and of which 73 families have intensive family support over the last year. Ofsted reported; '*It is intensive, well organised and cost effective and has led to clear improvement in the lives of particular families*.'

A longer term piece of work is underway to integrate early help and statutory work to support vulnerable children and families. The focus is on services for 'children in need' i.e. for those who meet the statutory thresholds for services but are not deemed to be at the level of significant harm which would warrant a child protection plan. The intention is to develop more robust early help and reduce the numbers of children who are escalated to children's social care. Following an update to the Board on the impact of this work in April 2015 the OSCB is holding Children's Services to account for a further report in 2015 on implications of this change.

Multi-agency safeguarding hub

The Oxfordshire MASH (Multi Agency Safeguarding Hub) has been live since September 2014. The team comprises Children's Social Care, The Early Intervention Service, Thames Valley Police, Health, the Youth Offending Service and the South Central Ambulance Service and Education. Work is underway to increase the MASH partnership to include Probation and the District Councils. The MASH has receives all enquiries which previously went to children's social care teams.

The OSCB partners have influenced the planning and implementation of this new service and its development has been reported in to the Board. The Chair has requested a full report from the MASH project Board evaluating its effectiveness after the first year of delivery. The OSCB needs to be assured that assessment is effective, risks are identified and concerns are appropriately escalated.

Multi- agency tools

The OSCB has a role in ensuring effective assessment, shared threshold points and plans which are good quality, responsive and well-coordinated at each stage. Emerging safeguarding concerns in the last year have led to the development of new 'practitioner tools' for self-harm and female genital mutilation. Embedding the tools remains a priority for OSCB partners.

- **Threshold of needs matrix**
- **Neglect toolkit: the child care and development checklist**
- **Child sexual exploitation screening tool**
- **Self-harm screening tool**
- **Female genital mutilation screening tool**
- **Parental substance misuse toolkit**
- **The multi-agency risk assessment and management plan**
- **Guide for Good multi-agency practice incorporation the Local Assessment Protocol**
- **Aide Memoire**
- **7 Golden Rules to Information Sharing**

The audits undertaken by the OSCB this year showed there was variable use of these tools by practitioners. For the childcare system to work effectively this usage needs to be consistent. A pilot led by the County Council to address neglect, reported that practitioners were not always using the neglect toolkit effectively. The challenge for OSCB partners is to ensure that neglect strategy gives clear leadership on the multi-agency tools having first checked that they are fit for purpose.

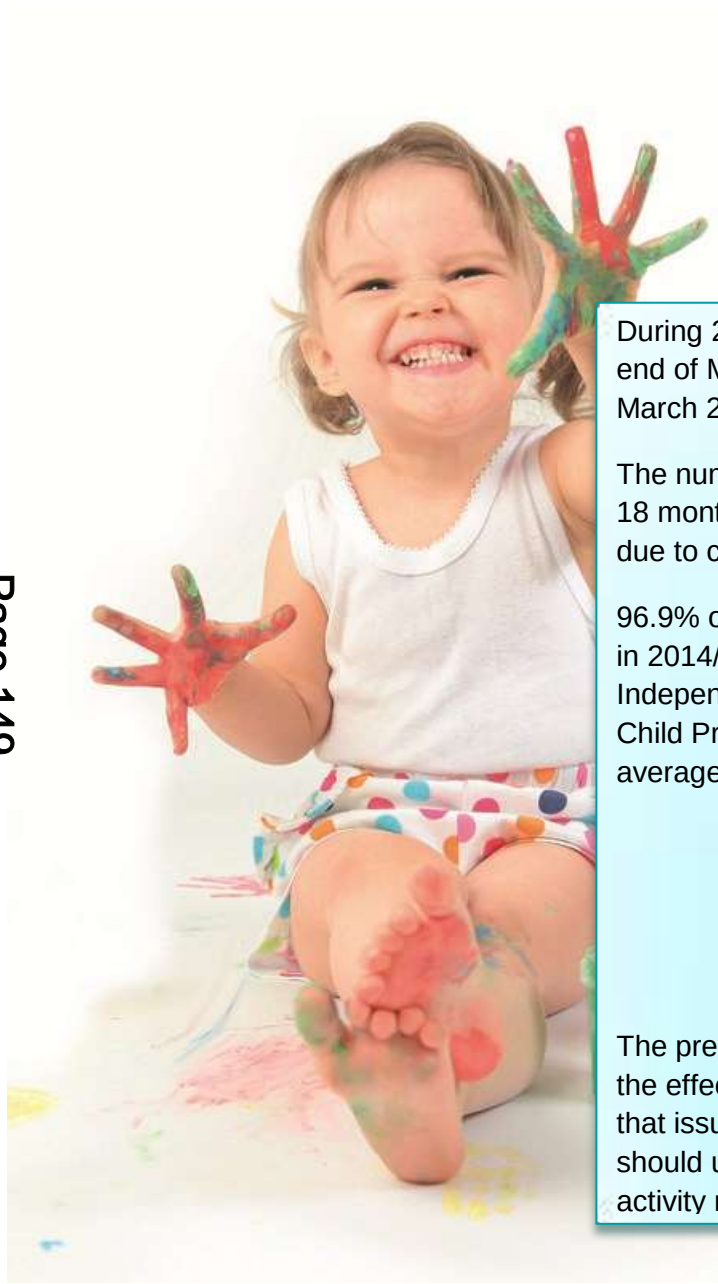
Addressing issues of neglect:
A pilot project has been run in 2014-15 to use as an evidence-base for the long term programme of change to children's services. The intention is to ensure that neglect is understood in the same way that child sexual exploitation is now understood so that practitioners can identify neglect and intervene directly and promptly. In order to do this the project will build a full picture of the extent and depth of neglect and then test new models of service delivery to ensure services address the needs of the whole family.

The pilot will build on the learning from the Thriving Families programme by seeking to develop whole family working, where families have a lead worker and one plan supporting them. The aims are to reduce the number of children requiring child protection plans due to neglect; to reduce the number of children becoming looked after due to chronic neglect and to introduce new ways of working that provide effective help and support to families. The OSCB endorses the dynamism behind this approach and expects a full evaluation of impact in 2015.

Child Protection Activity
During the year there were 5,278 referrals to Children's Services which was 9% lower than the previous year. However, referrals have met the criteria for support and have led to an increase in activity levels at all other key points across the child protection process. This increase in general activity reflects the analysis that there is greater identification, recognition and response to signs of abuse and neglect as well as sensitivity to risk. In short, children are staying on plans for longer and also having a new plan when risk is deemed to have increased. Ofsted inspectors agreed that services demonstrated '*improvements in the targeting of intervention, better decision making and more robust management oversight'.* The ability to complete 'section 47' enquiries to a timeframe of 15 days is slipping which reflects the level of activity in the system.

% of Initial Child Protection Conferences within 15 working days of Section 47 enquiry:

National 2013-14	**69%**
Oxfordshire 2013-14	85%
National 2014-15	Not yet available
Oxfordshire 2014-15	79%



During 2014/15 the numbers of children subject to a CPP have steadily increased. At the end of March 2013 the numbers stood at 430 and at the end of March 2014, 504. At 31st March 2015 it was 572 and at the time of this report is 616.

The number of children on a child protection plan for a second or subsequent time within 18 months has decreased from 9.3% in 2013/14 to 6.2% this year. This decrease is in part due to children being subject to a Child Protection Plan for longer periods of time.

96.9% of plans were reviewed within timescales in 2013/14 but this has decreased slightly in 2014/15 to 95.3%. This decrease in timeliness reflects the increased pressure on the Independent Reviewing Service in particular who have to chair each Initial and Review Child Protection Conference, however performance remains better than the national average or that of comparable authorities:

	2013-14
Oxfordshire	96.9%
Stat Neighbour	90.4%
England	94.6%

The pressures on the system are apparent. The challenge for the OSCB is to check that the effectiveness of work is not being compromised. Feedback from practitioners is clear that issues are more complex and are multiple. The OSCB quality assurance subgroup should use its report card system to analyse and report back on the impact of increased activity not just on the experience of the child but on practitioners also.

Children in care

At the end of March 2015 28.1% of looked after children (148/527) were placed out of county in foster homes, residential children's homes, residential schools. This also includes those children placed for adoption. This is a rise from 26.8% (125/467) at the end of March 2014. 14% (74/527) of looked after children were placed more than 20 miles away (not in a neighbouring county) at the end of March 2015 which was an increase from 10.9% (51/467) at the end of March 2014.

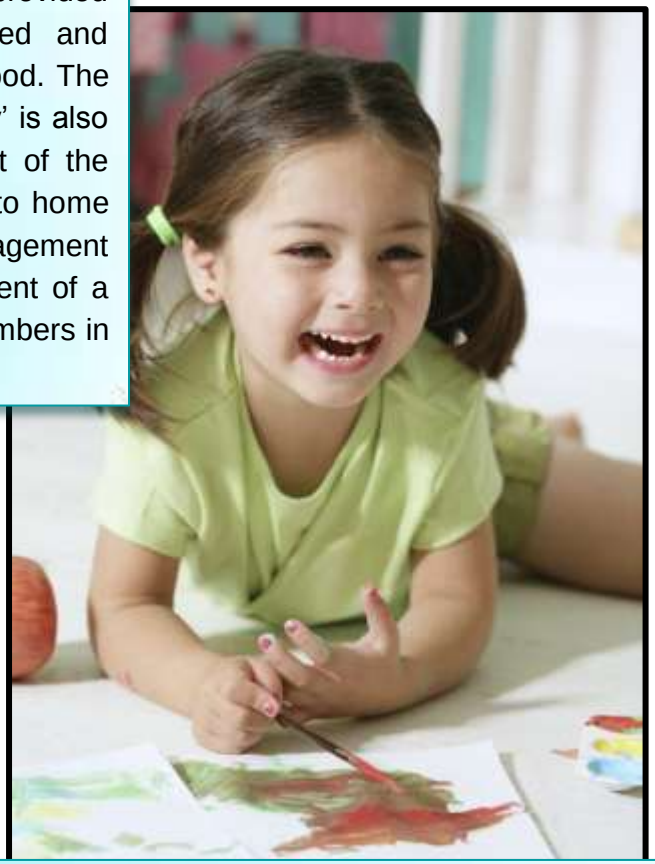
Children in care and leaving care have high level emotional and behavioural needs compared to Oxfordshire's statistical neighbours and the national average. This brings into sharp relief the importance of social care, health and education services working together to provide high quality support, therapeutic interventions and learning opportunities for our young people.

The county council currently supports 383 care leavers to become independent adults. 256 of these are former relevant young people and 79 of these are unaccompanied asylum seeking children. The county council's teams are in contact with 96% of the leaving care population which gives them the ability to assess needs and risks appropriately so that they are safe. It means that the young person will have an allocated Social Worker or Leaving Care Personal Advisor.

One of the biggest challenges is the housing: housing stock in Oxford is limited and there is a large university student population competing for space. In 2014-15 92% of leaving care young people were suitably housed. These young people are also supported by the 0-25 ys virtual school which include the provisions of a specialist 16+ 'education, employment and training' (EET) team 63% (211 young people) were engaged in EET.

Given the high levels of emotional and behavioural needs identified the OSCB wants reassurance that focus is tightened on the risks faced by this group to ensure that they are prepared for adulthood and have the skills and resilience they need to live healthy, happy adult lives.

The OSCB partners acknowledge that the Ofsted inspection May 2014 provided assurance that looked after children are being appropriately safeguarded and performance for both looked after children and care leavers were judged as good. The county's aspiration to become 'the most fostering friendly county in the country' is also endorsed. Challenges are also noted, however, as being the development of the county capacity to ensure that those children with highest needs are closest to home (through the creation of new homes for children in care) as well as the full engagement of partners in health, schools, police and housing providers in the development of a therapeutic model of care. This is set against the context of the rise in the numbers in care and the need for more effective earlier interventions to prevent this.



In summary,

The OSCB is able to endorse the Ofsted 2014 assessment that there is effective safeguarding practice **in the child's journey** from early help to very high need. However the challenges can be summarised as follows: developing more robust interventions to avoid children becoming subject to a plan or being taken in to care; assessing the impact of pressures on the safeguarding system; implementing the promise to manage risk locally for children in care; delivering the aspiration to increase the foster care capacity in the county and also remembering the duty of care not just to children but to the workforce facing the challenges of increased pressures on family life and parenting. Finally, the emerging evidence of increased numbers of adolescents in the child protection system requires a more co-ordinated, strategic response. These challenges cannot be underestimated especially within the context of financial pressures on the safeguarding system.

Oxfordshire's children's workforce comprises practitioners working in all fields in different ways to keep children safe.

Here is…

A day in the life of a district council anti-social behaviour officer, from Cherwell district council

My working day is a mixture of being out on the street, multi-agency meetings and direct engagement with alleged offenders and victims in their homes.

For example I may receive a call from a resident raising a concern and alleging anti-social behaviour by a neighbour. Dependent on the content of their complaint I would do a couple of things before visiting: I might contact the local neighbourhood police team and, if they are in social housing, their housing provider. Complaints range from excessive noise to minor damage and, sometimes, abuse as a result of taking up with the issue the other resident. Many agencies get involved in the solution to these circumstances.

My role in relation to safeguarding is to be a link to those children who are hanging about and making their own fun in ways we wouldn't promote. This involves identification of children not in school or on the edges of criminal behaviour; consultation with other agencies to raise concerns and support for plans to re-engage the child or teenager with their school and their family.

I work closely with the Thames Valley Police to engage with children who are believed to be in possession of or consuming alcohol; this can be as a result of reports of underage House parties or large gatherings in parks or recreational facilities. Any child under 18 found in possession of alcohol will have it seized from them and an assessment will be made to ascertain if they are able to get home safely or if they need to be taken home by the Officers.

Since the recent prosecutions for child sexual exploitation we have changed the way that we work. Now when we approach a group of children we engage with all of them and not just the underage offenders; specifically any person present over the age of 18 questions will be asked as to what his/ her connection to the children is.

Priority 2: improving our quality assurance work

The OSCB links its quality assurance work to learning and improvement. Quality assurance work includes agencies self-auditing, joint-agency auditing, the schools' and early years' audit; the section 11 safeguarding self-assessment; reporting from the Local Authority Designated Officer (LADO); reporting from the Independent Reviewing Officers of the County Council and the OSCB data set.

OCSB partners audit work

Eight agencies reported back on their internal safeguarding practice having reviewed 478 case records. The audits have enabled partners to have an informed view of the safeguarding arrangements and performance in single agencies. At least 50% of audits rated safeguarding practice as effective or better. They demonstrated that agencies were challenging internal safeguarding practice and they had good practice which could be shared with others. Areas highlighted for learning concerned management of self-harm cases in emergency departments and work to ensure that information on children is always considered when working with parents who have mental health problems. Follow up audits in 2015-16 will check that learning from these findings has had an impact.

Three multi-agency audits were reported on last year which reviewed 27 cases from the perspective of the key agencies involved. The purpose was to check how well agencies worked together. OCSB partners reviewed cases against the themes of mental health, assessment and decision making in multi-agency working and the Multi-agency Risk Assessment Management Plan (MARAMP) for children at higher risk of harm. They have provided an oversight of the quality of frontline multiagency practice and given good examples of risks being identified, responded to and reduced through both child protection conferences and the use of the multi-agency risk assessment and management plan. Areas highlighted for learning concerned participation in child protection conferences and core groups: this keeps the plan around a child strong and supports sharing of information. Absence from these can hinder the development of joint plans. This learning has informed the OSCB business plan for 2015-17 which includes a focus on core group working to effectively address neglectful parenting. Learning summaries are produced for all multi-agency audits and shared with practitioners at the safeguarding groups across the county.

A gap in the audits has been the inclusion of feedback from children. The challenge for OSCB partners is to ensure that the experience of children is a standard part of audit work.

100% audit return rate from schools including academies, independent and free schools.

Schools and further education colleges audit work

Primary and secondary schools in the county are requested to complete the schools' safeguarding audit. The DfE statutory guidance 'Keeping Safe in Education' released in 2014, states that 'Under section 14B of the Childrens Act 2004 the LSCB can require a school or college to supply information in order to perform its functions; this must be complied with'. In 2014-15 there was a 100% (338) audit return rate from schools (including academies, independent and free schools). Two free schools and six independent schools opened in 2013/2014 so have not been audited. The returned audits report on the full range of safeguarding requirements in schools and showed good compliance e.g. whether the school has had child protection training, adheres to safer recruitment guidance, implements child protection procedures. The audits indicate good levels of compliance with the guidance, the most frequently recommended action for the coming year, is to update safeguarding training for staff.

The requirement for Further Education (FE) colleges to report on their safeguarding arrangements was not an explicit expectation under the 2014 guidance, and one college responded out of five. The OSCB welcomed at the end of this reporting year the guidance 'Keeping Safe in Education' March 2015 which now places an expectation on all FE colleges to return an annual report for the 2014/2015 academic year.

Tutorial and language colleges do not fall within the remit of the DfE guidance and are not currently audited. Some colleges have started to accept students between the ages of 14 – 18. They will have to register with Ofsted and become subject to the inspection regime. It is of concern that the OSCB may not be able to require all of these colleges to return an annual safeguarding report. At present the Local Authority Designated Officer (LADO) Team is supporting those tutorial colleges that are actively seeking help to make them compliant but they cannot compel all to do so. They have also run training for host families. Some are 'pop-up' establishments who rent premises for short periods of time and then close.

The challenges for the OSCB are to extend its reach in terms of voluntary compliance with safeguarding audit processes and encourage peer review of self-assessed returns.

Early years audit work

Private, voluntary and independent nurseries and pre-schools are audited annually using e-consult. The county council followed up all settings which resulted in a final response rate of 100%. The 2014 safeguarding audit had a positive impact on the quality of provision as evidenced in inspection reports: the number judged to be inadequate by Ofsted for safeguarding reasons decreased. The challenge for the OSCB is to further improve safeguarding as only 43% of settings were fully 100% compliant with local requirements. Childminders registered with Ofsted were encouraged to use the audit for self-assessment prior to 2014. The response rate was so low it was not sufficient to assess current strengths and weaknesses in these sectors. The OSCB will promote this self-assessment audit in 2015.

The section 11 safeguarding self-assessment

OSCB received Section 11 self-audit responses from 26 agencies. This was 100% compliance of statutory returns as well as additional returns from commissioned services such as provider services British Pregnancy Advisory Service, Outdoor Learning and Lifeline. Five agencies returned completed practitioners questionnaires. A peer review was held by OSCB in April 2015, which reinforced the responsibility of all Board members to challenge. Providers, commissioners and senior leads scrutinised and compared the results of their S11 audits. Twenty agencies attended.

The peer review provided good examples of improved ways of working, such as feedback from district council housing services about how they incorporate the risk management assessment into their work with children; fire and rescue service staff who were showing a greater awareness of how to report concerns as a direct result of safeguarding training; children's social care managers as to how they promptly challenge children's placements which fall below safeguarding standards and from the hospital trust safeguarding leads on their close work with colleagues to handle complaints in relation to safeguarding work in a sensitive and supportive way for parents.

The challenge for statutory board members is to more clearly gather practitioner feedback. Only 5 out of the 26 agencies completed the practitioner questionnaire. The OSCB chair will participate in the next peer review to monitor if this takes place. A good LSCB can demonstrate that board members are involved in meeting frontline workers to assure themselves that safeguarding practice is well understood and part of their everyday practice.

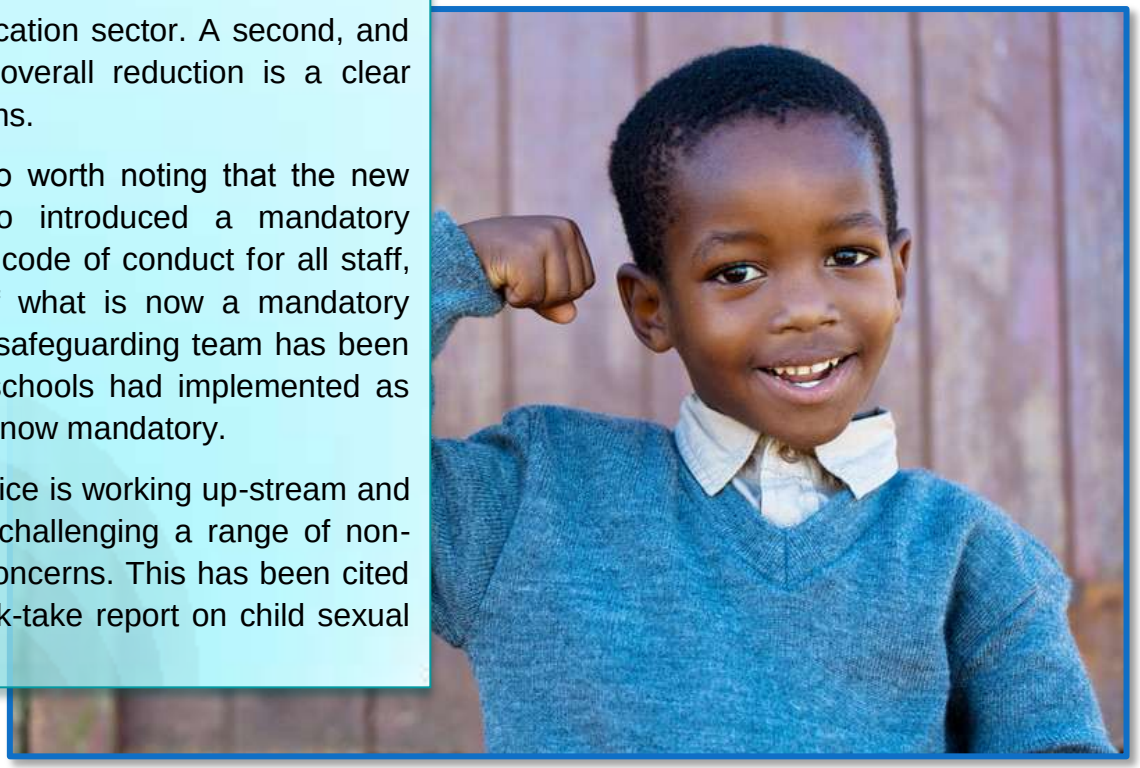
Local Authority Designated Officer

The LADO should be informed of all allegations against adults working with children and provides advice and guidance to ensure individual cases are resolved as quickly as possible. There has been a 22% decrease in referrals, a total of 138, to the LADO service during the academic year September 2013 to August 2014 compared to the previous year when there were 177. Most referrals come from schools but in the last year they have increased from non-educational settings.

There are a number of factors that have influenced this decrease. Firstly, in April 2014 the DFE released revised safeguarding guidance for the education sector. This guidance changed one of the referral criteria for referral into LADO for allegations in the education sector. A second, and an additional possibility, in explaining the overall reduction is a clear reduction in the number of historical allegations.

While it's hard to measure impact, it is also worth noting that the new guidance for education settings has also introduced a mandatory expectation that all schools will now have a code of conduct for all staff, which will be provided to them as part of what is now a mandatory induction period. This is something that the safeguarding team has been advising for many years and which many schools had implemented as good practice. From April 2014 however, it is now mandatory.

As awareness is being raised the LADO service is working up-stream and playing an effective role in supporting and challenging a range of non-educational organisations on safeguarding concerns. This has been cited as good practice nationally in the 2015 stock-take report on child sexual exploitation.



Independent Reviewing Officers of the County Council

The Independent Reviewing Officer (IRO)/ Independent Chairs (IC) service has expanded over the last year as part of a drive to reduce caseloads and thus ensure IRO's are able to meet all of their statutory responsibilities for the children that they work with. Key objectives have been to ensure that meetings for children looked after by the local authority and children with a child protection plan are held in a safe and timely manner and written records are distributed appropriately, that children remain central to all work and that Looked After children are seen by their IRO between the reviews of their care and fully engaged in the process which reviews their care. Further, that children of a sufficient age and understanding are able to be part of Child Protection Conferences as and where safe and appropriate for them to be so. The administration support for IRO's has been increased, and it is anticipated will be further, to reduce the time IRO's have to spend undertaking administrative tasks and recording, freeing up their time to be able to give a greater focus on the children.

There has been an increase in staffing, which is positive, but this has been matched by an increase over the past year of children subject to Child Protection and in care. With caseloads remaining relatively high, and the statutory responsibilities of IRO's increasing, it is more challenging for IRO's to maintain contact with and/or see all of the children on their caseload between LAC reviews. This remains a key target for the service.

The IRO service plays a critical role in ensuring all Looked After children and children subject to CP planning have safe and effective plans which are rigorously reviewed. The IRO service also plays an essential quality assurance role for the department with a view to maintaining best practice across all areas of child care. The OSCB raises the serious concern presented to it by the IRO services that not all children have contact with and/or see their IRO between LAC reviews. Children's Services need to respond promptly as to how this shortfall is being addressed.

The OSCB data set: what does it tell us?

The Board has an agreed dataset which views key points across the child protection arrangements in the county. There are eight messages from the data on the safeguarding system in Oxfordshire:

1. Increase in early intervention work**:** more assessments done using the Common Assessment Framework. 44.5% of the population of under 5's were seen at least once at an event or activity at a children's centre.
2. Increasing levels of general activity across child protection plans; neglect being the most common reason for a child protection plan
3. Increasing numbers of children in care; the highest level for many years
4. Lower levels of children becoming subject to a second or subsequent plan
5. Children at risk of sexual exploitation continue to be identified at the same rate
6. Children missing from home: increased reporting of those missing repeatedly
7. Children who offend: fall in numbers involved with YOS
8. The implications of increased workloads on ensuring children are kept safe; the system is under pressure.

These messages have informed the business plan. The challenge for OSCB partner agencies is to better analyse the performance information within the dataset. The quality assurance group which oversees this dataset has set up a 'report card' system for 2015-16 to provide analytical commentary for the purpose of the OSCB and the Children's Trust. This includes reviewing the capacity with the safeguarding system.

Day in the life of a health visitor...

I arrive at the office at 8.30 and check the answer machine for messages. I check my electronic diary and make preparations for my day ahead – allocation meeting with the team, core group meeting, home visits then back to the surgery for the baby clinic and some scheduled developmental checks.

During the team meeting work is allocated depending on who knows each family and the team skill mix. After ensuring I have the addresses and phone numbers for my visits on my iPad I set off.

A 'core group' meeting is held at the Children's Centre which mum's her preference. She has a toddler and a young baby. The professional team arrives – social worker, children's centre outreach worker, and a lady from Connections. Productive discussion around housing issues, and some health issues of both children which could possibly be a consequence of the current very damp environment each member takes ownership of actions at the end of the meeting, the mother appears very satisfied with this joint approach to supporting her and we plan to meet again the following month.

First visit – a pregnant lady and her partner – I use the evidence based tool Promotional Guides to make an assessment of any anxieties they may have about becoming parents. The agenda of the visit is led by the parents. The mother expresses her concern about giving up work, and feeling isolated. I discuss with her about the groups which run at the local Children's Centre. Both parents are encouraged to be present at this visit.

Second visit – I find the address using my iPad to a lady I have never met with post natal depression. I spend nearly an hour with her as she talks at length about how she is finding it difficult to bond with her baby, and the guilt feelings she is experiencing as a consequence. I refer her to one of the post natal depression groups facilitated by health visitors. I love the fact health visitors can plan to make longer appointments with clients, based on clinical need.

Short break with colleagues, informal discussions around the morning work and then back to documenting today's contacts.

Back at the surgery I prepare the room for the drop in baby clinic – parents and carers come in and ask advice on a range of issues such as feeding their babies, skin rashes, and sleep. Then 3 scheduled appointments for developmental checks which are carried out using evidence based Ages and Stages tool. These checks are part of the Healthy Child Programme for all children aged 9 months and 2 years old. I make a referral to a speech and language therapist after seeing one of the 2 year olds.

Before the end of the day, I return a phone message to a Social Worker about a child who is on a child protection plan, and phone a mother to make an appointment to visit her the following week with her newborn baby.

I finish my day preparing for a meeting the following day as I am leading a project on increasing the public health role of health visitors in managing minor illnesses - high on the political agenda!

Priority 3: capturing the views of children and practitioners

The OSCB has collated the views and experiences of children, parents and carers as part of its quality assurance work. They have told us a range of things, some of which are captured below:

What children, parents & carers said:	What OSCB partners are doing:
The serious case review conversations with parents told us a range of things for example, that they wanted: To have their concerns listened to and be taken seriously, To not have to chase the services for answers and information, To receive interventions sooner, for them and their child, especially when it was so painful to have to ask for help The conversations with children told us: Sometimes the fear of speaking up is too great They would give lots of small details thinking (hoping) that workers would connect the dots They want workers to meet them at their starting point	OSCB has had input from families at four of the multi-agency learning events in 2014/2015. The moving talks from children and parents formed an integral part of the learning for frontline and senior staff, and practitioners reported them having an impact on the messages they took away with them. One of the multi-agency learning events was dedicated to listening to parents / children The OSCB has included parents' messages in the training on child sexual exploitation The OSCB child sexual exploitation strategy is being developed in partnership with previous victims of this abuse The OSCB is putting together a summary of learning points from parents and carers involved in case reviews for use by practitioners so that we fully understand what it means to be a child in the safeguarding system
The Youth Parliament told us they didn't know enough about the role of school health nurses and what they could talk to the nurse about	This was taken on board by the service and posters were available in each school. Oxford Health NHS FT school health nurses are now an integral part of partnership working and are linked in more closely to the board, for training, sharing of learning resources, and a helpful way of raising awareness with children.
The sounding board meetings told us: their safeguarding concerns: fear of speaking up; boundaries and safe relationships; mental health and suicide; drugs	From this initial meeting a group of 12 will be established (some children in care and some not) to take forward issues form the Sounding Board and 'new issues' which arose such as "how police talk to children and children". The OSCB supported the 'keeping safe' section of the Oxford City council 'Bungee app' for use by children in the school holidays The OSCB endorsed the NSPCC Childline assemblies for all primary schools in Oxfordshire OSCB partners (the county council and the police) funded Values versus Violence which encourages children to speak up and make good decisions for themselves OSCB partner (the county council) funded Chelsea's Choice for the third year running for all secondary schools in Oxfordshire
The Children in Care Council told us: they have developed a pledge with the Corporate Parenting Panel and includes issues raised about keep safe	Ensuring that the issues regarding staying safe are reported back to the OSCB as part of the annual children in care report by the county council

The OSCB has collated the views of practitioners. This includes views from children's social care practitioner listening events; serious case reviews; audits; child protection conferences and reviews, training and the three area safeguarding groups. Through this means practitioners have told us a range of things, some of which are captured below:

What practitioners told the OSCB:	What the OSCB partners are doing:
The area safeguarding groups which meet across the county told us: - Child protection cases are more complex now; children and families have a range of issues which take time to address – the volume of children in the child protection system at presents additional pressures - …as a result multi-agency work is more effective when everyone understands their own role and what is expected of them: - The issues that are coming to the fore currently are: self-harming, sexting (and e-safety), male harmful sexual behaviour, appropriate and healthy relationships between children, accessing mental health support for children; unaccompanied asylum seekers, tackling child sexual exploitation; domestic violence amongst children	- Training on 'working as part of a core group' for children with child protection plans is being developed; the good-practice guide to multi-agency working has been promoted at the four learning events - Ran multi-agency learning events on tackling child sexual exploitation; accessing mental health support for children which reached over 200 practitioners - Developed training on sexual health and consent and developing more of a focus on appropriate and healthy relationships to meet the needs of practitioners - Ran awareness raising on 'sexting' through the area safeguarding groups - The Business plan for 2015-17 is taking on board the safeguarding issues raised by practitioners - The OSCB 2015 annual conference is covering safeguarding risks facing vulnerable adolescents, which will pick up on issues such as domestic violence amongst children
Practitioners told us through their Board members they had concerns about: - female genital mutilation highlighted through health settings - self-harm amongst children in particular in the north of the county highlighted through the LADO, schools and health settings - transport for disabled children highlighted through schools and voluntary organisations - representation of community, voluntary and faith organisations on the board's structures	- OSCB partners assessed the prevalence of **FGM** in the county; produced a screening tool and procedures for working on this and worked with the Department of Health to run a conference on FGM in the county. The OSCB supported the community organisation "Oxford Against Cutting" to access local schools and run an awareness raising project. OSCB trainers received training on FGM. - OSCB partners formed a North Oxfordshire Self-Harm Network which produced a screening tool and provides a regular information-share to ensure that children were safe and had supported - OSCB partners are including a focus on transport for vulnerable children in the 2015 section 11 safeguarding self-assessment and set up a Task and Finish Group to review transport issues across the county and districts. - The OSCB worked with the OCVA to run two forums to recruit VCS members to the Board and subgroups; OSCB attended VCS workshops and conferences to raise awareness of safeguarding messages, opportunities to participate and training

Priority 4: improving our inter-agency focus on safeguarding risk groups

In the last year the Independent Chair has requested safeguarding updates on work with the most vulnerable groups of children, who are known to be most at risk of harm. For example: the referral processes and management of information for children living in homes with domestic abuse; the licensing of taxis; information sharing by voluntary agencies supporting vulnerable children; improvement to mental health services and the emotional wellbeing of adolescents and young adults. All these issues are challenged at Board level. A regular reporting schedule the OSCB maintains a focus on safeguarding risk groups. Below is a summary of this challenge.

Troubled children with a complex range of needs

The OSCB scrutinised the work of the complex case panel which brings together senior manager to support practitioners to move forward on the most complex cases through focused discussion, clear decision making an identification of actions. The OSCB has set in place a more robust mechanism now so that twice yearly reports are submitted to the OSCB executive on those children most at risk so that there is a collective response for those most at risk and in need. These 'needs' have been summarised through the quality assurance group and informed the Business plan: peer on peer domestic abuse; issues of self-harm; mental health problems; homelessness and sofa-surfing. They also informed the practitioner learning events.

Self-harm

The issue was escalated to the Board in 2014 through the county's schools safeguarding team. A uniform approach in assessing risk and sharing information has been developed to assist schools and agencies. Guidance has been provided, such as The Oxfordshire Self Harm Forum's Guidance for Professionals (2012) and DfE Guidance 'Mental health and Behaviour in Schools' (June 2014). School Nurses, Camhs and Children's Drug & Alcohol service have provided advice and training to schools.

A Risk and Resilience Tool has been designed to provide teachers and practitioners with a means to assess risk and target the right support and services for children and their parents. The schools are reporting that they are finding this a useful tool. Recent anecdotal evidence is showing that coping strategies implemented over the year have helped children during periods of increased anxiety such as during the exam period.

An agreed set of information from the schools and colleges is analysed for the network by Public Health to understand prevalence. Guidance on information-sharing is provided, based on the OSCB information-sharing protocol for incidents of self-harm/attempted suicide. This is to help teachers and practitioners make judgements about when it is appropriate and justified to share information without parental consent. Links have been made with the Oxfordshire Self-Harm Forum that meets termly in Oxford.

Children missing

The county council has a strategic lead for missing children, who receives daily missing reports from Thames Valley Police and is connected in to the Kingfisher Team. This daily update along with information from the Police 'Safe and Well' sighting of the child ensures that each missing person's case is individually understood and any concerns addressed. Oxfordshire has implemented the timescales outlined in the DfE January 2014 statutory guidance to ensure that when a child, who is known to Children's Social Care or the Youth Offending Service, has gone missing a return interview is completed within 72 hours of the child returning.

An operational group has been set up to co-ordinate efforts. The aim is to ensure that the response is proportionate to risk and need and that partners are effective in reducing the likelihood of missing episodes and risky behaviour. Missing episodes are also monitored on a monthly basis to maintain oversight. This includes return interviews, responses, and how missing information is followed up and escalated to senior management and police accordingly. The group quality assures the Multi Agency Risk Assessment and Management Plans (MARAMPS) and return interviews for all frequent runaways, ensuring there is a collation between the information and intelligence gathering, the analysis, and how this is used to inform risk management strategies cross agency. The OSCB is pleased to see the improved vigilance and recording but is concerned by the increase of children who are repeatedly going missing.

Vulnerable Learners

Recent serious case reviews have highlighted increased risks faced by vulnerable learners and raised awareness of school as a protective factor for them. Children who are not in school during normal school hours are at an increased risk of harm. The findings of a recent learning review also included comments from victims of CSE questioning the appropriateness of the use of prosecution for non-attendance when a child is a possible victim of CSE.

The county's Vulnerable Learners Service was re-structured in 2014. This resulted in the reduction in a number of teams responsible for closing the attainment gap for vulnerable pupils. The Pupils Missing Out team was created as part of the re-structure and has specific responsibility for maintaining a list of children who are missing from education either due to lack of a school place or who because they are on a reduced timetable at their current school. The team work directly with schools to ensure that reduced timetables are kept to a minimum and are within the law, they also work with colleagues to minimise the length of time that children are without school places and challenge processes that cause delays in admission.

The OSCB notes that financial pressures have led to reductions in staff within these teams and needs reassurance as to how this cohort of children and their families will be supported.

There has been significant investment into school health nursing which Oxford Health NHS FT provides. The dedicated team of school health nurses for primary schools and, as recognised the nurses in each state secondary school are having a positive impact in identifying cases of CSE and helping to safeguard children who are at risk of exploitation as well as neglect and other types of harm.

A Day in the life of a School Nurse from a school in West Oxfordshire...

Over the last 18 months Public Health at Oxfordshire County Council has ensured that every secondary school in the county has a qualified School Health Nurse. Our service works hand in hand with school staff, parents, carers and the young people themselves to address all aspects of health. The vision is to develop young adults who are resilient, can manage their own health needs and are equipped to seek appropriate advice and help to do so.

At 8.30am I arrive at the school and can often find students waiting to see me. I try to be flexible and either deal with the problem immediately, or book an appointment at a more appropriate time. Today I am able to do some preparation for an assembly I am giving later in the week. I will be talking to the Year 11 students about drink, drugs and vulnerability.

I have five students booked to see me today. The students value the privacy of seeing the School Health Nurse so I always make my confidentiality boundaries clear when I first see a student. Their safety is the most important consideration, and I have to be clear that it is not always possible to guarantee keeping all information confidential; it is a difficult area at times. I consult with our Safeguarding Named Nurses on occasion, to assist me when deciding whether a young person's confidence needs to be broken.

I love working with teenagers, no two days are the same! A large proportion of my work centres on emotional support. Of the five students I see today, four have anxiety and emotional problems, and two of them are known to self-harm. I am trained to take a non- judgmental approach, which is reported helpful by the students. There is much misinformation about this subject. We have good links with our PCAMHS colleagues and are able to consult with them on a regular basis.

My fifth student is here to see me for a follow up appointment. She required emergency hormonal contraception three weeks ago. Being school based allows me the opportunity to spend time discussing healthy relationships, and giving detailed sexual health advice. I can deliver this work at the pace of the student and ensure they have plenty of time for questions and follow up. When working with sexually active teenagers, I am aware of the potential for sexual exploitation and abuse. I assess all students for risk factors that may raise safeguarding concerns and complete an assessment tool to support this. I am also required to assess any sexually active students under the age of 16yrs in accordance with the Fraser and Gillick guidance. These processes provide me with robust support for this element of the role.

In addition to individual student support, I work closely with school teaching staff to assist with input into health related aspects of the curriculum. I love teaching and there is nothing more entertaining and enjoyable than teaching a classroom of 13 & 14 yr olds about contraception. The condom demonstrations have to be the highlight of the session; I challenge any teenager to put a condom on a plastic condom demonstrator (in a vile green colour too!) without giggling! I also provide a "drop in" at lunchtime. Students can stop by to see me for advice and support. Today a group of students have come to ask about smoking cessation and another student has come to tell me of concerns he has for a friend.

I attend TACs (Team Around the Child), Core Groups and Child Protection meetings. I signpost students to their GPs, Mental Health services, Early Intervention HUBs and other health services. Importantly I link in with the school and their aim to provide the best environment for a happy, healthy and successful future for all the young people at school through the school health improvement plan.
I feel that the support I have provided today will help increase resilience and give the young people tools and strategies which can be used now and in the future. Now that's job satisfaction!

FGM – Female Genital Mutilation

A combined effort has led to some real progress in Oxfordshire to address the issue of 'female genital mutilation'. It has been a priority for OSCB partners as well as the Police and Crime Commissioner. Agencies have assessed the prevalence of FGM in the county which is low but is being tracked now that risk factors and indicators are more widely understood. A screening tool and procedures for local working have been developed. OSCB partners also worked with the Department of Health to run a conference on FGM in the county. The OSCB supported the community organisation 'Oxford against Cutting' to access local schools and run an awareness raising project, which produced a booklet for children. OSCB trainers received training on FGM so that they are confident in communicating the issue to delegates.

Radicalisation

Radicalisation is defined as the process by which people come to support terrorism and extremism and, in some cases, to then participate in terrorism. "*Extremism is vocal or active opposition to fundamental British values, including democracy, the rule of law, individual liberty and mutual respect and tolerance of different faiths and beliefs. We also include in our definition of extremism calls for the death of members of our armed forces, whether in this country or overseas*" (HM Government Prevent Strategy 2011)

Children should be protected from messages of all extremism including, but not restricted to, those linked to Islamist ideology, or to Far Right / Neo Nazi / White Supremacist ideology, Irish Nationalist and Loyalist paramilitary groups, and extremist Animal Rights movements. Over the last 12 months the OSCB has worked alongside the Oxfordshire Safe Communities Partnership to safeguard children from extremism. All training includes these messages, procedures have been updated to reflect this and partners are working on improved co-ordination of other preventative measure.

Children at risk of domestic abuse

Emerging learning from serious case reviews this year led to OSCB partners setting out a new 'referral pathway' for children involved in domestic abuse through their own relationship. The referral pathway is for all new and open cases where there is a notification of a domestic abuse incident between two children. The group consists of representatives from the county council, police and health and a range of agencies supporting families around Domestic Abuse, including Refuge, the Helpline and IDVA's.

All cases are subject to a 'Strategy Meeting', the purpose of which is to share as much information as possible about the victim and perpetrator even if the incident presents as relatively low level. The reason for this is, whilst the presenting incident may be low level, there may be intelligence relating to incidents in previous relationships that inform the risk assessment and any action that needs to be taken.

The county council has also developed new post to support address the issue of domestic abuse across both adults and children's services, which should lead to greater co-ordination going forward.

Child sexual exploitation

The partnership in Oxfordshire has moved a long way to address the problem of child sexual exploitation, identify collective solutions and produce some tangible evidence of impact. The Board is informed and engaged in this issue.

The Kingfisher Team has been at the heart of the change in Oxfordshire enabling the identification of need and the provision of specialist services for children at risk. A parent of a child victim of Operation Bullfinch told the OSCB chair in April 2015, *'I have no doubt the Kingfisher team would have been very helpful to us if they had existed 12 years ago.'*

The team comprising health, police and social care colleagues gathers intelligence and information about children and suspects of concern. The Missing Person's Co-ordinator is also part of the team; this has increased knowledge on potential perpetrators or venues where CSE may be taking place. The Team also provides consultancy and support to other professionals working with children at risk of CSE and co-ordinates information sharing through 'extended team meetings'.

A huge amount of training and awareness-raising has been and continues to be delivered to a wide range of professionals across the county. This includes staff in schools and GPs. In 2014 over 7,500 practitioners who have contact with children received training on CSE. The impact from this can be seen in the significant increase in the number of CSE screening tools completed and the range of agencies referring into the Kingfisher team. Training and awareness raising has taken place across a range of faith and community groups including the pastor's forum and mosques. However, the OSCB notes the…

difficulty in mandating safeguarding training to wider sectors of the community and recommends that licensing of taxi drivers should be linked to mandatory safeguarding training across Oxfordshire and the rest of the country. Training to hotels, guest houses, door staff, parks and street scene staff and others who can act as 'eyes and ears' on the ground is equally important.

More than 18,000 children have seen Chelsea's Choice, a drama that tours Oxfordshire schools to raise awareness of child sexual exploitation. Thousands more children have viewed the drama this last year. Oxford primary schools have been involved in piloting the Values Versus Violence programme which aims to develop children's core values, self-esteem and resilience and as such is seen as a very early preventive measure in terms of children becoming victims or perpetrators.

CSE is seen as child abuse and responded to as a crime. In 2013 32 Abduction Warning Notices were issued with 2 recorded breaches. In 2014 28 Abduction Warning Notices were issued with 1 recorded breach. Two of the 3 males breached were charged with substantive offences. Through the profiling and convictions for CSE in Oxfordshire we are aware that particular groups of young men are being drawn into offending. In 2014 Operation Reportage, March 2015 was an example of using experience from Operation Bullfinch to inform new investigations. It also demonstrated on-going commitment to never giving up on children, allowing the time they need to build trusting relationships and to disclose their abuse and a determination to hold perpetrators to account for their actions.

CSE is understood as a community safety issue and the district community safety partnerships are well embedded into the county-wide approach to tackling CSE through the CSE sub group. Prevalence reports detailing the current risks, hot spots and planned disruptions and operations are routinely shared. The impact of operations and interventions and outcomes from prosecutions is monitored. The CSE sub group has undertaken a mapping exercise of community based provision and will use the information to identify which services are currently meeting identified needs, which could do so and where there are gaps which will need to be filled through the commissioning of services. It is leading on an update of the strategy to address CSE in 2015.

Priority 5: improving our effectiveness as a board

Ofsted's review of the LSCB

The OSCB was judged as **"GOOD"** by Ofsted published during this reporting in May 2014. This provided assurances to the OSCB, partners and the public that local partnership work is effective in safeguarding the welfare of children. Ofsted proposed five areas for improvement which have been addressed as follows:

Increase the influence of the Board by clarifying relationships with key strategic groups in Oxfordshire	The Board has protocols with Children's Trust and the HWB to show clear lines of accountability. The Board's business plan reflects shared objectives with these partnerships. The Independent Chair has set up a twice yearly safeguarding summit with chief officers. The Board has a renewed constitution and refreshed terms of reference for all subgroups. It has effective governance arrangements and operating structure. The Performance, Audit and Quality Assurance subgroup is now formally accountable to both the Children's Trust and the OSCB. The challenge now is to improve cross agency engagement with the City and District Councils on safeguarding.
Ensure that this annual report has a closer focus on the child's experiences of safeguarding services	Children's views from serious case reviews, the Children in Care Council; the Youth Parliament and local sounding boards have contributed to this report. This report challenges board members to provide more focus on the child's experiences in their auditing work.
Ensure that the views of children and their families inform planning and training and that this contribution is then fed back to families	Parents and children 's views have directly contributed to OSCB training events on parental substance misuse, mental health, child sexual exploitation and managing risk for vulnerable teenagers. Partner agencies have examples of views informing the 'placement strategy', the child sexual exploitation strategy, FGM promotion, school health nurse promotion and the Values versus violence programme.
Evaluate the learning and impact of training delivered across the partnership particularly its longer term impact on the quality of practice in partners agencies	A review was undertaken on the impact of training, which collated feedback from trainers and delegates. Responses confirmed the practical application of the OSCB training courses; that attendees felt more knowledgeable about local safeguarding issues; that they knew how and where to raise a concern; that they would share their learning with colleagues. Agencies are now also required to gain feedback through the section 11 feedback and through an annual report in to the training subgroup. Read more about training below.
Accelerate the implementation of a strategy in relation to female genital mutilation.	OSCB partners assessed the prevalence of FGM in the county; produced a screening tool and procedures for working on this and worked with the Department of Health to run a conference on FGM in the county. The OSCB supported the community organisation 'Oxford against Cutting' to access local schools and run an awareness raising project, which produced a booklet for children. OSCB trainers received training on FGM so that they are confident in communicating the issue to delegates.

Learning and improvement: OSCB safeguarding training

Who delivers it?

Free OSCB training is delivered on a voluntary basis by over 30 local practitioners including police officers, teachers, social workers and clinical leads from across health. OSCB trainers work with children, childcare professionals and safeguarding issues on a regular basis. Many are specialists in their own setting. They are first trained by the OSCB, observe and then co-train before they are fully fledged. They are then kept up-to-date on the learning from case reviews and local tools endorsed by the OSCB. Over the last year they have helped to develop the new core safeguarding courses due to be launched in 2015/2016.

What is delivered?

The OSCB delivered nearly 150 learning events last year. It has a comprehensive range of training. As well as core safeguarding courses the OSCB runs courses for practitioners working with vulnerable groups such as young g carers or disabled children. It also runs early years courses funded through the county council and risky behaviours courses funded through public health such as: child sexual exploitation; sexual health awareness; substance misuse; healthy and unhealthy sexual behaviour; mental health and anxieties.

How many people benefit?

Training in 2014/15 deserves a big thank-you to all involved as over 8000 learning events were recorded. More face to face training and learning was delivered: 3664 delegates compared to 2170 last year. More online learning was completed: 4537 courses compared to 1338 last year. There was a roll-out of a new format for learning following serious case reviews.

What difference does it make?

An OSCB training review in 2014 evidenced the provision as being of good quality. Evaluation indicated that training is highly valued and confirmed the practical application of the learning e.g. increased awareness of local safeguarding issues as well as how and where to raise a concern. Course feedback is that 80% of delegates rate it as good or excellent. They have told us:

- *It was very informative and offered reassurance in confirming the referral process*
- *Really enjoyed this course. The content and timings were pitched perfectly. There was plenty of information exchange*

In 2015/16 the OSCB needs to set up automatic post-course evaluation after a three-month time period has elapsed.

Learning and improvement: OSCB procedures

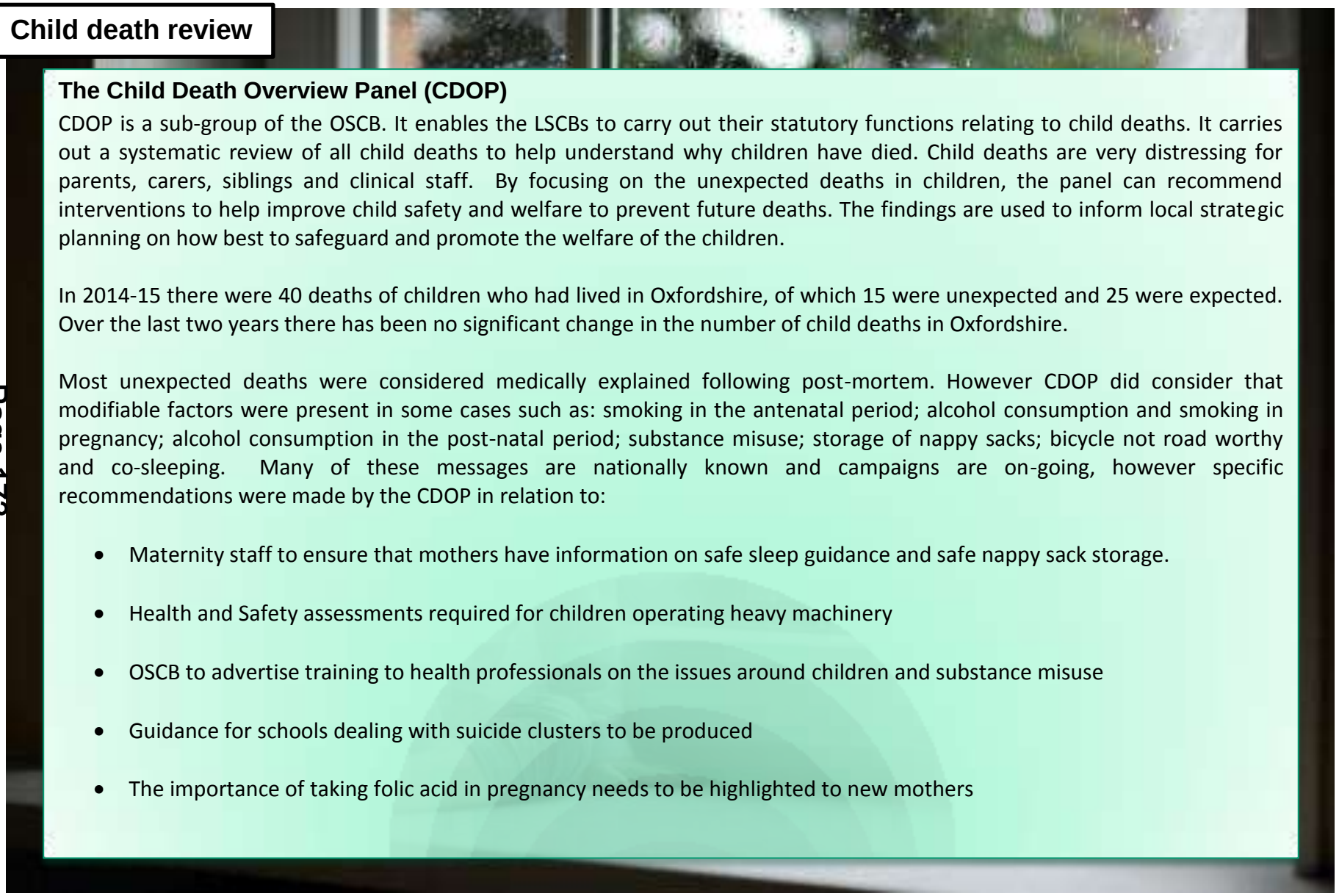
OSCB online procedures were rated by Inspectors as "*comprehensive and up to date*". All priority procedures have been reviewed and updated in light of new legislation and guidance. The layout has been improved to provide better clarity and more coherent formatting. Emerging national and local issues, such as Female Genital Mutilation, have been addressed and procedures have been put in place in a timely fashion. The group is currently reviewing the procedures on self-harm. The challenge is to increase reference to and usage of the online manual.

Learning and improvement: OSCB communication

The OSCB was highly productive in ensuring that the learning from the three audits and three newly published case reviews reached frontline practitioner and was used to develop practice. Examples of work to communicate safeguarding messages are:

- Five multi-agency learning events following case review and audit themes. They were on neglect, parental substance misuses; tackling child sexual exploitation; accessing mental health support for children and working with vulnerable adolescents. Most of these events were chaired by the OSCB Independent Chair and involved the county's interim deputy director for safeguarding, the county's designated nurse, parents and children and experts in the chosen field. which reached over 200 practitioners
- 'Eyes on' learning documents were produce on the themes from case reviews and audits. They cover neglect; parental substance misuse, another successful annual conference for over 200 delegates with 6 workshops on key subjects such as; self-harm, behaviour and attendance, child sexual exploitation, social media and the internet, drugs & alcohol and working together on high risk cases.
- e- bulletin on safeguarding issues for safeguarding leads in education
- workshops on MASH; female genital mutilation and the 'prevent' programme for OSCB trainers
- meetings with the children in care council; sounding boards; Children's Parliament to explain OSCB purpose and role in safeguarding
- meetings with voluntary, community and faith groups at conferences OSCB purpose and their role in safeguarding
- new cross-agency communications group and strategy in order to communicate messages from case reviews

Child death review



The Child Death Overview Panel (CDOP)

CDOP is a sub-group of the OSCB. It enables the LSCBs to carry out their statutory functions relating to child deaths. It carries out a systematic review of all child deaths to help understand why children have died. Child deaths are very distressing for parents, carers, siblings and clinical staff. By focusing on the unexpected deaths in children, the panel can recommend interventions to help improve child safety and welfare to prevent future deaths. The findings are used to inform local strategic planning on how best to safeguard and promote the welfare of the children.

In 2014-15 there were 40 deaths of children who had lived in Oxfordshire, of which 15 were unexpected and 25 were expected. Over the last two years there has been no significant change in the number of child deaths in Oxfordshire.

Most unexpected deaths were considered medically explained following post-mortem. However CDOP did consider that modifiable factors were present in some cases such as: smoking in the antenatal period; alcohol consumption and smoking in pregnancy; alcohol consumption in the post-natal period; substance misuse; storage of nappy sacks; bicycle not road worthy and co-sleeping. Many of these messages are nationally known and campaigns are on-going, however specific recommendations were made by the CDOP in relation to:

- Maternity staff to ensure that mothers have information on safe sleep guidance and safe nappy sack storage.
- Health and Safety assessments required for children operating heavy machinery
- OSCB to advertise training to health professionals on the issues around children and substance misuse
- Guidance for schools dealing with suicide clusters to be produced
- The importance of taking folic acid in pregnancy needs to be highlighted to new mothers

The Rapid Response Service

When a child dies unexpectedly a process is set in motion to review the circumstances of the child's death called the 'rapid response' process. Colleagues work together to gather information in a timely, systematic yet sensitive manner to inform understanding of why the child has died.

In Oxfordshire, the rapid response service is well established. It is provided by the Chaplaincy and Bereavement Team at the John Radcliffe Hospital. In collaboration with the Designated Doctor for Child Deaths the rapid response service provides support to families, professionals and the wider community in the event of a sudden and unexpected child death.

The service has continued to work collaboratively with other organisations including the Coroner's office, Schools, Youth Projects, Social Care, South Central Ambulance Service, Thames Valley Police, Oxford University Hospitals NHS Trust, Oxford Health NHS FT, Helen and Douglas House Hospice and the child bereavement charity SEE SAW, in order to enhance the quality of care provided to all those whose work brings them into contact with bereaved families.

Home visits take place in consultation with Designated Doctor for Child Deaths and other responding agencies including the Coroner's Officer. Home visits inform the rapid response multi-agency meeting and assist in developing a programme of support based on the family's particular needs as well as providing extended support and information to other agencies involved with the family.

Update on recommendations from 2013/14

- Oxfordshire Sports Partnership added to its safeguarding training a case scenario about alcohol cultures within sports settings and about the issue of private hire of their premises. This was to raise awareness of the issues linked with under-age drinking and mental well-being.
- There have been discussions between Oxfordshire Family Liaison Officers the Safeguarding Services Manager and See Saw on the rapid response process, responding to a child death and the impact on child witnesses. This has resulted in improved understanding and clarification of roles and stronger working relationships
- There has been work within bereavement teams to identify when support is required for children who are witnesses to a child death to minimise Post Traumatic Stress Disorder. In situations when a child is a witness consideration is now given to the capacity of the child to give evidence and this capacity is discussed at the rapid response meeting to ensure appropriate support is in place.

Reviews of serious cases

A serious case is one where:

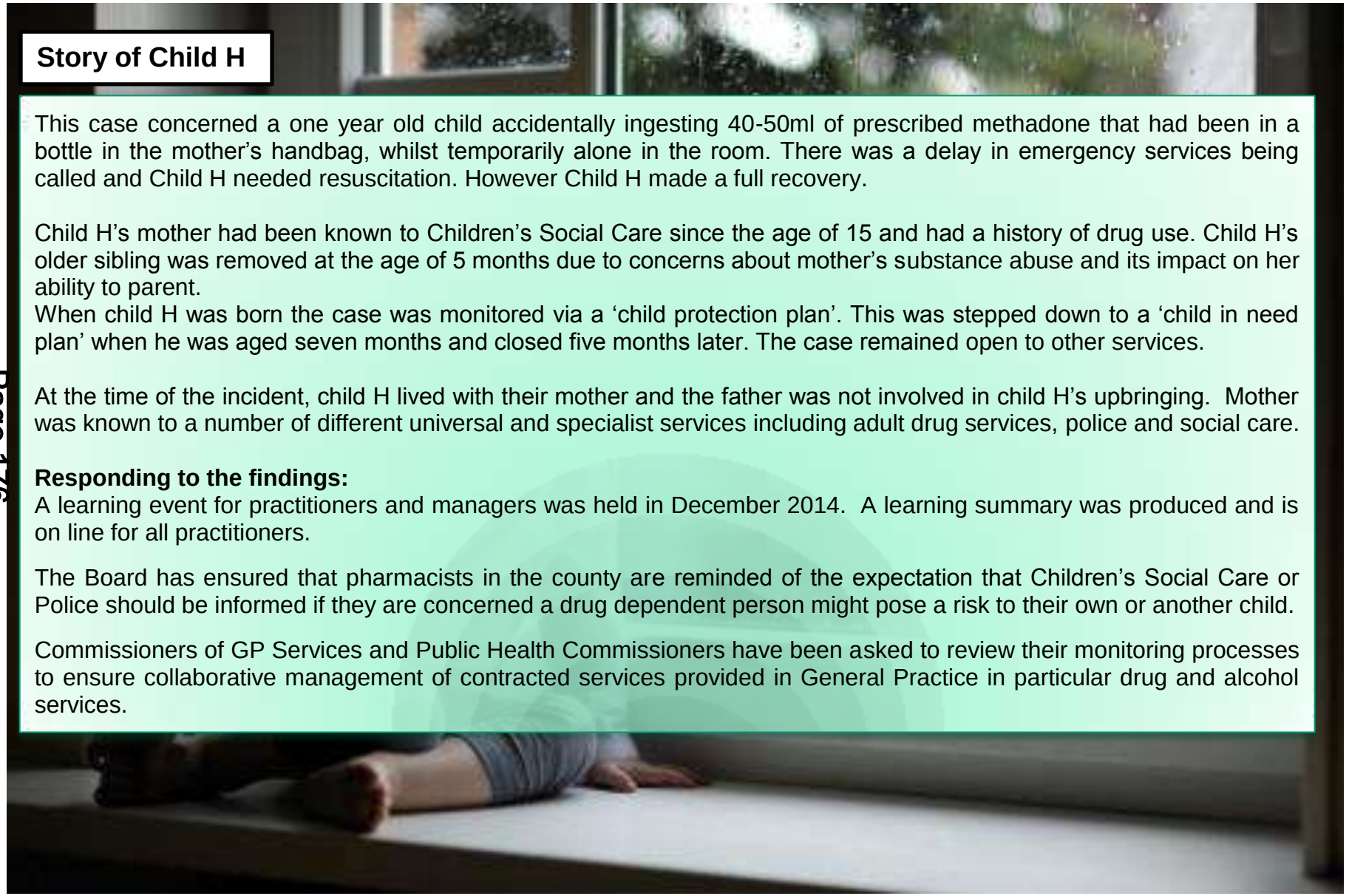
(a) abuse or neglect of a child is known or suspected; and
(b) either (i) the child has died;
or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

Serious case reviews (SCR)

LSCBs must always undertake a review of cases that meet the criteria for an SCR. The purpose of a SCR is to establish whether there are lessons to be learnt from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children. OSCB has also been committed to undertaking smaller scale partnership reviews for instances where the case does not meet the criteria for a serious case review but it is considered that there are lessons for multi-agency working to be learnt.

There has been an exceptionally high volume of work on serious case reviews. During 2014-15 three serious case reviews were completed and one was amended and re-published. Seven new cases were brought to the attention of the OSCB for consideration; of these two serious case reviews were commissioned, one was subject to a learning review with partners and the remainder led to no further action by the OSCB. The OSCB has another two on-going serious case reviews: one which is waiting for a criminal investigation to complete and one which has been delayed due to an Independent Police Complaints Commission investigation which is now complete. All **case reviews** and **learning from reviews** can be found on the OSCB website.

The OSCB is generating a lot of learning f about how we can work better together. It takes seriously its responsibilities to ensure that lessons learned from case reviews are disseminated and embedded into frontline practice and used to support improvements across agencies. The themes of sexual exploitation, supporting adolescents at risk, the impact of mental health problems and substance misuse on parental capacity have emerged from the three serious case reviews published in 2014/15. The outlines of the three reviews completed are provided below.



Story of Child H

This case concerned a one year old child accidentally ingesting 40-50ml of prescribed methadone that had been in a bottle in the mother's handbag, whilst temporarily alone in the room. There was a delay in emergency services being called and Child H needed resuscitation. However Child H made a full recovery.

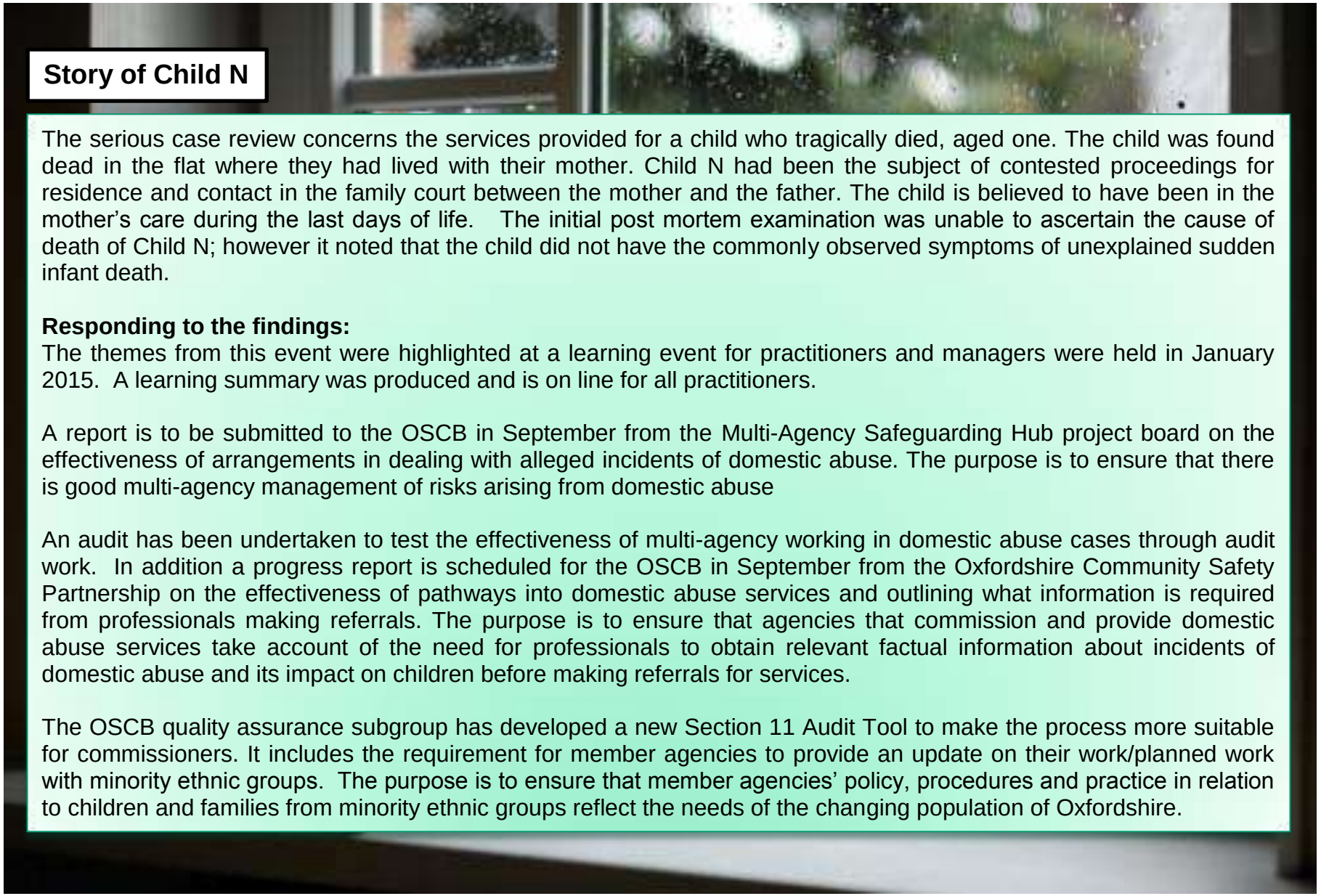
Child H's mother had been known to Children's Social Care since the age of 15 and had a history of drug use. Child H's older sibling was removed at the age of 5 months due to concerns about mother's substance abuse and its impact on her ability to parent.
When child H was born the case was monitored via a 'child protection plan'. This was stepped down to a 'child in need plan' when he was aged seven months and closed five months later. The case remained open to other services.

At the time of the incident, child H lived with their mother and the father was not involved in child H's upbringing. Mother was known to a number of different universal and specialist services including adult drug services, police and social care.

Responding to the findings:
A learning event for practitioners and managers was held in December 2014. A learning summary was produced and is on line for all practitioners.

The Board has ensured that pharmacists in the county are reminded of the expectation that Children's Social Care or Police should be informed if they are concerned a drug dependent person might pose a risk to their own or another child.

Commissioners of GP Services and Public Health Commissioners have been asked to review their monitoring processes to ensure collaborative management of contracted services provided in General Practice in particular drug and alcohol services.



Story of Child N

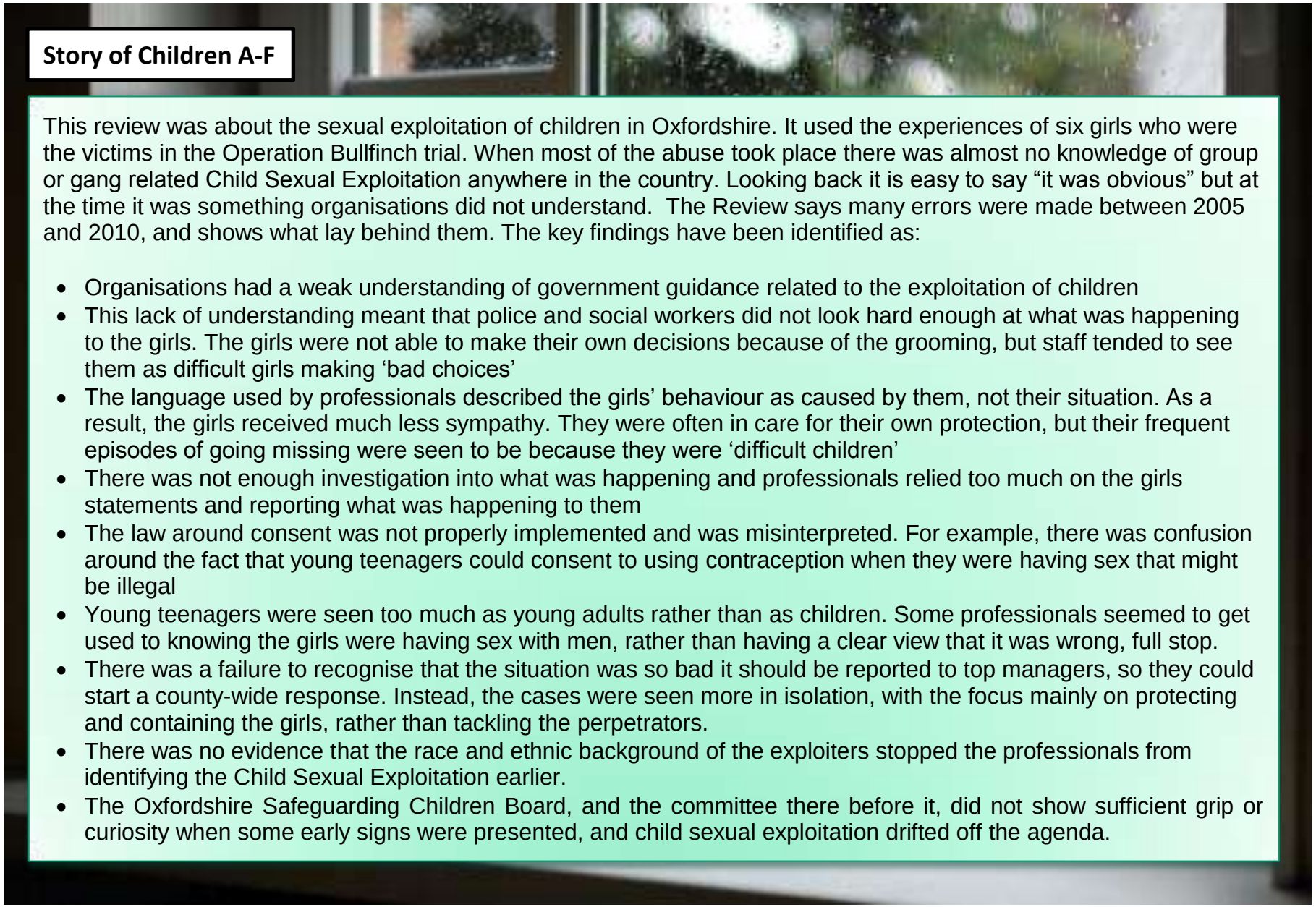
The serious case review concerns the services provided for a child who tragically died, aged one. The child was found dead in the flat where they had lived with their mother. Child N had been the subject of contested proceedings for residence and contact in the family court between the mother and the father. The child is believed to have been in the mother's care during the last days of life. The initial post mortem examination was unable to ascertain the cause of death of Child N; however it noted that the child did not have the commonly observed symptoms of unexplained sudden infant death.

Responding to the findings:
The themes from this event were highlighted at a learning event for practitioners and managers were held in January 2015. A learning summary was produced and is on line for all practitioners.

A report is to be submitted to the OSCB in September from the Multi-Agency Safeguarding Hub project board on the effectiveness of arrangements in dealing with alleged incidents of domestic abuse. The purpose is to ensure that there is good multi-agency management of risks arising from domestic abuse

An audit has been undertaken to test the effectiveness of multi-agency working in domestic abuse cases through audit work. In addition a progress report is scheduled for the OSCB in September from the Oxfordshire Community Safety Partnership on the effectiveness of pathways into domestic abuse services and outlining what information is required from professionals making referrals. The purpose is to ensure that agencies that commission and provide domestic abuse services take account of the need for professionals to obtain relevant factual information about incidents of domestic abuse and its impact on children before making referrals for services.

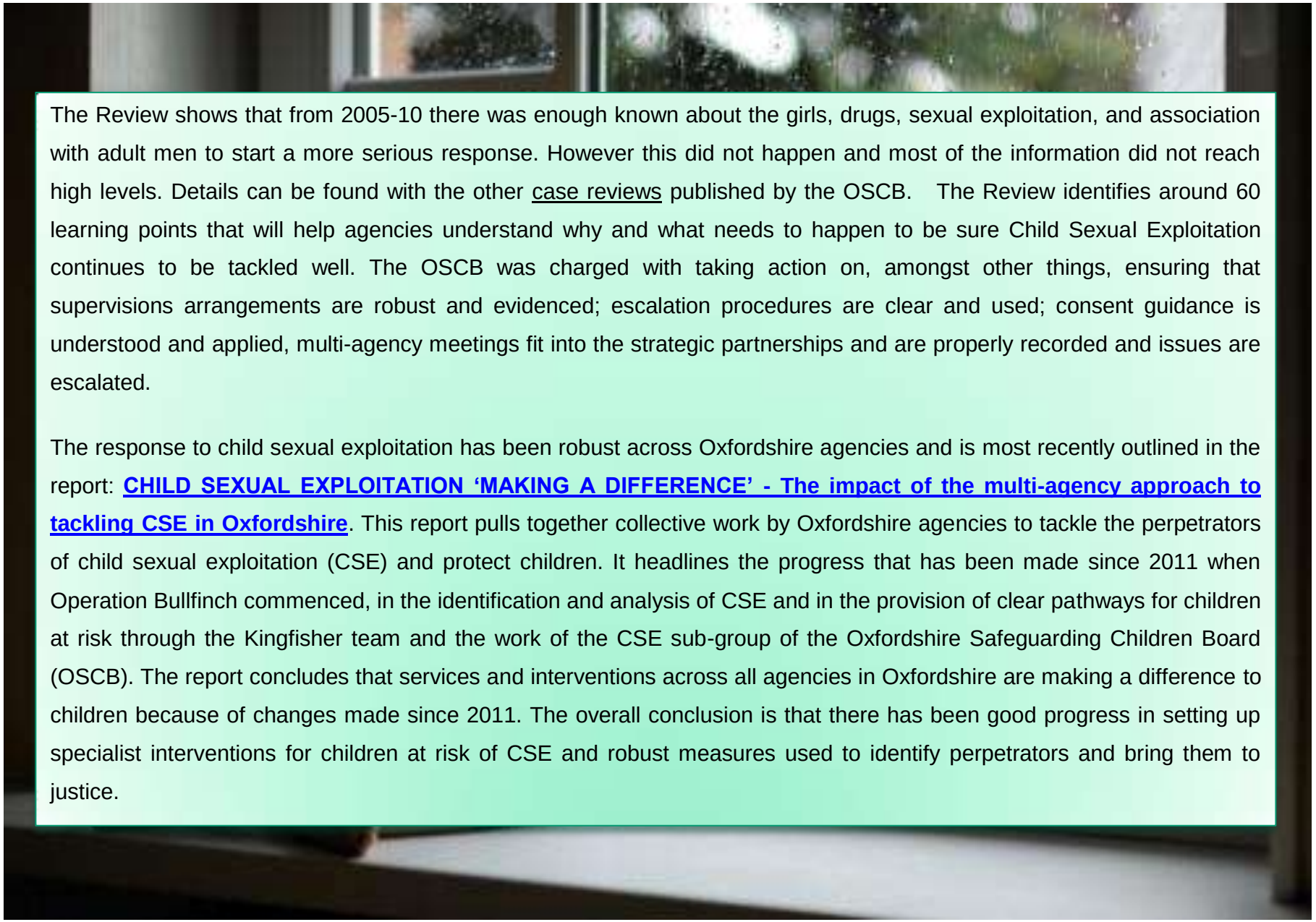
The OSCB quality assurance subgroup has developed a new Section 11 Audit Tool to make the process more suitable for commissioners. It includes the requirement for member agencies to provide an update on their work/planned work with minority ethnic groups. The purpose is to ensure that member agencies' policy, procedures and practice in relation to children and families from minority ethnic groups reflect the needs of the changing population of Oxfordshire.



Story of Children A-F

This review was about the sexual exploitation of children in Oxfordshire. It used the experiences of six girls who were the victims in the Operation Bullfinch trial. When most of the abuse took place there was almost no knowledge of group or gang related Child Sexual Exploitation anywhere in the country. Looking back it is easy to say “it was obvious” but at the time it was something organisations did not understand. The Review says many errors were made between 2005 and 2010, and shows what lay behind them. The key findings have been identified as:

- Organisations had a weak understanding of government guidance related to the exploitation of children
- This lack of understanding meant that police and social workers did not look hard enough at what was happening to the girls. The girls were not able to make their own decisions because of the grooming, but staff tended to see them as difficult girls making ‘bad choices’
- The language used by professionals described the girls’ behaviour as caused by them, not their situation. As a result, the girls received much less sympathy. They were often in care for their own protection, but their frequent episodes of going missing were seen to be because they were ‘difficult children’
- There was not enough investigation into what was happening and professionals relied too much on the girls statements and reporting what was happening to them
- The law around consent was not properly implemented and was misinterpreted. For example, there was confusion around the fact that young teenagers could consent to using contraception when they were having sex that might be illegal
- Young teenagers were seen too much as young adults rather than as children. Some professionals seemed to get used to knowing the girls were having sex with men, rather than having a clear view that it was wrong, full stop.
- There was a failure to recognise that the situation was so bad it should be reported to top managers, so they could start a county-wide response. Instead, the cases were seen more in isolation, with the focus mainly on protecting and containing the girls, rather than tackling the perpetrators.
- There was no evidence that the race and ethnic background of the exploiters stopped the professionals from identifying the Child Sexual Exploitation earlier.
- The Oxfordshire Safeguarding Children Board, and the committee there before it, did not show sufficient grip or curiosity when some early signs were presented, and child sexual exploitation drifted off the agenda.



The Review shows that from 2005-10 there was enough known about the girls, drugs, sexual exploitation, and association with adult men to start a more serious response. However this did not happen and most of the information did not reach high levels. Details can be found with the other case reviews published by the OSCB. The Review identifies around 60 learning points that will help agencies understand why and what needs to happen to be sure Child Sexual Exploitation continues to be tackled well. The OSCB was charged with taking action on, amongst other things, ensuring that supervisions arrangements are robust and evidenced; escalation procedures are clear and used; consent guidance is understood and applied, multi-agency meetings fit into the strategic partnerships and are properly recorded and issues are escalated.

The response to child sexual exploitation has been robust across Oxfordshire agencies and is most recently outlined in the report: **CHILD SEXUAL EXPLOITATION 'MAKING A DIFFERENCE' - The impact of the multi-agency approach to tackling CSE in Oxfordshire**. This report pulls together collective work by Oxfordshire agencies to tackle the perpetrators of child sexual exploitation (CSE) and protect children. It headlines the progress that has been made since 2011 when Operation Bullfinch commenced, in the identification and analysis of CSE and in the provision of clear pathways for children at risk through the Kingfisher team and the work of the CSE sub-group of the Oxfordshire Safeguarding Children Board (OSCB). The report concludes that services and interventions across all agencies in Oxfordshire are making a difference to children because of changes made since 2011. The overall conclusion is that there has been good progress in setting up specialist interventions for children at risk of CSE and robust measures used to identify perpetrators and bring them to justice.

Chapter 5: Challenges ahead and future priorities

National Drivers

- Addressing child sexual exploitation
- Implementation of new safeguarding guidance
- Focus on safeguarding across the inspection regime to drive local compliance with audits

For the Board

- Strengthening partnership arrangements
- Working and engaging with local community, voluntary and faith groups
- Ensuring compliance against safeguarding standards
- Testing if learning from case reviews is embedded across partner agencies

For local multi-agency work

- Improving practice to address neglect
- Progressing work to better safeguard vulnerable adolescents
- Remaining vigilant to where the next pressure points lie and escalating safeguarding concerns
- Ensuring there is sufficient provision of 'early help' and services are integrated

Key priority areas

Reviewing the challenges ahead the Board is committed to delivering on its priorities with due attention to

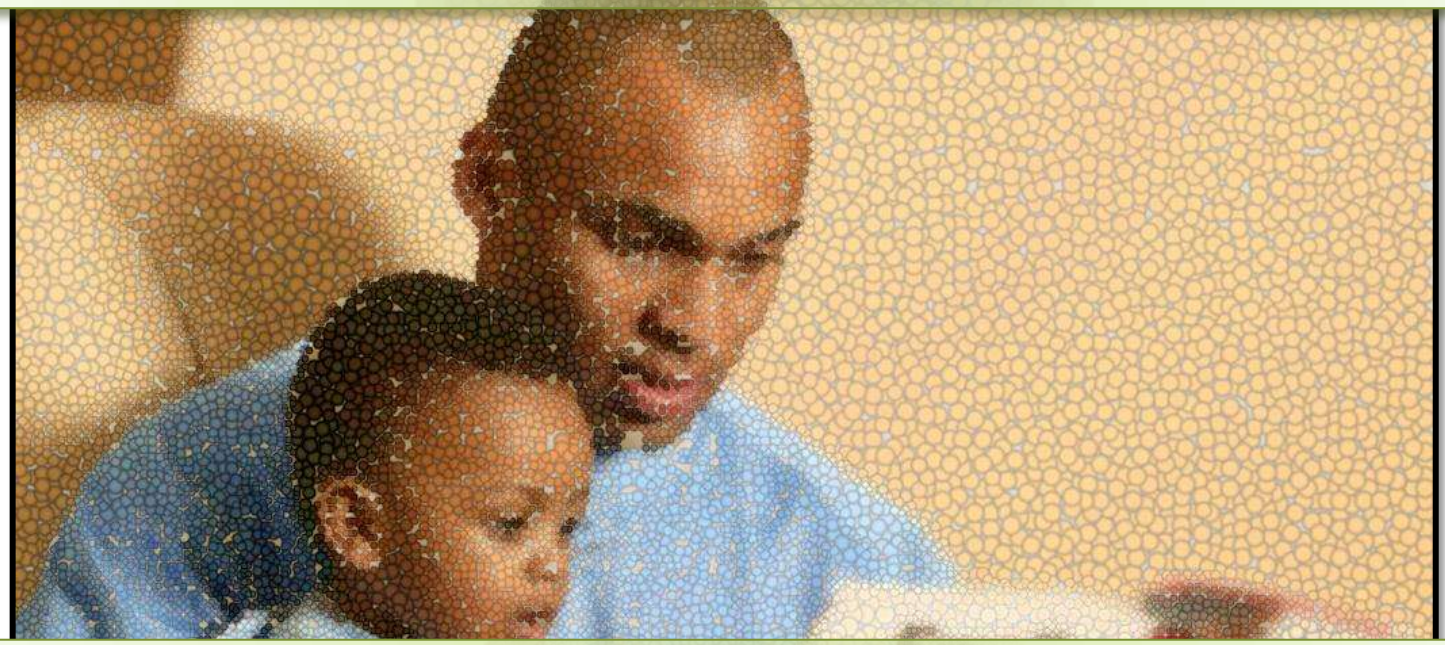
- The increasing pressures on the safeguarding system as the number of children with child protection plans and in care rises
- Safeguarding in transport: regulation of taxis and commissioning of transport for vulnerable children
- Commissioning of services to provide help and therapy for children into adulthood

CHAPTER 6: WHAT NEXT FOR CHILD PROTECTION IN OXFORDSHIRE

Key messages to:

Children

Your voices are most important. Tell us what you think when we ask and help us to improve the way that agencies help you and your family



Children's workforce

- Ensure that you have attended all safeguarding courses and learning that is relevant to your role
- Get the basics right: be informed; use the multi-agency tools and procedures on the OSCB website
- Use your representative on the safeguarding board to escalate concerns
- Be connected to your local safeguarding group as appropriate

The community

- You are in the best place to look out for children and to raise the alarm if something goes wrong
- We all share responsibility for protecting children. Report a concern if you are worried.

The community, faith and voluntary sector

- Ensure that you have attended all safeguarding courses and learning that is relevant to your role
- Use online resources available through the NSPCC
- Find out about and use the multi-agency tools where they are relevant to your role

Head and Governors of schools

- Complete the OSCB endorsed safeguarding audit for your setting
- Ensure your workforce is trained and get involved in the delivery of OSCB safeguarding training
- Be aware of the latest statutory guidance on safeguarding and ensure your safeguarding lead is signed up to the OSCB e-bulletin
- Understand and know how to deal with safeguarding concerns like self-harm; sexting; online safety and radicalisation of children
- Access and promote road safety information for pupils and their families
- Take responsibility for ensuring that all pupils' whereabouts are known; children out of school are at increased risk of harm
- Make the most of local safeguarding initiatives e.g. NSPCC Childline assemblies and Chelsea's Choice

Clinical commissioning groups

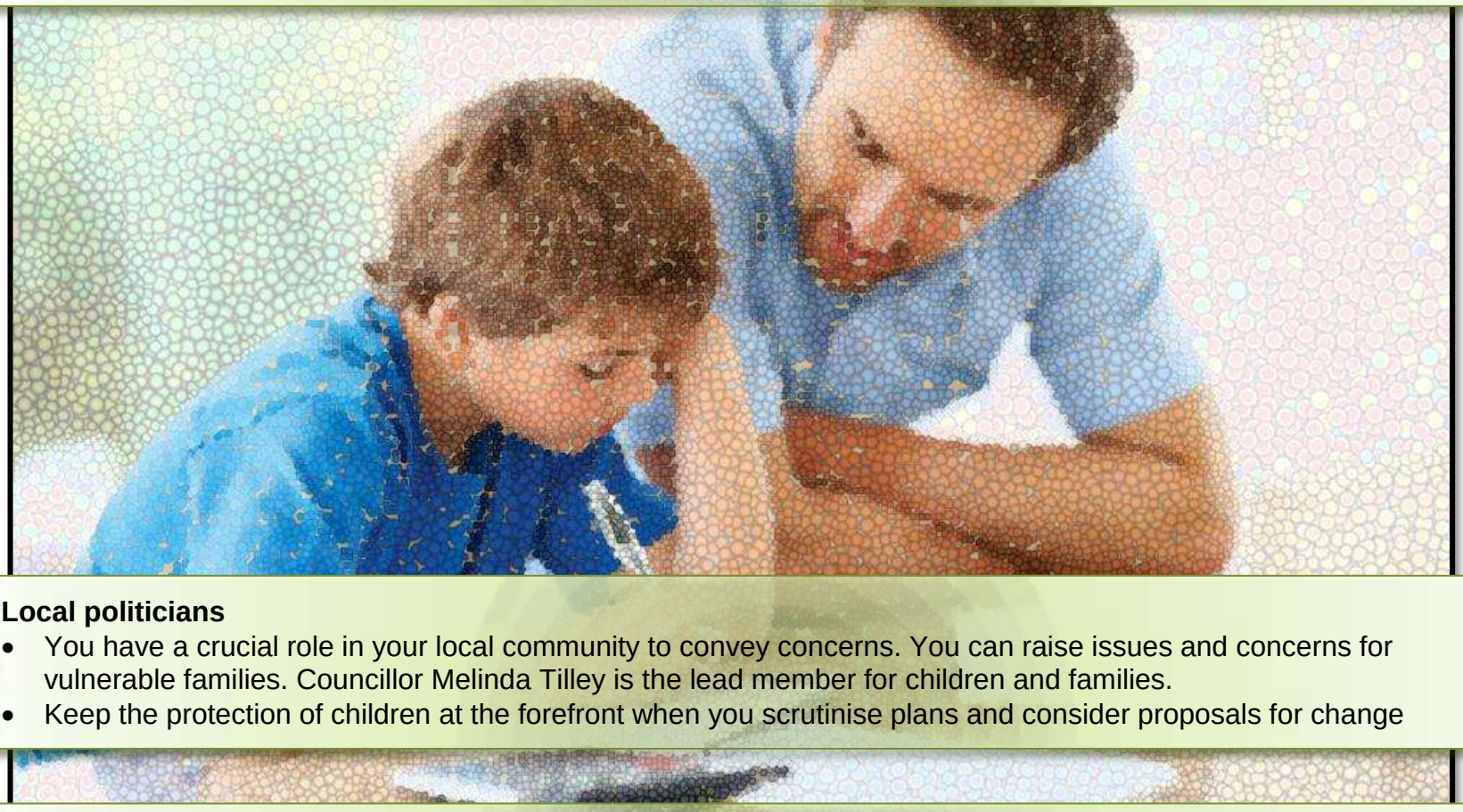
- You have a key role in the health sector to scrutinise the governance and planning across a range of organisations. Consider the needs to vulnerable families within the course of this work
- You are required to discharge your safeguarding duties effectively and ensure that services are commissioned for the most vulnerable children

Chief executives and directors

- Your agency's contribution to the work of the OSCB should be of the highest priority; you have made good progress in working collectively to tackle issues such as child sexual exploitation, female genital mutilation and self-harm but there is *continuing* need of strategic co-ordination of activity across your organisations
- Take responsibility to ensure that all serious safeguarding matters are escalated to the Board for challenge by the partnership
- Ensure that senior managers meet with frontline practitioners and are assured that safeguarding practice is well understood
- Strong and persistent leadership will change culture and attitudes towards vulnerable children; be vigilant to where the next pressure points lie

Police and crime commissioner

- Ensure that victims voices are taken notice of within the criminal justice system
- Monitor and support the work of the Oxfordshire Safer Community Partnerships and the local community safety partnerships



Local politicians

- You have a crucial role in your local community to convey concerns. You can raise issues and concerns for vulnerable families. Councillor Melinda Tilley is the lead member for children and families.
- Keep the protection of children at the forefront when you scrutinise plans and consider proposals for change

Local media

- We all share responsibility for protecting children; you are in a crucial position to convey this to your readers
- Find out about the Safeguarding Board and current concerns; this will be of interest to your readers

Reporting Concerns

Multi-Agency Safeguarding Hub (MASH) **For any new concerns or enquiries please contact the MASH:**	**0845 050 7666**
Oxford City (including Cowley, Botley, Headington, the Leys and Kidlington)	**01865 328563**
North Oxfordshire (including Banbury, Witney, Bicester, Carterton and Woodstock)	**01865 323039**
South Oxfordshire (including Faringdon, Wantage, Thame, Didcot and Henley)	**01865 323041**
The Emergency Duty Team Please contact this number if your call is outside of normal office hours	**0800 833 408**
John Radcliffe Hospital Assessment Team for antenatal safeguarding concerns and issues concerning children in the hospital	**01865 221236**
Child Sexual Exploitation (the Kingfisher Team) If a child or young person has made a disclosure regarding sexual exploitation or if you think a child may be at risk of being sexually exploited, please contact the Kingfisher Team on: *Out of hours calls to this number will be diverted to the Thames Valley Police Referral Centre*	**01865 335276**

Division(s):

HEALTH & WELLBEING BOARD – 5 NOVEMBER 2015

THE INCREASE IN CHILD PROTECTION CASES REPORT CARD

Report by Children, Education & Families

1. The following report card sets out the growth in activity in the child protection (CP) system and its impact across the partnership.

   Key issues to note:

   - A rapid and continuing increase in activity in both child protection and children in care.
   - A changing profile of risk with older children becoming a larger proportion of children subject to CP plans.
   - An increase in sexual offences especially against girls.
   - An analysis the demonstrates that all professionals are more attuned to identifying and understanding risk, leading to a growth in numbers subject to CP plans and in care, and reduced effectiveness of preventative services.
   - An increased pressure on social workers' caseloads and the capacity of all professionals to respond to demand.
   - Recognition that the county council is facing budget cuts which increases the risk to children and this is being addressed by a restructuring of services.
   - Recognition that all public sector organisations are in similar straitened curcumstances which could compromise the partnership's capacity to respond effectively to vulnerable children's needs.

RECOMMENDATION

2. **The Health and Wellbeing Board is recommended to consider any additional measures to mitigate against the risks set out in the report card.**

Jim Leivers
Director, CEF.

Contact Officer: Hannah Farncombe, Deputy Director, Corporate Parenting & Safeguarding; Tel: (01865 815273)

23 October 2015

Increase in Child Protection Cases
Report card

1. There has been an increase in child protection cases in Oxfordshire over a number of years. This has been greater than the increase nationally.

2. This is not necessarily bad and may simply demonstrate that we are protecting more children. The growth is in line with other areas that have had high profile CSE cases. Also authorities judged 'good' by Ofsted have overall seen a bigger rise in numbers than the national average. The change in numbers for inadequate authorities is mixed - though for example, in Buckinghamshire they dropped by 35% in the 3 year period when Oxfordshire's increased by 50%. The only ‘good’ authority which has seen a decrease is Essex, where numbers have more than halved.

3. The number of older girls on plans has increased. This coincides with an increase in girls who are the victims of crime - especially sexual offences. Child protection is changing and new threats are developing. As the age profile of ‘at risk’ children changes, so does the response. Managing risks for adolescents focusses on both the community and the home.

4. There is a significant impact on resources across the system (e.g. police, health visitors, social care, GPs, education etc.). Failure to address this may mean we stop protecting children well. The greater the number of children subject to statutory oversight, the lower the capacity to work preventatively with children in need. This in turn fuels the growth in child protection numbers.

5. The key reasons for the growth in numbers are:
- Greater sensitivity to risk of abuse/neglect by professionals
- More older children, particularly girls, with high levels of risk being identified.
- Services for children in need / edge of social care are not having the preventative effect we might expect, despite the increase in CAFs etc.

6. The current focus of the work, and performance monitoring, is focussed on the social care management of children at risk, rather than the source of harm (e.g. victims of crime, children attending A&E as a result of intentional injuries etc.). Organisations are currently highly sensitised to children’s services’ responsibilities to safeguard children as victims, rather than addressing the threats within communities and building children’s resilience.

7. Practice has become more defensive in the light of both local and national issues. If we are to change our risk management practice to be less defensive, decision-making needs to be supported at senior level across organisations with a strong accountability and assurance framework. We have successful practice to learn from in the Kingfisher Team’s emphasis on controlled caseloads linked to good child in need planning and quality assurance. This is a similar model to Essex, which has a ‘good’ inspection judgement.

8. To ensure we continue to protect children and manage the pressures in the system we need to improve the impact and effectiveness of services for children in need / edge of statutory services. The county council is currently consulting on changes to its early intervention services but this entails reductions in funding. There is a need to create a new multi-agency model of family support, led by the Children's Trust and held to account by the safeguarding board. Whilst the most efficient model to deliver this agenda will be developed within the resources available there is a risk that the combination of reduced budgets and increased activity could adversely affect the ability of local services to keep vulnerable children safe and prevent harm at an early point. The Children's Trust considered this report at its September meeting. The Oxfordshire Safeguarding Children Board received this report at its Full board meeting on 22nd October 2015 and has requested all representative agencies to undertake an impact assessment of the savings they are required to achieve.

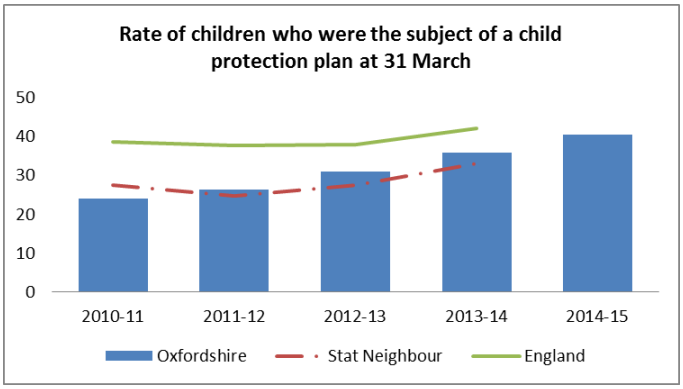
9. The Health and Wellbeing Board is recommended to consider any additional measures to mitigate against the risks set out below.

Introduction

1. This report was commissioned by the Performance, Quality Assurance and Audit subgroup of the Safeguarding Board in response to the growing safeguarding activity across all agencies alongside reducing public sector budgets. It was co-ordinated by the county council, but includes input from all agencies across the partnership. A copy of this report will be presented to the Children's Trust, the Safeguarding Board and the Performance Scrutiny Committee of the County Council.

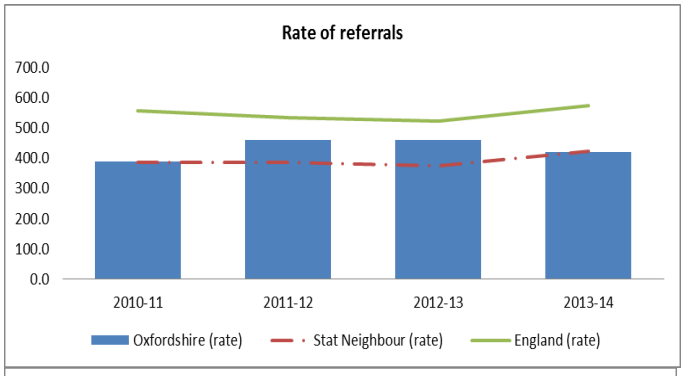
Comparative data and trends

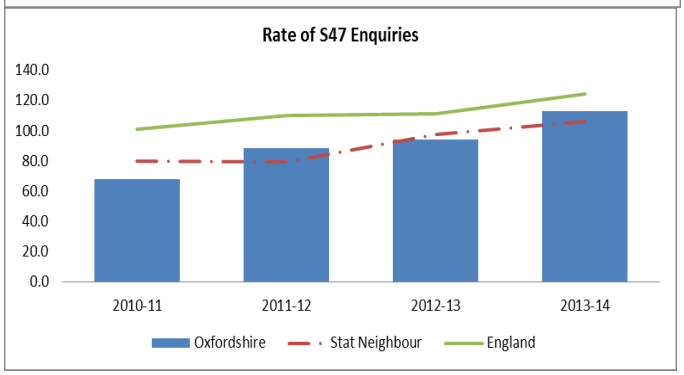
2. The rate of children subject of a child protection plan is rising more quickly in Oxfordshire than elsewhere. Between March 2011 and March 2014 it rose by 50% compared to 21% for statistical neighbours and 9% nationally. In 2014/15 in Oxfordshire there was a further rise of 13% and in the first quarter of 2015/16 another increase of 11%, with 634 children now subject of a child protection plan.



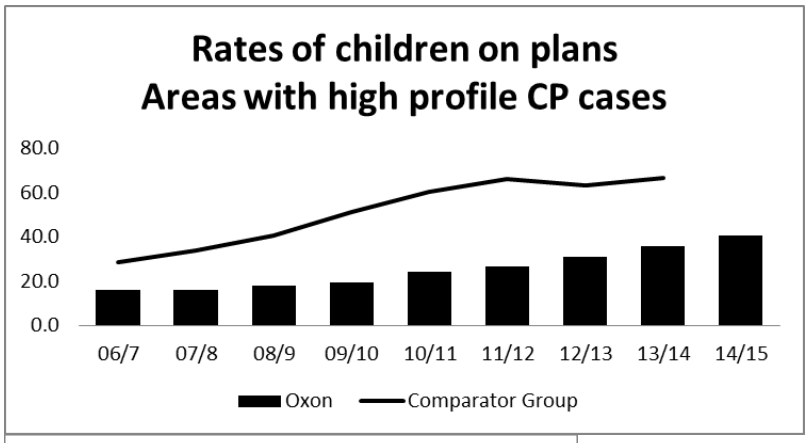
3. The increase has not been driven by an increase in referrals which, in line with the rest of the country, has remained constant. There has however been an

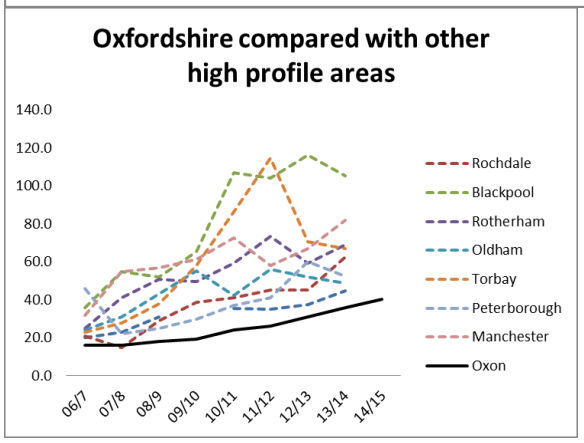
increase in section 47 (child protection) investigations of 63% in Oxfordshire compared with 43% for statistical neighbours and 23% nationally.





4. When Oxfordshire's increase in child protection cases is compared to those in other areas which have been through high profile CSE cases, a common trend is detected. Derby, Rochdale, Blackpool, Rotherham, Oldham, Torbay, Peterborough, and Manchester have all seen steep rises in their numbers of children subject of a child protection plan. Oxfordshire's rate of growth is slightly below the group average, increasing by 124% since 2006/7 compared with 134% for the whole group. Oxfordshire also has the lowest rate of children on a plan of any of these areas.





5. The local impact on practice of this, added to national changes in policy and regulation (such as the Francis enquiry) has led to more defensive practice across the system. Although audits have repeatedly shown that thresholds around child protection have not changed, this growth in defensive practice has made people across the system more readily favour child protection plans as a response to risk rather than using alternatives. If alternatives are to be used it will require a more integrated model of support across the localities to allow professionals sufficient time to work effectively with families, as well as an accountability framework that ensures staff are supported by their senior leaders in managing risk.

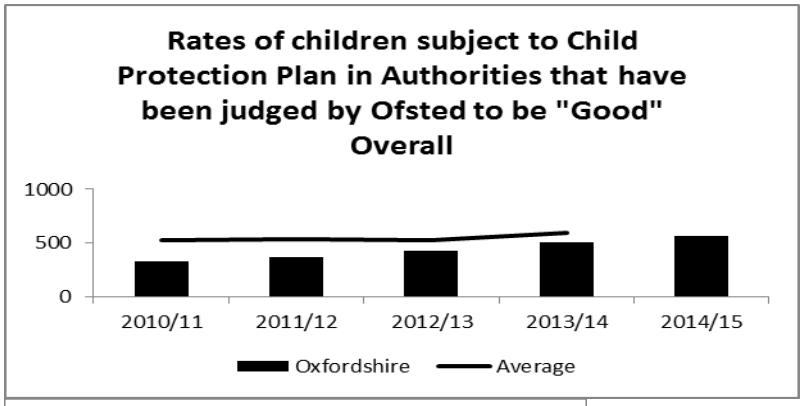
> "It can't be yes (being safe) all the time – you can't feel safe all the time"
>
> Child

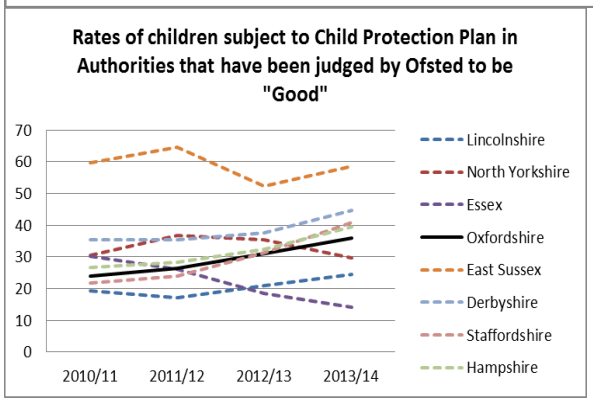
6. So far 58 out of 152 authorities have had their children's services inspected by Ofsted within their latest inspection methodology. Of these 14 have been described as 'good' overall; 30 'require improvement' and 14 were 'inadequate'. On the specific judgements of children who need help and protection 14 were 'good' overall; 33 'require improvement' and 11 were 'inadequate'. Oxfordshire was good in both categories as were 11 other authorities[1] 8 of which were shire authorities. The rate of growth of children on plans in the 8 shire authorities rated as 'good' in both categories over the 4 years is 16% (compared with a national average of 9%). Patterns across these authorities are not consistent, 3 have had

[1] The authorities rated as good in both categories are Derbyshire; East Sussex; Essex; Hampshire; Hartlepool;
Leeds; Lincolnshire; North Yorkshire; Oxfordshire; Salford; Staffordshire; Trafford

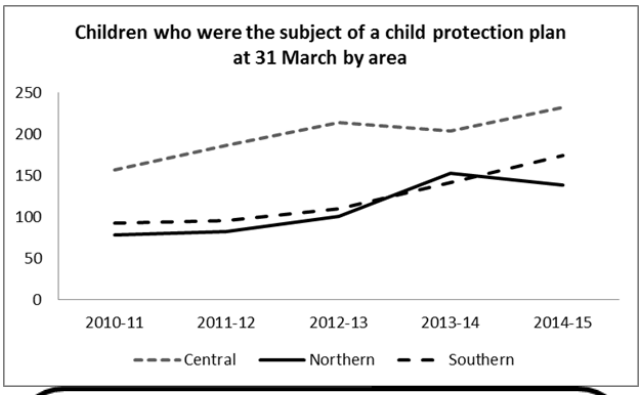
falling numbers with the rate halving in Essex and 5 have seen increases. Oxfordshire's increase is in line with Hampshire, but below that of Staffordshire.

7. Essex County Council has adopted a concerted strategy to reduce its child protection and looked after populations by improving the effectiveness of multi-agency services to children in need, thereby preventing children from entering the statutory systems. Key features of this strategy are low caseloads for social workers (12 - 15 children) and improved quality assurance and inter-agency confidence in CIN planning through the use of independent chairs' oversight. This has entailed significant investment from the local authority. However, savings from the care system are helping to offset the costs.





8. Within Oxfordshire, although there has been a growth in each area of the county it has been less pronounced in the central area where it grew by 48%, compared to 78% in the north and 87% in the south.



"Every month I have a core meeting. I say what I want and people listen. I understand what gets said at those meetings. They check back with me that I've understood".

Child

9. The biggest increase has been in older girls. In the four years the number of children over 10 on a plan rose by 115% compared to 65% for the under 10s. Despite this most children on plans remain under 10 with 71% at the end of March 2015. A higher proportion of children under 10 are on a plan in Oxfordshire than elsewhere.

% increase in cases 2011 to 2015

Ages	Increase
0 to 4	64%
5 to 10	167%
11 to 15	216%
16 to 17	210%
Total	177%

% increase in cases 2011 to 2015

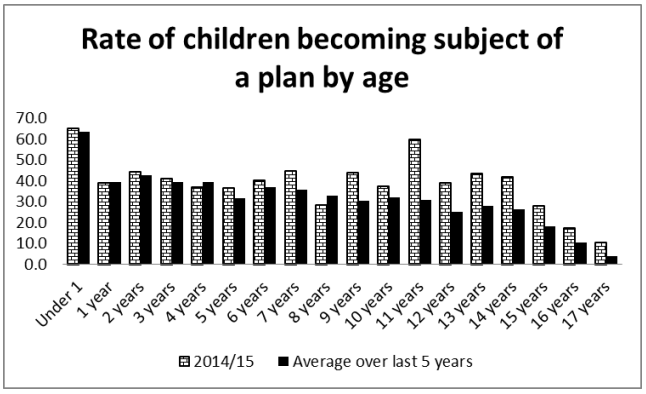
Gender	Increase
Female	85%
Male	66%

10. Schools have suggested that a key trigger for a child may be when they transfer from primary to secondary school. The attached graph looks at how many children become subject to a child protection plan per 10,000 population both last year and over the last 5 years. Over the last 5 years the likelihood of any child becoming the subject of a plan drops with each year they live. However last year this pattern changed with a growth in the 9-15 year olds starting a plan. Last year, 11 year olds were the second most frequent age for children becoming subject of a plan. Providing appropriate support from schools

"If they (the girls) are lonely or not getting what they need at home then they are going to look for it elsewhere"

Parent

and other appropriate professionals to vulnerable children in this transition period will be important to manage risk.



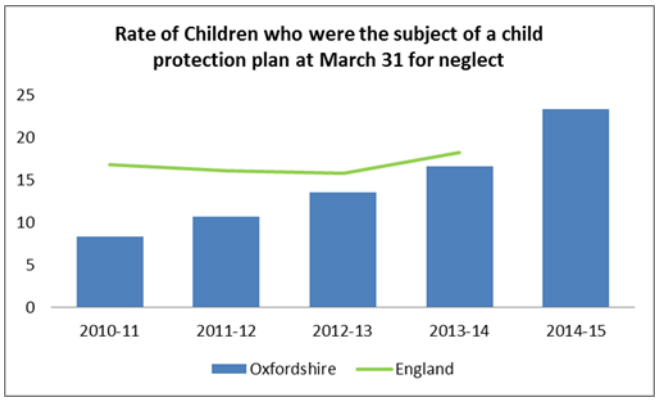
11. It had been suggested that school attendance prior to starting a plan could be a good predictor of whether a child would become the subject of a plan. This does not seem to be the case. 24% of children had 100% school attendance in the term before they came onto a plan, and 67% had more than 85% attendance. Schools need to continuously examine a range of data and ask questions about it to ensure they are managing risk. Attendance is frequently an issue raised in serious case reviews as an early indicator of concern. However some children seek the refuge and safety of school when the home environment is less stable so any simple correlation would not be expected.

> "Schools need to work more with Social Services".
>
> *Child*

> "School were like 'she's too much trouble let's let her go'"
>
> Child

12. Learning from serious case reviews both locally and nationally has highlighted the vulnerability of older children. There is now greater awareness of their vulnerability and risk particularly in relation to neglect. This may partially account for increased numbers of referrals to services including social care. Also the impact of child abuse via social media which represents a risk or vulnerability that previously would not have been considered or identified.

13. Most children are the subject of a plan because of neglect - at the end of March 2015, 56% of children were on a plan for neglect. This compares with 47% for statistical neighbours and 43% nationally. The rate of children on a plan for neglect is now considerably higher than nationally.



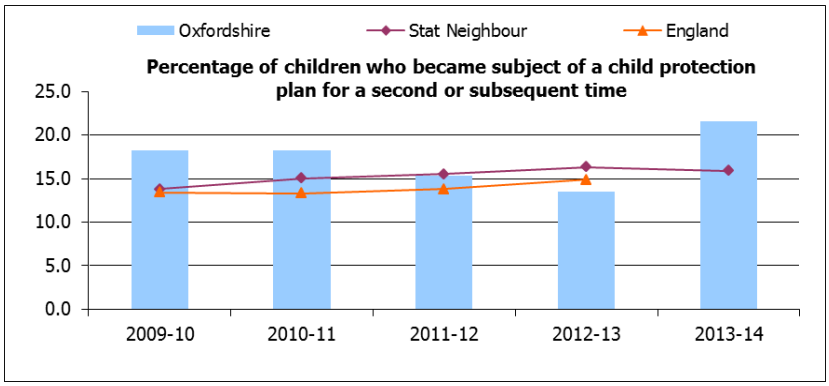
"Most things they find out, the majority or things. I don't even know how, they just seem to know"

Child

14. Since April 2011, 2361 children have ceased to be on a plan. On average they were on a plan for 303 days. Each of the individual years (11/12; 12/13; 13/14; 14/15 and 15/16 to date) is within 10% of the 303 days with no discernible trend. The growth of numbers is about more children becoming subject of a plan rather than them staying on a plan for longer.

15. However children do stay on plans for slightly longer in Oxfordshire than elsewhere. The latest comparative data is for 2013/14 when 9.3% of children in Oxfordshire who ceased being on a plan had been on a plan for 2 years compared to 4.5% nationally. In 2014/15 this fell to 6.3%. It is well-established that the greater the number of children on child protection plans, the longer children will stay on a plan.

16. The number of children subject to repeat plans in Oxfordshire is consistently higher than elsewhere. (This is not the measure in the dataset, but a measure of any repeat plan as opposed to one in 18 months). Previous audits of children becoming subject of a second or subsequent plan has shown that the improvements made during the child protection plan have not subsequently been sustained. Intervention services for children at the edge of social care therefore have to be enhanced for both step up (those that support a child before they reach the threshold for statutory services) and step down (supporting a child leaving statutory services).



2 Shift away from voluntary interventions

17. Since 2013, the number of children being worked with under Child In Need (CIN) plans has reduced. The following is a snapshot showing the increasingly statutory nature of children's social care's interventions

	July 2013	July 2014	July 2015	% change
Child Protection	422	454	626	48.3%
Looked After	427	500	555	30%
Children in Need Plan	2451	2243	1801	-26.5%

18. Previous interventions: Of the 630 children who became the subject of a Child Protection plan in 2014/15:
    - 26 (4%) were subject to a children in need plan in the 6 months prior to their child protection plan.
    - 112 (18%) were known to early intervention in the 6 months prior to their child protection plan.

3 Impact of Early Intervention

19. In the academic year 13/14 there were 816 completed Common Assessment Frameworks (CAFs). This was the 7th consecutive year of increasing CAFs and a 9% increase on the previous year. In 2014/15 between September to June 761 CAFs were completed and logged, so there is a degree of confidence that the number will grow again. The number of referrals to social care that had a preceding CAF also remains above the target of 5%. The actual number is believed to be higher than this with some CAFs not adequately reported. However despite this increase it still remains a relatively small number compared to the 17,889 contacts made with social care in 2014/15 and 5663 referrals.

20. A recent audit of 40 early intervention cases held by the council's early intervention services showed that 30% of the cases they were holding were being co-worked with social care. The number of open cases in the service is around 2100 whereas the social care case list is around 4000 - so by extension an estimated 15% of the social care case-list are co-worked. The risk factors identified in these cases mirrored those identified in social care cases.

21. Where cases were referred to the MASH and directed to early intervention - in a sample of 46 cases - there was a substantial (43%) reduction in referrals to social care after early intervention involvement with the service. Given the sample size care needs to be taken in extrapolating the results, but the impact of appropriate early intervention in reducing demand can be seen.

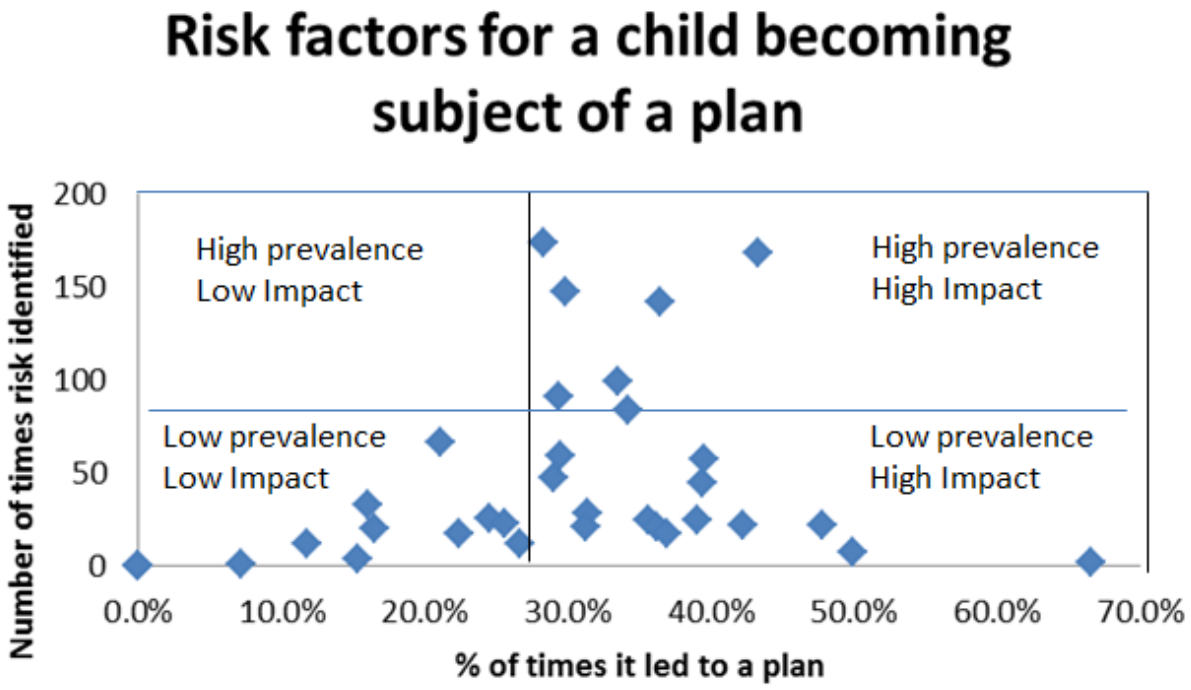
4 Risk factors

22. The following table identifies the 10 most common risk factors identified at social care assessment that led to a child becoming the subject of a child protection plan. 630 children became the subject of a plan in 2014/15. In 28% of cases one of the risk factors identified was parental domestic violence. However in 439 other assessments in the year, domestic violence was identified as a risk, but the child did not end up on a plan - so only 28% of times when parental domestic

violence was identified in the assessment, did the child end up on a plan. In slightly fewer cases (27%) child emotional abuse was identified as a risk factor, but in 43% of cases where it was identified as a risk factor at assessment did the child become the subject of a plan.

Risk Factor	How often a child went on a plan where this risk factor was recorded		Number of assessments identifying this risk	% of times it went to a plan
	No	**%**		
Parent Domestic Violence	174	27.6%	613	28.4%
Child Emotional Abuse	168	26.7%	388	43.3%
Parent Mental Health	147	23.3%	492	29.9%
Child Neglect	142	22.5%	389	36.5%
Parent Alcohol Misuse	99	15.7%	295	33.6%
Child Physical Abuse	91	14.4%	309	29.4%
Parent Drugs Misuse	84	13.3%	245	34.3%
Child Domestic Violence	66	10.5%	312	21.2%
Child Unacceptable Behaviour	59	9.4%	200	29.5%
Child Sexual Abuse	57	9.0%	144	39.6%

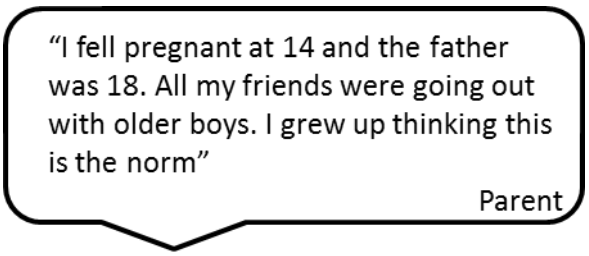
23. The chart below looks at how often a risk is identified in assessment and if it identified the likelihood that the child will be placed on a plan.



High prevalence / Low Impact	**High prevalence / High Impact**
	Child Emotional Abuse Child Neglect Parent Drugs Misuse Parent Alcohol Misuse Parent Mental Health

	Child Physical Abuse Parent Domestic Violence
Low prevalence / Low Impact Child Alcohol Misuse Child ASC Parent Physical Disability Child Drugs Misuse Child Domestic Violence Child Physical Disability General Other Other Physical Disability Child Learning Disability Other Learning Disability Child UASC Child Privately Fostered Child Gangs	**Low prevalence / High Impact** Child Trafficking Parent ASC Other Alcohol Misuse Other Drugs Misuse Child Sexual Abuse Other Domestic Violence Child Sexual Exploitation Parent Learning Disability Child Missing Child Self Harm Child Young Carer Other Mental Health Child Unacceptable Behaviour Child Mental Health

24. Clearly a key factor is to ensure that services work with the whole family and where issues such as parental mental health, drug abuse or domestic violence are key risk factors appropriate information is shared with all colleagues both on the child and on the adults in the family.



25. Health visitors across Oxfordshire receive domestic abuse notifications where there is a child under 5 years. The service received a total of 2,805 notifications during 2013-2014 and 1,922 notifications during 2014-2015. This represents a decrease of 31.3%. Thus domestic abuse does not appear to be a factor associated with increased health visitor workload. (This data however does not provide data about level of risk). This seems to be in line with other agencies data, but work is needed to understand this more fully. We do not have data about children 5 -18 years.

5 Care system

26. Overall the number of looked after children has increased and within the Looked After system a higher proportion of the children are subject to care orders, especially full care orders. The growth in looked after children has not been as great as that of children on plans and the number of looked after children in Oxfordshire remains relatively low. However any such growth in looked after numbers places additional pressures across the system

Legal Status @ 31 March 2015	2010/11	2011/12	2012/13	2013/14	2014/15	Change 10/11 to 14/15
Full Care Order	127	145	142	170	189	48.8%
Interim Care Order	96	103	63	78	61	-36.5%
All Care Orders	223	248	205	248	250	12.1%
Placement Order	26	48	57	58	65	150%
Voluntary - Section 20	177	154	153	155	197	11.3%
Remand	0	0	1	1	0	0.0%
Police Protection or Emergency Protection	1	0	0	1	2	100%
Total	**427**	**450**	**416**	**463**	**514**	20.4%

27. Within the care system there has been a steep rise in the number of unaccompanied asylum seeking children in the last year. Nearly all these children are accommodated rather than the subject of orders. Many unaccompanied asylum seeking children attend the orientation programme run by the Children's Society for Oxfordshire. Not all unaccompanied asylum seeking children are over 16, some are of a school age.

31st March:	2010/11	2011/12	2012/13	2013/14	2014/15	Change from 31st March 14
No. LAC who are UASC	34	30	26	24	49	104%

6 Impact of growth in activity on social care caseloads

28. The data below relates to the family support teams in children's social care as these are the teams which carry case responsibility for all the child protection and children in need cases of non-disabled children. These teams also work with non-disabled looked after children as they enter care and those in care proceedings. Looked after children transfer to looked after/leaving care teams once they become accommodated (by agreement with parents) or subject to full care orders. The central area has three family support teams, south and north areas have two teams respectively.

> "Yes sometimes they are in a hurry or rush. When I've got something to say and I say it at the end when there's only 10 minutes left but she [social worker] has to go to another call. And I don't like to make her late or let other people down so then I don't say it"
>
> Child

29. The average Family Support social worker's caseload across the county is 20 children. This is a low estimate as it does not take into account variations in

individual social workers' working hours. In the last year caseloads have increased from an average of 15/16. Children's social care has an ambition to reduce caseloads to a maximum of 14 per fte social worker. The range is great, between 14-32 cases. This range reflects differences in working hours and also the impact on experienced workers of recruiting newly qualified workers who have protected caseloads for one year.

	South	Central	North
Total family support caseload by area	417	578	498
Child Protection cases by area	163	223	208
Looked after cases in family support teams by area	51	58	36
Children in Need cases by area	203	297	254
Family support team caseload	209	192	249
Average caseload by worker	22	18	20
Unallocated Child Protection cases	0	0	0
Unallocated Children in need cases	37	17	7

30. Despite huge pressures in the teams caused by the rise in child protection and looked after cases, and difficulties in recruiting to vacancies, the teams allocate all their child protection and looked after cases. These cases are allocated immediately, or at worst, wait for only one or two days before being allocated. However, the growth in activity has an impact on the teams' capacity to work with children in need, leading to some unallocated work. This is notable in the south area where recruitment to vacancies has been especially challenging. Unallocated cases at these levels are a recent phenomenon, emerging as a significant factor in the last year.

> "It's annoying when my social worker is out of the office. Sometimes it's important [what I want to tell them is important to me] and it's frustrating and annoying not being able to get hold of them. The office say 'do you want to leave a message' but I say no, because it's important to me and I can't say what I wanted"
>
> Child

31. The three disabled children teams separately work with over 500 complex disabled children and include all statuses: children in need, child protection, looked after children and leaving care. Demand has risen amongst all children with special educational needs (SEN).

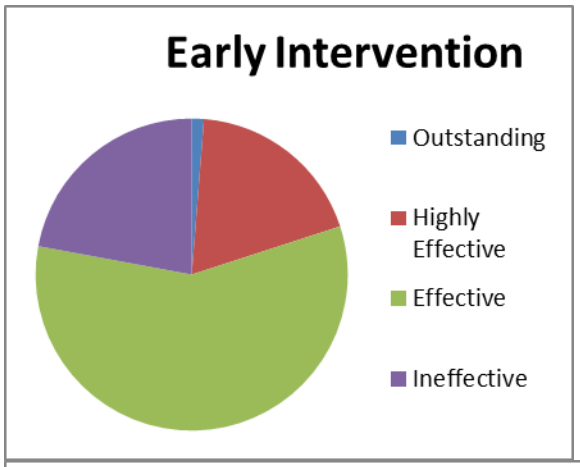
	2011	2015
Number of children with statements of SEN	1981	2245
Children and young people with SEN/Disability in county placements	96	146
The number of children supported by the autism advisory team	1115	1406
Number of disabled children receiving short break support	1269	1350
% of children accessing short break services identified as having highly challenging behaviour	22%	42%

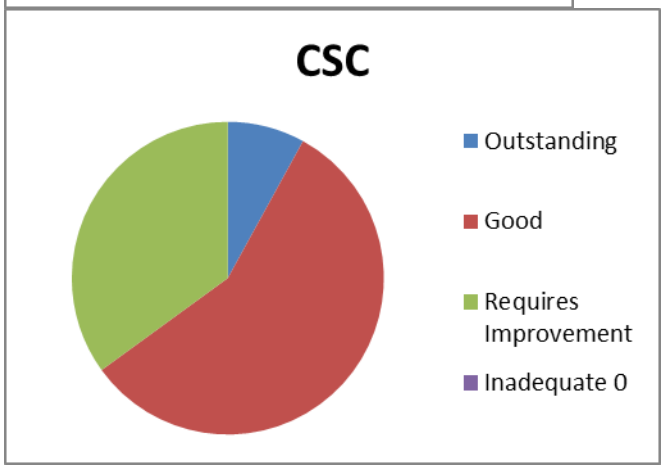
% of children accessing short break services who have complex health needs	11%	14%

32. The Kingfisher CSE Team has average caseloads of 7-10 children. The team has developed a 'persistence' model of working which entails allocating a consistent worker from first identification of high risk of CSE through to post-court support. These cases are typically very challenging, time-intensive and emotionally demanding for staff. However, as a model of working to lower caseloads the team provides some important learning for future service development in children's social care.
    - The average length on a child protection plan for Kingfisher is 208 days i.e. almost 7 months. For children in family support teams most plans range from 12-18 months. This is another indicator of the impact of caseload on the time taken to achieve progress.
    - Although Kingfisher is dedicated to working with children at high risk, the team is not placing large numbers of children on child protection plans. At 31st March 2015, 13 (17%) out of 76 children were subject to child protection plans. The same number were in care. 49 children were subject to child in need plans or were being worked with in different ways without requiring statutory interventions.
    - All the children's cases open to Kingfisher are subject to quality assurance by a dedicated independent reviewing officer (IRO) who provides oversight and challenge to the team to ensure children are progressing towards safety and improved outcomes. The CSE Stocktake audits provided strong evidence that the practice is sound and the impact is good.
    - The similarities with practice in Essex (low caseloads/high scrutiny) stand out as significant features.

7 Qualitative findings

33. Between April 2014 and March 2015 children's social care and early intervention audited 614 cases. The outcomes of these audits were





- Of the 440 cases audited by Early Intervention 80% were rated effective or above.
- Of the 68 cases audited by Children's Social Care 66% were good or outstanding
- Outcome Star performance at the end January 2015 indicated that 79% of cases had a positive impact overall across Children's Centres, Hubs and Thriving Families.

34. The findings that may impact upon the increase in the number of child protection cases are:

35. From Early Intervention Services:
    - There has been an improvement in early intervention services use of the assessment, planning, review process, which has improved the focus of work with families.
    - An increased use of actuarial measures and outcome tools by early intervention workers (such as Family Outcomes Star) to identify risk e.g. Strengths & Difficulties Questionnaire; Neglect Tool; Three Houses; Signs of Safety case mapping
    - There is an increased attendance at core groups and child protection conferences by early intervention workers
    - Early intervention services report difficulties in accessing documentation from children's social care and YOS.

- Little evidence of referrals being made to early intervention where cases are closed after one child protection episode by children's social care.
- A lack of clarity and joint focus between early intervention plans and children's social care plans on the same child

36. These findings may indicate that improved assessment and monitoring by early intervention workers are enabling them to establish 'significant harm' earlier than before.

37. The increase in attendance at child protection conferences and core groups indicate that early intervention workers are more involved in child protection cases, but their planned focus may not be effectively joined with social workers on child protection plans and therefore not supporting the child protection planning and intervention sufficiently.

38. From Children's Social Care:
    - Where there is a clear and reviewed plan, outcomes for children are more effective.
    - Where there is evidenced multi-agency working, including support for placements, outcomes for children are more effective.
    - Planning and engagement is less evident as children reach 18
    - Supervision is regularly taking place and is reflective and positively impacting upon case management across both services
    - The views and experiences of children were not adequately captured within child protection plans and in 40% of cases children had not been seen on their own after the initial investigation.

> "I felt more safe, everyone got involved. Most of them gave me a lot of help. It was the right help. It needed to be done"
>
> *Child*

39. These findings suggest that an accurate picture of any changes in the family functioning is too reliant upon the parents or carers view and children are not involved in identifying and reporting progress with change.

40. Additional work from Education and Learning shows:
    - Where there is effective leadership, good schools work well with other agencies ensuring effective outcomes for pupils
    - When all agencies focus on the achievement of pupils and closing the gap for vulnerable learners, children's outcomes are improving and their self-esteem and independence grows.
    - Where there is strong parental engagement with schools, attendance is high and closely monitored.
    - Where leaders engage actively with local hubs, early intervention is a powerful tool. This practice is inconsistent.

> "I trust teachers more than parents sometimes, Sarah [a teacher] she's good to talk to – she's done it been there, got the t-shirt" *Child*

41. The Neglect Pilot in the North of the county shows:

- Importance of strong multi-professional working to support and challenge families, with key services including social care, education, health and community support. Central to this is a shared understanding among professionals and the family of the changes that are needed to improve things.
- Engagement of the family is critical to enabling change. Families must understand what needs to change and feel involved in decisions about how to make that change.
- Understanding, and planning for, the needs of the whole family are vital to achieving better outcomes. Services for children, and those for adults, need to work together to provide coherent support to families, not just individuals within the family.
- Enabling professionals to participate in joint training sessions, and in particular for social workers to share their knowledge with practitioners in universal services, builds confidence and understanding across local networks.
- Benefits for families with children on child protection plans receiving support from workers other than just their social worker. Different professionals bring different skills and expertise which they can use to bring about positive change for children.
- Importance of families receiving intensive, practical support to help bring about change, including introducing routines and boundaries

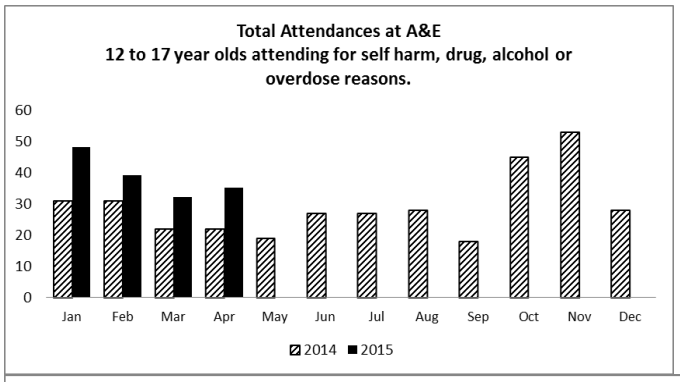
42. Work from Thriving Families shows:

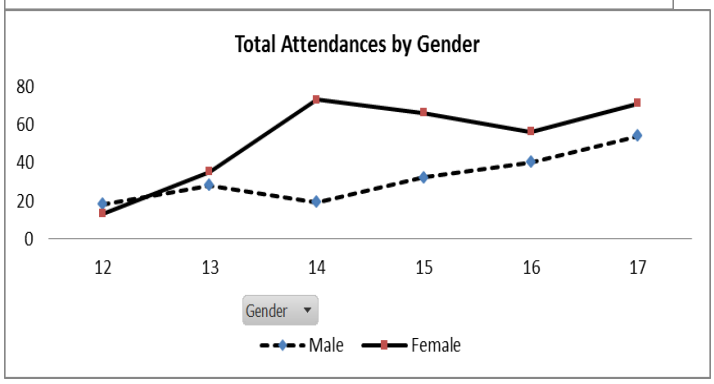
- Importance of having one worker that understands the needs of the whole family and is able to spend time with the family to understand how they function as a unit
- Benefits of workers having low caseloads meaning they have the flexibility to offer practical support when it is needed, including accompanying the family to appointments and supporting the development of routines
- Enabling workers to focus on supporting families to make sustainable changes, rather than only having capacity to respond to crises, is important in order to address the root cause of problems
- Use of tools such as the 'outcome star' with individuals and families enables everyone to see the progress being made
- Co-ordinated working between key agencies such as social care, health, schools, the Police and youth justice services and the Department of Work and Pensions is key to enabling families achieve changes

8 Growth in activity in other services

<u>Activity in the Oxford University Hospital (OUH)</u>

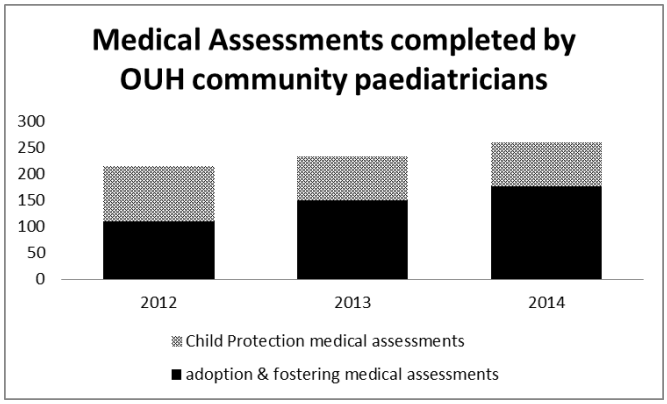
43. The following graph shows how often 12-17 year olds have presented in A&E for self harm, drug, alcohol or overdose reasons. In the first 4 months of the year there has been a 45% increase in attendance as 9 children per week are attending A&E for these categories. 62% of attendances have been girls, reflecting the pattern seen in other services.



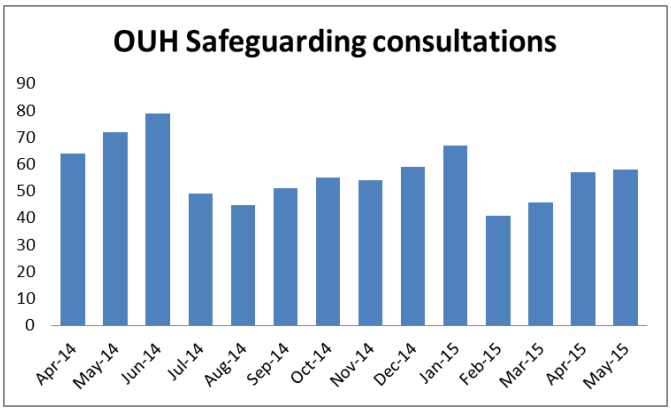


44. A third of a attendances were for self harm; 28% for drug abuse; 27% for overdoses and 12% for alcohol abuse.

45. Between 2012 and 2014 the number of medical assessments completed by community paediatricians grew by 21%. In 2014 there were 84 child protection assessments, by June 2015 there had already been 62.



46. In 2014/15 there were 682 safeguarding consultations in the OUH acute trust, averaging 57 per month.



Oxford Health Foundation Trust:
Child & Adolescent Mental Health Services (CAMHS)

47. In the CAMHS service there has been a 45% increase in accepted referrals over the past 3 years, which is leading to an increase in waiting times. Waiting times at March 2015 for PCAMHS were that
    - 6% were being seen within 4 weeks
    - 17% within 8 weeks and
    - 25% were seen within 12 weeks

48. In CAMHS this was
    - 34% in 4 weeks
    - 46% in 8 weeks
    - 64% in 12 weeks.

49. Since March the service has introduced the “Waiting Time Initiative” which is reducing waiting lists.

50. The short term focus is to provide extra locum staff to undertake a focused assessment/ intervention programme alongside some local changes in practice in tier 2 services
    - PCAMHS ways of working have been overhauled. They are offering more group work, which maximises greater reach of the service, more efficiently whilst maintaining effective evidence based treatment. This will free up more time for clinical staff to offer assessments in a more timely fashion
    - Introduction of a range of group work options for young people with similar conditions where clinically indicated. Group work is being offered as the initial preferred treatment option where clinically indicated.
    - All cases on the waiting list have been reviewed to assess the suitability for group work.
    - Where appropriate, assessments and follow up sessions will be carried out over the phone or by using FaceTime/Skype
    - There has been a review of staff working practices resulting in allocation of extra assessments. Locum clinical staff 3.8 fte have been employed to assist with this waiting-list initiative on a short term basis.
    - Alongside this Tier 3 CAMHS assessment clinics are being overhauled to ensure capacity to assess in a timely manner.

51. The longer term plan: (doing things differently)
    - Remodelling mental health services for children and young people. The current model needs reviewing in response to the increased need and developing evidence base. There is also a strategic plan to work closely with the county council to give better outcomes for children and young people to avoid duplication and offer a more efficient service.

Health Visitors

52. Health Visitors work with children and families from 0-5 years. They are routinely involved in children protection cases for this age group. The impact on work load with increased child protection cases include attendance at case conference and core groups, increased number of home visits, report writing, liaison with other professionals and child protection supervision. Often those cases that lead to court proceedings also include writing a report for court and court attendance. Once a child becomes looked after then health assessments are required. The increase in child protection work by health visitors may affect their capacity to undertake early intervention and preventative work.

School Health Nurses:

53. A new model of School Health Nurses (where all secondary schools have a nurse based within the school) has meant that they have increased contact with young people and hence more referrals. Although this is very positive, school health nurses are reporting that young people are disclosing significant vulnerabilities such as self-harm, relationship issues, emotional health difficulties. This in turn is expected to result in an increased number of referrals to social care.

Safeguarding Nurses:

54. The safeguarding nurses in Oxford Health form a team to provide consultation and advice to colleagues when they have a safeguarding concern. In the last 3 months the team have completed 393 consultations. While most (62%) come from colleagues in the children and family directorates 150 consultations were provided to colleagues in adult directorates, who in their work with the adult had concerns over the welfare of children.

Number of Children's Consultations undertaken by Oxford Health Safeguarding team

Month	Children and Families Directorate	Adult Directorate	Older Adult 75+ Directorate
April 2015	82	51	0
May 2015	76	52	1
June 2015	85	46	0

55. Specifically there were 55 consultations from CAMHS, 45 consultations from School Health Nurses and 61 consultations from Health Visitors. Across the system people are experiencing a growth in child protection consultations

56. The community children's nurse team (CCN) are describing an increased role in safeguarding / child protection work. The children have more complex health needs that are now being managed in the community. This is coupled with

increased life expectancy. Also, an increased number of disabled young people now stay on in education post-16 and hence have a longer period of engagement with school based care provision.

57. The Kingfisher nurse post was introduced in November 2013. The caseload has steadily expanded and now stands at around 70 children. The commissioners have recognised that there needs to be increased health input into the team, and an additional full time band 6 post has now been funded.

Thames Valley Police

58. Over the last 3 years (2012/13 to 2014/15)
    - There has been a 23% increase in the victims of crime aged under 17
    - This includes a 43% increase in victims of sexual offences
    - Since 2009/10 the number of victims of sexual offences has more than doubled (from 281 in 2009/10 to 581 last year)
    - The number of missing children has risen by 10% (from 630 to 694) and those missing on 3 or more occasions has risen from 77 to 132
    - Girls in all areas are being subjected to increased sexual offences and the numbers are high in all areas, but remain lower in West Oxfordshire.

> "In our area … if there is a lad grooming girls people re-post and news articles get shared. We post their pictures so we can let others know and we know to watch out for them"
>
> *Parent*

    - Crime rates are rising in all areas except in the Cherwell area where crime is showing a slight fall.
    - Crime rate for boys who are aged 17 or under is falling in the Vale of White horse area.

> "I didn't want to go to the police, but other than to go to the police, who do you turn to? Who do you go to for some friendly advice? Who do you go to instead of the police, is there anyone? "
>
> *Parent*

    - In the last two years girls are more likely to be subjected to crime compared to males in all areas.
    - Oxford has the highest crime rate and West Oxfordshire has the lowest crime rate.
    - The victim rates for robberies are very low in all areas for the under 17 year olds.

59. The police are working on doubling the size of the child abuse investigation teams across the force over the next two years due to the fact that workload will have doubled by then.

9 Possible explanations for the increased activity and changing profile

Oxfordshire is experiencing greater levels of deprivation and need? No current evidence.

60. At the end of 2012/13, Oxfordshire had a rate of 30.9 children on a child protection plan for every 10,000 children and young people countywide. Whilst this is lower than the national rate of 37.9, when it is weighted for the number of income deprived children/young people, Oxfordshire has a higher rate than would be expected. Nationally, for every 60 deprived children/young people, there is one on a child protection plan. In Oxfordshire the ratio is one child on a plan for every 40 deprived children/young people.

Thresholds are lower? No current evidence.

61. Dip-sampling is undertaken at intervals to test the threshold at which a child enters a child protection plan does not indicate a risk-averse culture or a lowering of the threshold at this point, but rather a greater awareness amongst the professionals of the potential for serious harm in a child's situation. All agencies have developed their identification and assessment processes to be more aware and responsive to children at risk of harm. Defensive practice across the system may indicate that professionals feel more safe when a child is on a child protection plan as opposed to a children in need plan or early help

Child in Need planning is not having a preventative effect? Yes there is evidence

62. Child in need planning is not taking place as much as before (reduction of 26.5% since 2013). 18% of early intervention cases convert to child protection plans within 6 months, indicating that complex cases are 'leap-frogging' the child in need system and entering child protection planning as risks are identified within schools, universal settings and early help services.

63. Findings from children's social care audits indicated that for children in need plans there was often a lack of multi-agency working or support for older children and the plans did not sufficiently address education, health or social needs. The reasons for this may be part of a vicious cycle:
    - Social workers' case priorities are currently child protection cases due to the increase in numbers.
    - Children in need cases are getting less attention and consequently multi-agency professionals have less confidence in the effectiveness of Section17 plans and support. This drives a demand for child protection plans.
    - Cases of children with complex needs who do not receive timely, effective risk-focussed interventions get worse and 'tip into' child protection planning
    - At child protection conferences professionals are highly unlikely to agree to a children in need plan as an effective way of managing cases that straddle thresholds.
    - Nationally there is an increased awareness of abuse and a climate of fear being created for any professional who fails to recognise this and take action

Greater sensitivity to risk of abuse/neglect by professionals? Yes there is evidence

64. Greater sensitivity to risk amongst professionals and in the community may be having an effect. When Oxfordshire's rate of increase in child protection numbers

is compared against the rates in other local authorities which have been through high profile CSE cases, a common trend upwards is detected. In Oxfordshire this has not led to significantly more referrals; it has led to more referrals converting into assessments and child protection plans. This would indicate more in-depth appreciation of risk and responsibility. There is a better recognition of the combined accountability of professionals to identify and protect children. The Stocktake Report provides evidence that partnership working to identify and mitigate risk is being undertaken pro-actively, including by professionals who did not historically see child protection as their core business, for example district council workers, housing providers.

65. In addition there has been recent multi agency training on the use of assessment tools i.e. the threshold of needs matrix, neglect tool kit and CSE screening tool. These tools inform the assessment process and facilitate a more accurate and thorough risk assessment, leading to a higher number of S47 referrals. A current audit of referrals into MASH from Oxford Health may provide some data to support this. This work will be completed in September 2015.

66. Also, there may be increased awareness of child protection issues amongst professionals working in adult health services, as a result of the Think Family agenda. This encourages practitioners to consider the needs of children within a family, if they are working directly with an adult. This is borne out by the data from Oxford health which shows 28% of chid protection consultations with the safeguarding nurses came from people working with adults.

67. A recent audit of thresholds on child protection cases looked at 18 cases in which the Principal Social Worker assessed that 4 may have been managed under Section 17/ family support in the past. This was generally due to a difference in professionals' awareness of the long term impact of abuse upon a child; which appears to suggest that the 'potential' for significant harm is a major deciding factor for professionals now in relation to making child protection plans. Previously evidence of actual harm was a significant threshold factor.

Older children, particularly girls, with higher levels of risk identified by referrers, than previously? Yes there is evidence

68. Over the last four years the Oxfordshire partnership has worked together to increase professionals' awareness and understanding of risk across in older children and teenagers. 'Everyone on alert' has been key learning from the Bullfinch serious case review. Schools, health professionals, police, housing and children's services have increased their understanding of the safeguarding significance of older children's behaviours i.e. looking beyond the presenting issue and recognising the symptoms of abuse and exploitation. This cultural change was evidenced in the Stocktake report. The recent OSCB partnership review of agencies actions (2013-15) in safeguarding a large group of teenage victims of CSE, provides additional evidence of a much improved child-centred culture.

10 Summary

69. Oxfordshire's pattern of increased growth does not follow the national pattern, however it is more in line with authorities that have had a high profile CSE issue and/or are judged as good by Ofsted, with both groups showing a greater increase in child protection activity than the national figure. This appears to be because of greater awareness of both professionals and the public and more responsive services.

70. Across all agencies we now appear to be reaching a point where demand is outstripping supply and without improved capacity then there is a danger that Oxfordshire will not safeguard children in future, leading to more harm and family breakdown. The impact of the growth of child protection work falls across all agencies e.g. GPs are now unable to attend all case conferences due to the number taking place at the same time.

71. Additionally, the local authority and partner agencies may attract a 'requires improvement' or 'inadequate' inspection judgement unless we do things in a fundamentally different way.

72. There has been a growth of children in secondary schools more readily recognised as vulnerable children rather than difficult adolescents, in previous years. The number of adolescents presenting in A&E this year has risen and the number of adolescent girls who have been the victim of crime is increasing.

73. With increased multi agency working it has become apparent that children's social care data tends to drive the debate across the partnership, when it is evident that other sources e.g. the police data on victims of crime can help to describe the picture of how safe children are in Oxfordshire.

11 What needs to be done?

74. Recognise that the increase in activity does not reflect poor performance but improved identification of risk leading to very high usage of child protection planning. A reduction in resources, without addressing the current configuration of early help services and social care, may lead to children not being protected. Changes need to be co-ordinated across all agencies to ensure children are best protected.

75. The Children's Trust should create a coherent multi-agency model of family support, within which all agencies' resources are directed towards collaborative working, without duplication or gaps. The Trust should be held to account by the Oxfordshire Safeguarding Children Board.

76. The nature of child protection is changing and new threats are developing (e.g. revenge porn). As the age-profile changes, so does the response. Managing risk for adolescents is a home and community-based risk, whereas for younger children it is primarily a home-based risk. Going forward there is a need to continue to build safeguarding capacity in schools and the community.

77. Across the system we need to move from management of risk for children to reducing the sources of harm - from cure to prevention. This includes the

development of support to schools and community services to build resilience, including best use of the voluntary sector, and supporting initiatives in community safety. Successful schemes such as the school nurses should be identified and lessons learnt.

78. The level of multi-agency support for children in need and children on the edge of statutory services needs to be improved. This will entail adopting the learning from the multi-agency Neglect pilot project which strengthens core group working, holding agencies to account in achieving safeguarding objectives.

79. The council is currently consulting on the future of its social care arrangements, to meet savings targets over the next four years. Key features of this model aim to address the findings of this analysis and include:
    - Recognising that statutory safeguarding must be protected
    - Retention of the current area based social care team structure: North area covering Cherwell and West Oxfordshire District Councils; South area including Vale of White Horse and South Oxfordshire District Councils; Central area covering Oxford City Council
    - Ending or reducing the local authority's role in delivering universal services
    - Development of a new locality support service to offer advice to schools and community services, to support the shift from 'cure to prevention'.
    - Development of a more robust child in need casework system to address children's needs effectively without immediate resort to child protection planning. The management of risk outside the statutory system requires a clear accountability and assurance framework led by senior managers in all agencies.
    - Delivering both child in need and child protection plans via a new Family Support Service supporting 0-19 year olds (25 years if young people have additional needs). This brings together some of the functions of the current Early Intervention Service with those of the Family Support Teams currently within Children's Social Care.
    - Maximising the capacity of staff to keep caseloads low enough to support high quality practice.
    -

Whilst the most efficient model to deliver this agenda will be developed within the resources available there is a risk that the combination of reduced budgets and increased activity could adversely affect the ability of local services to keep vulnerable children safe and prevent harm at an early point. The OSCB has requested at it Full Board meeting on 22nd October 2015 that each representative agency should undertake an impact assessment of the savings it is having to achieve. The Children's Trust considered the content of this report at its September meeting. The Health and Wellbeing Board is recommended to consider any additional measures to mitigate the risks and the Oxfordshire Safeguarding Children Board will continue to monitor the impact of these developments.
END

Oxfordshire Health and Wellbeing Board
5 November 2015
Children's Trust Briefing

This paper outlines the activity of the Children's Trust since the last update which was provided to the Health and Wellbeing Board in July 2015. The Trust has met twice since the last update.

1. Members of the Trust have discussed and fed into issues including:

    a. The **Supported Housing Pathway for children and young people**. The Trust discussed barriers faced by young people seeking housing and the benefits of the new supported housing pathway for those who cannot return home due to neglect, abuse, etc. It was recognised that partners need to work together to develop flexible solutions, so that young people do not remain in the pathway, but are able to move on successfully. The Trust will continue to receive updates on the new supported housing pathway, although performance will be monitored by the Health Improvement Board, alongside the supported housing pathway for adults.
    b. **Outcomes for vulnerable learners.** The Trust discussed progress towards developing a strategy for vulnerable learners, with its central aim being equity with excellence. Members emphasised the importance of having input from primary care providers and the wider community, as well as acknowledging school as a protective factor in the lives of vulnerable young people. The changing role of the council was also recognised as the strategy will be able to influence and guide schools, but not instruct them. The Trust will have the opportunity to comment further when a draft is ready to be shared.
    c. **Key messages and pressure points** from across the system in relation to children and young people. The Trust was made aware of the increasing volume of work across agencies dealing with child protection and safeguarding, and acknowledged that awareness of abuse and neglect has increased, as well as self-awareness of risky behaviour. The challenge of measuring the impact of training and preventative services was discussed and members emphasised the importance of working together to reach children and young people in different ways, particularly those who remain 'hidden' until crisis point. The Trust recommended that the Health and Wellbeing Board is made aware of the key risks in relation to children and young people.
    d. The **proposals for transforming Early Intervention services and Children's Social Care.** The Trust discussed the future service model and the three options that are the focus of public consultation. Members raised a number of points in relation to the content and timing of the consultation; the location of services; the future use of buildings; and the effects of reducing universal services on partners and the public. The Trust's comments were considered in preparation for the public consultation.

2. At its July meeting the Trust welcomed **new members**: Alexandra Walker from the Balsam Family Project, Simon Brown from the FASD Trust, and Katy Thompson from VIVA, as representatives from the voluntary and community sector.

    Katie Read / Ben Threadgold
    October 2015

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Oxfordshire Health and Wellbeing Board
5 November 2015
Older People's Joint Management Group Briefing

This paper outlines the activity of the Older People's Joint Management Group since the last update provided to the Health and Wellbeing Board in July 2015.

1. The Group has met twice since the last update, on 28 July and 29 September 2015, and had discussions on the following issues in addition to matters arising from the previous meetings.

2. The Older People's Joint Management Group monitors activity, performance and spending from the pooled budget to meet the six priorities of **the Older People's Joint Commissioning Strategy,** which are:

    - I can take part in a range of activities and services that help me stay well and be part of a supportive community.
    - I get the care and support I need in the most appropriate way and at the right time.
    - When I am in hospital or longer term care it is because I need to be there. While I am there, I receive high quality care and am discharged home when I am ready.
    - As a carer, I am supported in my caring role.
    - Living with dementia, I and my carers receive good advice and support early on and I get the right help at the right time to live well.
    - I see health and social care services working well together.

3. The discussions on priorities and activity have focused on responding to the increasing demand for services within a diminishing budget. It is imperative for health and social care to work together to develop new ways of delivering the services people need, and items brought to the Group reflected this. Integrated Locality Teams are one example which was discussed at the meeting in July. Specific areas the Group addressed included:

    - **Care homes activity:** The Group agreed to have a detailed discussion about care home activity and spending in its meeting in November to analyse the reasons for a high number of permanent admissions to care homes. They will also examine the reasons behind the high number of admissions from home, which, unusually, exceeded admissions from hospital this year.
    - **Reablement**: work is on-going to improve access to reablement from the community, which has continued to be half the rate of that expected.
    - **Care at home activity**: the Group will continue to monitor care at home activity. The demand for care at home is greater than expected and care packages are getting bigger and more complex, putting pressure on teams' capacity and the budget.

4. The group approved the actual pooled budget to date as £48.472m which equals a year-end overspend forecast of £2.190m.

5. The group approved the **Ensuring System Resilience in Oxfordshire** paper that summarised on-going actions and additional funding to ensure a resilient and effective social care service over the winter period. The Clinical Commissioning Group was asked to fund this additional activity subject to agreement at their Board.

6. The group discussed **the new Choice Policy** and the impact of choice on delayed discharges from hospital. Over the period 2014/15 to date the number of delays from acute and community hospitals has remained high (weekly average c155) where choice delays have constituted around 10 percent of the total. To remedy this, a new Choice Policy was agreed and enacted across acute and community hospitals in April 2015, along with a new local counting system that provides more detailed information on the reasons for delay was implemented in August 2015.

   The policy sets out the process for managing patients who are ready to be discharged from acute care to their home with a care package or to a residential care/nursing home, or transferred to a community health or social care service. An update report will come to the Older People's Joint Management Group in January 2016 when the full impact of the changes will be clearer.

7. The group received information on the projects piloted in Oxfordshire with £4.9 million secured from **the Prime Ministers Challenge Fund** and on the **Adult Social Care Workforce Strategy 2015-2018.**

Fulya Markham
Policy & Partnership Officer

19 October 2015

An update of the work of the Health Improvement Board
Report to the Oxfordshire Health and Wellbeing Board
October 2015

The Health Improvement Board met on 27th October to receive updates on performance and a range of other issues.

The Board often calls for more in-depth reporting on performance where there are causes for concern and at this meeting they received a "report card" on successful completion of treatment for opiate and non-opiate use. This set out the work underway to improve performance.

The main item on the agenda was a discussion on the Healthy Weight Strategy. This comprised an overview of current work from each of the partners – all the local authorities and the CCG – plus Oxfordshire Sport and Physical Activity and the Oxford University Hospitals Trust who have a range of options to help staff maintain healthy weight. The Healthy Weight Strategy will now be updated and revised in the light of the discussion at the board.

The papers from the meeting can be seen here:
http://mycouncil.oxfordshire.gov.uk/ieListDocuments.aspx?MId=4656&x=1&

The next meeting of the Health Improvement Board is scheduled for 18th February 2016.

The membership of the Board is now:

Chairman – City Councillor Ed Turner	Oxford City Council
Vice Chairman - Councillor Anna Badcock	South Oxfordshire District Council
***Board Members**:*	
Ian Davies	Cherwell & South Northants District Council
Cllr John Donaldson	Cherwell District Council
Laura Epton and Emma Henrion	Healthwatch Ambassador (job share)
Cllr Hilary Hibbert-Biles	OCC – Cabinet Member for Public Health & Voluntary Sector
Dr Jonathan McWilliam	Director of Public Health
Cllr James F. Mills	West Oxfordshire District Council
Dr Paul Park	Oxfordshire Clinical Commissioning Group
Cllr Monica Lovatt	Vale of White Horse District Council
Jackie Wilderspin	Public Health Specialist
Val Johnson	In attendance as officer supporting District Councils

Jackie Wilderspin, October 2015

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Oxfordshire Health and Wellbeing Board

Date of Meeting: Thursday, 5th November, 2015

Title of Presentation: Oxfordshire's Health and Social Care Transformation Plans

Purpose: To brief the Health and Wellbeing Board on the emerging system-wide plans for transformation of the way in which Oxfordshire's health and social care will be delivered to address population growth, demographic demands and pressures on available resources now and in future years.

The paper also provides an overview of the governance arrangements for the system wide transformation programme and indicative development and implementation timescales.

Members of the Board are invited to comment on the proposed approach and emerging vision.

Senior Responsible Officer's: Stuart Bell, Chair of Oxfordshire's Transformation Board/David Smith, CEO Oxfordshire CCG

1. Introduction

Challenges facing local public services, including health and social care are many and varied and well-known to the members of the Board.

One of the key issues in Oxfordshire is the rising demand from a growing, ageing population (with the number of over-85s in the county expected to rise from around 15,000 to around 24,000 between 2011 and 2026). This coincides with significant funding constraints on the public sector commissioners and providers of health and social care services, as public sector organisations play their part in deficit reduction.

Another major driver for change is the increasing prevalence of co-morbidities and complexity of patients the health and care system looks after.

The NHS Five Year Forward View (June 2015), describes a vision for health and care service that will be needed in 2020. One which empowers people, their families and carers to take more control over their own health, care and treatment supported by easy access to integrated holistic care, in settings closer to where people live and organised to effectively support people with multiple conditions not just a single disease.

Achieving this vision will require further work so that:

- Individuals taking greater responsibility for their own health
- Preventing and managing demand
- (Re-)designing services and finding innovative ways of delivering outcomes for the society that lives longer and expects more
- Maximising the value of our health and social care spend.

The Five Year Forward View Into Action (December 2015) produced by NHS England develops this vision further and outlines new ways of working and new models of care that can help us realise this vision over the coming years.

Health and care organisations across Oxfordshire are committed to working together as a system to shape the future of health and social care and develop local solution in response to local needs.

To this end Oxfordshire established a system wide Transformation Board in March 2015. Membership includes Oxford Health NHS Foundation Trust (OHFT), Oxfordshire University Hospitals NHS Foundation Trust (OUHFT), South Central Ambulance Trust (SCAS), Oxfordshire Clinical Commissioning Group (OCCG), Oxfordshire County Council (OCC) and the Oxfordshire primary care federations. The board is chaired by Stuart Bell, Chief Executive of Oxford Health NHS Foundation Trust.

The aim of the Board is to plan and design the next generation of integrated GP, hospital and social services and drive forward system transformation across Oxfordshire. More specifically it serves to bring together in one place all the system wide projects, which will deliver significant change in the health and care system, and provide a place for an in-depth discussion about new models of care and system enablers.

We are in the early stages of developing plans and models for the future of health and social care in Oxfordshire. Having agreed the scope of the programme, the 'case for change' and direction of travel, we are now in a position to start engaging a broad range of stakeholders to shape the future of health and social care in Oxfordshire.

2. Oxfordshire – the local picture

The population of Oxfordshire currently enjoys good overall health. In 2010 Oxfordshire was ranked the twelfth least deprived upper tier local authority out of 152 in England. However, there are pockets of social deprivation, with 18 local areas featured among the most deprived 20% nationally.

Increases in life expectancy mean that people are living with good health for longer and with new treatments people are also living longer but with long term chronic conditions.

Oxfordshire's health needs are changing, driven by increasing chronic disease and an ageing population as well as increase births from the growing populations accross the county, particularly in Cherwell and Didcot.

Oxfordshire's performance across many outcomes is in the top 25% nationally (e.g. one year survival from cancers, mortality rates in Cardio Vascular Disease, Respiratory) and we have low levels of hospitalisation (approx. 600 per 100,000 per head of population compared to over 1300 per 100,000 in Manchester).

However, pressure on services is increasing, particularly where demand is more highly concentrated among older people. We are seeing a demand for both children's and adult's social care, growing at an even faster rate than would be expected by population growth suggesting that previously unmet need is coming forward. There are also pressing problems such as mental health in children and some outcome areas where we should be better such as diabetes.

Healthier behaviours are more prevalent in Oxfordshire, with higher than average levels of physical activity, fewer people overweight or obese, and relatively low levels of smoking than nationally. Still, obesity and diabetes continue to increase locally with 55% of Oxfordshire's adult population being overweight or obese.

The number of people with diabetes is forecasted to increase by 32% to 41,000 by 2030. At the same time we have specific local challenges including 22,000 new homes being built in Didcot and 23,000 in Cherwell (including Bicester). Black and minority ethnic communities numbered 60,000 (9% of Oxfordshire's population) in 2011, almost double the 2001 figure, with the largest increase in Oxford and Cherwell.

A lot of progress has been made in integrating health and social care services across Oxfordshire; a number of care pathways have been transformed as a result of in-depth consultation with clinicians and patients; real difference to patients is being made as providers are being paid on patients' outcomes rather than on them turning up for appointments. GPs are working collectively to share resources and change the way they deliver services and the implementation of locally based community health and social care teams is well underway.

However in the past year Oxfordshire has fallen short of a number of national performance targets and we continue to struggle to reduce the number of people who are delayed in hospital. Many of the problems we face require a whole-system approach to resolve them. For example we know are aware that contributing factors to the problem of Delayed Transfers of Care (DToC) involve almost all parts of the system, from ambulance providers to social care teams and we are working through the Systems Resilience Group to collectively address them.

Our challenge in Oxfordshire is to ensure the highest quality care for all patients within the finite resources available. As a whole health and social care system we need to improve the quality of health and social care services provided in Oxfordshire ensuring they represent best value for money, while keeping the system in financial balance. This will involve redesigning the wide range of health and care services currently provided throughout Oxfordshire. Financial challenges facing the NHS means that we need to find savings in the region of £270 million by 2020/21 within Oxfordshire. This is money that we need to save to invest in meeting the new demands – it is not a saving as a result of resources being reduced. We will also have to take account of financial pressures faced by local government and the challenges for social care.

With the growth in demand due to an aging population, population growth and rising expectations amongst the public we need to respond by continuing to develop our services adopting emerging models of care where appropriate.

3. Vision for the future of health and social care in Oxfordshire

Our initial vision for a new integrated health and social care system has been developed with support from leaders and medical directors across the system and is further supported by an emerging Out of Hospital Strategy. It is depicted in Figure 1, below:

Our Vision for Oxfordshire –
Best Care, Best Outcomes, Best Value for all the people of Oxfordshire

Figure 1

Figures 2 – 4, below, illustrate how services may operate in the future.

Our newer services are increasingly tailored to support self care and person-centred care…

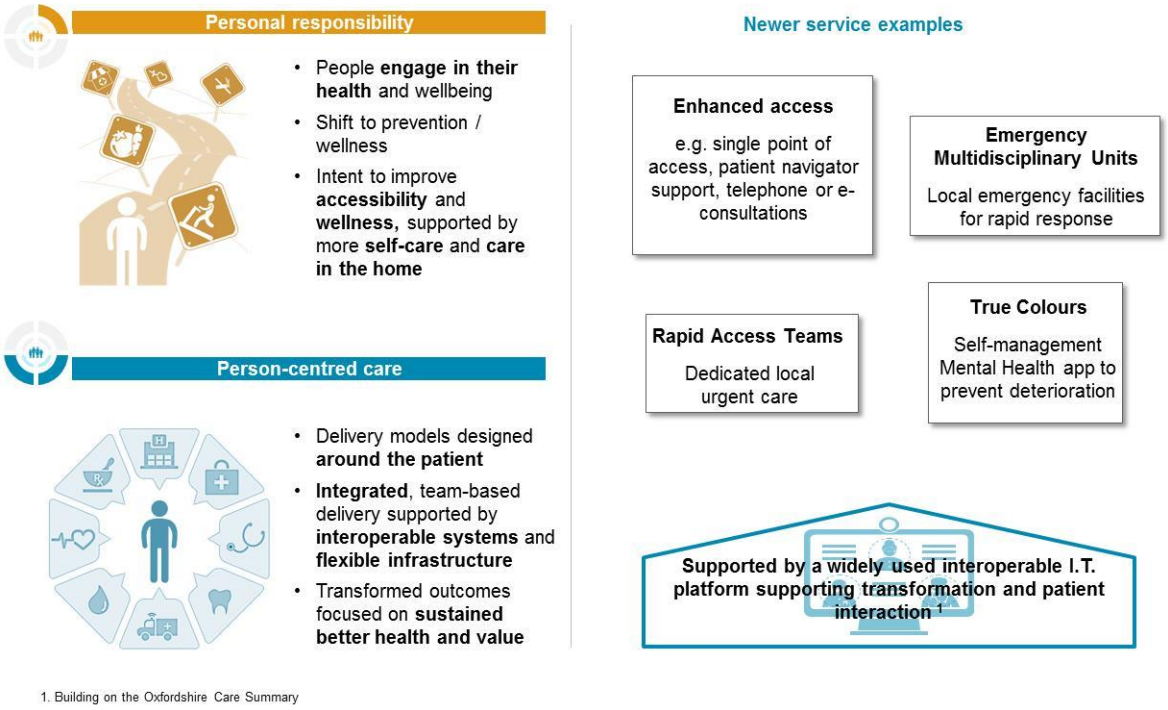


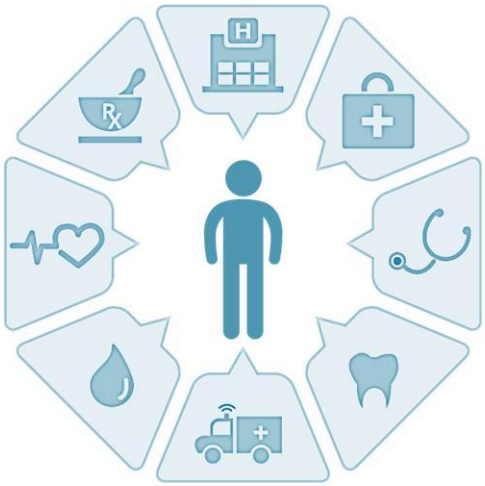
Figure 2

…and by 2020 we will have made significant changes that aligned our staff and infrastructure…

Accountability to patients will be clear and consistent – a designated clinician will be responsible for the patient 24/7

Staff **make full use of their skillsets**, cutting across organisational boundaries, supported by agile, interoperable IT

Patient-centred care



Resources and infrastructure will be **reallocated to match need and enhance convenience,** e.g. on-line monitoring, longer appointments available through various channels, diagnostic centres in the community etc

Significant changes to buildings and beds so that people are only admitted to a bed when and where it's absolutely appropriate to their needs

'The best bed is your own bed'

Figure 3

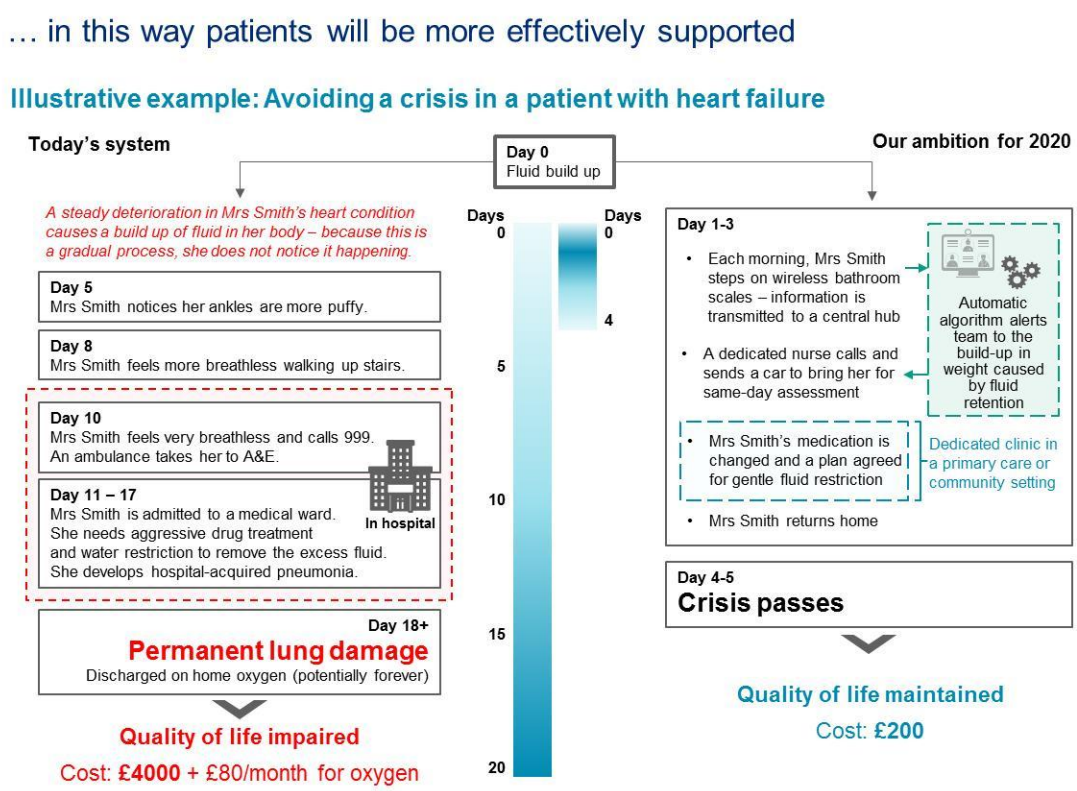


Figure 4

3. Oxfordshire's Transformation Programme: scope, approach and priority areas

The Transformation Board is part of the new 'system architecture' (see Figure 5, below), bringing health and social partners together to address long-standing issues in Oxfordshire.

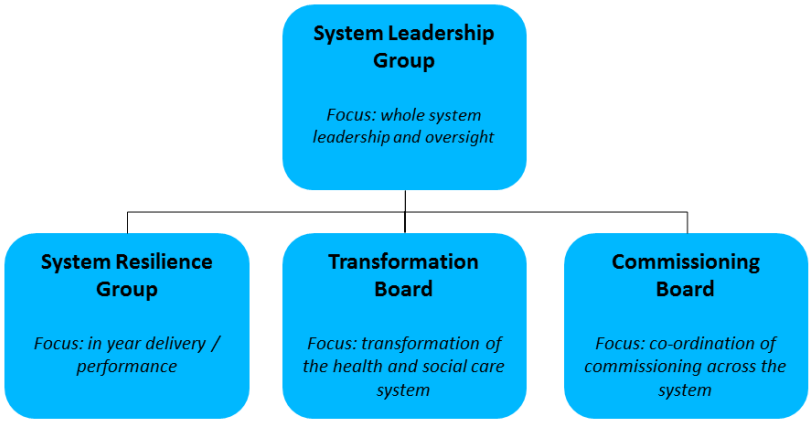


Figure 5

The Transformation Board aims to bring coherence and simplicity to a number of change initiatives across Oxfordshire.

The scope of the Transformation Board's work includes strategic change programmes in:

- Primary and community care
- Urgent and emergency care
- Older people
- Mental health
- Elective (planned) care
- Maternity services
- Children services
- Public health/prevention
- Supporting functions (e.g. IT, workforce, estates)

As the Board is not an executive body, it will look to work through the existing structures in the county, e.g. the boards of individual organisations, the Health and Wellbeing Board and Oxfordshire Joint Health Overview and Scrutiny Committee.

Since its inception in March 2015, the Transformation Board has made good progress in scoping the transformation programme and engaging executive teams across the system.

The Board has developed a case for change and is developing a joint ambition for the future. The Board is in the process of building an evidence base and articulating possible future models of healthcare delivery. Comprehensive 'models of care' will be developed in consultation with stakeholders over the coming months.

This will build on existing initiatives such as the Prime Minister's Challenge Fund to deliver primary care through modern channels; a range of integrated care teams to support people with complex needs; and Emergency Multidisciplinary Units (EMUs) across the county to assess and treat patients closer to home; as well as Older People and Mental Health Outcome Based Commissioning.

The Board will also be reviewing the role and services provided by current community hospitals across Oxfordshire, and in particular how they support an ambulatory model of care. This model of care builds on the shift in Oxfordshire towards ambulatory care that has already been made with the introduction of the Emergency Multidisciplinary Units (EMUs) in Abingdon and Witney and the development of a Rapid Access Care Unit (RACU) in Henley. These Units are supported by GPs, community services and hospital specialist teams who work together to best meet the needs of patients by providing care in or close to their

home, wherever possible. This strand of work includes an assessment of healthcare provision delivered by local hospitals across the County.

Our plans for the near future include working with stakeholders across the system to develop and test future health and social care models (autumn 2015 – spring 2016), followed by a more formal consultation process with stakeholders on proposed changes (spring/early summer 2016). Following the consultation, we would be aiming to make decisions about future ways of delivering social care and health in Oxfordshire – likely to be late summer 2016.

The emerging Transformation Programme, spanning several years, will lead to services being delivered in new ways with increased emphasis on prevention, self-care, bringing more care into the community and further integration of health and social care.

Our focus in the coming months will be on out-of-hospital care, i.e. co-ordinating changes in primary care, community services, social care and acute services.

4. Delivering the vision

We believe all the stakeholders in the system have a clear understanding of the need for new care models that have the potential to deliver a better user experience, higher quality and the potential to lower costs (by as much as 40%). All partner organisations support the vision and direction of travel.

As stated: our aim will be to bring the bulk of care closer to home, recognising that the best bed is, for majority of people, their own bed. This will of course require a cultural shift from reactive to proactive healthcare approaches and focus care more effectively around patients/service users, their families and local communities.

However we do not build the future of health and care in Oxfordshire starting with a blank canvass; there are a number of initiatives already underway that will support system change. These include:

- Formation of primary care federations
- Prime Ministers Challenge Fund Schemes e.g. early visiting service; Skype consultations; cross-practice referrals
- The Alliance (OHFT and OUHFT) to deliver Older People care
- Mental Health partnership
- Integrated Locality Teams bringing together community health workers with social workers and occupational therapists employed by the County Council so that they work together with GP's to improve services for patients and service users
- Emergency Medical Units (EMU's) in Witney and Abingdon and the Townland Hospital Rapid Access Unit (RACU)

The Transformation Board is reviewing the portfolio of initiatives to ensure they fit with the vision and are aligned to transformation themes.

While the exact governance arrangements are yet to be agreed, we envisage a number of projects grouped into programmes, each with a Senior Responsible Owner (CEO or Executive Director).

A cross-organisational Programme Team, led by Programme Director and supported by CCG's Portfolio Management Office (PMO) will support the delivery.

4. Consultation and Engagement

Our 'case for change' and emerging vision has been shared, and positively received, with Oxfordshire MP's and Oxfordshire County Council's Cabinet gaining encouragement and support for our bold local solutions.

The 'storyboard' is not a strategy, blueprint or a detailed plan nor does it contain all the answers. Rather it is a common platform that allows us to begin a series of conversations with stakeholders to help us shape our future health and care service offer.

The Transformation Board plans now include a period of pre-engagement with a wide range of partners through to the end of 2015. We will also be working with stakeholders to develop and test future health and social care models from now through to spring 2016.

We are initiating discussions with HOSC, Oxfordshire's Health and Wellbeing Board, partner organisations' Boards.

This will be supported by a period of formal public consultation to help us shape our plans further in the spring/early summer of 2016.

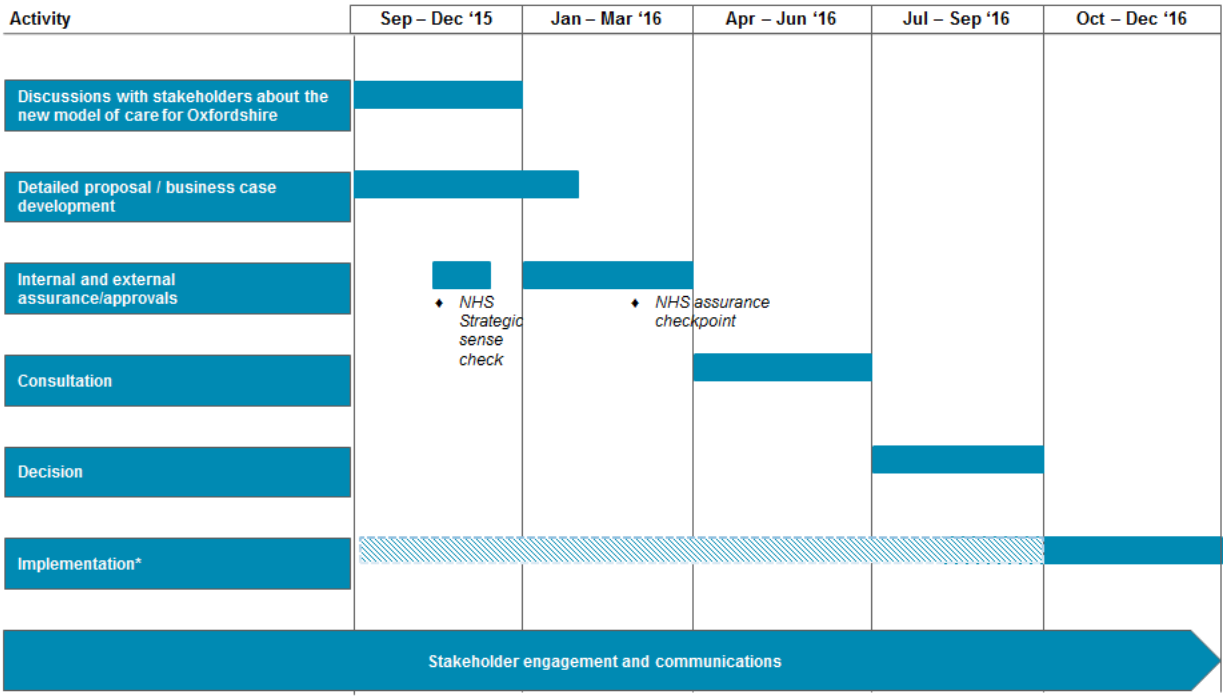
Oxfordshire will also have to satisfy the four tests set out in the 2014/15 Mandate from the Government to NHS England around proposed service changes and demonstrate evidence of:

- Strong public, patient and service user engagement
- Consistency with current and prospective need for patient choice
- A clear clinical evidence base
- Support for proposals from clinical commissioners

We are determined to 'go slow to go fast': spend necessary time engaging patients, carers and other stakeholders to ensure the case for change is understood and supported, before we move on to jointly creating solutions which will last well into the future.

5. Timeframe

Transformation on the scale we are planning in Oxfordshire is complex and will take time. The 'roadmap' below is just indicative and gives an overview of the steps in the process for 'Phase 1' of the transformation (out-of-hospital care / older people integrated care).



NB Some transformation initiatives, e.g. Prime Minister's Challenge Fund projects, do not require formal consultation. Their implementation is under way

6. Next Steps

The Transformation Board will provide further reports to the Health and Wellbeing Board in 2016 showing how the engagement and consultation is helping to further develop Oxfordshire's transformation plans.

Members of the Board are invited to comment on the proposed approach and emerging vision.

Appendix 1 - Glossary:

Ambulatory Care: or outpatient care is medical care provided on an outpatient basis, including diagnosis, observation, consultation, treatment, intervention, and rehabilitation services. In other words, a patient is seen and treated by medical professionals without being admitted to hospital, and discharged to their ordinary places of residence as soon as practicable.

Delayed transfers of care (DToC): is a situation when a person is fit enough to be discharged from hospital but is delayed because their onward care is not yet in place, e.g. no support to help them function in their own home; no place in care home etc.

Emergency Medical Units (EMUs): the aim of the Emergency Multidisciplinary Units is to provide assessment and treatment for adults with sub-acute care needs as close to patients' homes as possible. Providing medical, nursing and therapist assessments and treatments, the units are designed to offer patients a faster and more convenient alternative to admission to an acute hospital. EMUs operate in Witney and Abingdon and are a means of delivering ambulatory care (see above).

Five Year Forward View/ Five Year Forward View Into Action: National policy documents, published by NHS England, in June/December 2015, painting a vision for the future of the NHS. A key premise is breaking down the barrier between primary and secondary care to ensure seamless and coordinated care for patients based in the community with less reliance on acute care for managing long term conditions. Five Year Forward View, DH, June 2015: Five Year Forward View Into Action: Planning for 2015/16, DH, December 2015

Transformation Board: non-executive body set up in March 2015 by Oxfordshire's health and social care partner organisations – Oxford Health NHS Foundation Trust; Oxford University Hospitals NHS Foundation Trust; Oxfordshire Clinical Commissioning Group; Oxfordshire County Council; South Central Ambulance Service NHS Foundation Trust; and primary care federations - to drive longer term system transformation

Rapid Access Care Unit (RACU): Unit at the new Townlands Hospital that will provide a next day service led by a consultant and a team of health and social care professionals including community nurses, physiotherapy and occupational therapy practitioners, social care staff, mental health staff and hospital clinicians. The service would be open seven days a week (8am-8pm) with consultant led clinics Monday to Saturday mornings. The RACU will provide assessment and treatment of patients with a crisis or deterioration in their health or long term condition – including patients with complex medical, social and/or mental health needs. The service would offer a next day clinic so that patients could be assessed by a consultant and then, if needed could receive diagnostic tests or treatments such as blood transfusions and intravenous antibiotics all on the same day. RACU is a means of delivering ambulatory care (see above).

‘Storyboard’: a document agreed by health and social care partner organisations setting out the case for change and vision for future of healthcare in Oxfordshire; it is not a strategy or a blueprint. Storyboard will now be used to engage stakeholders in discussions about transformation

System Leadership Group: system-wide Chief Executives’ forum for coordinating strategic issues

System Resilience Group: system-wide forum for driving in-year performance and resolving operational issues

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NHS
Oxfordshire
Clinical Commissioning Group

Paper for Health and Wellbeing Board

Date of Meeting: 5 November 2015	**Paper No:**

Title of Presentation: Oxfordshire CCG 2016/17 Commissioning Intentions

Is this paper for	**Discussion**		**Decision**		**Information**	X

Purpose of Paper: To present Oxfordshire CCG's 2016/17 Commissioning Intentions. Oxfordshire CCG Commissioning Intentions are intended to serve as formal notice to our providers of the CCG's plans for services for 2016/17. They reflect our ambition in delivering transformational change and improving patient outcomes whilst managing levels of spend to match available resources.

Their prime purpose is to enable providers to make early preparations; to engage clinical service leads and commissioners in early discussions and realise change that benefits patients. They will inform providers' strategic, operating, financial, workforce and business plans, as well as contract negotiation plans.

It is important to note that these contracting intentions are published at a time when the full impact of the County Council proposals have not been fully worked through.

Action Required: The paper is presented for information.

Author: Libby Furness, Head of Planning and Transformation	**Director Lead:** Diane Hedges, Director of Delivery and Localities

1. Introduction

Oxfordshire CCG was required to develop and issue to its providers, by 30 September 2015, a copy of its commissioning intentions for the coming financial year (2016/17).

The CCG's Commissioning Intentions are intended to serve as formal notice to our providers of the CCG's Commissioning, Improvement or Development plans for services in 2016/17. They will provide notice to providers about our plans for service change and developments in commissioning and delivery of services.

Their prime purpose is to enable providers to make early preparations and to engage clinical service leads in early discussions that will result in the service changes we want for the benefit of patients.

2. How the Commissioning Intentions have been developed

This year's Commissioning Intentions reflect the work that the CCG has been progressing to deliver the CCG's 5 Year Strategic Plan, its annual Operating Plan and the implementation of the service improvement/developments we have been working on in year.

Programme Leads working with Locality Clinical Directors have helped to develop the commissioning intentions which have been discussed at:

- CCG Governing Body Workshop
- In localities through the Practice Commissioning Pack meetings and presentations to each locality during September
- CCG Senior Managers Team meeting (including OCC key managers)
- All Localities Meeting
- Locality Forum Chairs Meeting

Section 4 of the Commissioning Intentions contains an updated version of the plan on the page that has been revised in line with the development of Oxfordshire's Single Plan.

Oxfordshire
Clinical Commissioning Group

Commissioning, Contracting & Procurement Intentions 2016/17

Final


North


North East


Oxford City


South East


South West


West

Table of Contents

1.0 Introduction

Oxfordshire CCG Commissioning Intentions are intended to serve as formal notice to our providers of the CCG's plans for patient services for 2016/17. They reflect our ambition in delivering transformational change and improving patient outcomes whilst managing levels of spend to match available resources.

These intentions provide notice to healthcare providers about changes and planned developments in commissioning and delivery of services. Together with national planning guidance, the NHS Contract, National Tariff Document and CQUIN guidance, they will form an agenda which will be reflected in contracts, in-year service development plans, service reviews and procurement opportunities for 2016/17.

Their prime purpose is to enable providers to make early preparations; to engage clinical service leads and commissioners in early discussions and realise change that benefits patients. They will inform providers' strategic, operating, financial, workforce and business plans, as well as contract negotiation plans.

It is important to note that these contracting intentions are published at a time when the full impact of County Council proposals need to be fully understood and fully worked through.

2.0 Chief Executive's and Clinical Chair's Foreword

We enter the next commissioning round with a firmer foundation than we have had in previous years. The improvements in delivering performance targets, our financial position and improved ways of working across the system put us in a stronger position on which to build for the future.

In 2015/16 we have planned for a £6.9m (1%) surplus and remain on track to deliver this, however the ability of the system to continue year on year to generate savings through better commissioning, service redesign and being more efficient is a constant struggle. If we are to manage our service and financial pressure in the medium term then we must radically transform the way services are delivered.

Our local transformation programme has to be the way to deliver improved outcomes at lower cost. The scale of change required will be a challenge for all of us, but the key to changing the system lies in shifting resources into services in the

community to support the development of out of hospital care, preventing admission of patients to hospitals and changing service models to provide less bed based care.

This has to be supported by new and different primary care services, taking forward the initiatives being piloted through the Prime Ministers Challenge Fund. In addition, we need better integration between those services traditionally delivered by GP practices and those provided by Oxford Health Foundation Trust; the continued development of the alliance between Oxford University Hospitals Trust and Oxford Health Foundation Trust; and greater integration of health and social care delivery and commissioning.

Performance has improved across many domains, such as the improved A&E waiting times and reduced waits for cancer treatments and this needs to be sustained. But as a system we have far too many delayed transfers in our hospitals and ambulance standards are not being delivered.

We are implementing the Mental Health Outcomes Based contract with Oxford Health Foundation Trust and will continue to work with providers on an outcome based approach to contracting for older people during 2016/17.

Our commissioning intentions signal our commitment to the pace and scale of change that is needed and a fundamental belief that it is only by working as a system that we will be successful in tackling Oxfordshire's problems to ensure the Best care, Best Outcomes and Best value for the people of Oxfordshire.

3.0 Oxfordshire CCG's Strategic Priorities - 2016/17

Oxfordshire's health needs are changing, driven by increasing chronic disease and aging as well as births from the growing populations in Didcot, Bicester and other parts of the county.

There are some outcome areas where we should be better such as diabetes and pressing problems such as mental health that require scaled system wide solutions. Over 80% of our hospital resources are used by around 10% of the population and increasingly we are struggling across the system to deliver good access for our population when they require it. Rising activity and workforce gaps provide another layer of challenge to our sustainability.

Meeting these challenges and delivering the NHS 5 Year Forward View is going to require a more transformational approach and newer services tailored towards greater person centred and self-care.

A Single Plan for the Oxfordshire system is being developed through Oxfordshire's system wide Transformation Board, that includes the CCG, CCG Lead Clinicians, Oxford Health Foundation Trust, Oxford University Hospitals Trust, Primary Care Federations and Oxfordshire County Council, that will describe the scale, shape and impact of Oxfordshire system's shared ambition for change to manage population growth, demographic changes and financial pressures. The Single Plan will

influence the CCG's service improvement plans and saving schemes and have an impact on the CCG's commissioning and contracting intentions this year and beyond.

Oxfordshire's vision is that people get the best care at the best value. For Oxfordshire CCG, its partners and providers this means that our highest priority will be collaborating to adopt the most efficient models of care and delivering an agreed agenda of system wide service change.

The vision for Oxfordshire is that it is a place where people have access to the 'Best Care, Best Outcomes and Best Value' for everyone living in Oxfordshire'. Whilst the vision for 2020 outlined below describes how care should be delivered there is still considerable work to do to ensure that we are clear of the need for change, have engaged in wholescale consultation and can implement change with confidence.

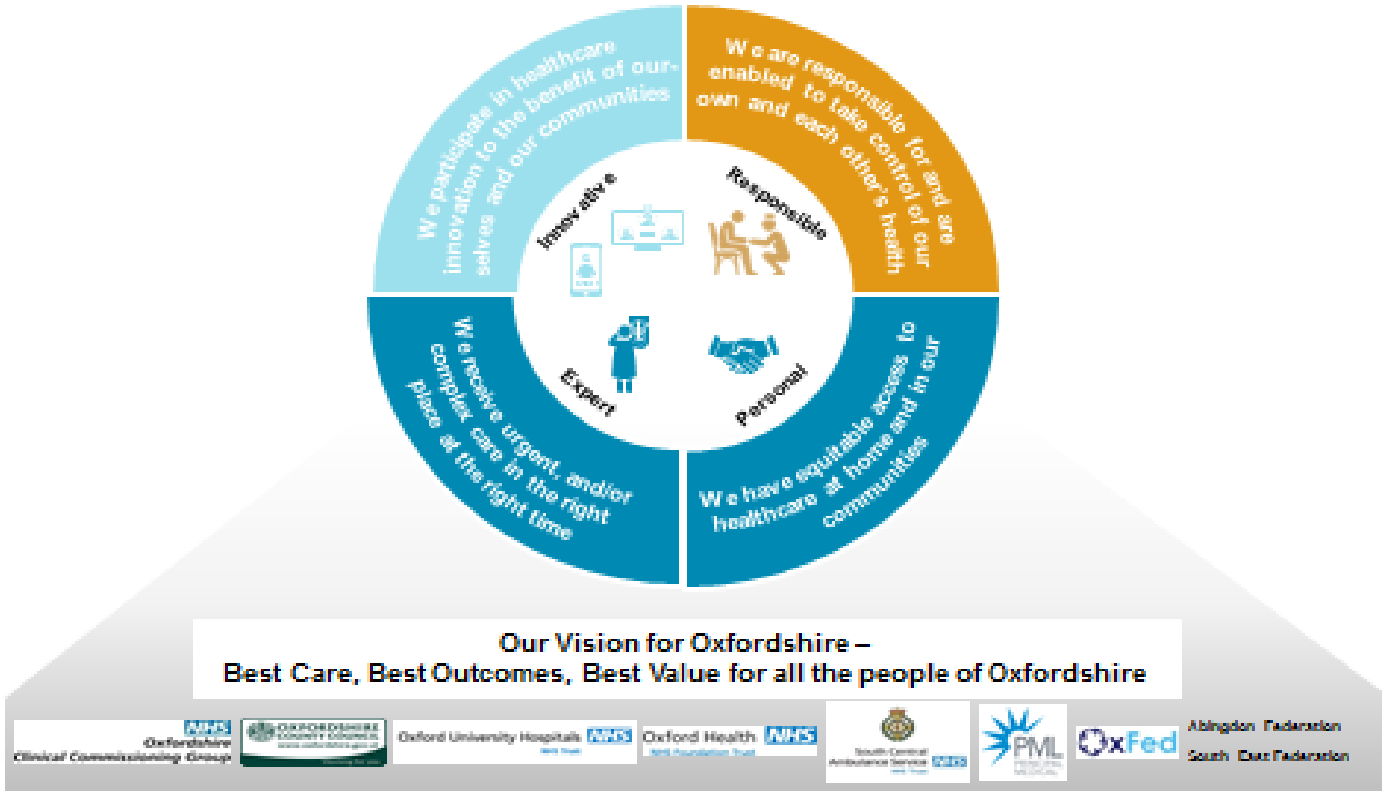
The Transformation Board will be developing and delivering a system wide Communication and Engagement Strategy as it takes the Single Plan forward. Within this will be messages for stakeholders and the public for a greater need for self-care and care of others wellbeing.

The CCG is committed to supporting sustainable primary care and will continue to shape the provider market to facilitate the shift of services from secondary to primary and community care settings supporting the development and role of Federations to ensure consistency and high quality Primary Care coverage for the total population.

Working with community and primary care providers the CCG will be exploring opportunities for piloting new models of care as outlined in the Five Year Forward View e.g. Multi Specialist Provider.

Oxfordshire's Draft Single Plan Vision

Oxfordshire Healthcare Transformation Programme
Discussion Document v3.2 WIP



…and by 2020 we will have made significant changes that aligned our staff and infrastructure…

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Significant changes to buildings and beds so that people are only admitted to a bed when and where it's absolutely appropriate to their needs

'The best bed is your own bed'

13

The Draft Single Plan Vision for 2020

Oxfordshire CCG Transformation Plans

This year's commissioning and contracting intentions have been developed in the context of our understanding of patient need, our system wide transformational plans and national and local priorities taking into account the implementation of the Health and Social Care Act.

As a committed member of Oxfordshire's Transformation Board the CCG actively supports the development and delivery of a system wide transformation programme, seeking opportunities for greater integration of health and social care to optimise joint commissioning and pooling of budgets as appropriate.

We aim to work with Oxfordshire County Council Public Health and NHS England to respond to the recommendations in the Director of Public Health's Annual report, using evidence based interventions, to support the increased uptake of targeted NHS Health Checks and Bowel Screening, a more sustainable Primary and Community Care Stop Smoking Service and the development of a business case for greater secondary care alcohol brief interventions.

Engagement

The CCG's Programme Leads have worked with the Locality Clinical Directors and localities to shape and agree Oxfordshire CCG's 2016/17 Commissioning Intentions. The emerging Commissioning Intentions have been shared with Locality Forum Chairs for their comment.

4.0 Oxfordshire CCG's Plan On A Page

DRAFT – OXFORDSHIRE CCG PLAN ON A PAGE 2016/17		
BY WORKING TOGETHER, WE WILL HAVE A HEALTHIER POPULATION, WITH FEWER INEQUALITIES, AND HEALTH SERVICES THAT ARE HIGH QUALITY, COST EFFECTIVE AND SUSTAINABLE.		
OCCG OBJECTIVES	**MAKING MEASURABLE CHANGE**	**HOW WE WILL MAKE THIS CHANGE**
1. `Be financially sustainable. 2. Primary care driving development and delivery of integrated care, and offering a broader range of services at a different scale. 3. Provide preventative care and tackle health inequalities for urban and rural patients and carers. 4. Deliver fully integrated care, close to home, for the frail elderly and people with multiple physical and mental healthcare needs. 5. Enable people to live well at home and to avoid admission to hospital when this is in their best interests. 6. Be providing health and social care that is rated amongst the best in the country.	1. Maintain compliance with all NHS financial planning rules. 2. Reduce years of life lost from conditions amenable to healthcare by 3.2% by 2020. 3. Meet all agreed Health and Wellbeing Board targets every year. 4. Hold Non Elective activity (non ambulatory) at 2014/15 outturn through to 2020 5. Reduce the number of people delayed on any given day from 155 to below 100 by October 2016. 6. Reduce A&E activity by 10 % by 2020 7. Continue to act on feedback from patients, carers, and GPs to constantly strive to improve the quality of care for patients. 8. Hold outpatient activity at 2014/15 outturn through to 2020 9. Contain planned inpatient activity and outpatient procedures (including day cases) to a 0% growth through to 2020. 10. Increase the number of children accessing CAMHS services by 7000 by 2020 11. Meet all NHS Constitution measures in full.	1. Deliver more efficient, better quality care in all settings. 2. Integrate commissioning and provision of all aspects of physical and mental health care. 3. Help GP practices work together to improve access, sustainability and quality. 4. Increase GP capacity to deliver care to most complex patients. 5. Provide community based planned and urgent care services. 6. Provide transformational person centred community and home based integrated health and social care to the most complex patients, including those with mental health needs. 7. Deliver partnership programme with Councils, 3rd sector and NHS England to tackle health inequalities and their underlying causes. 8. Reduce inappropriate A&E attendances by providing viable alternatives and improving 111. 9. Reduce avoidable admissions by: a. Improving pathways for people with chronic conditions needing urgent care b. Improving support to care and nursing homes c. Improving end of life care. 10. Reduce lengths of stay by working together to improve discharge and by contracting across providers for an integrated acute pathway of care. 11. Improve access to diagnostics. 12. Ensure only appropriate outpatient referrals are made. 13. Streamline planned care pathways. 14. Streamline the out of hospital pathways to ensure right services are available when required. 15. Improve integration of physical and mental health care. 16. Improve dementia diagnosis and care.
ROBUST GOVERNANCE ARRANGEMENTS: 1. Programme Management Office in place 2. Effective locality level patient, public and stakeholder forums. 3. Oversight by the Health and Wellbeing Board.		**PRINCIPLES UNDERPINNING DELIVERY IS THAT PEOPLE:** 1. Are able to participate in healthcare innovation to the benefit of themselves and their communities 2. Are responsible for and are enabled to take control of their own and others health 3. Receive urgent, and/or complex care in the right place at the right time 4. Have equitable access to healthcare at home and in their communities

5.0 Financial Resources and System Risk Profile

2015/16 has been the first year that OCCG has been able to plan to meet the requirements set for CCGs by NHS England. This follows a trajectory of financial recovery from actual and underlying deficit positions in previous years. To achieve this financial recovery the CCG has been reliant on allocation growth, non-recurrent brought forward surpluses and risk transfer in contracts, with the inherent support therein from our main providers.

While our financial position has stabilised, our system partners have seen considerable pressure on their own financial performance; Oxford Health have set a c£4m deficit plan for 15/16, SCAS are in deficit, OUH set a plan for break-even and Oxfordshire County Council have placed reliance on an £8m transfer from the CCG, through the Better Care Fund, to maintain current levels of social care provision. As a health and social care system, taken in aggregate, we may be at breakeven or a marginal surplus (<0.1%) at best. Given the challenge described for the NHS in the 5 Year Forward View and in repeated spending reviews for local authorities then this position neither resilient or sustainable in the medium to longer term.

It is recognised that the balance of risk and benefit in our healthcare contracts should be fair and proportionate. It is recognised that this should be kept under continual review to prevent pressures and/or benefits accruing disproportionately to either side; this is in the spirit of what are ultimately long standing, system stakeholder and partner arrangements. This is particularly the case in the face of ever increasing demand and cost of demand, for our healthcare services.

This position should be the same for our section 75 pooled budget arrangements with Oxfordshire County Council.

The sustainability of the improvement in the CCG's financial position remains a risk due to the dependency on the current structure of contractual agreements in Oxfordshire, in particular our main acute contract. The sustainability of these agreements in turn is fragile, as a result of the increased demand for secondary acute and community healthcare services and the pressures on our provider colleagues.

OCCG's ability to fund health and social care in Oxfordshire in 2016/17 will be constrained by our distance from target funding; it will be further impacted on by any potential requirement to transfer additional resource to the County Council in order to protect adult social care and then also by the ever increasing demand arising from demographic, public expectation and technological change.

It is hoped that 2015/16 will have given us the opportunity, within the certainty of our 15/16 contractual agreements, to plan for whole system transformation. This will be essential to allow the system to 'right-size' its services to match to demand, within the constraints of our system's funding.

Whilst balanced risk share arrangements have been a feature of the NHS landscape in Oxfordshire and reflected in contractual agreements for 2015/16 and in the health and social care arrangements through pooled budget, the underlying position of the system and the additional challenges of the national NHS financial position mean that these arrangements should become more widespread and more transparent. They will also need to support service transformation to improve quality and productivity in the system.

In our commissioning and contracting intentions for 2015/16 we stated our intention to protect as much of our allocation growth as possible and ring-fence this to be held as a system 'Risk Management Sum' (RMS). This would have been used to help manage system financial risk in the short term, while moving towards a genuine system Transformation (investment) Reserve, linked to a whole system transformation plan, which would seek to address system risk in the medium term. The outcome of contract negotiations with providers meant that we weren't able to deliver that objective; the risk that would have been built upfront into contracts to create the RMS was too great.

For 2016/17 it is our intention to hold a Transformation Reserve to invest in and support the required changes in the Oxfordshire System. Investment decision making criteria and access to these funds will be agreed with those system partners who form the Transformation Board. The creation of a separate system risk management reserve remains an option to be explored but, as was the case in 2015/16, this is likely to test the balance of risk between partners. As part of our discussions we would like to test the viability of a single shared verses separate organisational, risk management reserves.

From our perspective we commit to be fully transparent with partners on the resources we will have available for contracting in 2016/17 and the context in which they have been set for us by national and some local decisions. A CCG contribution to any system pooled funding arrangements will need to be created from the allocation growth the CCG receives. We would wish to engage with our main system partners as soon as that resource envelope can be identified to jointly agree how best it should be applied, having due regard for our organisational duties.

Oxfordshire CCG will continue to lead whole system engagement and share its financial position transparently with partners and the public. Working with system partners through the Transformation Board we intend to deliver the transformation of services

within Oxfordshire by integrating pathways and obtaining high value for money from public resources, including the use of our estate.

To support this approach, provider partners are invited to work with Oxfordshire CCG and adopt the following principles in managing risk, which we believe will enable us to secure a sustainable system:

1. To commit to risk sharing, underpinned by an open book approach to current service provision and its fixed and marginal costs, and to a collaborative approach to opportunities for transformation with early sharing of candidate areas.

2. To improve the services and outcomes for the patients and users of Oxfordshire, whilst simultaneously taking costs out of the system and maintaining the financial viability of risk sharing partners – both commissioners and providers.

3. To work together to define what good care or services look like and in doing so, adopt a 360 degree perspective. This means considering not just the selected pathways but the broader implications of changing them, for the system as a whole. In agreeing what good care or services look like, seeking the views of both clinicians and senior managers in risk sharing partner organisations.

4. By virtue of being risk sharing partners, those providers will be engaged with commissioners in a collaborative process to scope and agree service designs that will fulfil our shared principles.

5. Partners will adopt a process map to set out clearly how priorities for change will be chosen, service redesigns undertaken, risk identification, mitigation and sharing will occur.

6. In securing services the CCG will seek to satisfy itself that its existing providers and risk sharing partners are most capable. This will be done prior to a decision on whether to competitively tender services. In doing so it will be demonstrated that the provider is best placed to meet the needs of our local population and that it delivers the best value for money in doing so. This assessment of value will take into account the provider's role in the system and the impact of related services. If, having initiated a most capable provider approach, assurance that the objectives of delivering best value and meeting patient needs cannot be met then the full range of procurement options will be available to the CCG.

7. Partner organisations would remain independently accountable for discharging their legal obligations

8. The risk sharing partners will agree contractual mechanisms that support the achievement of shared goals.

9. The risk sharing partners will agree access to and governance of a Risk Management Sum, if created, which will enable the partners to manage and mitigate risks and invest in transformation where it can be demonstrated to lead to more productive services.

This is an approach that we see being progressed beyond 2016/17, aligned to the system's transformation blueprint. Its sustainability will be dependent on our risk profile as determined by our allocation growth and by our contractual arrangements with providers.

6.0 Oxfordshire CCG's Key Commissioning Priorities for 2016/17 are:

Implementation of the:

- Out of Hospital Provider Programme to support sustainable primary care and a shift of secondary care services to primary and community care settings
- Community Nursing Review
- Musculo Skeletal pathway
- Ophthalmology pathway
- Bladder and Bowel pathway
- Child and Adolescent Mental Health Service Review
- Local Transformation Plan to improve children's mental health and wellbeing in line with *Future in Mind*
- Pathway for survivors of Child Sexual Abuse Exploitation
- Outcome of the consultation on the 111 and Out of Hours service model
- Expansion of the successful Emergency Multidisciplinary Unit (EMU) Programme
- Better Care Fund Programme
- New Dementia pathway
- Oxfordshire Big Plan

Commissioning:

- The new Townland Hospital RACU service
- Improved Email advice service

- Successful Prime Ministers Challenge Fund Schemes
- An Outcomes Based approach for Older People
- Simplified discharge pathways to reduce delayed transfers of care
- Continued Trauma and Orthopaedic activity from Horton Independent Sector Treatment Centre
- Effective pathways for stroke services

Reviewing:

- Services for headache, movement disorders and epilepsy
- Maternity services
- The CCG's approach to long term conditions
- End of Life Care services
- Older Adult Functional Mental Health care

7.0 CCG 2016/17 Commissioning and Contracting Intentions

7.1 Urgent Care

Clinical Director Lead: Dr Andrew Burnett

Lead Manager: Sharon Barrington

2016/17 Commissioning Intentions	2016/17 Contracting or Procurement Implications
Ambulatory Care To increase the number of adults, including those with long term conditions, being treated on an ambulatory care pathway to reduce non-elective admissions and improve patient outcomes.	• OUH: Building on the 2015/16 pilot develop an agreed Ambulatory Care pathway and service specification for inclusion in contract • OUH/CCG: To review and refine local prices for Ambulatory Care pathways that are in the 2015/16 contract • OUH: Where an attendance at an ambulatory care facility is followed by a non-elective admission for the same presenting diagnosis or condition, admission to CDU will be deemed part of the overarching admission and should not be charged for separately • OUH/CCG: To agree for a package of care where patients have had an admission avoided but require multiple attendances for treatment in a day centre. Conditions to be considered for local price, will include but not be limited to, daily IV infusions, anti-biotics and transfusions

Ambulatory Care To increase the number of children and young adults being treated on an ambulatory care pathway to reduce non-elective admissions and improve patient outcomes	• OUH: To clarify ambulatory care pathways for children and young adults and define a service specification for inclusion within the contract • OUH/CCG: To agree local prices for children and young people's ambulatory car and CDU attendance • OUH: Where an admission to paediatric CDU is followed by a non-elective admission for the same diagnosis or condition, admission to CDU shall be deemed part of the overarching admission and shall not be charged separately • OUH/CCG: To agree a local price for a package of care where children and young people have had an admission avoided but require multiple attendances for treatment in a day centre. Conditions to be considered for local price will include, but not be limited to ,daily IV infusions, anti-biotics and transfusions
Falls Service To undertake a review of the effectiveness of the Falls Service	• OUH/OH: Future funding for this service dependant on evidence of effectiveness and value for money following review
Ambulatory Care – Data To work with OUH and OH to develop Ambulatory Care Pathways including the development of coding and monitoring arrangements to evaluate impact	• OUH/OH: To support the development and implementation of new ambulatory care pathways
Delayed Transfers of Care (DTOC) and Discharge To reduce the number of delayed transfers of care within secondary care and to consider the following enablers for this: • Informing GP on admission of one of their patients to engage them more in the patient pathway and decision making	• OUH/OH: To ensure that GPs are informed when one of their patients is in hospital on the day of admission. • Primary Care: To work with secondary care to pro-actively manage discharge once they have been informed of an admission of one of their patients

• Increase the use of Personal Health budgets • Developments of cross service protocols for acute and community services • Reduce the number of delays linked to social care packages • Subject to successful pilot in quarter 2 of 2016/17 commission a single holistic service for supported home discharge, Hospital at Home and rehabilitation	• OUH: To implement the red/amber/green Oxfordshire discharge protocol - the secondary to primary care pathway. • OUH: To develop a new data set around the patient pathway • SHDs: With appropriate notice de-commission Supported Home Discharge Service (SHDs) • OUH: To provide improved discharge documents, email advice lines, continued datix use and use of technology e.g.Apps
Older People's Outcome Based Commissioning To continue working with providers, during 2016/17, on the development and implementation of an outcomes based contract for older people in line with discussions taking place through the Transformation Board	• To be agreed
Older People – Mental Health To review community support provided by the voluntary sector to improve admission avoidance and effective, timely discharge	• Age UK: To de-commission the Generation Games service reinvesting in a new model that supports people in the community. Model and contracting mechanism to be advised
Emergency Medical Units (EMU's) and Admissions To implement the findings of a review into the effectiveness of EMU services and use the recommendations from this in the 2016/17 contracting round, where appropriate including:: • Increased capacity within current EMUs to: ▪ See a greater number of patients ▪ Improve the acceptance of the level of acuity for patients referred through adapting some of the acute care pathways (e.g. chest pain, low risk patients; suspected GI bleeds in stable patients; PE for patients with co morbidities)	• OCCG: To work with OH to improve capacity within existing EMU • OH: To develop the EMU pathway and clinical/information protocols • OH: To work with OUH, Primary Care and Ambulance Services to develop stakeholder engagement plans and implement them

• Improved communication with Primary Care; • Development and implementation of clinical/information protocols between EMUs and other services – including different acute departments, primary care, and ambulance services • Commissioning an EMU approach in the North of Oxfordshire and Oxford City which has a clearly defined pathway and is directly accessible by primary care.	
Townlands Hospital Rapid Access Care Unit (RACU) To commission a Rapid Access Care Unit in the new Townlands Hospital to provide early intervention for vulnerable adults (older people and those with LTC's)	• OH/RBH: Contract variations for provision of the new service
Townlands Hospital Rapid Access Care Unit Intermediate Care beds To commission Step Up and Step Down bed provision to support the RACU and discharge from acute care	• OSJ: OCCG Beds being contracted via OCC • OH: Inpatient facilities at Townlands to be decommissioned
Communication To encourage the development of effective communication links between primary care and OUH acute services to discuss complex patients prior to admission or on discharge To establish a single point of access for GP emergency admissions – a single telephone line for all referrals	• Contracting intentions to be determined
Integrated Commissioning of 111 & Out of Hours To procure a fully integrated 111 and Out of Hours (OOH) service model during 2016/17 following completion of the consultation.	• OH/SCAS/PML: Contracting intentions to be confirmed following completion of the consultation

Lavender Statements OCCG will ensure that a rigorous validation process is in place for all procedures requiring lavender statements and PLCVs. The cataract PLCV statement will be updated to include second eye cataract operations being restricted.	• All Providers: Payment will not be made for any treatments carried out outside of the new process
Transport To ensure all inter-hospital transport is included within reference costs.	• OH/OUH/SCAS: OCCG will not pay for inter-hospital transport

7.2 Planned Care

Clinical Director Lead: Dr Stephen Attwood

Lead Manager: Sharon Barrington

2016/17 Commissioning Intentions	2016/17 Contracting or Procurement Implications
Outpatient referrals To maintain or reduce, where possible, contracted levels of all Outpatient (OP) referrals including: • Ensuring all 1st OP referrals are relevant and necessary • Instigating a rapid pre-referral process to better inform 1st OP referrals • Monitoring 1st OP referrals by treatment function (see follow-up ratios) • Manage growth in referrals to 2014/15 levels (Taking into account 2015/16 growth and demographic changes)	• OUH/RBH/GWH/Bucks/Ramsay/Foscote/Manor/Circle/Spires/BIH: To ensure coding is reported accurately on all procedures - there are too many unresolved treatment functions linking to code 999. • OUH/Ramsay/Foscote/Manor/Circle/Spires/BIH: To review referrals that relate to lavender statements and procedures of limited clinical value before seeing patients

Townlands Hospital To agree a shift of outpatient activity from where it is currently provided to the new Townlands Hospital. Consider the commissioning of new clinics to be provided on this site.	• RBH: To work with the CCG to agree and implement a plan to shift some outpatient activity for Oxfordshire patients from where it is currently provided to the new Townlands Hospital. Other providers to be considered.
Follow up ratios To reduce follow-up ratios for selected treatment functions by ensuring outpatient and follow ups ratios reflect best practice. OCCG will also work with selected treatment functions to reduce 1st outpatient and follow ups. OCCG will seek to ensure there are no follow ups in specific speciality areas where there is no clinical benefit.	• OUH/Ramsay/Foscote/Manor/Circle/Spires/BIH: To agree areas for reduction - to include Trauma and Orthopaedics
Consultant to Consultant referrals To rationalise the level of Consultant to Consultant referrals outside the agreed policy in line with the suggested 23% increase in activity in 2014/15 by: • Reviewing the data and updating the policy to ensure that any reduction in consultant to consultant referral does not transfer activity back to the GP for re referral. • Ensuring appropriate, first time, right place referrals • Ensuring consistent monitoring is undertaken of available data on consultant to consultant referrals	• OUH/Ramsay/Foscote/Manor/Circle/Spires/BIH: To ensure that there is only one chargeable first outpatient attendance for an individual within the same speciality within any 6 month period (based on the same referral/condition). • All Providers: To carry out joint audit of consultant to consultant referrals annually. Evidence of non-compliance with protocols shall result in non-payment of consultant referred outpatient firsts according to the percentage of the audit sample found to be non-compliant
Day Case to Outpatient activity To move day case activity to an outpatient setting, where possible, by identifying opportunities to perform day case activity within outpatients and transferring activity units against specific HRGs and Treatment Function where there are parallel tariffs.	• OUH/RBH/GWH/Bucks/Ramsay/Foscote/Manor/Circle/Spires/BIH: To ensure that all agreed day case HRGs identified and performed as outpatient procedures, where appropriate, are properly recorded in order to attract payment.

Inpatient to Day Case activity To reduce the number of inpatient episodes through transfer to day case procedures where possible	• OUH/RBH/GWH/Bucks/Ramsay/Foscote/Manor/Circle/Spires/BIH: To ensure all agreed appropriate inpatient HRGs are identified and performed as day case procedures, where appropriate, in order to attract payment.
Excess Bed Days To reduce the numbers of excess bed days. Specialities to be included (whilst not excluding other areas) are : • Endoscopy • Trauma and Orthopaedics • General Surgery • Gynaecology • Urology • Ear Nose and Throat • Dermatology	• OUH/RBH/GWH/Bucks/Ramsay/Foscote/Manor/Circle/Spires/BIH: To ensure that excess bed days per speciality are in the top 5% of the national benchmark as OCCG will not pay for follow up activity in excess of this.
Cancelled Operations To investigate ways to ensure that OCGG only pays for cancellations by a provider that are due to patient's clinical condition as all other cancellations will not be paid for.	• OUH/RBH/GWH/Bucks/Ramsay/Foscote/Manor/Circle/Spires/BIH: This includes WA14Z spells where cancellation was due to patient's medical condition. Current tariff will be applied for non-medical reasons
Email Advice & Guidance To ensure that all relevant speciality email and telephone advice services are providing responsive and effective guidance to GPs by ensuring that: • Service specifications are in place for all relevant specialities • There are improvements in speciality areas of concern • Speciality areas that have been withdrawn are reinstated, where appropriate	• OUH: OCCG to make payment of single local tariff for email advice and guidance. • OCCG to contract for a pilot telephone advice service for planned care

• There is regular submission against KPIs • There is a single local tariff for all relevant specialities • Referrals for advice and guidance resulting in an Outpatient referral have the advice and guidance charge refunded	
Gastroenterology To review direct access endoscopy provision in line with NG12 NICE Guidance (suspected cancer) with a view to commissioning community wide direct access to this service, incorporating the 2 week wait cancer pathway. The aim is to reduce demand, reduce redirection rates and ensure quick turn around on histology results back to the GP.	• Contracting intentions to be determined following review
Diagnostics To review direct access to radiological diagnostic provision in line with NG12 NICE guidance with a view to commissioning community direct access - including 2 week wait referrals. Review and pilot 'Point of Care' pathology testing in primary care	• Contracting intentions to be determined following both reviews
Cancer To undertake a Programme of work with a focus on: • Mandatory referral pro-formas from GPs to providers • Potential alternative rapid access clinics for underperforming specialties (ACE bid) • Peripheral diagnostics review (see above) • New NICE guideline implications - prioritisation and review to revise local pathways. • Improved direct access for GP's to exclude cancers earlier	▪ Contracting intentions to be determined

• GP Educational events • Implementation of nationally identified areas in the "National Cancer Strategy: Achieving World-Class Cancer Outcomes: A Strategy for England 2015 – 2020"	
Neurology To review services commissioned for headaches, movement disorders and epilepsy in Quarter 1 of 2016/17 implementing the outcomes of the review in year.	• Contracting intentions to be determined following review
Cardiology To review cardiology and develop new pathways including a programme of education around management in primary care	• Contracting intentions to be determined following review
Musculo Skeletal (MSK) Integrated Pathway To decommission the MSK Hub and direct access physiotherapy service as of 31st March 2016 (Notice has been served on the provider) and review pain management services to ensure integrated community provision and MSK service.	• To contract for an integrated MSK and direct access physio service to commence 1st April 2016
Bladder and Bowel To establish an integrated Oxfordshire Bladder and Bowel service, for both adults and paediatrics, implementing the agreed pathway in the most appropriate setting.	• To contract with a prime provider for an integrated bladder and bowel service to commence on 1st April 2016
Ophthalmology To commission an integrated Ophthalmology Decision Unit (ODU) across primary and secondary care from a prime provider for patients aged 5 years and over for minor eye conditions (MECs)	• To contract with a prime provider for an integrated ophthalmology pathway with an Ophthalmology Decision Unit

The review has been undertaken and is supported by a full business case for the establishment of an Ophthalmology Decision Unit (ODU), to include community service provision for specific conditions, provided across Oxfordshire by optometrists.	
Dermatology To review current dermatology provision to identify areas that could be provided in primary care including low risk Basal Cell Carcinoma management - surgically and conservatively. To develop the skill and expertise within primary care to deliver the new service	• Contracting intention to be confirmed following outcome of review
Maternity To review Maternity Services by April 2016 in line with the national review of capacity in maternity services	• Contracting intention to be confirmed following the outcome of the review
Horton Independent Sector Treatment Centre (ISTC) To ensure the ISTC contract for current services is maintained for Trauma and Orthopaedics to provide choice in Oxfordshire. To review the current contract when it expires in August 2016 in partnership with associates to the contact.	• To agree future contract arrangements post August 2016

7.3 Primary Care

Clinical Director Lead: Dr Paul Park

Lead Manager: Julie Dandridge

2016/17 Commissioning Intentions	2016/17 Contracting or Procurement Implications
Sustainable Primary Care To support sustainable primary care by developing and implementing an Out of Hospital Care Strategy. This includes reviewing workforce requirements and supporting practices in expanding their skill mix including building on the learning from those practices that have clinical pharmacists or physician associates. Alongside this working with NHS England in the development of primary care workforce to increase its skill mix.	
Primary Care Provider market/Federations To continue to shape the primary care provider market to facilitate the shift of services from secondary to primary care and community settings and supporting the development and role of Federations to ensure consistency and total population coverage by primary care.	OCCG: To review the contracting of : • Home based phlebotomy • Flu vaccinations (Non caseload) • Primary care dementia assessments to determine their alignment with new care and provider models
Prime Ministers Challenge Fund To evaluate and review the outcomes of the schemes within the Prime Ministers Challenge Fund and consider which schemes should be commissioned by OCCG in 2016/17. These include: • Neighbourhood Access Hubs • Early Visiting Service • Practice Care Navigators	• OCCG: To contract for the continued provision of specific services following evaluation of pilot schemes

• Access to GP records • E-Consultations • Online Health Resource – COACH (N.B. OCCG is committed to funding those schemes that are shown to be of benefit, demonstrate value for money and have the potential to be successful)	
Quality Outcomes Framework To consider alternatives to the national Quality and Outcomes Framework (QOF) to improve the care of identified cohorts of patients, e.g. those with cardiovascular disease.	• Contracting intentions to be confirmed following outcome of review
Commissioning Primary Care To consider full delegation of the commissioning of primary care medical services from April 2017 following consultation with members and explore running full delegation in shadow form during 2016/17.	• Implementation of recommendations following consultation
Population Growth – Primary Care Provision To consider, in partnership with NHS England, the level of primary care provision needed in areas with large population growth e.g. Bicester, Didcot and Barton Park.	• Working with NHS England to identify the need and range of services to be provided
Pooling Funding – NHSE/OCCG To explore areas where pooling CCG and NHS England funds for APMS contracts would enable the commissioning of a wider range of services, for example diagnostic centres or enhanced care for vulnerable older people	• Working with NHS England to identify the need and range of services to be provided

Primary Care Skill Mix To work with NHS England in the development of the primary care work force to expand its skill mix To support practices to increase their skills, including implementing learning from practices that have a clinical pharmacists or physician associates.	• To develop and implement workforce development plans
PMS Premium To consider and determine options for reinvestment of any available PMS premium into primary care using defined, pre-agreed criteria in line with national direction and agreed principles	• Contracting intentions to be confirmed following outcome of the review
Patient participation Groups To scope, in partnership with NHS England, ways in which the CCG can improve engagement with patients through Patient Participation Groups	
Out of Hours Services To ensure that there is community based provision of services normally provided by primary care across the out of hour period e.g.: dressing changes	
Primary Care Locum service To support the Oxfordshire locum bank to ensure there is a first class pool of locum staff able to support Primary Care across Oxfordshire	

7.4 Learning Disabilities

Clinical Director Lead: Dr David Chapman

Lead Manager: Ian Bottomley

2016/17 Commissioning Intentions	2016/17 Contracting or Procurement Implications
The Big Plan To implement the Oxfordshire Big Plan for people with learning disability. OCCG will become the lead commissioner for Learning Disabilities (LD) (from OCC) requiring a change to s75 agreement	• CCG to lead transition of LD health services to mainstream or redesigned specialist services by December 2017 • OH: Potential early changes to contract. This would include integration of LD continuing health care (CHC) into mainstream CHC functions e.g. service lines such as physiotherapy, Speech and Language Therapy where a lift and shift approach is feasible and could support Big Plan delivery • SH: To improve contract monitoring information
Learning Disability Health Checks To improve the uptake of health checks for people with learning disabilities in primary care and improve outcomes for people with learning disability across the health care system	• Primary Care/SH: CCG to develop external support to improve delivery in primary care of the national Directly Enhanced Scheme. Possible CQUIN within SH contract • Primary Care: Potential local incentive scheme to improve delivery of national Directly Enhanced Scheme Learning Disability Health check scheme • All providers: To report on access and use of services by people with learning disability within Information schedule • All providers: To report on outcomes for people with learning disability within quality schedule

	• All providers: To audit to evidence staff competence to recognise and manage the needs of people with learning disability

7.5 Autism

Clinical Director Lead: Dr David Chapman

Lead Manager: Ian Bottomley

2016/17 Commissioning Intentions	2016/17 Contracting or Procurement Implications
Adult Autism Diagnosis Pathway To re-commission an adult autism diagnostic pathway, based on the outcome of the 2015/16 Autism Review with the aim of improving health outcomes for people with autism	• OCCG to commission new pathway via Any Qualified Provider or standard contract from April 2016
Health Outcomes To improve health outcomes for people with autism using mainstream services	• All Providers: To report access and use of services by people with autism within the Information schedule • All Providers: To report outcomes for people with autism within quality schedule • All Providers: To audit evidence of staff competence to recognise and manage the needs of people with autism

7.6 Personal Health Budgets and Continuing Healthcare

Clinical Director Lead: Dr David Chapman

Lead Manager: Ian Bottomley

2016/17 Commissioning Intentions	2016/17 Contracting or Procurement Implications
Personal Health Budgets – Learning Disability/Acquired Brain Injury To create an offer of a personal health budget for people living with learning disability and people with acquired brain injury from April 2016. Including reviewing : • All people in learning disability health placements and assess or offer a personal health budget • All people in a health funded acquired brain injury placement and assess or offer a personal health budget	• OCCG: To commission a brokerage service to support people who opt to receive their personal health budget as a direct payment • SH: To vary contract to enable people with learning disability to source their own care via a personal health budget
Personal Health Budgets – Mental Health To develop an offer of a personal health budget to support people with mental health problems and high cost "frequent fliers" during 2016/17 subject to national guidance In line with any national learning, scope opportunity to offer a personal health budget as an alternative to a commissioned intervention where this will deliver better patient outcomes	• Contracting intentions to be confirmed following outcome of the review
Personal Health Budgets – Children and Young People To develop an offer of personal health budgets for all young people who are eligible within Children's Continuing Healthcare	• OH: To implement personal health budgets within the new Children's Continuing Health Care service

Continuing Healthcare Review To implement the outcome of the 2015/16 Adults and Children's Continuing Health Care reviews to provide a new delivery model	• OH: The CCG will either commission a new service from April 2016 or negotiate contract variation • OH: Negotiate contract variation for children's continuing health care
Continuing Health Care Deliver retrospective cases in line with the national Previously Unassessed Period of Care programme by September 2016	• OH: Either implement within new CHC service from April 2016 or negotiate with OH via the contract

7.7 Dementia

Clinical Director Lead: Dr Julie Anderson

Lead Manager: Ian Bottomley

2016/17 Commissioning Intentions	2016/17 Contracting or Procurement Implications
Dementia Diagnosis Pathway To review and develop a new dementia diagnosis pathway across primary and secondary care by April 2016	• OCCG To recommission a new dementia pathway based on the finding of the review
Health Outcomes To improve health outcomes for people with dementia	• All Providers: To report outcomes for people with dementia within quality schedule • All Providers: To report on outcomes for people with dementia in the quality schedule • All Providers: To audit evidence of staff competence to recognise and manage the needs of people with dementia

7.8 Adult Mental Health

Clinical Director Lead: Dr David Chapman

Lead Manager: Ian Bottomley

2016/17 Commissioning Intentions	2016/17 Contracting or Procurement Implications
National Standards To meet national standard requirements for Adult Mental Health in line with the Five Year Forward View into Action.	• OCCG: To ensure that mental health services support system priorities around long term conditions self-management, adult survivors of child sexual exploitation, older adults and people with learning disability through the setting of KPI and quality measures within mental health contracts • OH: To implement the mental health outcomes based contract to ensure 50% of people with early onset in psychosis are in treatment within 2 weeks
Carers – Mental Health To ensure that Mental Health Carers' services are aligned with OCC commissioned services	• Rethink Carers: De-commissioning contract from April 2016 • OCC: Include Mental Health carers services into OCC contracts
Psychiatric Liaison Service To commission an effective psychiatric liaison model based on the development of a business case and national guidance OCCG to ensure 24/7 mental health care across all age groups in hospital by 2020	• OCCG: To develop KPI's that will evidence impact • OH: Based on community psychological medicine pilot evaluation consider options for re-commissioning the service from April 2016
Urgent Care – Mental Health To implement an effective Mental Health Urgent Care model in line with the Crisis Concordat review	• OH: To ensure 24/7 access to crisis care within the outcome based contract • All parties to deliver the Crisis Concordat collaboratively and

OCCG will be categorising the use of police cells as s136 for children and young people to ensure it is a never event	implement the revised pathway including: ▪ Ensuring Directory of Service links to mental health provision ▪ Ensuring the protocol for the triaging of mental health calls and referral and response measures (time and use of s136) in 999/111/OOH is written into relevant Sch 2 KPI's ▪ OH/Primary Care: OCCG to commission s12 doctor service either through OH outcome based contract or primary care/federations ▪ OH: To align OCC Approved Mental Health Practitioner service into OH outcome based contract ▪ Aligning psychiatric liaison services in hospital with mental health urgent care protocol ▪ OH/SH/SCAS: To agree patient conveyance requirements in line with protocol in Sch 2 KPI ▪ SCAS/Primary Care: To audit evidence staff competence to recognise and manage the needs of people in mental health crisis
Complexity- To develop a care pathway that supports better outcomes, system and financial efficiency for people with complex (mental health and other problems) high cost needs including people with learning disability who need to be supported via the transforming care programme; people with severe mental illness; people with acquired brain injury (including Huntingdon's) and those with co-morbid autism spectrum disorder	• OCCG: To develop and implement the intensive support team to manage complex behaviours in people with learning disability (part of Big Plan) • OH(impact for continuing health care service): OCCG to develop and implement a community based service as an alternative to high cost placement for people with acquired brain injury • OCCG: To explore option for single service to provide

To implement the bid for Social Investment Bond funding to manage high cost complex cases	community based support to all of the above groups plus people in the homeless sector possibly via a Social Investment Bond • OH: OCCG to review, in partnership with NHSE and the City Locality,the case for co-commissioning to better manage the health needs of homeless people (Luther Street Medical Centre)

7.9 Children and Young People's Mental Health

Clinical Director Lead: Dr Andy Valentine

Lead Manager: Ian Bottomley

2016/17 Commissioning Intentions	2016/17 Contracting or Procurement Implications
Children and Young People's Mental Health (CAMHS) To implement the CAMHS review, updated to reflect the Local Transformation Plan. In 2016/17 this includes: • Increasing the number of children accessing CAMHS • Reducing waiting times for CAMHS • Ensuring that there is a no more than 2 week wait for young people with an Eating Disorder • Open access to IAPT for all young people aged 16 and over • Clinical pathways published for most common conditions	• OH: To deliver these outcomes if they are identified as the 'Most Capable Provider' for all specialist and targeted children and young people's mental health services

7.10 Children and Young People

Clinical Director Lead: Dr Miles Carter

Lead Manager: Ian Bottomley

2016/17 Commissioning Intentions	2016/17 Contracting or Procurement Implications
Vulnerable Children and Safeguarding To implement a pathway for survivors of Child Sexual Exploitation and children who have been sexually abused.	• OCCG: To manage contract variation in line with Partity of Esteeem funding
Looked After Children To improve the pathway for health outcomes of Looked After Children	• OCCG: To manage contract variation in line with Parity of Esteem funding • OH: OCCG to explore a co-commissioning approach for statutory medical assessments with NHSE and implement through a commissioning or contract variation from April 2016. • Primary Care: OCCG to explore options to commission primary care support for new Children's Homes • OCCG: Review and improve quality indicators so that there is a clear plan to meet target during 2016/17.
Children with Special Educational Needs and Disability (SEND) To implement the SEND reforms outlined in the Children and Family Act 2014	• All Providers: To identify children with SEN, including those under 5 years • All Providers: To support the development and maintenance of a local offer • All Providers: to actively participate in the Education, Health and Care Plan (EHCP) process
Multi-Agency Safeguarding Hub (Lead**:** Sula Wiltshire) To ensure active contribution and involvement in the	• All providers: To identify how they will deliver their statutory

multiagency safeguarding hubs (children and adult) as a core element of providers safeguarding responsibilities including: • Agreeing a model that meets the requirements • Securing alignment across providers for delivery of the agreed model • Supporting processes to streamline activity	safeguarding functions through the children and adults MASH from April 2016

7.11 Long Term Conditions

Clinical Director Lead: Dr Amar Latiff

Lead Manager: Sara Wilds

2016/17 Commissioning Intentions	2016/17 Contracting or Procurement Implications
Holistic Approach To develop a holistic approach for the management of long term conditions across Oxfordshire which encompasses a preventative, proactive and whole person approach to managing care based on a supported self-management approach. This will include: • Considering new ways and models of working within current organisational structures and future potential providers of care. • Ensuring alignment with primary care commissioning and contracting intentions and the community nursing review • Ensuring there is a focus on self-care in the personal care plans of those with a long term conditions	• Primary Care: To ensure there is proactive identification of long term conditions in primary care –eg:CVD, diabetes, COPD, asthma • OCCG: To explore and consider an alternative funding model to identify how innovative models can be used to promote transformation

Capacity To create capacity and resource for increased patient management in primary and community care settings closer to home freeing up acute capacity for more specialist work. This will require more collaboration in primary/community care supported by IT solutions to enable this.	• All Providers: OCCG exploring IT solutions including interoperability of clinical systems and finding technical solutions eg EMIS web access • Primary Care/All providers: OCCG intends to support and expand IT interoperability across primary care and other providers to ensure the right information, for the right patient, at the right time, wherever the patient is seen
Care Plans To promote the increased use of care plans and the Oxfordshire Care Summary to enable sharing of care plans and relevant clinical information across the system.	• Primary Care: To ensure increased use of digital care plans • All providers: To ensure that information is appropriately inputted in patient records to enable it to be accessed and incorporated into the Oxfordshire Care summary as and when needed • All Providers: To ensure the Oxfordshire Care Summary is acceseed as a means of optimising the quality of patient care • All urgent care providers (OH,OUH, SCAS): To ensure increased use of Digital Care Plans via the Oxfordshire Care Summary in all urgent care situations i.e. A&E, OOH, 111 & 999 (for all patients that have a digital care plan) •
Digital Care Plans – Social Care To ensure relevant social care information is incorporated into digital care plans and make information available via Oxfordshire Care Summary.	• Social Care Providers: To agree to the use of Oxfordshire Care Summary/digital personal care plans.

Education To scope opportunities to improve education for patients with Type 2 diabetes so that patients are aware of a range of ways of improving their ability to self-manage their condition.	• OH: Potential to decommission Type 2 diabetes education service and recommission a more diverse educational offer through procurement`
Community Nursing To strengthen capacity of nursing in the community by implementing the recommendations from the community nursing review including: • Piloting and evaluating new ways of working for a 6 month period in order to assess whether to proceed to county wide implementation and retain current contract.	• OH: Subject to evaluation in July 2016 that demonstrates successful outcomes from the pilot the CCG will consider whether to continue with OH contract or re-procure the service
Integrated Neighbourhood Teams 2015/16 will see integrated teams working at a neighbourhood level to support people to live at home successfully through to the end of their life supported by a Joint Front Door and single referral pathway OCCG will continue to support Oxford Health and Adult Social Care to deliver integrated community services for adults and older people with mental health issues wrapped around primary care in partnership with voluntary organisations.	• OH/OCC: To agree a Memorandum of Understanding to cover the governance arrangements for the integrated service
Care Home Support To review the Care Home Support service and other health services provided in care homes during 2016/17 to ensure they provide added value to patient care.	• OH: Recommendations from the review may lead to changes to the current contract

7.12 End of Life Care

Clinical Director Lead: Dr Julie Anderson

Lead Manager: Sara Wilds

2016/17 Commissioning Intentions	2016/17 Contracting or Procurement Implications
Palliative Care To ensure equitable and appropriate 24/7 access to specialist palliative care services for the whole population of Oxfordshire to enable people to die where they prefer where appropriate. OCCG will review the range of End of Life Care services currently commissioned by OCCG including bereavement and hospice services including looking at outcomes and value for money to ensure we are commissioning high quality services for End of Life Care. This will include reviewing current contracts to: • Re-align funds to secure a fuller range of services at best value • Re-align geographical gaps and inequalities in provision • To develop robust KPI and data requirements to measure provider responsiveness and effective discharge planning	• OUH and OH: To deliver an improved service specification and data requirements for end of life and palliative care to achieve better value and equity in patient care. • OUH and OH: To implement improvements to current end of life pathways and provision • All Providers : To provide increased end of life education, training and awareness for their staff
Joint Working To work with 3rd Sector Organisations to explore opportunities for increased joint working:	• Sue Ryder: To develop and pilot a hospice at home model incorporating learning from partnership for excellence in palliative support • Macmillan Partnership: To explore opportunities to develop partnership opportunities/bids. • Marie Curie: Decommission parts of the current contract to transfer to alternative night sitting service

Advance care Planning/Digital Care Records To promote the increased use of advance care planning/digital care plans.	• Primary Care: To increase the use of digital care plans for end of life care • All urgent care providers (OH,OUH, SCAS): To ensure increased use of Digital Care Plans via Oxfordshire Care Summary

7.12 Medicines Optimisation

Clinical Director Lead: Dr Miles Carter

Lead Manager: Julie Dandridge

2016/17 Commissioning Intentions	2016/17 Contracting or Procurement Implications
Take Home Medicines To improve the turnaround time for take home medicines. This includes the time from the decision to discharge is made through to when the patient receives their take home medicines	• OUH: To provide metrics for the measurement of turnaround time for take home medicines in order that an improvement can be shown. • All Providers: It is expected that all providers will be able to provide the above data during 2016/17
Zoledronic Acid Infusions To commission an annual zoledronic acid infusion for those patients unable to tolerate oral bisphosphonates via hospital at home or EMUs. New service specification to be developed	• Primary Care: To reduce the use of denosumab
Anticoagulation To implement a new anticoagulant pathway for the treatment of patient with new oral anticoagulants and warfarin to ensure that OCCG is in line with other commissioners	• OUH: Contract variation for a new pathway will be developed

Excluded Drugs To consider and implement additional risk/gain share agreements for drugs excluded from tariff To review the dataset for excluded drugs to bring it in line with the expectations from Specialised Commissioning.	• OUH – contract variation to be developed • OUH: To provide data in line with NHS drugs taxonomy and monthly dataset specification (Gateway 03097) for PbR excluded drugs.
SIP Feeds and Stoma Products To review the commissioning and provision of sip feeds, continence and stoma products.	• Contracting intentions to be determined following review

7.14 Quality

Clinical Director Lead: Dr Richard Green

Lead Manager: Tony Summersgill

2016/17 Commissioning Intentions	2016/17 Contracting or Procurement Implications
Clinical Communication To ensure all clinical communication is effective and timely moving to electronic communication, where appropriate and eliminate paper copies for all clinical communication. To continue to support the development of remote working for care home support staff, social care staff, community nurses, GPs in care homes and similar locations.	• OH: To ensure more clinical communication is transferred electronically to GP practices and vice versa; • OUH and Primary Care: To improve electronic document transfer between providers where possible (e.g. supporting expansion and resilience of the EDT hub (secure server); to cover all OUH to GP documents e.g. outpatient letters, radiology requests and results).

Performance OCCG intends to advise GPs to refer elsewhere, making this information publically available, where poor performance has been identified and providers fail to rectify these issues in a timely way	• All Providers: To be aware of OCCGs intention and ensure services are fit for purpose.
CHOICE To ensure hospital appointment systems are effective and efficient and patients are offered choice of providers and are able to use directly bookable service where appropriate	• Primarily OUH: to ensure full roll out of directly bookable services utilising the NHS e referral system
C Dificile To reduce primary care C. difficile infections by a further 20% from the 2014/15 final figures	• Primary Care/OUH/OH: Changes required to GP management of patients with C. difficile. Continue ongoing work with OUH and OH.
Pressure Sores To work with providers to innovate and eliminate avoidable pressure damage, all grade 3 and 4 avoidable pressure ulcers, in Oxfordshire.	• OUH/OH: To improve all aspects of nursing care to eliminate avoidable pressure sores
Quality – Monitoring To undertake targeted visits to clinical areas to monitor quality of services.	• All Providers: OCCG will target quality visits based on risk.
Primary Care Indicators To visit all GP practices that are outliers for 4 or more for the NHSE High level Primary Care Indicators	• Primary Care: OCCG will undertake visits based monitoring of NHSE High level Primary Care Indicators
Individual Funding Requests To improve the efficiency of the Individual Funding Request system by implementing an electronic system in secondary care.	• OUH: Clinicians to complete an electronic request form similar to primary care to improve the speed of decision making and reduce inappropriate requests.

Stroke Care Pathway To work with providers to improve the current Stroke Care pathway to enhance rehabilitation from stroke across Oxfordshire. OCCG will be scoping opportunities for improving the effectiveness of early discharge for stroke patients as well as ensuring an equitable service across Oxfordshire.	• OCCG may consider using new providers to ensure equitable services for patients.
Stroke Mortality To work with providers to improve the current care pathway for stroke to impact on levels of stroke mortality. The pathway should include taking eligible patients directly to an acute setting that is delivering evidence based care similar to that of a Hyper Acute Stroke Unit	• OUH/SCAS: Potential for need to redesign services to improve patient outcomes

7.15 Health Inequalities

Clinical Director Lead: Dr Andy Valentine/Dr Joe Mc Manners

Lead Manager: Sara Wilds

2016/17 Commissioning Intentions	2016/17 Contracting or Procurement Implications
Social Prescribing To review the evaluation of Age UK's Circles of Support and the impact of social prescribing	• Age UK: OCCG to consider commissioning or decommissioning the service based on the outcome of the evaluation to provide a more targeted intervention that supports hospital avoidance
Social Prescribing Pathway To explore opportunities to combine primary care and community assets through the development of social prescribing pathways.	• Primary Care/Voluntary Sector: OCCG will identify contracting options, including collaborative opportunities, to support this model

7.16 Business Intelligence

Clinical Director Lead: Dr Paul Park

Lead Manager: Cecile Coignet

2016/17 Commissioning Intentions	2016/17 Contracting or Procurement Implications
Pathway Analysis To source comprehensive patient pseudo-identifiable, clinically informed event level (e.g. spells) community and community Mental Health data in order to enable full patient pathway analysis	• All community providers: To provide agreed information schedules specifying data supporting all critical services purchased
Pathway Analysis To source national datasets and/or develop specification for alternative local datasets where appropriate (new services or where national requirements are insufficient) to support comprehensive clinically relevant patient pathway analysis across the health economy	• ·All providers: To provide agreed information schedules specifying data supporting all critical services purchased
Coding To agree coding approach to new schemes in all relevant datasets so that impact can be clearly understood and evaluated, e.g. AEC in SLAM and SUS.	• . • Data specification to be produced as part of the project and included in the information schedule
Data Quality Strengthen data quality requirements as specified in the Data Quality Improvement Plan (DQIP), ensuring comprehensive use of IDs, and all other critical data items (e.g. diagnosis) where required, to reduce data processing and maximise the ability to build pathway datasets and the ability to reconcile data as cost effectively as possible.	• All providers: To provide agreed Data Quality Improvement Plan as part of information schedule

Capacity and Demand Analysis To ensure joint working to analyse patient pathways and/ or forecasting /capacity and demand analysis across the system	• All Providers: To support joint analysis of demand and capacity

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Oxfordshire Health and Wellbeing Board – 5 November 2015

Oxfordshire County Council Budget saving options 2016/17 Consultation

Introduction

Oxfordshire County Council provides more than three-quarters of the local government services in the county. They include:

- children's services and some education services
- roads and transport
- adult social care, supporting vulnerable adults and older people
- waste disposal and recycling
- fire and rescue and trading standards
- libraries and museums
- public health.

As government reduces funding to local government, the county council has to continue to make budget savings. At the same time demand for services is increasing, partly due to the ageing and growing population, and increasing demand for children's social care services.

The council has already saved – or has plans to save – a total of £292 million between 2010/11 and 2017/18. We now anticipate the need to save up to £50 million more in the four years between 2016/17 and 2019/20.

As a result, county council services will be reduced and some may stop altogether. The services left will be targeted at those who really depend on them – particularly children at risk of abuse and neglect, and adults who cannot look after themselves.

The proposals can be accessed through the county council website

https://www.oxfordshire.gov.uk/cms/content/budget-savings-options-201617

Consultation

The council has to set a budget every year. As part of that process, partners, residents and service users can have their say on the budget savings options before they are considered by all councillors who vote on the budget in February.

The council is consulting on 95 savings options that we have identified across all areas of the council (excluding public health, as this remains a ring-fenced grant).

Overall, the total savings options proposed probably adds up to more than we think we will actually have to save. However we will not know the final savings target until the local government finance settlement expected in mid- December.

Timescale

Public Consultation	20 October – 30 November
Government Spending Review & Autumn Statement	25 November
Performance Scrutiny consider savings options and public consultation	17 December
Draft Local Government Finance Settlement	w/c 14 December
Cabinet – proposed budget	26 January
Council – agree budget	16 February

Health and Wellbeing Board

The impact of the budget options will inevitably have an impact on the council's partners. The need to improve efficiency through joint working in order to mitigate the impact on service users is crucial.

RECOMMENDATION

The Health and Wellbeing Board is asked to consider the impact of the savings options and provide comments as part of the consultation process.

Peter Clark
Head of Paid Service
Oxfordshire County Council

October 2015

Communications received by the Chairman July – October 2015
Report to the Health and Wellbeing Board, November 2015

The Chairman of Health and Wellbeing Board receives correspondence from a range of partners and stakeholders. The Board agreed a process by which this correspondence can be responded to or directed to the most appropriate individual, organisation or group for action. The table below summarises activity from July to October 2015

Date received	Communication topic	Action taken
3.8.15	Request for support for the National Wheelchair Charter and campaign, which was launched by the National Wheelchair Leadership Alliance on July 20th.	A response was sent which confirmed that the Health and Wellbeing Board supports the objectives of the charter in principle.
6.8.15	Information about AllActive which is an approach to help address the problem of physical inactivity in the older population	The information was forwarded to Public Health officers and information was shared about the local Generation Games programme.
22.8.15	A request to sign the Charter for Homeless Health	A response was sent to the correspondent outlining the work of the Health Improvement Board on housing and homelessness issues.
10.8.15	An email asking for support for the services at Thame & District Day Centre	A response was sent from the Adult Social Care directorate of the County Council.
23.9.15	Information and a report from Fixers, a charity who work with young people to raise awareness of mental ill-health	The information was passed to commissioners of children and young people's mental health services.

Any questions on this report can be directed to jackie.wilderspin@oxfordshire.gov.uk

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Mental Health Crisis Concordat – Update on Progress and Next Steps in Implementation

Purpose of paper

1. The Health and Wellbeing Board on 13 November 2014 agreed that Oxfordshire County Council (OCC) and Oxfordshire Clinical Commissioning Group (OCCG) would sign off the Mental Health Crisis Care Concordat (MHCCC) declaration and action plan on behalf of the Oxfordshire Health and Wellbeing Board, and approved the proposed governance arrangements and submission of the final action plan to the national website portal prior to the deadline of 31st December 2014

2. As agreed at that meeting, this paper provides a high level information update of progress in setting up governance arrangements and delivering the action plan in the past year. A more detailed report will be presented to the Health and Wellbeing Board in March 2016. This will set out OCCG plans for 2016-17 subsequent to the NHS planning round (which will commence December 2015). We also anticipate that there will be a national review of local Crisis Concordat implementation plans prior to the next meeting of the Board in March 2016.

Background and local governance arrangements of the Mental Health Crisis Care Concordat (MHCCC)

3. In February 2014, 22 national bodies for health, policing, social care, housing, local government and third sector came together to sign the mental health Crisis Care Concordat, (link to national website). This focused on four main areas:
   - Access to support before crisis point – making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously.
   - Urgent and emergency access to crisis care – making sure that a mental health crisis is treated with the same urgency as a physical health emergency.
   - Quality of treatment and care when in crisis – making sure that people are treated with dignity and respect, in a therapeutic environment.
   - Recovery and staying well – preventing future crises by making sure people are referred to appropriate services
4. From the initial joint statement it was mandated that, for the Crisis Care Concordat to become a reality, it needed to be adopted and implemented at a local level. In Oxfordshire the local concordat was signed in November 2014 by OCCG, Oxford Health NHSFT, Oxford University Hospitals Trust, South Central Ambulance Service, Thames Valley Police, OCC, NHS England Thames Valley, Thames Valley Police and Crime Commissioner, local representatives of British Transport Police, Principle Medical Ltd, and voluntary sector organizations including Restore, Response, Oxfordshire Mind, Elmore and Connections. This was agreed at the Health and Wellbeing Board on 13 November 2014.
5. An implementation group made up of all these partners was formed in December 2014 and has been meeting bimonthly to date. There is continued commitment from all organisations to work together better and there is the right spirit and drive in local partners to ensure that existing and new initiatives work well together. The implementation group reports to the Mental Health Joint Management Group bi annually and escalates issues to that group as necessary.
6. Since the inauguration of the Crisis Care Concordat nationally, the planning requirement to deliver parity of esteem as set out in the NHS England *Five Year Forward View* and a national

Care Quality Commission thematic review of mental health crisis services has driven a review of local action plans. There remains a high level of scrutiny from central government, the Department of Health and NHS England ensuring that local systems have appropriate services in place to meet the needs of people in mental health crisis. All counties are expected to refresh local action plans and upload them to the national web portal by November and Oxfordshire is currently in the process of doing this.

7. In addition the Terms of Reference for the Oxfordshire Systems Resilience Group were amended at its September meeting to ensure that mental health is appropriately reflected in its work. In October the group was updated on the current crisis concordat work to improve delivery of Mental Health Urgent Care. It agreed a number of proposed mental health measures to be reported which will enable the Systems Resilience Group to assure the system regarding the delivery of care to people in mental health crisis and the resilience of the wider health and system in relation to mental health care. Specifically, NHS England has made available one off investment to support the development of better care for people in mental health crisis who end up in emergency departments of our main hospitals. A plan to meet this is being developed by the partners in the System Resilience Group.

Implementing the Oxfordshire MHCCC action plan – progress to date

8. The Oxfordshire action plan has been jointly agreed based on national and local evidence, the table below gives a high level summary of some of the actions being progressed and current status :

MHCC Concordat outcomes	Oxfordshire action plan	Current status	Partner lead(s)
Access to support before crisis point	Information review and partners agreed action plans	Review complete. Partner actions to be agreed.	Oxfordshire County Council – Public Health and Oxfordshire Mind
	Training review and provider agreed action plans	Initial review complete. Further work needed to understand accurate position	Oxfordshire County Council – Public Health
	Liaison and Diversion schemes in Criminal Justice system	Roll out of pilot complete and monitoring in place	NHS England Thames Valley Health & Justice team
Urgent and emergency access to crisis care	Local partners 'working together' joint protocol	Draft completed and to be circulated to partners – assurance of sign off needed	OCCG and Oxford Health NHS Foundation Trust (OHFT)
	Ensure access to 24/7 psychiatric liaison service in A&E	24/7 response in place. Further work underway to review 'on site' response out of hours and in particular at Horton hospital	OHFT
	Mental health practitioner in South Central Ambulance Service (SCAS) control room – pilot	Recruitment delayed start until September. Initial monitoring suggests service prevents inappropriate conveyance to A&E	OHFT and SCAS
	Mental health practitioner acts as street triage at night working with the police	Reduction in people with MH problems being detained under police powers of at least 25%.	OHFT and Thames Valley Police

Quality of treatment and care when in crisis	Patient and Carer survey	Initial survey drafted and ready to send. To be repeated after 6 months	MH carers Reference Group and Carers Voice
	Children and Young people using MH services have crisis management plan	Review and audit underway	OHFT
Recovery and staying well	Delivery of the new Mental Health Outcomes Based Contract (OBC) will measure how people with mental illness recover and stay well.	OHFT have the Recovery College, Recover Star and Triangle of Care all established. Monitoring will commence through contract review meetings	OCCG/OHFT

9. Whilst all partners continue to be driven to improve services for people in MH crisis the scale of the remit for the Concordat does present some challenges, such as:
    - Developing a Joint Working Protocol, listed in the table above, around roles and responsibilities within the deployment of the Mental Health Act 1983. There are occasions when the system fails a person and the problem escalates very quickly to chief officer level, often apparently due to a lack of clarity within joint operational protocols. The local Crisis Concordat plan is to develop an overarching joint working protocol which over lays partner organisations protocols and is adopted by all; this would set out the principles and behaviours that each organisation would work to and describe the escalation processes. It would need to be reflected in individual organization duty and escalation protocols and delivering this in a timely systematic way across all partners will take robust management.
    - Development of a dataset around the impact and needs of people with mental health presentations across the system. As the table above sets out there is a significant level of activity that seeks to manage the needs of people with mental health presentations and this is distributed across a number of settings. We currently lack the data that would evidence this impact at a system level. A number of the interventions will contribute to this intelligence but it will need more work to systematically collect and agree which partner will monitor on behalf of the system.

Future report to the Health and Wellbeing Board

10. This information paper provides a brief snapshot of the progress to date and demonstrates that it will take time for the system to be able to report collectively to capture the improved outcomes that these initiatives are starting to provide. A more detailed report will be presented to the Health and Wellbeing Board in March 2016 by which time the roll out and monitoring mechanisms of this MH urgent care pathway should be becoming more embedded and it will give an opportunity for partner agencies to describe how working together has produced positive outcomes and impact for both individuals, and on the health and social care system

Comments and suggestions for updating the action plan

11. Members of the Health and Wellbeing Board and partner organisations are invited to comment on the progress in delivering the Mental Health Crisis Concordat Action Plan, and to make suggestions for inclusion a refreshed and updated plan. These will be considered as part of the NHS planning round (due to start in December 2016, and reported to the Health and Wellbeing Board in March 2016. Comments and suggestions should be sent to:

Juliet Long
Senior Commissioning Manager – Mental Health
Oxfordshire Clinical Commissioning Group
Tel: 01865 334606
Email: **Juliet.Long@oxfordshireccg.nhs.uk**