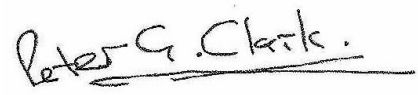
Public Document Pack

To: Members of the Shadow Oxfordshire Health & Wellbeing Board

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

Thursday, 14 March 2013 at 2.00 pm

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



Peter G. Clark
County Solicitor

March 2013

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

Membership

Chairman – Councillor Ian Hudspeth
Vice Chairman - Dr Stephen Richards

Board Members:

Councillor Mark Booty *(West Oxfordshire District Council)*	Chairman of the Health Improvement Board
Sue Butterworth	Chair of Oxfordshire LINk
Councillor Louise Chapman *(Oxfordshire County Council)*	Chairman of the Children & Young People's Board
Councillor Arash Fatemian *(Oxfordshire County Council)*	Chairman of the Adult Health & Social Care Board
John Jackson	Director for Social & Community Services
Dr Mary Keenan	Vice Chairman of the Children & Young People's Board
Dr Joe McManners	Vice Chairman of the Adult Health & Social Care Board
Dr Jonathan McWilliam	Director of Public Health
Councillor Val Smith *(Oxford City Council)*	Vice Chairman of the Health Improvement Board
Jim Leivers	Director for Children's Services
Matthew Tait	Area Director (Designate), Thames Valley NHS Commissioning Board

Notes:

- ***Date of next meeting: 25 July 2013 – which will be the inaugural meeting of the statutory Board.***

Declarations of Interest

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

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

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

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

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

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

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

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

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

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

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

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

AGENDA

1. Welcome by Chairman, Councillor Ian Hudspeth

2. Apologies for Absence and Temporary Appointments

3. Declarations of Interest - see guidance note opposite

4. Petitions and Public Address

5. Note of Decisions of Last Meeting

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

6. Terms of Reference for Statutory and Partnership Boards

2:05
5 minutes

Person(s) responsible: Members of the Health & Wellbeing Board
Person giving report: Peter Clark, Head of Law & Culture

Peter Clark will advise on the pathway for approving the Terms of Reference for the statutory Board and for the Partnership Boards.

7. Performance Report

2:10
15 minutes

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

There will be a review **(HWB7)** of current performance against all the outcomes set out in the Health & Wellbeing Strategy. Performance for each Partnership will be presented in turn:

- Children & Young People (Jim Leivers and Dr. Mary Keenan)
- Adult Health & Social Care (John Jackson and Dr Joe McManners)
- Health Improvement Board (Dr Jonathan McWilliam)

Action Required: Members of the Board are asked to note the report and presentations and to consider any action required.

8. Themed Discussion - Implications for Oxfordshire of the Mid-Staffordshire Report

2:25
30 minutes

Person(s) Responsible: Lorraine Foley, Director of Commissioning & Partnerships, OCCG
Person giving report: Dr. Stephen Richards, Chief Clinical Officer, OCCG

In the light of the mid-Staffordshire report, there will be a discussion led by Dr. Stephen Richards, on the assurance available in Oxfordshire.

There are two background documents attached at **HWB8**. These are:

(a) The Mid Staffordshire NHS Foundation Trust Public Inquiry Press Statement – delivered by Robert Francis QC; and
(b) Briefing entitled 'Considering the Implications for Oxfordshire of the Francis Report on the Mid Staffordshire NHS Foundation Trust Public Inquiry Current Clinical Assurance available in Oxfordshire.'

9. Safeguarding Adults Board - Annual Report 2011-2012

2:55
15 minutes

Person(s) responsible: John Jackson, Director of Social & Community Services
Report presented by: Donald McPhail, Chairman of the Adult Safeguarding Board

Donald McPhail, Chairman of the Oxfordshire Adult Safeguarding Board will present the Annual Report **(HWB9).**

Action Required: to note the Annual Report and to discuss its recommendations.

10. Planning processes and information on resources that can be influenced by the Health & Wellbeing Board

3:10
35 minutes

This item concerns the operational planning and financial issues for Oxfordshire Clinical Commissioning Group and Oxfordshire County Council in delivering Health & Wellbeing priorities, including the use of pooled budgets.

There will be a discussion, led by the Director of Social & Community Services, the Director of Commissioning & Partnerships, OCCG, the Director of Public Health and the Director for Children' s Services, on the integration of budgets for the Oxfordshire Clinical Commissioning Group and Oxfordshire County Council and the arrangements for transparent governance in joint working.

Two background papers are attached at **HWB10** relating to:

- The Oxfordshire Clinical Commissioning Group planning process; and
- An overview of resources that can be influenced by the Health & Wellbeing Board.

11. Reports from Partnership Boards

3:45
15 minutes

The Vice - Chairman of the Children & Young People Partnership Board and the Chairmen of the Adult Health & Social Care Partnership Board and the Health Improvement Board will each present an oral update on the activities of the Boards since the last meeting.

Action Required: To receive updates from each Partnership Board.

PAPERS FOR INFORMATION ONLY

- The Dementia Plan - which can be viewed through the following link: http://www.oxfordshirepct.nhs.uk/your-health/mental-health/dementia.aspx

- The Joint Strategic Needs Assessment (JSNA) summary report for the Health & Wellbeing Board 2012 – 13 is attached.

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SHADOW OXFORDSHIRE HEALTH & WELLBEING BOARD

OUTCOMES of the meeting held on Thursday, 22 November 2012 commencing at 2.00 pm and finishing at 4.00 pm

Present:

Board Members: Councillor Ian Hudspeth – in the Chair

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

Officers:

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

Part of meeting — Jim Leivers (Oxfordshire County Council)

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

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

	ACTION
1. Welcome by Chairman, Councillor Ian Hudspeth (Agenda No. 1)	
2. Apologies for Absence and Temporary Appointments (Agenda No. 2)	

Councillor Arash Fatemian and Matthew Tait sent their apologies. Councillor Melinda Tilley attended in place of Councillor Louise Chapman.	
3. Declarations of Interest - see guidance note opposite (Agenda No. 3)	
There were no declarations of interest submitted.	
4. Petitions and Public Address (Agenda No. 4)	
There were no requests to petition or to address members of the Board.	
5. Note of Decisions of Last Meeting (Agenda No. 5)	
The decision note (HWB5) of the meeting held on 26 July 2012 was approved and signed as a correct record.	Julie Dean
6. Amendment to Terms of Reference (Agenda No. 6)	
It was **AGREED** that the Terms of Reference, as agreed on 24 November 2011, be amended to include the post of National Commissioning Board Local Area Team Director for Thames Valley within the membership of the Health & Wellbeing Board.	Peter Clark
7. Performance Report (Agenda No. 7)	
The Board had before them a performance report reviewing current performance against all the outcomes set out in the Health & Wellbeing Strategy (HWB7(a)). A table showing the agreed measures under each priority in the Strategy, expected performance and current performance was attached at HWB 7(a) Appendix A. It was noted that: • 6.1 and 6.4 were the subject of discussion later in the Agenda (Item 9); • The targets relating to 4.4, 4.5, 9.2,11.2 would improve	

during the year/academic year. With regard to: Priority 1.2 - 'Reduce emergency admissions to hospital with infections by 10% year on year – it was agreed that the data should be investigated to see whether causes of infection could be identified, in order that current trends could be explained. Priority 6.2 - 'No more than 400 older people per year to be permanently admitted to a care home from October 2012' - Sue Butterworth directed the Board's attention to a recent report produced by the Oxfordshire LINk on Dignity & Quality of Care in Homes, particularly in Dementia care. Val Messenger, Deputy Director of Public Health, presented an in-depth report on the Bowel Screening indicator which was not meeting its target (HWB7(b)) asking why the target of 60% over the last 2 years had not been reached; what initiatives and actions were currently in place to improve the position; and what further initiatives and planned actions had been identified for the future. Members of the Board suggested the following actions which might be built into the campaign: • GP's could promote the bowel screening programme to improve uptake; • To replicate the useful process of analysing the data collected from various GP practices (as has been the practice with immunisation data) to gain insight into who was not taking up the screening offer); • Distribute information at popular events attended by the target population such as football/rugby matches or training events etc; • To target people living in retired people's housing developments and with groups planning for retirement. It was **AGREED** to note the reports and to note also that further information would be available as part of regular performance reports to the Board.	)))) Jonathan McWilliam)))))
8. Public Involvement Network (PIN) (Agenda No. 8)	
Sue Butterworth, Chair of Oxfordshire LINk gave an update on the activities undertaken by the Public Involvement Network to ensure that public engagement was embedded and to ensure that the genuine opinions and experiences of people in Oxfordshire	

underpin the work of the Health & Wellbeing Board. Examples included a new PIN website to allow two way engagement and proposals for PIN briefing sessions prior to future Board meetings. She welcomed a number of young people who were in the audience and who were contributing to public engagement. These were part of a dynamic, diverse group being formed which included faith groups, disability groups and the military, to name a few. The Board viewed a short film that had been produced by the PIN, which reproduced the draft Older People's Commissioning Strategy in visual form, helping people to engage in its development. The Board thanked Sue Butterworth for her report.	
9. Frail Older People - Draft Action Plan (Agenda No. 9)	
The Board were asked to endorse a covering report and draft Action Plan (HWB9) which related closely to several of the adults' indicators in the joint Health & Wellbeing Strategy, in particular around delayed transfers of care, reablement services and admission to care homes (indicators 6.1, 6.2 and 6.4). The Action Plan was prepared in response to the Themed Discussion on Frail Older People item of business at the last meeting, and also in response to continuing performance issues. The Plan focused on immediate priorities (by March 2013) as well as longer term actions that would link closely to action plans for the joint Health & Social Care older people's commissioning strategy, due for completion by April 2013. Dr Richards commented that much work was in progress to deliver a discharge pathway, covering a broad spectrum of activity. Some of this work had been escalated in order to deliver a reduction in delayed transfers of care. John Jackson endorsed this pointing out that an agreement with the Oxfordshire Clinical Commissioning Group had been reached on a Discharge Policy. Feedback on the Plan had been given by Age UK and the Older People's Panel and all that was required was a discussion with Oxfordshire Health and Oxford University Radcliffe NHS Trust. The Board gave the following responses: • It was a good Plan with a multiplicity of initiatives, giving greater accountability and more of a sense of what the priorities were. It was hoped that it would initiate proactive	

activity which would, in turn, lead to greater efficiency; • It was imperative that all organisations work together in a coordinated and integrated manner ie. a single multi-disciplinary team to be in place to make the discharge and following this, a single point of access team to plan and co-ordinate services. Assessments to be undertaken at home following discharge. A monitoring group to be formed to ensure that the outcomes are good, together with a number of indicators to be recognised by commissioners within the public domain; • It is necessary for information to be in the system as a whole for GP's to access; • The reality was that the numbers of older people would increase, but the public purse would be tighter. However, locally progress had already been made to implement the recommendations in the Director of Public Health's Annual Report for more Plans to be joint and commissioners more united; • The three areas to be focussed on were firstly, the integration of clinical and social care teams; secondly, the prevention agenda; and thirdly, the need to give constructive help to villages and communities in order for them to help themselves. There is a requirement for more supporting volunteers and, in turn, for volunteers and carers to be supported in a more co-ordinated way; • There was still a need to keep the agreed shared finances in an uncomplicated, formalised pooled budget as part of the approach to outcomes based commissioning; • More liaison between the GP Locality Leads and the District Councils was required, in light of the latter's involvement with the Public Health portfolio and their contact with the voluntary sector; and • There was a need for a county wide specialist money management advice service to be provided for individuals managing their own care. Following a lengthy debate, it was **RESOLVED** to endorse the draft Action Plan and to agree to wider discussion with NHS providers, GP localities and representatives of older people and carers.	John Jackson/ Dr Stephen Richards/ Dr Joe McManners
10. Reports from Partnership Boards (Agenda No. 10)	
Councillor Mark Booty, Dr Joe McManners and Dr Mary Keenan gave oral progress reports on the recent activity of each of the three Partnership Boards:	

Health Improvement Board – Councillor Mark Booty reported that the Board was pleased with progress to date but recognised that there was a great deal of work to be done. Activity included:

- A workshop had been held in July where participation of the voluntary sector and other partners was welcomed. A range of affiliated projects were identified which would help to achieve the aims of the Health Improvement Board;
- Work was underway to identify priorities and targets for the Board in respect of housing/homelessness issues in the Strategy;
- The Board had recognised the value of joint working with Trading Standards on enforcement of under age sales legislation including alcohol and tobacco sales;
- The next steps included joint workshops with the Adult Health & Social Care and Children & Young People Partnership Boards; and
- A joint meeting had taken place between the district council members sitting on the Boards to initially open up discussion on housing, with the aim of sharing ideas across all stakeholders.

All acknowledged that Government changes to the Welfare Benefits system would be of crucial importance to service delivery. This will be a feature of the work of the Health Improvement Board in their priority of preventing homelessness. However, before issues could be tackled, the manner in which the Supporting People programme would move forward had to be dealt with.

Sue Butterworth pointed out positive signs of collaboration across agencies. Furthermore, the Oxfordshire Rural Community Council, the Oxfordshire Community & Voluntary Action and the Oxfordshire Wheel were encouraging organisations to work together and to look for different solutions.

Adult Health & Social Care Partnership Board – Dr Joe McManners gave a brief presentation on the work of the Board as follows:

- Universal credits had been the focus of discussion at the last meeting. Discussion was to continue at the next meeting;
- A successful workshop had been convened as a prequel to the consultation on the launch of the Older People Commissioning Strategy which was to take place during December and January;
- The Board had discussed the development of Capable Community Services;

• A flow chart of services was to be developed to assist people to access services; • Links were being forged with the Safeguarding Adults Board. <u>Children & Young People Partnership Board</u> – Dr Mary Keenan reported that the Board had been busy with the following activities: • A workshop had been held in July to focus on the period of transition from the Child & Adolescent Mental Health Services (CAMHS) to the Adult Mental Health services; • A joint workshop had been convened with the Children's Board on child sexual exploitation, which was attended by 200+ people, with the aim of developing a Strategy and a toolkit for supporting staff. The event featured the drama production 'Chelsea's Choice' which had proved highly innovative in tackling the issue nationally; • The Board was also focusing on maternity services with the aim of providing a high quality service for all, particularly for vulnerable groups; • Links for various vulnerable groups were being made with Safeguarding Children's Board; and • Good practice was being shared with partners on raising achievement in education. Councillor Booty, Dr McManners and Dr Keenan were thanked for their updates. .	

..... in the Chair

Date of signing .....

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Shadow Health and Wellbeing Board
14 March 2013

Performance Reporting

Current Performance

1. A table showing the agreed measures under each priority in the Joint Health and Wellbeing Strategy, expected performance and current performance is attached as Appendix A.

2. It is worth noting that although the most up to date figures possible have been included, in some cases this relates to quarter 2 (July - September) as quarter 3 (October - December) is still being verified. Where possible, interim performance has been indicated in the notes column.

3. There are also a number of targets that will not be reported on a quarterly basis. This may be where data is collected or released less frequently (as the result of an annual survey for example), or because work this year is focused on establishing baselines for new measures.

4. Current performance can be summarised as follows:

   18 indicators are Green
   2 indicators are Amber (defined as within 5% of target)
   6 indicators are Red
   2 indicators expected to report in Q3 do not have information available yet
   23 indicators were not expected to report this quarter.

5. Current performance is varied, and appropriate action is being taken where it does not meet expected levels to improve this. This has been summarised in the notes column of the appendix.

6. It is worth noting that performance on three indicators has improved from Amber to Green. These are schools rated outstanding by OFSTED (indicator 4.4), young people not in employment, education or training (indicator 4.5) and breastfeeding (indicator 9.2).

7. It is also worth noting that performance on two indicators has dropped from Green to Amber. These relate to mental health service users in employment (indicator 5.2) and carers breaks (indicator 7.10).

Action Planning

8. Each of the priorities and measures in the Joint Health and Wellbeing Strategy has a clear owner, an organisation or partnership that is responsible for reporting progress.

9. However, it is important to capture the wide range of activity happening across the county that contributes to each of them. The workshops are

proving to be important in understanding the work of partner organisations, how this contributes to meeting the priorities and measures in the strategy, and the opportunities they present for further joint working.

10. The Children and Young People's Board has hosted three workshops this year, focused on key priorities within the strategy: mental health transitions, children's safeguarding and raising achievement.

11. The Adult Health and Social Care Board has hosted workshops on Frail Older People and the older people's commissioning strategy.

12. The Health Improvement Board has hosted workshops focused on housing and action planning.

13. There was also a workshop focused on prevention hosted jointly by the Adults and Health Improvement Boards.

14. Further workshops over the coming months will focus on carers, learning disability and obesity.

Ben Threadgold, Strategy Manager, Joint Commissioning, Tel: (01865) 328219

February 2012

Updated : Wednesday 27th February 2013

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes

Oxfordshire Health and Wellbeing Board
Performance Report

No.	Indicator	Q1 report Apr-Jun		Q2 report Jul-Sept		Q3 report Oct-Dec		Q4 report Jan-Mar		Notes
	Priority 1: All children have a healthy start in life and stay healthy into adulthood									
1.1	Reduce emergency admissions to hospital for episodes of self-harm by 5% year on year. This means reducing admissions by 8 young people in 2012/13 (currently 155)	Expected 37 admissions **Actual 36 admissions**	G	Expected 74 admissions **Actual 66 admissions**	G	Expected 111 admissions **Actual 96 admissions**	G	Expected 148 admissions Actual		
1.2	Reduce emergency admissions to hospital with infections by 10% year on year. This means reducing emergency admissions by 145 in 2012/13	Expected 417 admissions **Actual 413 admissions**	R	Expected 834 admissions **Actual 805 admissions**	R	Expected 1251 admissions **Actual 1986 admissions**	R	Expected 1668 admissions Actual		This is a challenging target set against a national trend of increased admissions, but is part of the NHS outcomes framework. The original baseline for 2011/12 has been increased from 1450 to 1853, meaning the quarterly targets and overall reduction have also been amended
1.3	Review and redesign transition services for young people with mental health problems. This would mean there would be a new service in place from 1st April 2013							Expected New service to be in place		A project group led by the Director of Children Education and Families has been established to take this forward, following a successful workshop held by the Children and Young People's Board

Updated : Wednesday 27th February 2013

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
	Priority 2: Narrowing the gap for our most disadvantaged and vulnerable groups									
2.1	Maintain the recently improved rate of teenage conceptions (currently at 22 women aged 15-17 per 1000 - in 2010 this was 251 conceptions)	Expected 62 **Actual 62**	G	Expected 125 **Actual 123**	G	Expected 187 **Actual 182**	G	Expected 251 Actual		2011 Calendar Year (Q3). Latest data July-Sept 2011. Revised data published Dec 2012
2.2	The 'Thriving Families' project will have begun work with the first 100 families by April 2013							Expected 100 families Actual		512 families have been identified who meet the criteria and of these 262 currently have a worker. Team started working with families from January 2013 and will be working with 100 families by end of March.
2.3	Reduce persistent absence (15% lost school days or more) from school for children looked after to 4.9% for 2011/12 academic year (currently 11.7%)			Expected 4.9% **Actual 7.7%**	R					This figure is for those children continually looked after for at least 12 months as of 31 March 2012.
	Priority 3: Keeping all children and young people safer									
3.1	Collect information to establish a baseline of prevalence and trends of child sexual exploitation in Oxfordshire by March 2013							Expected Baseline established and targets set		This work is being undertaken by the Child Sexual Exploitation sub group of the Safeguarding Children's Board. Although the national data collection model has not been confirmed, it is likely to be based on the University of Bedfordshire model. A local data collection model based on this, including some local indicators, has been set up and is being tested. It will then be applied to all known cases by end

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
										March. A baseline and target will be established as a result and reported to the next meeting of the Board.
3.2	Reduce the number of children who need a subsequent Child Protection Plan (following a previous completed plan) to no more than 15%, which will require full multi-agency commitment (in 2011/12 15.3%)	Expected 15% rolling year 15% year to date **Actual** **11.5% rolling year 2.6% year to date**	**G**	Expected 15% rolling year 15% year to date **Actual** **10.3% rolling year (44/429) 10.2% year to date (22/216)**	**G**	Expected 15% rolling year 15% year to date **Actual** **12.3% rolling year (55/446) 13.2% year to date (44/333)**	**G**	Expected 15% rolling year 15% year to date Actual		The measure is the proportion of children who became subject to a child protection plan who had previously been subject to a plan (the national definition is within 2 years, this report is all children)
	A regular pattern of quality assurance audits is undertaken and reviewed through the Oxfordshire's Safeguarding Children Board covering the following agencies: children's social care; youth offending service; education services; children and adult health services; early intervention services; services provided by the police. Over 50% of these audits will show a positive overall impact (baseline to be confirmed in 2012/13)							Expected Programme of audits in place and baseline established Actual		The Quality Assurance and Audit sub-group of OSCB have set up a working group to develop this measure fully, to report by March 2013. An update is also being provided on the agenda for CYPB meeting on 25th Feb.

Updated : Wednesday 27th February 2013

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
	Priority 4: Raising achievement for all children and young people									
4.1	76% (5,000) children achieve Level 2b or above in reading at the end of Key Stage 1 of the academic year 2011/12 (currently 74.3% for the academic year 2010/11)			Expected 76% **Actual 78%**	G					Performance is now above national average (76%). Oxfordshire still ranks below its statistical neighbour average
4.2	80% (4,880) of children achieve Level 4 or above in English and Maths at the end of Key Stage 2 of the academic year 2011/12 (currently 75% for the academic year 2010/11)			Expected 80% **Actual 82%**	G					Oxfordshire now performs above national average (80%) and above the statistical neighbour average (81%). Only 1 primary school is below floor standard compared with 18 in 2011.
4.3	59% (3,500 out of 6,000) of young people achieve 5 GCSEs at A*-C including English and Maths at the end of the academic year 2011/12 (currently 57.4% for the academic year 2010/11)			Expected 59% **Actual 57.9%**	R					In the key performance measure of pupils achieving 5+A*-C inc English and maths Oxfordshire has increased slightly to 57.9%. However, in this measure Oxfordshire is performing below the Statistical Neighbour and National averages and is ranked 8th out of Statistical Neighbours
4.4	66% (153) primary schools and 70% (24) secondary schools will be judged by Ofsted to be good or outstanding in 2012/13 (currently 61% (142) of primary schools and 65% (21) of secondary schools)	Expected 62% (Primary) 66% (Secondary) Actual **60% primary 65% secondary**	A	Expected 63% (Primary) 67% (Secondary) **Actual 62% primary 65% secondary**	A	Expected 64% (Primary) 68% (Secondary) **Actual 65% primary 71% secondary**	G	Expected 66% (Primary) 70% (Secondary) Actual		The proportion of both primary and secondary schools judged as Good or Outstanding continues to rise. Between Sep and Dec, 11 schools (41% of those inspected) had increased their judgement to this level. End of January figures show that this has increased further to 16 schools.

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
4.5	Reduce the number of young people not in education, employment or training to 5% or 864 young people (currently 5.7% in the financial year 2012/13)	Expected 5.6% Actual **5.2%**	G	Expected 8.3% (NB figures always peak in September) **Actual 8.4%**	A	Expected 6.6% **Actual 6.1%**	G	Expected 5.0% Actual		The proportion of young people that are not in education, employment or training continues to reduce from the seasonally high figure reported in September. This reduction is due to confirmation from schools and colleges about the activity of young people post-16. The proportion of "Not Knowns" remains high. Measures are in place to address this such as the recruitment of a casual tracking team and the commissioning of Welfare Call to provide an intensive follow up service
	Priority 5: Living and working well: Adults with long-term conditions, physical disabilities, learning disabilities or mental health problems living independently and achieving their full potential									
5.1	75% of working age adults who use adult social care say that they find information very or fairly easy to find (currently 72.4%)							Expected 75% Actual		This target and baseline was set using the 2012 annual survey, so we will report on the 2013 survey – results will be available by May with benchmarking information in August.
5.2	15% of adults on the care programme approach receiving secondary mental health services will be in paid employment at the time of their most recent assessment / review (currently 10.7%)	Expected 11.8% **Actual 11%**	A	Expected 12.9% **Actual 13.4%**	G	Expected 13.9% **Actual 13.6%**	A	Expected 15% Actual		The wording of this indicator has been changed slightly to more accurately reflect the targeted individuals, although the baseline and targets remain the same
5.3	86% of people with a long-term condition feel supported to manage their condition (currently 84%)							Expected 86%		This target and baseline was set using the 2012 annual survey, so we will report on the 2013 survey – results will be available by May with benchmarking

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
								Actual		information in August.
5.4	95% of people living with severe mental illness will have an annual physical health check by their GP (currently 93.7%)							Expected 95% Actual		This indicator is no longer part of the national outcomes framework, however it remains a priority locally and will be reported on an annual basis
5.5	50% of people with learning disabilities will have an annual physical health check by their GP (currently 45%)							Expected 50% Actual		The data for this indicator is only collected at the end of the financial year and so will be available after end March.
	Priority 6: Support older people to live independently with dignity whilst reducing the need for care and support									
6.1	A reduction in delayed transfers of care so that Oxfordshire's performance is out of the bottom quarter (current ranking is 151/151)	Expected 146 **Actual 151**	R	Expected 103 **Actual 144**	R	Expected 72 **Actual 104**	R	Expected 72 Actual		Note – figures are actual number of people delayed. Although Oxfordshire remains in the bottom quartile nationally, the number of people delayed has reduced. The introduction of 'discharge to assess' (assessing people's ongoing care needs at home rather than in hospital) in November should also have a positive impact, although increased demand due to winter pressures may also impact on the number of delays.
6.2	No more than 400 older people per year to be permanently admitted to a care home from October 2012 (currently 546)					Expected 150 **Actual 136**	G	Expected 300 Actual		It is anticipated that a higher number will be placed in Q3 and Q4 due to winter pressures – the expected figures have been amended to reflect this. Of the total figure, 64 were placed from

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
										hospital, 9 from Intermediate Care Beds, 63 from the community
6.3	50% of the expected population with dementia will have a recorded diagnosis (currently 37.8%)			Expected 43.9% **Actual 46.7%**	G	Expected 46.95% **Actual 47.4%**	G	Expected 50% Actual		Data being collected from Q2 due to changes in collection methods
6.4	3,140 people will receive a reablement service (currently 1,812)	Expected 654 **Actual 492**	R	Expected 1526 **Actual 1020**	R	Expected 2420 **Actual 1566**	R	Expected 3140 Actual		The introduction of a new contract for reablement in November 2012 has not yet lead to the intended increase in the number of people receiving a service.
6.5	Maintain the current high standard of supporting people at home with dignity as measured by people themselves (currently 91.6%).							Expected 91.6% Actual		This target and baseline was set using the 2012 annual survey, so we will report on the 2013 survey – results will be available by May with benchmarking information in August.
6.6	By the end of March 2013, commission an additional 130 Extra Care Housing places, bringing the total to 407 and by			Expected 130	G					Target for this year has been achieved – 40 new ECH places have opened at Thame, 70 at Banbury (Stanbridge) and 20 at Bicester.

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
	the end of March 2015 an additional 523 places, bringing the total number of places to 930			**Actual** **130**						
6.7	75% of older people who use adult social care say that they find information very or fairly easy to find (currently 73.8%)							Expected 75% Actual		This target and baseline was set using the 2012 annual survey, so we will report on the 2013 survey – results will be available by May with benchmarking information in August.
6.8	Review transport in the community to understand the best way of meeting community needs by June 2013							Expected Review complete and action plan in place Actual		A programme has been established and is on track to complete this review by June 2013.
	Priority 7: Working together to improve quality and value for money in the Health and Social Care System									
7.1	Deliver a joint single point of access to health and social care community services, provided by Oxford Health and Oxfordshire County Council by the 1st December 2012					Expected Single point of access in place Actual An integrated health and social care Single Point of	**G**			The single point of access has staff co-located at Abingdon Community Hospital adopting a multi-agency/multi-professional approach towards ensuring the delivery of seamless integrated care. During December the newly integrated Single Point of Access handled 654 referrals, supporting 56 avoided acute hospital admissions. It also supported the new Oxfordshire discharge to assess policy – by brokering the process

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
						Access has been established and operational since the 3rd December 2012				for discharge from hospital and participating in the newly established 'Discharge Pathway Teams' at both the John Radcliffe and the Horton Hospital.
7.2	Deliver fully functioning, locality based and integrated health and social care services by March 2013							Expected Integrated health and social care services operational in localities Actual		OHFT and OCC have been working in partnership to deliver integrated community services throughout 2012/13 with significant progress being made with the development of the integrated Single Point of Access and the implementation of the Oxfordshire Discharge to Assess Policy. A detailed plan for fully integrated health (community and older adult's mental health) and social care services has been jointly developed by Oxford Health Foundation Trust and Oxfordshire County Council and will be fully implemented during 2013/14
7.3	A single Section 75 agreement to cover all the pooled budget arrangements by April 2013							Expected Single section 75 agreement in place Actual		A joint County Council and Clinical Commissioning Group working group has been set up to oversee this work, and is on track to deliver by end March 2013

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
7.4	A joint older people's commissioning strategy covering both health and social care by April 2013							Expected Joint strategy agreed and delivery plans in place Actual		The draft strategy has been developed by a multi-agency working group, and consultation took place between Dec – Feb. The strategy has now been amended to reflect the outcomes of consultation, and work to develop action plans will be completed by June 2013.
7.5	Oxfordshire's Clinical Commissioning Group will be authorised by April 2013							Expected CCG to be authorised Actual		Oxfordshire Clinical Commissioning Group has been formally authorised to take on commissioning responsibilities for Oxfordshire from 1 April 2013. There are five areas to address before the end of March 2013: • two relating to the constitution which was reviewed in January to reflect necessary changes, and • three relating to the clear and credible plan. OCCG will update its Operational and Quality, Innovation, Productivity and Prevention (QIPP) Plan which includes developing further the financial plans for 2013/14, 2014/15 and 2015/16. OCCG will continue to monitor delivery of the current plan and mitigation where plans are not on course. It is anticipated that sign off of 2013/14 plans by the NHS Commissioning Board will confirm that these criteria have been met.

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
7.6	More than 60% of people who use social care services in Oxfordshire will say they are very satisfied with their care and support (currently 59.4%)							Expected 60% Actual		This target and baseline was set using the 2012 annual survey, so we will report on the 2013 survey – results will be available by May with benchmarking information in August.
7.7	Achieve above the national average of people satisfied with their experience of hospital care (when the nationally sourced information for Oxfordshire is available)					Expected Above national average England 2011/12 = 75.6% **Actual** **78.7%**	**G**			Published as NHS National Outcomes Framework 4b. Since it is for experience of hospital care the data is given for individual hospitals, performance is then averaged to give an overall figure. NOC and OUHT were separate in 2011/12 and so they are reported individually. The values are reported as values out of 100. OUHT 75.1/100 NOC 82.3 / 100 Oxford Mental Health Trust is not included.
7.8	Achieve above the national average of people 'very satisfied' with their experience of their GP surgery (when the nationally sourced information for Oxfordshire is available).							Expected Above national average Actual		Data for this indicator comes from the GP Patient Survey. 2011/12 data for the survey was collected in two waves. (NHS National Outcomes indicator 4a) 1st wave published (July-Sept) – 88.28% 2nd wave to be published March 2013
7.9	Establish a baseline for measuring carer satisfaction of services by May 2013							Expected Baseline established and targets set		A survey is taking place in November to establish current performance, the outcomes of which will be used to identify priorities and targets. Comparative data with other areas expected to be available in early

Updated : Wednesday 27th February 2013

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
								Actual		2013/14
7.10	800 carers' breaks jointly funded and accessed via GPs	Expected 200 **Actual 213**	G	Expected 400 **Actual 427**	G	Expected 600 **Actual 594**	A	Expected 800 Actual		Achieved Q1 and Q2 targets
	Priority 8: Preventing early death and improving quality of life in later years									
8.1	100 smoking quitters above the national target (the nationally set target for Oxfordshire is 3,576)	Expected 840 **Actual 852**	G	Expected 1617 **Actual 1668**	G	Expected 2490 Actual		Expected 3676 Actual		Target has been amended slightly to reflect higher national target for Oxfordshire. Achieved Q2 target
8.2	2,000 adults receiving bowel screening for the first time (meeting the challenging national target of 60% of 60-69 year olds every 2 years)	Expected 500 **Actual 406**	R	Expected 1000 Actual		Expected 1500 Actual		Expected 2000 Actual		Not achieved Q1 target as number of people invited fluctuates quarterly. Plans are in place to ensure the annual target is met
8.3	30,000 people invited for Health Checks for the first time (currently 25,000)	Expected 7500 **Actual 8848**	G	Expected 15000 **Actual 20707**	G	Expected 22500 **Actual 27658**	G	Expected 30000 Actual		

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No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
Priority 9: Preventing chronic disease through tackling obesity										
9.1	Ensure that the obesity level in Year 6 children is held at no more than 15% (in 2011 this was 14.9%)					Expected 14.9% or less **Actual 15.6%**	R			Provisional data expected end of Q3 and final in Q4
9.2	60% of babies are breastfed at 6-8 weeks of age (currently 58.4%)	Expected 60% **Actual 59.8%**	A	Expected 60% Actual **59.3%**	A	Expected 60% **Actual 60.3%**	G	Expected 60% Actual		
9.3	5,000 additional physically active adults (Data available twice per year) Baseline: 125,500 Adults Annual target:130,500 Adults			Expected 128,000 Adults **Actual 136,000 Adults**	G			Expected 130,500 Adults Actual		Numbers fluctuate as Active People Survey is based on a sample of approximately 2,500 people
Priority 10: Tackling the broader determinants of health through better housing and preventing homelessness										
10.1	A reduction in the number of households at risk of fuel poverty through use of improvement							Expected Basket of relevant indicators to		The HIB has established a working group to develop appropriate indicators and targets

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
	grants and enforcement activity							be agreed to enable monitoring and setting of outcomes Actual		
10.2	Action to prevent homelessness and ensure a joint approach in times of change.							Expected Review in the light of information on best practice Actual		Report on proactive work in all districts and pilot work on direct payments in the City is being considered at the next meeting of the Health Improvement Board
10.3	New arrangements for partnership work to ensure vulnerable people are supported to remain in appropriate accommodation e.g. young people, victims of domestic violence, offenders and other adults with complex needs.							Expected New partnership arrangements to be in place Actual		New Terms of Reference for the Supporting People Core Strategy Group are being agreed
Priority 11: **Preventing infectious disease through immunisation**										
11.1	8,000 children immunised at 12 months, maintaining the high coverage (this means we will meet the challenging national	Expected 2000	G	Expected 4000	G	Expected 6000	G	Expected 8000		Achieved Q3 (cumulative) target

No.	Indicator	Q1 report Apr-Jun	RAG	Q2 report Jul-Sept	RAG	Q3 report Oct-Dec	RAG	Q4 report Jan-Mar	RAG	Notes
	target of 96.5%)	**Actual** **2038**		**Actual** **4074**		**Actual** **6055**		Actual		
11.2	7,700 children vaccinated against Measles Mumps and Rubella (MMR) by age 2	Expected 1925 / **Actual** **1883**	**A**	Expected 3850 / **Actual** **3955**	**G**	Expected 5775 / **Actual** **6038**	**G**	Expected 7700 / Actual		Achieved Q3 (cumulative) target
11.3	7,300 children receiving MMR booster by age 5 (meeting the ambitious national target of 95%)	Expected 1825 / **Actual** **1857**	**G**	Expected 3650 / **Actual** **3775**	**G**	Expected 5475 / **Actual** **5684**	**G**	Expected 7300 / Actual		Achieved Q3 (cumulative) target
11.4	3,000 girls receiving Human Papilloma Virus vaccination to protect them from cervical cancer (meeting the national target of 90% of 12-13 year old girls)					Expected 3000 / **Actual** **3189**	**G**	Expected 3000 / Actual		3 doses required to achieve target - final data as at 08/10/2012 Dose 1 = 3259 Dose 2 = 3238 Dose 3 = 3189
11.5	80,000 flu vaccinations for people aged 65 or more (meeting the national target of 75% of people aged 65+)							Expected 80,000 / Actual		Data expected in Q4

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THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

Chaired by Robert Francis QC

Robert Francis QC

Press Statement

Today I publish the report of this Inquiry following my consideration of the evidence of over 250 witnesses and over a million pages of documentary material. It builds on my earlier report, published in February 2010 after the earlier independent inquiry on the failings in the Mid Staffordshire NHS Foundation Trust between 2005 and 2009. I recommend that those seeking a full understanding of all the issues read both reports.

This is a story of appalling and unnecessary suffering of hundreds of people. They were failed by a system which ignored the warning signs and put corporate self interest and cost control ahead of patients and their safety. I have today made 290 recommendations designed to change this culture and make sure that patients come first.

We need a patient centred culture, no tolerance of non compliance with fundamental standards, openness and transparency, candour to patients, strong cultural leadership and caring, compassionate nursing, and useful and accurate information about services.

The evidence at both inquiries disclosed that patients were let down by the Mid Staffordshire NHS Foundation Trust. There was a lack of care, compassion, humanity and leadership. The most basic standards of care were not observed, and fundamental rights to dignity were not respected. Elderly and vulnerable patients were left unwashed, unfed and without fluids. They were deprived of dignity and respect. Some patients had to relieve themselves in their beds when they offered no help to get to the bathroom. Some were left in excrement stained sheets and beds. They had to endure filthy conditions in their wards. There were incidents of callous treatment by ward staff. Patients who could not eat or drink without help did not receive it. Medicines were prescribed but not given. The accident and emergency department as well as some wards had insufficient staff to deliver safe and effective care. Patients were discharged without proper regard for their welfare.

The many experiences like this were truly shocking to hear. Many will find it difficult to believe that all this could occur in an NHS hospital. I want to pay tribute to the many patients and those close to them who bravely and with

great dignity gave evidence to me at the two inquiries. It is their efforts which have brought these shocking facts to light. It is important for them, and all others who have suffered as they have that the necessary changes are made to protect patients and to provide the proper and fundamental standards of care to which we are all entitled.

What brought about this awful state of affairs? The Trust Board was weak. It did not listen sufficiently to its patients and staff or ensure the correction of deficiencies brought to the Trust's attention. It did not tackle the tolerance of poor standards and the disengagement of senior clinical staff from managerial and leadership responsibilities. These failures were in part due to a focus on reaching targets, achieving financial balance and seeking foundation trust status at the cost of delivering acceptable standards of care.

The purpose of this inquiry was to work out why these problems many of which should have been evident over a period of years, were not discovered earlier. Regrettably there was a failure of the NHS system at every level to detect and take the action patients and the public were entitled to expect.

- The patient voice was not heard or listened to, either by the Trust Board or local organisations which were meant to represent their interests. Complaints were made but often nothing effective was done about them.

- The local medical community did not raise concerns until it was too late.

- Local scrutiny groups were not equipped to understand or represent patient concerns or to challenge reassuring statements issued by the Trust.

- The Primary Care Trusts which were under a duty to arrange for the provision of safe and effective care were not set up for and did not effectively ensure the quality of the health services they were buying; they did not have the tools to do the job properly

- The Strategic Health Authority was the regional representatives of the NHS and the Department of Health. It did not put patient safety and wellbeing at the forefront of its work. It defended trusts rather than holding them to account on behalf of patients. It was uncritical in its support of Foundation trust status for the Trust. It preferred to explain

away concerns such as those about high mortality rates rather than root out matters which would concern any patient.

- Monitor's duty was to ensure that trusts were fit to be granted the independence of Foundation Trust status. It focussed on corporate governance and financial control without properly considering whether there were issues of patient safety and poor care.

- The Department of Health did not ensure that ministers were given the full picture when advising that the Trust's application for Foundation Trust status should be supported. It was remote from the reality of the service at the front line.

- The Healthcare Commission was required to assess trusts against standards which did not adequately test the quality of care being provided to patients, but it was its painstaking investigation by a team of skilled inspectors that eventually brought the truth to light. Even then there was a reluctance by those who had the power to do so to intervene urgently to protect patients.

- Other organisations, including healthcare professional regulators, training and professional representative organisations failed to uncover the lack of professionalism and take action to protect patients.

At every level there was a failure to communicate known concerns adequately to others, and to take sufficient action to protect patients' safety and wellbeing from the risks arising from those concerns. In short the trust that the public should be able to place in the NHS was betrayed.

What caused such a widespread failure of the system? This is not something which can be blamed simplistically on one policy or another, or on failings on the part of one or even a group of individuals. There was an institutional culture in which the business of the system was put ahead of the priority that should have been given to the protection of patients and the maintenance of public trust in the service. It was a culture which too often did not consider properly the impact on patients of actions being taken, and the implications for patients of concerns that were raised. It was a culture which trumpeted successes and said little about failings. Standards and methods of ensuring compliance were not focussed on the effect of service deficiencies on patients There was a tolerance of poor standards and the consequent risk to patients. Agencies frequently failed to share their knowledge with each other.

Assumptions were continually made that important functions were being performed satisfactorily by others. The dangers of the loss of corporate memory from major reorganisations were inadequately addressed and during the reorganisation of PCTs and SHAs there was a loss of focus upon the care patients received.

The NHS is full of dedicated, skilled people committed to providing the best possible care to their patients. There is much to be proud of about what they do for us. However the service so valued in this country and respected internationally is in danger of losing public trust unless all who work in it take personal and collective responsibility to root out poor practice wherever it is to be found.

What do we need?

Conventionally, some might say depressingly, when a disaster has occurred in the NHS the usual approach has been to blame and sack individuals or to propose major reorganisations. What has been found to be wrong here cannot be cured by finding scapegoats, and/ or recommending major reorganisations yet again

What is required now is a real change in culture, a refocusing and recommitment of all who work in the NHS – from top to bottom of the system - on putting the patient first. We need a common patient centred culture which produces at the very least the fundamental standards of care to which we are all entitled, at the same time as celebrating and supporting the provision of excellence in healthcare.

We need common values, shared by all, putting patients and their safety first; we need, a commitment by all to serve and protect patients and to support each other in that endeavour, and to make sure that the many committed and caring professionals in the NHS are empowered to root out any poor practice around them. These values need to be the principal message of the NHS constitution, to which all staff must commit themselves.

How is this to be done?

The NHS is a complex and frequently re-organised system trying to maintain its service against a backdrop of increasing demands and challenging financial expectations. The last thing required is a set of proposals from me requiring more radical reorganisation. So my recommendations are intended above all to support all in the service to make patient centred values and

standards real, but also to bring teeth to the task of changing behaviours where required. Essentially I think five things are needed:

- First, a structure of clearly understood fundamental standards and measures of compliance, accepted and embraced by the public and healthcare professionals, with rigorous and clear means of enforcement: we need a list of standards, about patient safety, the effectiveness of treatment, and basic care - the requirements we will all agree should be in place to permit any hospital service to continue. These standards should be defined by what patients and the public want and are entitled to, and what healthcare professionals agree can be delivered. Non compliance with these fundamental standards cannot be tolerated. Any organisation unable consistently to comply should be prevented from continuing a service which exposes patients to risk. To cause death or serious harm to a patient by non-compliance with fundamental standards should be a criminal offence. Standard procedures, guidance and assessment tools designed to enable organisations and individuals to comply with fundamental standards in different clinical settings should be produced by the National Institute of Clinical Excellence (NICE), with the help of relevant professional and patient organisations. These should include guidance on staffing. Individuals should be supported to report non compliance or matters which might prevent compliance to their organisations. They should be protected when they do this.

  Fundamental standards must be policed by the Care Quality Commission. It is this inquiry's firm conclusion that physical inspection by well qualified, trained and experienced hospital inspectors is the most effective means of monitoring compliance with standards in hospitals. Regulation would also be more effective if compliance with fundamental standards and requirements for clinical and corporate governance and finance control, were regulated by one organisation. The CQC should regulate all these matters together rather than responsibility being divided between CQC and Monitor. The CQC would also be expected to intervene where necessary to protect patients from non-compliance with the fundamental standards.

In all walks of life the buyer wants to ensure that he gets what he pays for. Health should be no different. Therefore commissioners of healthcare services must be required to develop and require compliance with other standards – which I have called enhanced quality standards - of quality, effectiveness and other requirements over and above the fundamental standards. As the buyer of these services on our behalf commissioners must ensure that these enhanced standards are delivered by their providers. In this way the role of the regulator and commissioners responsibility would be simplified and clarified.

- Secondly, openness, transparency and candour throughout the system: A common culture of serving and protecting patients and of rooting out poor practice will not spread throughout the system without insisting on openness, transparency and candour everywhere in it. A duty of candour should be imposed and underpinned by Statute and the deliberate obstruction of this duty should be made a criminal offence.
    - Openness means enabling concerns and complaints to be raised freely and fearlessly, and questions to be answered fully and truthfully;
    - Transparency means making accurate and useful information about performance and outcomes available to staff, patients, the public and regulators.
    - Candour means informing any patient who has or may have been avoidably harmed by a healthcare service of that fact and a remedy offered where appropriate, regardless of whether a complaint has been made or a question asked about it.

Every provider trust must be under an obligation to tell the truth to any patient who has or may have been harmed by their care. It is not in my view sufficient to support this need by a contractual duty in commissioning arrangements. It requires a duty to patients, recognised in statute, to be truthful to them. It requires staff to be obliged by statute to make their employers aware of incidents in which harm has or may have been caused to patients so they can take the necessary action. The deliberate obstruction of the performance of these duties and the deliberate deception of patients in this regard should be criminal offences. So called “gagging clauses” which might prevent a concerned employee or ex employee raising honestly held concerns

about patient safety should be banned. Trusts must be open and honest with regulators. It should be an offence deliberately to give them misleading information. Information provided to the public about performance should be required to be balanced, truthful and not misleading by omission. Quality accounts should be independently audited. The CQC should be responsible for policing these obligations.

- Thirdly, improved support for compassionate caring and committed nursing: proper standards of nursing care lie at the heart of what is required to protect patients when in hospital. The majority of nurses are compassionate, caring and committed. They should be given effective support and recognition, and be empowered to use these qualities to maintain standards. Entrants to the profession should be assessed for their aptitude to deliver and lead proper care, and their ability to commit themselves to the welfare of their patients. Training standards need to be created to ensure that qualified nurses are competent to deliver compassionate care to a consistent standard and their training must incorporate the need to experience hands-on patient care. Named clinicians should be responsible for the welfare and care of each patient in hospital.

  Healthcare support workers are a highly important but insufficiently valued part of the workforce: they provide most of the hands on care for elderly and vulnerable patients. They need the help of consistent training, and standards of performance. Patients are not currently adequately protected from those who are unfit to do this work. The time has come in for healthcare support workers to be regulated by a registration scheme enabling those who should not be entrusted with the care of patients to be prevented from being employed to do so. This needs to be supported by common training standards and a code of conduct. No-one should have hands-on care of patients unless properly trained and registered. Patients and the public are entitled to greater clarity about the status of those who provide direct physical care to them.

  Nursing needs a stronger voice. This can be achieved by strengthening nursing representation in organisational leadership, enhancing the links with their professional regulators, better appraisal, and encouraging strong nursing leadership at ward level. I would like to see more recognition of the extremely important role nursing plays in the care of

older patients by the creation of a new registered status as a registered older person's nurse. I would like their profession to consider how greater authority can be brought to their representative voice.

- Fourthly strong and patient centred healthcare leadership: leadership generally in the NHS is under challenge and needs more effective support. The necessary culture will only flourish if leaders reinforce it every day in every part of the service. A NHS leadership staff college could be created, offering all potential and current leaders the chance to share in a form of common training designed to equip them to exemplify and implement the common culture. They should be supported by a common code of ethics and conduct for all leaders and senior managers.

  The public are entitled to expect leaders to be held to account effectively when they have not applied the core values of the Constitution, or are otherwise shown to be unfit for the role. Currently leaders who are registered as doctors or nurses can be disciplined by a regulator for failing to protect patients. Other leaders cannot. A more level playing field would enhance leadership teamwork and increase the public's confidence in the NHS. It should be possible to disqualify those guilty of serious breach of the code of conduct or otherwise found unfit from eligibility for leadership posts. This will require a registration scheme and a requirement that only fit and proper persons are eligible to be directors of NHS organisations. While this regulatory function could be performed by an existing regulator, the need for a separate entity for this purpose should be kept under review.

- Finally, accurate, useful and relevant information: information is the lifeblood of an open transparent and candid culture. All professionals, individually and collectively, should be obliged to take part in the development, use and publication of more sophisticated measurements of the effectiveness of what they do, and of their compliance with fundamental standards. Patients, the public, employers, commissioners and regulators need access to accurate, comparable and timely information. Improvements are needed in the core information systems for the collection of data about patients, both to support their individual treatment and the accurate collation of information for statistical purposes. Difficulties in achieving this are no

excuse for inaction. The Information Centre for Health and Social Care has an important role to play in this field. Boards must be accountable for the presentation to the public of balanced and candid information about their trusts' compliance with fundamental standards. It should be a criminal offence to be a party to a wilful or reckless false statement as to compliance with safety or fundamental standards.

Many of my recommendations will require development in detail to be implemented. The suffering undergone by patients and those close to them in Stafford demands that the lessons to be learned are not considered for a day or two and then forgotten. Government and the Department of Health have an important role to play in changing the culture, but this does not mean everyone else in the system can sit back and wait to be told what to do. Every single person and organisation within the NHS, and not only those whose actions are described in this report, need to reflect from today on what needs to be done differently in future. All have a responsibility to consider what is exposed by my two inquiries, and to consider how to apply the lessons themselves, individually and collectively. I have recommended that every organisation should report publically on a regular basis on whether they have accepted my recommendations and what they are doing to implement them, and that the House of Commons Health Select Committee should be invited to review regularly the progress being made by organisations which are accountable to Parliament.

My recommendations represent not the end but the beginning of a journey towards a healthier culture in the NHS in which good practice in one place is not considered to be a reason for ignoring poor practice somewhere else; where personal responsibility is not thought to be satisfied by a belief that someone else is taking care of it; where protecting and serving patients is the conscious purpose of everything everyone thinks about day in day out. Patients are entitled to be the first and foremost consideration of the system and all those who work in it. I very much hope that this report and its recommendations will help to bring this about.

6 February 2013

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Shadow Oxfordshire Health and Wellbeing Board – 14 March 2013

Briefing Document for Themed Discussion

Considering the implications for Oxfordshire of the Francis Report on the Mid Staffordshire NHS Foundation Trust Public Enquiry

Current Clinical Assurance available in Oxfordshire

1. Introduction

The first Francis report on the Mid Staffordshire NHS Foundation Trust was published in 2010. It identified extremely poor care being delivered in a number of areas of the trust. The second report was published in February 2013. This report goes further and looks at the wider responsibility of the NHS. The report makes 290 recommendations. The Department of Health's response to this report is currently being prepared.

This paper sets out the systems and processes in place in Oxfordshire with which the commissioners monitor and manage the quality of provider services. Oxfordshire Clinical Commissioning Group (OCCG) is building on the systems developed by NHS Oxfordshire (the PCT).

There are three aspects of clinical quality; clinical effectiveness, patient safety and patient experience. Commissioners collect data and intelligence on each of these areas. The types of intelligence and the methods used are detailed below.

The primary responsibility for quality sits with service providers. OCCG has a duty to act with a view to securing continuous improvements in the quality of services for patients and in outcomes; with particular regard to clinical effectiveness, safety and patient experience. OCCG also has a statutory duty to assist and support the NHS Commissioning Board in securing continuous improvement in the quality of primary medical services.

Providing assurance of the quality of services is complex and no system is infallible. Systems are evolving all the time and information becomes more sophisticated. The uncovering of poor quality within NHS commissioned services frequently leads to increased scrutiny and changes in the way in which we seek to understand the quality of services.

It is the role of Boards to seek assurance on quality. As far as possible the systems we use provide this assurance. However, it is important always to be alert to the possibility of poor quality. The acknowledgement that things can and do go wrong is essential and constant vigilance is required.

2. Clinical effectiveness

In seeking to establish quality there is clearly a desire to look at things which can be measured. This is a relatively new science and methods are constantly changing and being updated.

2.1 Dr Foster, HSMR and SHMI

Oxfordshire commissioners have, since 2008, used Dr Foster software to monitor clinical outcomes at Oxford University Hospitals NHS Trust (OUH) (previously Oxford Radcliffe Hospitals). The clinical outcomes measured by this software are mortality, readmissions, length of stay and day case rates. Using an algorithm, the software determines whether the expected numbers of negative outcomes (e.g. for mortality, this would be death) are exceeded by the monitored number. When any of these outcomes is statistically significantly higher than expected, Dr Foster will produce a 'red bell'. The OUH has regular monthly meetings to discuss red bell alerts which a member of the OCCG Quality team attends.

In some areas commissioners rely on the providers' use of Dr. Foster. In Oxfordshire the commissioners have their own Dr. Foster package. This makes the system more robust in that it allows for direct scrutiny of local data.

Dr Foster measures the Hospital Standardised Mortality Ratio (HSMR). The HSMR is an indicator of healthcare quality that measures whether the death rate at a given hospital is higher or lower than would be expected. HSMR is one of the range of indicators regularly reviewed by OCCG when assessing the quality of the clinical services. The OUH has had higher than expected mortality. However, this difference is within the range of normal variation and is not therefore considered to be statistically significant. This means that the hospital has not been mentioned as a hospital with a high mortality rate in the Dr Foster Hospital Guide. The Department of Health has recently introduced an additional mortality measure, the Summary Hospital-level Mortality Indicator (SHMI). This measure also indicates that the OUH has a mortality rate within expected limits.

NHS Oxfordshire and now Oxfordshire Clinical Commissioning Group (OCCG) attends meetings with OUH at which mortality alerts and all red alerts are discussed. Commissioners continue to work with the OUH to improve the HSMR. The OUH and OCCG's ambition is to have one of the lowest mortality ratios in the country.

2.2 Audits

Clinical audit is a quality improvement process. It seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the subsequent implementation of change. In Oxfordshire, clinical audits are requested from providers via the contract to assure commissioners that National Institute for Clinical Excellence (NICE) guidance is followed. Performance in clinical audits is reviewed by the Quality Team of OCCG and the evidence from these reports is triangulated with other information collected.

3. Patient safety

There are established systems for reporting and reviewing patient safety incidents. All providers manage incidents internally. There is a nationally designated list of Serious Incident Requiring Investigation (SIRIs). These incidents must be reported to the commissioner. The provider must then conduct a root cause analysis. The commissioner manages the investigation process and incidents are only 'closed' when commissioners are satisfied that incidents have been thoroughly addressed, that lessons have been learnt and that steps have been taken to prevent recurrence.

Where themes emerge in the investigation of serious incidents providers are required to understand these and to demonstrate that they are being addressed.

Issues about the culture of organisations often emerge in the analysis of SIRIs, as well as in the response of trusts to the events. In these circumstances the commissioners may require action to be taken to address these issues, for example, through increased clinical leadership.

We can begin to understand the safety culture of a trust by looking at how they respond to incidents. The ideal culture is one in which staff feel able to voice their concerns, and where patients are always listened to and their concerns attended to promptly. Trusts should be able to receive information which shows that they may have issues with a willingness to understand and investigate further.

3.1. Safeguarding

Commissioners have a statutory safeguarding function. They are notified of safeguarding alerts relating to both adults and children and are instrumental in responding to alerts. This means that safeguarding information can be viewed alongside other quality information to alert areas where poor care may be causing harm.

4. Patient Experience

Patient experience is perhaps the fastest growing area of quality information. In order to be assured of quality we need to put feedback from patients at the centre. Patient experience is a good early indicator of where thing may be going wrong.

Patient experience is also the most difficult area to measure. Patient satisfaction can be collected through simple scoring - as in the new 'Friends and Family test', but experience is not measurable. Methods of looking at experience include scrutinising complaints, PALs and MPs' letters. It is not sufficient to simply look at the number of complaints. The content of the complaint also needs to be understood in order to detect themes and possible trends. We also look at PALs queries as these give an indication of areas which patients are finding difficult and provides us with an indication of how well providers respond to patients' concerns. Crucially, we look at how trusts use the information they receive in

complaints to inform the way in which they deliver services and to make improvements.

There is a close correlation between overall patient experience and the quality of nursing care. In both Oxford Health NHS Foundation Trust and Oxford University Hospitals NHS Trust the quality of nursing has been a focus for improvement. We continue to work with them on developing leadership in this area.

4.1 Patient and Staff Surveys

The views of patients are frequently sought through local and national surveys. The national acute inpatient survey is conducted every year and allows comparison between trusts and within trusts over time. There are also more specific surveys, for example the cancer patient survey and the maternity survey, which provide a view of patients' experiences of individual services. The OUH generally scores well in the national inpatient survey.
It is well known that the well being of staff has a direct impact on the experience of patients. For this reason we look at the results of the staff survey in conjunction with those of the patient survey.

5. Contracts: Schedule 3 part 4

Commissioners receive monthly indicators on performance activity and quality. This range of indicators is set out in schedule 3 part 4 of the contract held between the commissioner and the provider. The contents of this schedule are agreed as a part of the contract negotiation. It sets out the quality markers expected from providers and includes limits for healthcare acquired infections such as MRSA bacteraemias and clostridium.difficile. It includes national targets relating to, for example A&E, cancer waits and 18 weeks referral to treatment times. It also includes relevant local indicators such as radiology turnaround times.

For the main providers schedule 3 part 4 is scrutinised monthly at performance meetings. Quality is discussed at the same meeting as activity. In this way it is given the same weight as performance and the impact of each on the other can be understood.

6. Quality Information system

OCCG uses a risk management software package called Datix. This enables a range of quality data to be stored. Datix includes data on complaints, PALs, MP letters, and incidents. Importantly Datix permits users to search for data – for example to see whether there has been a number of complaints about a particular area.

In 2012 the Datix system was expanded to provide GPs with direct access. They use this to report to the commissioners directly concerns they have about the quality of services. This facility provides the commissioners with a rich source of timely information which can be addressed rapidly to ensure quality is improved. Since being established in June 2012 we have received well over a thousand

reports through this system, all of which have been or are currently being followed up.

7. Whistleblowing

The PCT has, on occasion, received 'whistle blowing' allegations. When this has happened we always follow up allegations by conducting investigations.

8. Action to address quality concerns

When there are concerns about the quality of services a number of steps are taken. The first step would usually be to raise the issue locally, formally at a contract meeting. The provider is then expected to produce a detailed rectification plan. If the commissioner receives an inadequate action plan or the plan is ineffective then a contract query will be issued. If this approach fails or the concerns are significant then the commissioner will issue a performance notice. If OCCG believes a service to be dangerous it will suspend the service immediately. In parallel to this process provider executive directors and the Chief Executive would be informed.

OCCG also has the option of commissioning an external review of quality from national experts such as the Royal Colleges. This facility has been used by the PCT on a number of occasions to seek additional information and advice on issues of concern.

OCCG has a structure which puts quality at the heart of commissioning. It has established a formal sub committee of the board to focus on quality and performance. The group is chaired by a lay member of the governing board and has a lay member in attendance.

The Francis report identifies a number of recommendations for commissioners. OCCG will review these and agree a programme of implementation. We look forward to the establishment of the local Healthwatch, which will build on the achievement of the LINks, to help strengthen the patient perspective. We are developing the website to enable direct patient feedback to OCCG. The GP feedback (Datix) system is a recommendation which we are already using to good effect.

9. Conclusion

Where possible we use validated tools to measure the quality of commissioned services. These are not, on their own, sufficient to provide assurance of quality. We also use the 'soft intelligence' we receive. Where there have been extreme cases of poor quality, culture is usually cited as a cause. While it may not be the cause of the poor quality itself, it is a culture of acceptance and of secrecy which prevents the issues being tackled.

It is essential that providers are open in their reporting and consideration of quality issues. The quality team has built good working relationships with provider trusts. This means that we can work together to understand and address potential

quality issues while crucially maintaining the critical distance which scrutiny and assurance requires. Importantly, data which suggests poor performance and data which indicates good performance should be afforded the same degree of scrutiny.

Seeing the organisation or service as a whole is also crucial. Indicators when viewed on their own may not be the cause for a high level of concern. When viewed in the context of a range of other information a high level of concern may be indicated. This whole picture view is achieved through close working within the quality team and across the organisation.

This paper sets out the range of tools, methods and intelligence which are currently in use in Oxfordshire to provide commissioners with assurance of the quality of the services they commission. OCCG has intentionally placed quality at the centre of the organisation. The Quality team work closely with providers and have developed a relationship where they are expected to challenge. When necessary decisive action is taken to address situations where quality fall below the standard we would expect.

Sula Wiltshire, Director of Nursing & Quality, Oxfordshire & Buckinghamshire PCT Cluster

February 2013

Oxfordshire Shadow Health and Wellbeing Board
14 March 2013

Safeguarding Adults Annual Report

Donald McPhail, Independent Chairman of the Oxfordshire Safeguarding Adults Board will present the 2011-12 annual report of the Adult Safeguarding Board followed by a discussion on the recommendations.

The discussion will include the Winterbourne View Oxfordshire Action Plan. The plan was developed by Oxfordshire Commissioners when they carried out a review of local commissioning arrangements.

Winterbourne review - next steps for Oxfordshire

- The work to provide the local register of all people with challenging behaviour in NHS funded care is in hand.
- Everyone in inpatient services will receive regular reviews and this information will be collated and provided to DH as requested.
- Oxfordshire already has a joint health and social care commissioning strategy for adults with learning disability which reflects the principles of the approach set out in the DH report.
- We propose to look at the strategies for adults and children together, review how these reflect the learning from Winterbourne, and identify any gaps which need addressing.
- We plan to consider the specialist health needs of older teenagers and younger adults around the time of transition through joint work between children's and adults commissioners.

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OSAB

Oxfordshire Safeguarding Adults Board

Safeguarding is everybody's business…

Agencies working together to ensure a coherent policy and a consistent and effective response for the protection of vulnerable adults at risk of abuse

Everybody's business...

The Oxfordshire Safeguarding Adults Board has maintained the support of all agencies to strengthen work across the County to safeguard adults in their own homes and in care settings. The Board is now well informed of the extent to which agencies identify safeguarding concerns and the response by agencies to the concerns.

Having established a strong structural base for the identification and response to the safeguarding needs of vulnerable adults, the Board is now set to focus on the quality of services and the prevention of abuse to vulnerable adults across the County. Within the last year, the Board has established a Dignity in Care sub-group and this has provided a strong basis for engaging with service providers to focus on how services are provided to the most vulnerable adults.

The Board remains committed to learning from local and national reviews of services to influence both policy and practice in Oxfordshire, and the Board has continued to develop links with other agencies and bodies to inform and be informed of the safeguarding needs of vulnerable adults in the County.

While the Board provides leadership and coordination, the Board is clear that it is the continuing commitment of staff across all agencies that makes a difference for the residents of Oxfordshire.

Donald McPhail

Independent Chair of the Oxfordshire Safeguarding Adults Board

Contents

Safeguarding adults is about helping people live free from abuse and neglect.

Abuse is a violation of an individual's human and civil rights by any other person or persons (No Secrets, Department of Health, 2000).

Anyone can be vulnerable to harm as a result of abuse or neglect at some time in their lives. Some adults are more at risk than others. They include adults with physical, sensory and mental impairments and learning disabilities. These adults' independence and wellbeing would be at risk if they did not receive appropriate health and social care support.

The report, *A step in the right direction: The policing of anti-social behaviour (2012),* showed that people self-defining as disabled, or who report a long-term health condition, are far more susceptible to being harmed by anti-social behaviour (Her Majesty's Inspectorate of Constabulary, 2012).

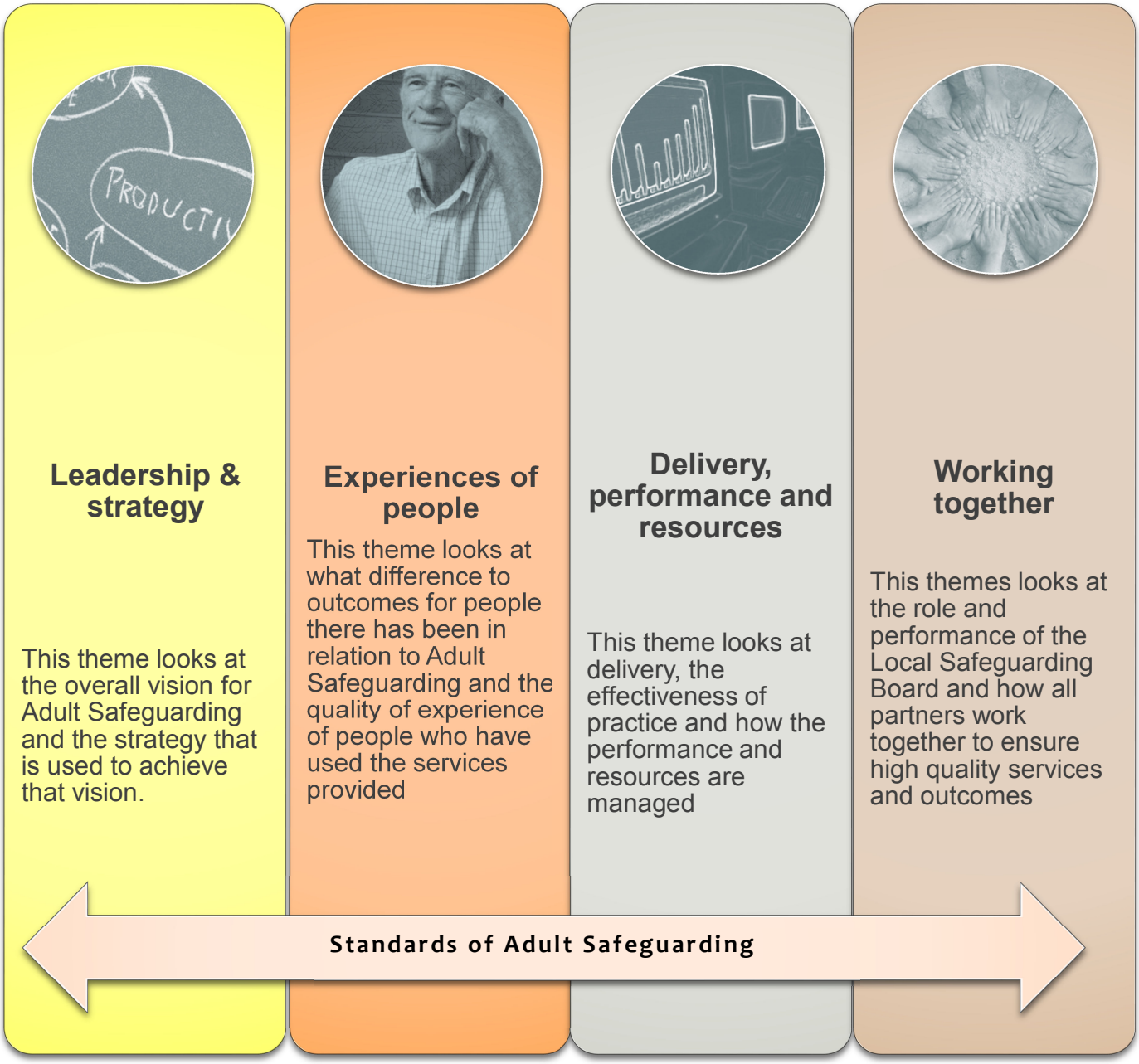
People with mental health problems are routinely subjected to physical and sexual abuse or theft by their neighbours (Mind, 2007).

At least half a million older people experiencing some form of abuse at any point in time (House of Commons, Health Committee, 2005).

Any person at risk of abuse or neglect should be able to access the support which enables them to live a life free from violence and abuse.

The Oxfordshire Safeguarding Adults Board has a critical role in the leadership and management of safeguarding. Its purpose is to create a framework within which all responsible agencies work together to ensure there is 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.

The **Standards for Adult Safeguarding** have been developed in partnership by The Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS), the NHS Federation and Social Care Institute for Excellence (SCIE). They are a framework for good practice. The themes identified within these standards have been used to report on the work of the Board for 2011-2012.



Adapted from the Standards of Adult Safeguarding (LGA, ADASS, SCIE, NHS Federation 2012).

1.

This theme looks at the overall vision for Adult Safeguarding in Oxfordshire and the strategy that is used to achieve that vision.

The creation of a local multi-agency management committee 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 (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 (ADASS, 2005)* led the committee to re-evaluate its existing title and terms of reference and become the OSAB.

OSAB
Oxfordshire Safeguarding Adults Board

Structure and function

The aims of OSAB are to ensure that all incidents of suspected harm, abuse or neglect are reported and responded to proportionately to:

- Enable people to maintain the maximum possible level of independence, choice and control.
- Promote the wellbeing, security and safety of vulnerable people consistent with his or her rights, capacity and personal responsibility and to prevent abuse occurring wherever possible.
- Ensure that people feel able to complain without fear of retribution
- Ensure that all professionals who have responsibilities relating to safeguarding adults have the skills and knowledge to carry out this function.
- Ensure that safeguarding adults is integral to the development and delivery of services in Oxfordshire.

Membership

Our OSAB includes members from all statutory agencies including Oxfordshire County Council, Thames Valley Police, National Health Service (NHS) Oxfordshire, Oxford Health NHS Foundation Trust and the Oxford University Hospitals NHS Trust. The Oxfordshire Drug and Alcohol Action Team (DAAT) is a new member of the Board.

The OSAB has an independent chair to ensure that all agencies involved can be impartially challenged or supported.

The Terms of Reference (Appendix 3) outline the responsibilities of the member organisations of the OSAB

Structure

Five subgroups support the OSAB

1. Policy and Practice

To oversee the development, implementation and review of local policies and procedures that ensure: the abuse of vulnerable adults is identified where it is occurring; that there is a clear reporting pathway; that there is an effective and coordinated response to abuse where it is occurring; that the needs and wishes of the vulnerable adult are central to the adult protection process.

2. Training

To provide a comprehensive multi-agency training programme to support single agency training in the areas of prevention, recognition and responsiveness to abuse and neglect.

3. Serious Case Review

To provide assurances to the OSAB that the recommendations and learning from all relevant serious case reviews (with multi-agency characteristics) have been considered, and that the relevant learning and recommendations are being implemented.

4. Dignity in Care

To help ensure that everyone in Oxfordshire experiences dignity in the care and support they receive, and to assist OSAB in its work.

5. Deprivation of Liberty Safeguards

To ensure that *Deprivation of Liberty Safeguards* are effectively and lawfully applied across Oxfordshire.

The *Deprivation of Liberty Safeguards* are part of the Mental Capacity Act (2005). They aim to protect people in care homes and hospitals from being inappropriately deprived of their liberty. Some people living in hospitals and care homes can't make their own decisions about their treatment and/or care because they lack the mental capacity to do so. They need more care and protection than others to ensure they don't suffer harm. Treating and caring for people who need extra protection may mean restricting their freedom to the point of depriving them of their liberty. The safeguards provide a legal framework for authorising a deprivation of liberty so that treatment or care can be provided in a care home or hospital (the Managing Authority) for people who lack mental capacity.

Board governance

The OSAB will report annually to the Oxfordshire County Council, Social & Community Services Scrutiny Committee.

In addition each core/statutory member of the Oxfordshire Safeguarding Adults Board is expected to report to its own management committee.

Board Budget

The OSAB is primarily funded by Oxfordshire County Council (Adult Social Care) with contributions from Oxford Health NHS Foundation Trust and Ridgeway Partnership (Oxfordshire Learning Disability) NHS Trust.

The Deprivation of Liberty Safeguards service is funded jointly by NHS Oxfordshire and Oxfordshire County Council.

Other costs and expenses, for example time spent by partner agencies on Board activities, facilitating staff release for training are borne by the individual organisations.

Legislation and the national context

All persons have the right to live their lives free from violence and abuse. This right is underpinned by the duty on public agencies under the *Human Rights Act (1998)* to intervene proportionately to protect the rights of citizens. These rights include Article 2: 'the Right to life'; Article 3: 'Freedom from torture' (including humiliating and degrading treatment); and Article 8: 'Right to family life' (one that sustains the individual).

No Secrets (Department of Health, 2000) is the core guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse.

Other legislation particularly relevant to safeguarding adults includes:

- Equality Act 2010
- Mental Capacity Act 2005
- Safeguarding Vulnerable Groups Act 2006
- Mental Health Act 1983
- NHS Act 2006

National developments this year

The Law Commission Paper

On 11 May 2011 the Law Commission published *Adult Social Care*, which reviews adult social care law in England and Wales and contains recommendations for reform.

The Dilnot Commission: Social care funding

On 4 July 2011 the Commission reported to Government with its finding and recommendations for a new funding system. The report highlighted that the current funding system is in urgent need of reform.

Health and Wellbeing Board

The Joint Health and Wellbeing Board is an important feature of the NHS reforms and are key to promoting greater integration of health and local government services. Work is currently being completed in Oxfordshire to ensure the local Joint Health and Wellbeing Board priorities are linked with the Safeguarding Adult Board priorities.

Other developments

Over the last year a range of guidance has been issued for partners in safeguarding. This includes guidance:

- By ADASS in the form of an Advice Note for directors
- From Department of Health (DH) in relation to personalisation and safeguarding
- For the NHS in the form of a suite of best practice guides
- From Association of Chief Police Officers (in draft) for the police
- From the Ministry of Justice for the police in working with vulnerable witnesses in the criminal justice system
- From DH on commissioning services for women and children who experience violence or abuse
- From SCIE, a number of guides, including on the Governance of Safeguarding Boards, a Guide to the Law, Involving People and Self-Neglect (funded by the Department of Health)
- Through LGA, on "Making Safeguarding Personal" (part funded by DH)
- From the City of London Police and the National Fraud Intelligence Bureau on Financial Abuse
- From ADASS and the Forced Marriage Unit on forced marriages and people with learning disabilities
- From the NHS Confederation, Local Government Group and Age UK, *Delivering Dignity: Securing dignity in care for older people in hospitals and care homes.*

2. Experiences of people

This theme looks at outcomes for people who have used the services provided and the quality of experience of people in relation to Adult Safeguarding.

The Oxfordshire population

Oxfordshire is a predominantly rural county in which 653,800 people live (2011 census). Indeed, the county is the most rural in the South East region and West Oxfordshire is one of the region's least densely populated districts. 37% of the population live in settlements of less than 10,000 people with 63% living in urban wards (more than 10000 residents).

The following data* gives an indication of the population who fall within safeguarding procedures based on the current definition of a 'vulnerable adult'.

Vulnerable adults

The safeguarding policy and the accompanying procedures cover any person, aged 18 or over, living or receiving care or services in Oxfordshire:

'*who is or may be in need of community care services by reason of mental or other disability, age or illness*'

And

'*who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation.*'

In 2011/12, a total of 5,355 people aged over 65 received a social care service funded by Oxfordshire County Council. This equates to 5.0% per cent of the population of Oxfordshire being aged 65 plus.

In 2011/12, a total of 1327 people with a learning disability (aged 18-64) received a social care service funded by Oxfordshire county council. This equates to approximately 0.33 per cent of the population of Oxfordshire aged 18-64.

In 2011/12, a total of 468 mental health service users aged 18-64 years received a social care service funded by Oxfordshire County Council. This equates to approximately 0.21% per cent of the population of Oxfordshire aged 18-64.

In 2011/12 a total of 711 people with a physical disability (aged 18-64) received a social care service funded by Oxfordshire County Council. This equates to approximately 0.18 per cent of the population of Oxfordshire aged 18-64.

* These figures exclude people who will fund their own care or receive informal support from family members

Report on last year's objectives and priorities

The 2010-2011 OSAB Annual Report outlined six priority areas for focused work by the OSAB to improve the outcomes of service-users.

1. Developing improved responses for vulnerable victims of domestic abuse
2. Tackling hate crime
3. Promoting better standards of care
4. Making sure that people are able to manage their own care without risk of abuse or neglect
5. Having safe places for people to go if they feel bullied or harassed
6. Working to ensure that people are treated with dignity and respect when they need care.

1. Develop improved responses for vulnerable victims of domestic abuse

Domestic abuse affects 1 in 4 women and 1 in 6 men in their lifetime. Those affected endure risk to their emotional wellbeing, behaviour, attainment and long-term life chances. Invariably, those individuals who experience domestic abuse have myriad needs, with 'adults at risk/vulnerable adults' making up the population of people who suffer domestic abuse.

Domestic abuse is defined by the government as:

'*Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality*' (Home Office)

This includes issues of concern to black and minority ethnic communities such as so called 'honour based violence', female genital mutilation and forced marriage.

In 2007, a prevalence study on elder abuse undertaken by the Department of Health and Comic Relief estimated that 227,000 older people had been neglected or abused in their own homes in the previous year and that domestic violence accounted for a significant proportion of that figure. Women with disabilities are particularly vulnerable to abuse; research has shown that disabled women experience abuse at least twice as often as non-disabled women. Abusers, including personal assistants and carers, may exploit a woman's particular condition or impairment. There are additional barriers that vulnerable adults must overcome, for example, a substantially less provision than that available proportionally to non-disabled women is accompanied by a greater need for such focused and specialist services (James-Hanman, 1994; Magowan 2003, 2004).

Any adult at risk of domestic abuse should be able to access support which enables them to live a life free from violence and abuse.

The Oxfordshire Domestic Abuse Strategy Group (ODASG) and the OSAB are working together to identify and promote best practice in Oxfordshire for the support of adults at risk/vulnerable adults who are suffering domestic and sexual abuse. This work has encompassed research; data analysis; and, a workshop in which delegates from a range of agencies identified gaps and barriers in current provision and highlighted some ways to overcome these gaps and barriers.

Recommendations

- Ensure that clear protocols with the lead authority and partner organisations are in place to include referral pathways, monitoring and review arrangements (Local Government Improvement and Development, 2010).
- Issues in relation to discrimination and lack of understanding of the needs of vulnerable people in accessing and using services for victims of domestic abuse need to be addressed.
- The needs of older or disabled victims should be taken into account when developing/providing information.
- Additional vulnerability and risk as a result of age, illness or disability needs to be taken into account in assessment.
- Access to services for victims of domestic abuse who have mobility or support needs to be taken into account.
- Identification of clear practice links between Multi-Agency Public Protection Arrangements (MAPPA), Multi Agency Risk Assessment Conferences (MARAC), Safeguarding Adults and Domestic Abuse meetings and Boards.

What have we done?

- Shared part-time post between the Safeguarding Adults Team and the Safer Communities Unit working on aligning Adult Social Care services with the domestic abuse agenda (secondment completed). Additional secondment opportunity with the Independent Domestic Violence Advisor service is being considered by Adult Social Care.
- Improved partnerships links with the ODASG.
- The Domestic Abuse Champion Network has been further developed to include people who work with vulnerable adults. This network of trained, supported and resourced

practitioners across a range of agencies is committed to supporting victims of domestic abuse across Oxfordshire. At present there are approximately 600 Champions in around 60 organisations, delivering a wide range of services. Bringing safeguarding adults issues to this network has improved the understanding of the needs of vulnerable people and provided a platform to discuss complex cases. This improved information sharing and increased understanding helps to reduce discrimination where it may exist.

- Resources developed by ODASG and OSAB have been improved to increase the awareness of the needs of vulnerable adults who experience domestic abuse.
- Three Designated MARAC Officers (DMOs) trained in the Council's Adult Social Care directorate.
- The use of the Domestic Abuse, Stalking, Harassment (DASH) and Honour Based Violence risk assessment being extended throughout the County Council's Adult Social Care directorate
- Domestic Homicide Review process closely aligned with the OSAB Serious Case Review protocol.
- Domestic Abuse and Safeguarding Adults training is more closely aligned.
- An action plan is in place and will be monitored by the ODASG and the OSAB.

2. Tackling hate crime

A web-based reporting and recording system in key agencies was introduced in four pilot areas across Oxfordshire as the first part of the *Hate Crime Strategy* for the county. This work has been led by the Oxfordshire County Council Community Safety Service.

It will contribute to fulfilling legislative requirements, under the 2010 Equality Act, for public bodies to provide services for reporting and recording hate crime incidents and crimes, other than to the police. However, the police are key and supportive partners. The work is coordinated by the Multi Agency Network for Tackling Aggravated Harassment.

The reporting, recording and supporting system will help to inform us about the prevalence, nature and impact of hate crime in Oxfordshire. In particular, hate crime motivated by race, religion and/or belief, disability, sexual orientation and trans-gender will be addressed.

The impact of hate crime can be severe, including fear, isolation and physical and mental harm and it can seriously affect children. Under-reporting is a universal issue.

3. Promote better standards of care

• Abuse in Domiciliary Care

Domiciliary care is provided to people who still live in their own homes but need additional support with household tasks, personal care or any other activity that allows them to maintain their independence and quality of life. There are approximately 1800 domiciliary care packages set up and funded by Oxfordshire County Council and Oxford Health NHS Foundation Trust.

A year-long inquiry into the home care system in England, conducted by the Equality and Human Rights Commission uncovered evidence of poor treatment of many older people. The final report, *Close to Home (2011)*, revealed *'serious, systemic threats to the basic human rights of older people who are getting home care services.* In Oxfordshire, just over 30% of concerns relating to the abuse, mistreatment or neglect of a vulnerable adult by a paid worker relate to domiciliary care workers (excluding people with a learning disability). The County Council has worked to mitigate against such concerns.

What have we done?

- Three full-time adult protection leads focusing on abuse in care have been recruited.
- Bi-monthly risk assessment reports based on analysis of adult protection alerts and complaints provided by safeguarding adults' team manager to OCC contracting team.
- Intelligence lead focused investigations and actions to support the development of less well performing provider services.
- Established good joint working between adult protection and specialist safeguarding services e.g. medicines management.

Next Steps & Recommendations

- A further three full-time locality adult protection leads to be recruited in spring/summer 2012
- The County Council will continue to maintain and improve the quality of externally purchased services

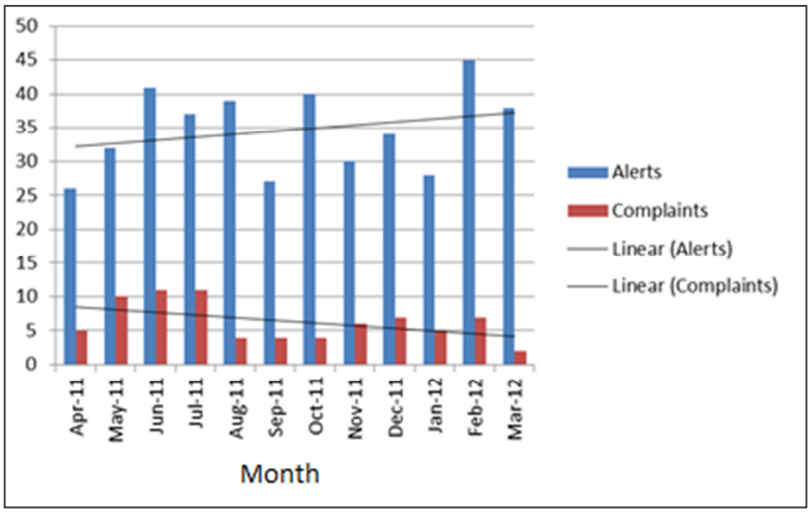
• Abuse in residential care and residential nursing homes

The neglect of vulnerable adults in residential care and nursing homes has emerged as an important issue nationally. *'Those at greatest risk of abuse appear to be older women, those living in a care home and those who have a long term illness* (particularly dementia).' (Beadle-Brown et al, 2006).

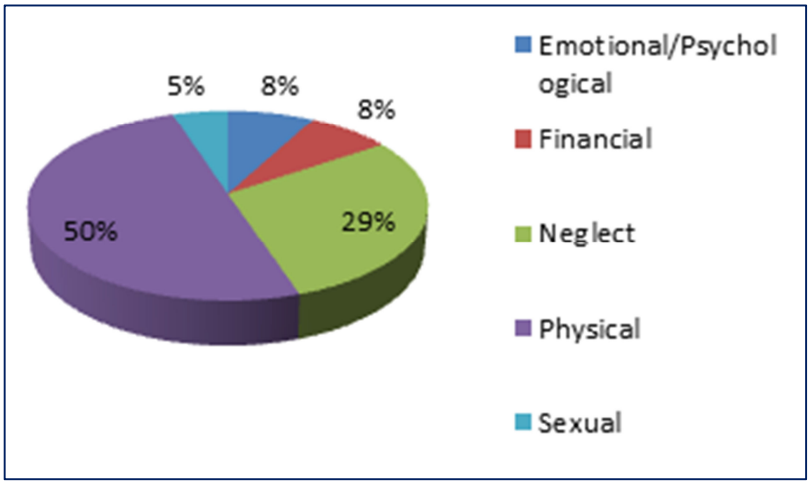
Oxfordshire experience

Safeguarding adult referrals received by Oxfordshire County Council about incidents of abuse occurring in care and nursing homes (excluding people with a learning disability).

Frequency of abuse



Type of abuse experienced



It is important that the care needs of the population of Oxfordshire are protected.

What have we done?

- Appointed three full-time adult protection leads focusing on abuse in care.
- Undertaken bi-monthly risk assessment reports, based on analysis of adult protection alerts and complaints provided by the safeguarding adults' team manager to Oxfordshire County Council contracting team.
- Intelligence lead focused investigations and actions to support the development of less well performing provider services.

- Established good joint working between adult protection and specialist safeguarding services, for example medicines management and tissue viability.
- The Oxfordshire Care Homes Support Service is to support the development of nursing and care standards in Oxfordshire.
- Liaised closely and communicated with the Care Quality Commission.
- Focused work in relation to meeting the needs of repeat perpetrators who are also vulnerable adults.

Next Steps & Recommendations

- Extend focus of preventing repeat abuse by other vulnerable adults.
- Increase joint working and information sharing between the Safeguarding Adults Team and the Care Home Support Service.

• Safeguarding people with limited or no capacity

In Oxfordshire, the County Council operates a joint supervisory body office for Deprivation of Liberty Safeguards (DOLS). A supervisory body is responsible for considering a deprivation of liberty request. All requests for DOLS authorisations are received by the DOLS team in Oxfordshire County Council. A team of 40 Best Interests Assessors (BIA) complete assessments on a rota system in both care homes and hospital settings. They are employed by the County Council, Oxford Health NHS Foundation Trust and Ridgeway Partnership and we have representatives from all 4 professional areas set out in the Regulations - social work, occupational therapy, nursing and psychology.

DOLS medical assessors are employed by Oxford Health NHS Foundation Trust, Oxford University Hospitals NHS Trust and Ridgeway Partnership.

The DOLS manager scrutinises all assessments completed by the assessors to ensure compliance with legislation, statutory guidance and case law, and authorisations are granted by senior officers of the County Council with responsibility for Adult Social Care - operations, or senior officers of the Primary Care Trust.

The DOLS manager is also available to advise health and social care professionals on issues of capacity and best interest decision making. Guidance is available on the Oxfordshire County Council public website and the *Safe from Harm* website.

The OSAB has recently formed a DOLS subgroup. The members represent partner agencies with responsibility for DOLS including managing authorities (hospital trusts and care homes), the supervisory bodies, a BIA, a medical assessor, the Independent Mental Capacity Advocate (IMCA) service and the Mental Health trust. Agencies are signatories to a *Joint Oxfordshire Policy on the Mental Capacity Act 2005* and have agreed to standardise the format of mental capacity assessments to assist consistency.

4. Making sure that people are able to manage their own care without risk of abuse or neglect

Increasing people's choice and control and ensuring services are safe

Self-Directed Support puts what is important to the person at the centre of all decision making. Based on the individual's needs which have been identified in their assessment, each person is allocated a personal budget to arrange their support with. The person will then have the option of receiving a "direct payment" to purchase the support they need or having someone to manage this on their behalf a 'managed account'.

In its restructure Oxfordshire County Council has retained a higher percentage of social workers than many local authorities. Social Workers remain at the heart of complex social care assessments. All safeguarding work is completed by a social worker.

5. Having safe places for people to go if they feel bullied or harassed

The first *Safer Places* scheme was piloted in Devon and Cornwall by the South Devon and Dartmoor Community Safety Partnership. It aimed to stop the bullying and abuse of individuals with learning disabilities and other vulnerable people. Several other Local Authorities are now operating *Safer Places* schemes.

Drivers for Safer Places

- Increase in vulnerable people living in the community
- Encouragement from the government for communities and public sector to work together - the 'Big Society'.
- Need to find generic, low-cost prevention services for vulnerable people
- Need to reduce the perception of crime and make people feel safer in their community

How a Safer Places scheme works

Local shops, businesses and agencies display a brightly coloured sticker to identify that they are part of the scheme and can offer help to someone who may be in distress.

The vulnerable person signed up to the scheme carries a card displaying the same logo as the sticker, their name and phone numbers of someone that they trust; for example a family member or a support worker.

Members of staff in the *Safer Place* receive training (in-depth scheme), or they have a resource pack (light-touch scheme) and will enable the vulnerable person to contact someone, or call authorities as appropriate.

The responsibility to report incidents remains with the vulnerable individual and not with the *Safer Places* location.

Safer Places are a place of temporary refuge from harassment, bullying or worse; a *Safer Places* should only be used if a vulnerable person requires help in contacting a carer/ support worker or support agency, if they are lost, feel distressed or have been a victim of some sort of harassment or criminal offence.

Oxfordshire Safer Places scheme proposal

- Develop a safer places steering group to develop local relationships
- Build understanding in the locality and identify and engage with local businesses
- Work with OSAB to ensure work is connected
- Connect with local businesses
- Involve service users, families and communities
- Pilot two schemes in Banbury and Oxford
- Include development of Safer Places in OSAB strategy

6. Work to ensure that people are treated with dignity and respect when they need care.

"Dignity is seeing me, the person. Respecting and valuing me as an equal. Meeting my needs and listening to me. Helping me to have the life I want, whatever my challenges"

Dignity in Care became a subgroup of the Safeguarding Adults Board in March 2011. In this short time the group have made great strides to meet the following priorities:

- Food, nutrition and hydration appropriate for individuals
- Improve the way people are received into hospital
- Communications e.g. dignity champions newsletter, dignity in care awards judged by service users and carers
- Performance framework, benchmarking and key performance indicators

Achievements

- Dignified gowns in hospital
- Information on specific needs of individuals
- Service users, carers and the Oxfordshire Local Involvement Network trained to support quality monitoring of services
- Dignity workshops for service providers
- First 'dignity in care' awards ceremony
- Support to the Dignity Champions Network
- Performance framework for measuring dignity

- Secured senior management buy-in to programmes of change across the leading statutory sector care bodies
- Delivery of training for service providers, care managers and staff.

Training, development and awareness raising

The OSCB has conducted a range of activities to:

1. Ensure that all staff working with adults are well trained and work together to protect people from harm.
2. Ensure that all people know how to raise concerns if they are at risk of or are being harmed in some way.

The OSCB training subgroup meets quarterly to review the training being delivered by agencies and to ensure it meets the OSAB competency framework. Data is collected from all agencies to measure the percentage of staff trained (2011-2012 are figures not yet available). Significant developments are:

- Fire and Rescue Service have trained 91% of front line officers in Adult Safeguarding.
- Oxford Health NHS Foundation Trust has commenced a programme of joint child protection and adult safeguarding training, resulting in a more cost effective use of staff time.
- Initial discussions have begun to look at a joint child protection and adult safeguarding e-learning package for use by The Oxfordshire Safeguarding Childrens Board.
- A quarterly standardisation meeting provided by OSAB supports safeguarding trainers across Oxfordshire to keep information and skills up to date. All training packages are measured against the competency framework. The Development and Information Officer has carried out quality assurance observations of training, where agencies have required this.
- Fourteen multi-agency training sessions were delivered across the county with one hundred and seventy five attendees. Due to the number of attendees at each session the programme will be reduced for 2012-2013 to ten sessions. The current climate of change in organisations may have impacted on engagement with the multi-agency session.
- Continual Professional Development workshops were run for safeguarding managers: topics were Domestic Abuse, Financial Abuse, Safeguarding and the Law, Mental Capacity and Safeguarding.

- Safeguarding information sessions were delivered to staff in: Oxfordshire District Council Housing Services, Oxfordshire Advocacy Services and Oxfordshire Rural Communities Council.
- A Dignity in Care workshop has been held with managers of organisations who provide contracted service to Oxfordshire County Council.
- A dedicated safeguarding training resource for professionals is available on the Safe from Harm website.
- A range of resources for the public and professionals are available to download on the Safe from Harm website.
- The Challenge of Empowering Adults at Risk was a multi-agency event to provide a forum for multi-agency networking and look at the challenges for professionals involved in safeguarding.

Good Practice: Oxfordshire Fire and Rescue Service

As part of their commitment to membership of the OSAB and Oxfordshire Children's Safeguarding Board (OCSB), Oxfordshire Fire and Rescue Service included, in their Integrated Risk Management Planning 2011/12 Action Plan, the requirement for all front line officers to attend safeguarding adults and child protection training. Working alongside the training leads for both OSAB and OSCB a training package was developed to be delivered by the Fire and Rescue Services Risk Reduction Team coordinator and Assistant Administrative Services Manager. The training was delivered to each Fire Watch in Oxfordshire, a total of 620 staff have been trained to date which is 91% of the total number originally identified. A plan is in place to deliver training to the remaining sixty staff.

The training session was not officially evaluated but the trainers believe that in most cases it was viewed positively by delegates. Concerns were raised by some officers in relation to their standing in the communities, as they both work and live in an area. They felt raising a concern following attendance at an incident may have a detrimental effect on their relationships with members of the community, as individuals would easily identify who had raised the concern. However there is no evidence to show that this has affected alerts being raised.

The training programme commenced in August 2011 and, as identified above, the final sessions are now planned to ensure 100% compliance. The figures provided by Fire and Rescue Service identify that in 2011, eight safeguarding concerns were raised by Fire and Rescue in relation to vulnerable adults. From 1st January 2012 to 13th May 2012 a total of twenty alerts have been raised. Whilst not all twenty have resulted in a safeguarding alert, all concerns were appropriately raised and referred to applicable services where necessary.

Initially the service had little feedback following the referrals, but this appears to have improved. It was emphasised that receiving feedback, whilst recognising the need for data protection, is a key factor in confidence to raise concerns in the future.

This project evidences the positive affect of safeguarding awareness training in teams, outside of the social and health care context, who have contact with vulnerable people and is a model that can be used to inform future development of training strategies.

Future developments:

- Consideration needs to be given to how agencies are measuring the effectiveness of training.
- Increase the availability of a generic e-learning package for the increasing number of community/voluntary agencies requiring safeguarding adults training.
- Continuing Professional Development (CPD) workshops planned for 2012-2013 are: Self- Neglect (this is a cross county event with Buckinghamshire and Milton Keynes), Pressure Care, Role of the Court of Protection, Personalisation and Safeguarding.
- In line with personalisation, the Board needs to ensure that service users know how to raise concerns. Work with agencies to develop resources or adapt existing resources.
- There is a Dignity project proposal to measure effectiveness of Dignity workshops on the quality of care.

3. Delivery, performance and resources

This theme looks at service delivery, the effectiveness of practice and how the performance and resources of the service, including its people are managed.

Delivery

Adult protection refers to investigation and intervention, where it is suspected that harm may have occurred as a result of abuse or neglect of a vulnerable person or adult at risk.

Adult Social Care, Oxfordshire County Council, have an enhanced duty to investigate adult protection cases or to cause an investigation to be made by other agencies.

The Oxfordshire County Council Social and Health Care Team is the contact point for all adult safeguarding alerts and enquiries. Its aim is to respond to customer needs quickly and ensures that they are directed to the place most appropriate to their needs.

All OSAB member organisations have specialist safeguarding leads within their organisation whose role is to develop adult safeguarding within their organisations.

The Safeguarding Adults Team provides a dedicated safeguarding function operating independently of practitioners but continuing to provide support and challenge to adult social care. This provides senior professional leadership with a continuing support and development function in relation to both adult protection leads within localities and the broader safeguarding information and development needs of adult social care teams.

Cases are managed by all locality teams with the safeguarding adults/vulnerable adult protection team taking specific responsibility for abuse in care cases.

The current Safeguarding Adults Team consists of:

- 1 full-time Unit Manager
- 1 part-time OSAB Administrator
- 2 full time Senior Practitioners
- 1 full-time Safeguarding Adults Board Development and Information Officer
- 1 full-time Adult Protection Administrator

To increase the team's capacity, 3 additional full-time Locality Adult Protection posts are to be established in 2012.

Systems and referral routes

While information sharing between teams and agencies in Oxfordshire has demonstrated significant improvement in relation to identifying risks to 'adults at risk' some challenges remain:

Information regarding risk in relation to potential perpetrators and 'adults at risk' is held on multiple systems, e.g. adult social care, mental health, learning disability, children etc. The work of the Board therefore has been to ensure that despite different systems, information is still shared so that people are safeguarded effectively.

To mitigate against the risks of having multiple systems, work has been completed to improve information sharing and access to systems:

- A recent development allows County Council staff using the children's system to look up information held in the adults system (without having to access the adults system)
- There is ongoing work to improve access to the electronic patient record system RiO
- Oxford Health NHS Foundation Trust has launched a new service, the Single Point of Access (SPA), which provides General Practitioners and other healthcare professionals with a quick and easy way of referring patients to the Trust's community health services e.g. community therapy and community nursing. This new service can be used for any referral to community health services.
- Data recording has been improved though the provision of training in the use of Adult Social Care systems, which has been given or is in the process of being given to all working age and older adult Mental Health Teams - including safeguarding recording training.
- Finally, Oxfordshire County Council has just procured a 'Secure File Sharing' solution that will make sharing sensitive and restricted information outside the organisation much easier and therefore will improve information sharing between the County Council and partner organisations.

Serious Case Review

There have been no Serious Case Reviews conducted in Oxfordshire. However, the subgroup has conducted Partnership Reviews to learn from Serious Incidents, significant safeguarding events and Serious Case Reviews in other regions.

Winterbourne View Hospital

On 31 May 2011, the BBC aired a Panorama programme where patients were subjected to horrific treatment and abuse at Winterbourne View Hospital, Bristol, owned and run by Castlebeck. As a result of this several members of staff were arrested and the hospital has been closed down. Following the broadcast several strands of review have been carried out. Locally, a serious incident review and a review of commissioning have been undertaken. These will be considered as a part of the national Serious Incident review and review of commissioning. Also being undertaken is: a criminal investigation, a Castlebeck internal review, a Gloucestershire safeguarding review and a programme of CQC investigations and inspections.

Oxfordshire had three patients at Winterbourne View and, as a result, was required to conduct an investigation in line with the Serious Incidents Requiring Investigation (SIRI) process into the commissioning arrangements at the time of placing these patients at Winterbourne View.

The purpose and remit of the local investigation was:

- To establish the facts and whether there were any failings in the commissioning process around the placements of the Oxfordshire patients;
- To identify any lessons to be learned and create an action plan to be implemented to prevent recurrence;
- The investigation did not identify any serious practice failings. It did identify some important learning points. These were: the need for clarification of the process for out of county placements, and the need for improvements in the quality assurance and monitoring process for placements. An action plan has been agreed between the County Council and Oxfordshire Primary Care Trust with the aim of improving commissioning processes.

It is likely that events at Winterbourne View will lead to an increased awareness and reporting of issues relating to safeguarding and learning disabilities.

An action plan has been put in place by the County Council in response to investigation into placements at Winterbourne View. A steering group involving key managers, service users and carers has been established to oversee delivery of action plan. The Serious Case Review subgroup (SCR) is maintaining an overview of this work to help ensure that learning is disseminated.

Buckinghamshire Serious Case Review

The OSAB maintained an overview of a Buckinghamshire Serious Case Review so that learning could be disseminated.

During February 2010, the dismembered body of 70 year old Mr C was found under concrete in the back garden of his home. In September 2010, Mr C's son, who was a 22 year old undergraduate, was found guilty of his father's murder.

The Thames Valley Police had become concerned that between August 2008 and February 2009, when all contact with this older man had ceased, neither the NHS nor Adult Social Care raised concerns about Mr C who was a Direct Payments Recipient. In the absence of information to the contrary, both Adult Social Care and the support agency commissioned to support all Direct Payments Recipients believed that Mr C employed Personal Assistants. However, the police were unable to trace them. Also, it has become subsequently apparent that Mr C's son might have fallen within the statutory definition of a carer but there is no evidence that he had been recognised as such by either the NHS or Adult Social Care.

About this Serious Case Review (SCR)

The review was commissioned by Buckinghamshire's Adult Safeguarding Board and is based on information from:

- Buckinghamshire County Council, Adult Social Care
- Milton Keynes Hospital NHS Foundation Trust
- National Health Service Bedfordshire and
- Oxford Radcliffe Hospitals NHS Trust.

Also, a Detective who contributed to the police investigation and murder trial shared insights from both procedures.

Issues identified

- Monitoring of Direct Payments
- Assessment & review process
- Importance of history
- Hospital discharge arrangements
- Carers Assessments
- Lack of multi-agency discussion
- Decision-making not risk assessed
- How is DNA data used in respect of vulnerable adults?

Monitoring and Quality Assurance

How the OSCB has monitored and evaluated local adult safeguarding arrangements

The Care Quality Commission, *Essential Standards for Quality and Safety* set specific outcomes for safeguarding and safety as a requirement for registration. The Care Quality Commission will take enforcement action where services fail to comply with standards and patients are put at risk.

In Oxfordshire the central Safeguarding Adults team provides a dedicated safeguarding function operating independently of practitioners providing support and challenge to adult social care.

The continued priority of Adult Safeguarding within Adult Social Care, Oxfordshire County Council is reflected in the 2012-2013 key quality measures.

- **Protection**: To ensure that services that are safe and vulnerable people are safeguarded
- **Prevention**: To keep people as independent as possible and living an ordinary life
- **Personalisation**: To provide services which meet the personal needs of clients and maximise the control they can exercise over their live

The OSAB provides challenge and support through scrutiny of performance reports, inspection and audits. The Board requests assurances that recommendations have been acted upon.

Information obtained from the *NHS Self-Assessment Quality & Performance Framework* has informed the Board. It has been identified that a standardized approach to quality assurance will be beneficial to the Board. This is an area of development to be taken forward in next year's Business Plan.

4. Working together

This theme looks at the role and performance of OSAB and how all partners work together to ensure high quality services and outcomes

Governance of Adult Safeguarding (Braye et al, 2011)

The research for the report 'Governance of Adult Safeguarding' (Braye et al -2011), commissioned by the Department of Health, explored the governance arrangements for local safeguarding adults. The findings focus on five key features of Safeguarding Adults Boards:

1. Strategic goals and purpose
2. Structures
3. Membership
4. Board Functions
5. Accountabilities

The OSAB completed a self-assessment exercise to evaluate its performance against the five key features.

The positive features of the OSAB include its established and committed membership; the increased prominence of the Board within partner agencies; the developed scrutiny function and reporting mechanisms; and, the expanded remit through the establishment of the Deprivation of Liberty Safeguards (DoLS) and the Dignity in Care subgroups.

The OSAB has members across a range of agencies involved in both prevention and intervention. The Board provides a challenge and scrutiny function through the routine items: performance reporting; feedback from inspections and audits, during which assurance that inspection recommendations have been acted upon is requested; capacity and organisational change; and subgroup reports.

Each core/statutory board member organisation must have a designated director for the implementation of safeguarding adults' work and a nominated senior lead representative on the Safeguarding Adults Board. Core/statutory board members must be sufficiently senior in their organizations to represent that organisation and make multi-agency agreements. See paragraph 6 and 7 of OSAB Terms of Reference (appendix 3) and OSAB role description (appendix 1)

The County Councillor, elected as Cabinet Member for adult services is a member of the OSAB. The OSAB Chair and Cabinet Member provide links to the Joint Oxfordshire Health and Wellbeing Board and Oxfordshire County Council's scrutiny function. Strategic links with Oxfordshire County Council Community Safety through joint membership and as outlined in the Oxfordshire County Council Community Safety Business plan.

Each subgroup is chaired by a board member. Reporting to the OSAB is via routine highlight reports. The cooperation of partners is evidenced by progress on actions. Other forums e.g. the Safeguarding Leads meeting provide a forum for multi-agency partners to discuss and scope situations in detail.

Multi-agency OSAB policies and procedures are in place and are available on the OSAB Safe from Harm website. The Board has also worked to ensure that Safeguarding Adults is appropriately referred to in other relevant policy, procedure and guidance e.g. the local Domestic Homicide Protocol.

Areas of development have been highlighted during this exercise.

The development of an OSAB strategy was identified as a key area of development.

Reporting mechanisms to other Boards are in place but there could be further work to develop their efficiency. Plans are in place to establish formal links with the newly established Oxfordshire Joint Health and Wellbeing Partnership Board and a protocol is being drafted between the OSAB and the Oxfordshire Safeguarding Childrens Board.

Currently, engagement with service users and carers is through the links and work of individual members of OSAB. The need to improve engagement with people who use services has been highlighted as an area of development.

These areas of development will be discussed in detail at the Board Business Planning day, planned in June 2012. Following this, a Board Business Plan will be written to outline the proposals for addressing the areas of development and priorities for 2012-2013.

Priorities for 2012

Through a combination of presentations, discussion and group work the attendees of the business planning meeting assessed the progress of the work of the Board over the last year, explored options to develop the Board and outlined priorities for the year ahead.

The Board priorities will be outlined in the Board Business Plan 2012-13.

The Annual Report will be taken to the Oxfordshire Joint Health and Wellbeing Board annually

Appendix 1

Role Description for Safeguarding Adults Board Members

1. The Board member must have (or be given) sufficient authority within their own agency to be able to represent their agency's view to the Board.
2. The Board member must be able to (or be given the authority to) commit the resources of their agency to support the work of the Safeguarding Board.
3. The Board member must ensure that the Board is informed of all relevant professional and practice issues that will impact on the ability of the agencies represented on the Board to work together to safeguard vulnerable adults in the County.
4. The Board member must be able to influence the strategic planning for safeguarding vulnerable adults within their agency.
5. The Board member must be able to secure appropriate information from their agency to support the work of the Board.
6. The Board member must represent the position of the Board within their own agency, whether this is in conflict with their agency or not.
7. The Board member must ensure that decisions of the Board are promoted within their own organisation and any impediments or delays to their implementation are reported to the Board.
8. The Board member must ensure that the work of the Board, its policies and decisions, is communicated effectively within their own agency.

Appendix 2

Role Description for the Independent Chair

1. To ensure that the Oxfordshire Safeguarding Adults Board (OSAB) operates effectively and exercises its functions and responsibilities as set out in No Secrets and Oxfordshire Safeguarding Adults Board's policies and procedures, and all new legislation, regulations and guidance regarding safeguarding adults.
2. Lead the Safeguarding Adults Board in the implementation of the Safeguarding Adults agenda and together with the executive group determine priorities in service development.
3. Providing independence and quality assurance in the conduct of the Oxfordshire Safeguarding Adults Board and its subgroups.
4. Ensure that performance management is integrated into the role and function of the Safeguarding Adults Board and its subgroups to deliver improved outcomes for vulnerable adults and their carers.
5. Encourage and support the development of partnership working between the partner members of the Safeguarding Adults Board and its subgroups.
6. To promote the Oxfordshire Safeguarding Adults Board's ability to independently fulfil statutory objectives of monitoring, challenge and scrutinise the effectiveness of inter-agency working to safeguard vulnerable adults/adults at risk.

Appendix 3

Oxfordshire Safeguarding Adults Board Terms of Reference

1. Background information about the Board

1.1. 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.

1.2. 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.

1.3. 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.

1.4. The Oxfordshire's Safeguarding Adults Procedures (2009) superseded Oxfordshire Codes of Practice for the Protection of All Vulnerable Adults from Abuse, Exploitation and Mistreatment (2002).

2. Purpose

2.1. 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.

3 Structure

3.1 The main board will be supported by five sub-groups: Policy and Practice; Training; Dignity in Care; Deprivation of Liberty Safeguards and Serious Case Review. The Chairs of these sub-groups will be members of the Oxfordshire Safeguarding Adults Board.

3.2 The structure chart below shows the roles and responsibilities of the committees responsible for implementing the safeguarding requirements.

4. Main Features & Responsibilities

The Oxfordshire Safeguarding Adults Board's responsibilities are:

4.1. To encourage and promote the development of services that: recognise the rights of vulnerable people; enable vulnerable people to live safely and free from abuse, and; actively promote individual's access to mainstream criminal justice and victim support services

4.2. To oversee the development and implementation and review of local policies and procedures for the protection of vulnerable adults from abuse in Oxfordshire that ensure:

- The abuse of vulnerable adults is identified where it is occurring
- That there is a clear reporting pathway
- That there is an effective and coordinated response to abuse where it is occurring
- That the needs and wishes of the vulnerable adult are central to the adult protection process

4.3. To encourage and promote a framework which ensures that all individuals and agencies working with vulnerable people understand what is meant by abuse and their role and responsibilities in reporting and responding to concerns of abuse, and actively work together to:

- Respond effectively to abuse where it is identified
- Act to reduce the risk of harm to vulnerable people as a result of abuse
- Develop & implement strategies designed to safeguard vulnerable adults from abuse

This includes:

i developing and agreeing local policies and procedures for inter-agency work to protect vulnerable adults, within the national framework provided by "No Secrets"

ii auditing and evaluating how well local services work together to protect vulnerable adults, for example through wider case audits

iii encouraging and helping develop effective working relationships between different services and professional groups, based on trust and mutual understanding

iv ensuring that there is a level of agreement and understanding across agencies about operational definitions and thresholds for intervention

v improving local ways of working in the light of knowledge gained through national and local experience and research, and to make sure that any lessons learned are shared, understood, and acted upon

vi undertaking case reviews where an adult has died or – in certain circumstances – been seriously harmed, and abuse or neglect are confirmed or suspected

vii making sure that any lessons are understood and acted upon

viii communicating clearly to individual services and professional groups their shared responsibility for protecting vulnerable adults, and to explain how each can contribute
ix helping improve the quality of adult protection work and of inter-agency working through specifying needs for inter-agency training and development, and ensuring that training is delivered
x raising awareness within the wider community of the need to safeguard vulnerable adults and promote their welfare and to explain how the wider community can contribute to these objectives
xi actively seeking to identify where there is a risk of institutional abuse to vulnerable adults, and
xii developing strategies to prevent the abuse of vulnerable adults whenever possible
xiii monitoring, collecting and analysing information in accordance with local and government requirements
xiv working with local and adjacent area child and adult safeguarding boards
xv ensuring compliance with formal government requirements.

5. Reporting

5.1. The Board will report annually to the Oxfordshire County Council, Social & Community Services Scrutiny Committee.

5.2. In addition each core/statutory member of the Oxfordshire Safeguarding Adults Board will be expected to report to its own management committee.

5.3. The Board will produce an annual report that will include a review of the previous years' work. This report will be subject to scrutiny by the Oxfordshire Social Services, Social and Community Services Scrutiny Committee

5.4. The five board subgroups will contribute to the Board's annual report

5.5. Individual member reports will be included as annexes to the annual Board report.

6. Membership

6.1. Each core/statutory board member organisation must have a designated director for the implementation of safeguarding adults' work and a nominated senior lead representative on the Safeguarding Adults Board. Core/statutory board members must be sufficiently senior in their organizations to represent that organisation and make multi-agency agreements.

7. Member responsibilities

7.1. Each core/statutory member of The Board is committed to the aims, objectives and principles outlined in the Oxfordshire's Safeguarding Adults Procedures (2009). To this end each partner agency will:

a. Have a set of internal guidelines and reporting structure, which are consistent with the Oxfordshire's Safeguarding Adults Procedures, and which set out the responsibilities of all workers to work within the Oxfordshire Codes of Practice

b. Ensure that all staff members and volunteers at all levels have training and information commensurate with their role in relation to the Oxfordshire Codes of Practice

c. Ensure that all adult safeguarding concerns are systematically logged along with the actions taken and outcomes arising

7.2. In addition each agency will undertake an annual risk assessment/review of services provided by the organisation and establish an agreed action plan for promoting the protection of vulnerable people served by the organisation.

7.3. Each core/statutory member of the Oxfordshire Safeguarding Adults Board will provide an annual report to the board detailing progress and developments in relation to 5.1 and 5.2 above.

8. Frequency of Meetings

8.1. Quarterly

Reporting your concerns

Everybody working with vulnerable people is responsible for making sure, within their Codes of Practice, that no action or omission on their part harms the wellbeing of service users.

If you are aware of any vulnerable person who has been harmed or abused or is at risk of harm you must **report it**.

Oxfordshire Social & Community Services

Oxfordshire Social & Community Services have procedures for dealing with cases of vulnerable adult abuse. They can offer information and advice to help you in deciding what you want to do and in some cases may be able to provide you with practical help and support. The first priority will be to try and ensure that you are safe.

Telephone**: 0845 0507 666**

SMS: **07788 571577**

Fax: **01865 783111**

Address: **Social and Health Care team, PO Box 780, Oxford, OX1 9GX**

socialandhealthcare@oxfordshire.gov.uk

Out of hours emergency: **0800 833408**

www.oxfordshire.gov.uk

Thames Valley Police

Abuse is often a crime. If you think a crime has been committed contact the police.

Non-emergency number: **101**

In an emergency dial: **999**

www.thamesvalley.police.uk

Care Quality Commission (CQC)

If you, a friend or relative, live in a care home or have care at home and are not happy with the care that you are getting you can contact CQC who can give you advice on what your rights are and how to complain.

Call them on: **03000 616161**

Email them on: enquiries@cqc.org.uk

Find out more at: www.cqc.org.uk

اشكال بديلة لهذا المنشور موجودة حسب الطلب. هذه تشمل لغات مختلفة و الطبعة البارزة وطريقة بريل و اشرطة كاست و اقراص الحاسوب او البريد الالكتروني.

Arabic

আপনি যদি অনুরোধ করেন তাহলে এই পুস্তিকাটি বিকল্প ছাঁদে, যেমন, অন্য কোনও ভাষায়, বড় হরফে, ব্রেইলে, অডিও-ক্যাসেটে, কমপিউটারের ডিস্কে বা ইমেলের মারফত পেতে পারেন।

Bengali

"本刊物備有其他的格式可供索取。這些包括有其他語言版，大字版，盲人用版，錄音帶版，電腦磁碟版或電子郵件版。"

Chinese

प्रार्थना करने पर यह प्रकाशन दूसरे रूपों में प्राप्त किया जा सकता है। जिस में सम्मिलित है, दूसरी भाषाओं में, बड़े छापे में, ब्रेअल, सुनने की टेप पर, कम्प्यूटर की डिस्क पर या ई-मेल द्वारा।

Hindi

"ਇਹ ਪੁਸਤਕ ਬੇਨਤੀ ਕਰਨ ਤੇ ਹੋਰ ਰੂਪਾਂ ਵਿਚ ਵੀ ਉਪਲਬਧ ਹੈ । ਜਿਵੇਂ ਕਿ ਹੋਰ ਭਾਸ਼ਾਵਾਂ ਵਿਚ, ਵੱਡੇ ਛਾਪੇ ਤੇ, ਬ੍ਰੇਲ ਵਿਚ, ਸੁਣਨ ਵਾਲੀ ਟੇਪ ਤੇ, ਕੰਪਿਊਟਰ ਡਿਸਕ ਜਾਂ ਈ ਮੇਲ ਤੇ।"

Punjabi

''اس اشاعت کو متبادل اشکال میں درخواست کرنے پر حاصل کیا جاسکتا ہے۔ اس میں دوسری زبانیں، بڑا پرنٹ، بریل (جسے اندھے چھو کر پڑھ سکیں)، آڈیو کیسٹ، کمپیوٹر ڈسک یا ای میل شامل ہیں۔''

Urdu

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Polish

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Oxfordshire Clinical Commissioning Group

NHS

OXFORDSHIRE CLINICAL COMMISSIONING GROUP
PLANNING PROCESS AND TIMELINES

PROCESS

Alignment with Health and Well Being Board

We held a joint workshop (Health and Well Being Board, County Council, Districts and Local Involvement Network) on 7th February to review available indicators and agree which need to be included in the revised Health and Well Being Strategy and which three will best measure improvement in our priority areas and should be reflected in the Clinical Commissioning Group (CCG) quality premium proposals. This workshop showed alignment of key themes and is being used to influence the development of our plan going forward.

Internal working

The Associate Director of Strategy and Governance leads a working group involving all Assistant Directors, Public Health and representatives from the Commissioning Support Unit. This group meets weekly to ensure that all input to the plan is coordinated and delivered to time. The main focus of work for the next few weeks is to ensure that all programmes of work have clear plans with milestones, timescales and key performance indicators.

Locality engagement

All the Localities have successfully involved their practices in developing a Locality plan. These plans form a part of the overall CCG plan. During February and the early part of March Localities will review the plan in its entirety to enable further refinement and get Locality sign up to their role in delivering the plan.

Provider engagement and alignment

The CCG Executive Team have held initial discussions with both Oxford University Hospitals (OUH) and Oxford Health outlining the main elements of this operational plan. A system wide meeting involving the CCG, OUH, Oxford Health, Social Care and the Ambulance Trust was held on 4th February to align commissioning intentions and share information about cost improvement plans across Oxfordshire. Contract discussions are ongoing and a session focusing on areas of activity reduction/change will be held on 15th March with OUH.

Engagement and alignment with HOSC

Members of the Executive team had an informal meeting with members of Joint Health Overview and Scrutiny Committee on 28th January and the draft Operating Plan was one of the areas for discussion.

TIMESCALES

25th January	First submission to Area Team
31st January	OCCG Shadow Governing Body review first draft plan
7th February	OCCG meeting with National Commissioning Board Area Team to receive feedback
End February	Resubmission of finance templates and update on contract negotiations
18th March	Presentation to NHS Commissioning Board regional and Area teams
28th March	OCCG Governing Body sign off plan
31st March	Contracts signed
5th April	Final OCCG plans submitted to Area Team

Catherine Mountford
Associate Director of Strategy and Governance
27 February 2013

SHADOW HEALTH & WELLBEING BOARD – 14 MARCH 2013

Resources that can be influenced by the Health and Wellbeing Board

This paper sets out the resources which the Health and Wellbeing Board can influence.

Table 1 shows the total budgets which will be held by some partners of the Health and Wellbeing Board in 2013-14. A proportion of the total amount is within pooled budgets – as set out in Table 2 below. As can be seen, this is a very small fraction of total spending. The Health and Wellbeing Board has influence over all of this, including the pooled budget elements which are formally the responsibility of the Joint Management Groups. It should be noted that the amounts quoted in Table 2 are for 2012/3

Both the County Council and the Clinical Commissioning Group are expected to increase their contributions to the Older People pool to create a genuinely pooled budget. However, work on this has not yet concluded.

The work of other partners which also contributes to Health and Wellbeing in the County includes:

1. **District Councils**

    - Leisure services
    - Cultural services,
    - Regeneration,
    - Housing Development,
    - Advice and support,
    - Community Safety,
    - Environmental Health,
    - Emergency Planning,
    - Air Quality,
    - Food Safety,
    - Contaminated Land,
    - Pest and Noise Control,
    - Fuel Poverty

    .
2. **Schools and Academies**
3. **Early Years Providers**
4. **Further Education**

Table 1. Total Budgets available in 2013-14 in some partner organisations

Organisation / Directorate	Budget for 2013-14	Major areas of expenditure
Oxfordshire Clinical Commissioning Group	£667m	• Acute care £350m • Community Health £73m • Mental Health £52m • Prescribing £81m • Continuing Care £42m • Other care £18m • Corporate and other £51m
National Commissioning Board Area Team (Thames Valley)	£524m	• Primary Care • Specialist commissioning • Offender health
Adult Social Care (Oxfordshire County Council)	£161.5m	This is split between • older people **£73m** • adults with a learning disability **£62m** • adults with a mental health need **£9m** • adults with a physical disability **£11m** • all client groups **£2.5m** • and joint commissioning **£4m**
Housing related support (Oxfordshire County Council)	£4.5m	• Preventing homelessness, including offenders, domestic abuse) • Floating support
Children's Services (Oxfordshire County Council)	£106m Schools and Academies £400m Other £26m	• Higher Level SEN £26m • Childrens' Centres £10m • Early Intervention £10m • Education Statutory Services* £12m *(excludes traded services, H2S transport, place planning, asset management) • Disabled Children £7m • Other Childrens' Social Care £39m • Directors Office / Safeguarding £2m • Schools & Academies £400m (includes estimates of academy funding) • Early Years Providers £24m • Higher Needs in FE colleges £2m
Public Health (Oxfordshire County Council)	£24m	• Sexual health services • Drugs and Alcohol Treatment services • Health protection • Health Improvement

Table 2 Pooled budgets for 2012-13

Joint Commissioning Arrangement for decision making	Total budget (2012-13)	Oxfordshire County Council Contribution	Clinical Commissioning Grp contribution	Current Accountability
Older People and Physical Disability Joint Management Group	Older People £107m	Older People £82m	Older People £25m	Director of Social and Community Services
	Physical Disability £ 17m	Physical Disability £10m	Physical Disability £7m	
Learning Disability Joint Management Group	£76m	£64m (£3.5m more in 2013-14 for housing related support)	£12m	Director of Social and Community Services
Mental Health Joint Management Group	£48m	£7m (£1.8m more in 2013-14 for housing related support)	£41m	Chief Clinical Officer, Oxfordshire CCG
Housing Related Support (recommendations will be made through Health Improvement Board from 2013-14)		£4.4m		Director of Social and community services

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Joint Strategic Needs Assessment
Information Report for Oxfordshire Health and Wellbeing Board, March 2013

Introduction

The Joint Strategic Needs Assessment (JSNA) is a shared data source which sets out the major health needs facing Oxfordshire. We are talking about health here in its broadest sense, not just about specific diseases. Producing a JSNA is a shared duty of County Councils and Clinical Commissioning Groups through their Health and Wellbeing Boards. The findings are expected to have a strong influence on the Joint Health and Wellbeing Strategy. The JSNA has been redesigned and refreshed during 2012-13 and its main findings are presented here. From this analysis it can be concluded that the current priorities set out in the Joint Health and Wellbeing Strategy should be continued.

Development of the Joint Strategic Needs Assessment in 2012-13 has resulted in a broader and more easily accessible collection of data. For the first time we have brought together a wider set of indicators for analysis, including community safety data, information on the Military Community in the county and data relating to social determinants of health such as housing, employment and skills. This information now sits alongside the health and social care data collection that has been so well used in previous JSNA reports. The data collection is also more accessible to a wide range of partners and stakeholders and they have been more engaged in the process of development.

This report covers the headlines of the JSNA. Further detail, including the raw data for further analysis, will be available through the JSNA pages of the Oxfordshire Insight website. This data should be seen as a starting point setting out major themes. All organisations will want to carry our further analysis on each issue that we have highlighted here.

Summary of Analysis for this report

Following discussions with partner organisations and the voluntary and community sector, the JSNA steering group agreed a wide range of indicators for analysis. These indicators were drawn from a wider range of sources than in previous years, including:

- Public Health
- Clinical Commissioning Group
- County Council Commissioning data
- District Councils
- Thames Valley Police
- 2011 Census
- The Office for National Statistics
- The Department for Work and Pensions

Where possible, the analysis looked at the historical trends to see whether needs had increased or decreased over the past year, and whether this was part of a sustained trend. Data was also looked at by Districts and smaller localities to see whether there were differences in health for different areas of the county.
Overall there were few statistically significant variations when compared to the previous year. This is to be expected given that health changes at the population level are slow

moving, and as such, any trends must be treated cautiously. Data from the census helped to give more information about longer term trends. Where relevant trends were observed, these have been outlined below.

The key trends are presented by theme below:

Key Findings

1. Population

- The population of Oxfordshire increased from 607,300 to 654,800 between 2001 and 2011. This is an increase of 8%.
- The number of people aged over 65 increased by 19% between 2001 and 2011. The rate of growth was much higher in the predominantly rural districts (over 20%) than Oxford City where there has been a 5% fall in the number of people over 65.
- The number of children aged 0-4 has increased by 13%. The rate of increase has been much higher in Oxford City (28%) compared to other districts (between 2% and 11%).
- The birth rate is relatively stable among UK born mothers but has increased by 37% among mothers born outside the UK.
- The proportion of black and minority ethnic groups in Oxfordshire has increased from 4% of the total population to 9% between 2001 and 2011.
- The proportion of the population who were born outside the UK increased from 10% of the population to 14% between 2001 and 2011.
- Eight wards in Oxfordshire (5 in the City and 3 in Banbury) show particularly poor outcomes across a range of indicators including child poverty, low skills, low income, poor attainment, higher crime and poor health[1].

2. Employment, economy and skills

- Whilst the percentage of people claiming the Job Seekers Allowance in Oxfordshire has remained below the national and regional level, the rate of increase was higher:
    - The number of Job Seekers Allowance Claimants increased by 115% in Oxfordshire compared to 98% in the South East during the period of February 2002 to February 2012.
    - The rate of increase for the ten year period was highest in Cherwell (141%) and West Oxfordshire (140%).
- The proportion of economically inactive people in Oxfordshire was lower (27%) than England (30%) and the South East region (28%) at the time of the Census (June 2011).
    - Oxford is the only district with an above average proportion of economically inactive people (37%) although this is primarily due to the number of economically inactive students (22% of the working age population).

[1] The wards are Blackbird Leys, Greater Leys, Littlemore, Rose Hill & Iffley, Barton and Sandhills, Banbury Ruscote, Banbury Neithrop and Grimsbury & Castle

- Oxfordshire contains a higher proportion of people (36%) with level 4 qualifications (undergraduate degree or equivalent) than England (27%) and the South East (30%).
    - The proportion is highest in Oxford City at 42% of the population.
    - Oxford City, Banbury, and Abingdon also contain wards with high proportions of people with Level 1 (1-4 GCSEs or equivalent) or no qualifications.
- The cost of housing relative to income for the poorest 25% of people is comparatively high in Oxfordshire at 9:1, representing a 33% increase from 2001 to 2011.
    - This is the fifth highest ratio of any county in the South East.
    - At district level this ratio is highest in Oxford City and South Oxfordshire at 10:1
- There have been a high number of unfilled job vacancies over the past 12 months in the Home Care/Care Assistant field.
    - This has been particularly pronounced in West Oxfordshire and Oxford City.

3. Housing and living environment

- There is a lack of affordable housing across the county and particularly in Oxford.
- The pattern of housing tenure is distinct in Oxford City with a much higher proportion of private rented housing (28%) than other districts (13% to 16%).
- There are higher rates of household overcrowding in the city (number of residents per bedroom) with 13.9% of households deemed to be overcrowded, compared to 6.9% for Oxfordshire. This may be due in large part to the high number of multiple occupancy student accommodation units.
- The number of new houses built each year has declined in recent years from 3500 in 2005/06 to 1500 in 2010/11. The number of newly built affordable houses has remained fairly constant, fluctuating between 500 and 600 over the same period.

4. Armed Forces, their families and Veterans

- There are approximately 9500 serving personnel in the county whose Primary Health Care is provided by the Defence Medical Services. The county also has approximately 1200 military family members whose Primary Health Care is also provided by military GPs and not by the NHS.
- According to longitudinal studies at the national level, outcomes are often good for veterans. However, there is an observable above-average incidence of depression/anxiety disorders and alcohol misuse for some veterans. This group is also more likely than the general population to find it difficult to seek help.
- There is currently little data available to calculate reliably the number of veterans in the local population.

5. Community safety

- The rate of police recorded offences in Oxfordshire fell from 87.2 to 57.9 per 1000 people between 2003 and 2012.

    - Oxford City had more than double the rate of offences (110.2) compared to Cherwell (55.0), South Oxfordshire (40.6), West Oxfordshire (34.4), and the Vale (36.6).
    - The Crime Survey for England and Wales suggests that the level of recorded crime does not reflect the true incidence of crime in the population. Although figures are not available for Oxfordshire, the estimated prevalence of crime for the South East region was around 83 incidents per 1000 people for the 12 months prior to 2012.
- Police recorded violent offences have been falling since 2008 across the county, from 15.9 to 11.5 per 1000 people.
- The police recorded incidence of Sexual Offences been relatively constant over the past 9 years fluctuating between 1.2 and 1.5 per 1000 people.

6. Giving Children and Young People the best start in life

- Breastfeeding rates at initiation are high in Oxfordshire at 78.7%. This is significantly higher than the national rate of 74.5%. A similar rate is found in all districts. .
- The proportion of overweight children in reception year is 7.3%. This is significantly below the national level of 9.4% Both local and national levels are rising gradually.
- The proportion of year 6 pupils considered obese is more than double the rate for reception age children at 15.5%. However it remains below the national rate for year 6 children, which is 19.20%.
- School attainment remains a mixed picture but there is improvement in performance in younger age groups. Inequalities in outcome remain.
- Teenage pregnancy rates reduced from 28.4 per 1000 females aged 15-17 (2007-2009), to 25.9 for the period 2008 to 2010. Oxford City remains significantly above the county rate at 33.6.
- The rate of referrals to children's social care increased from 389.5 to 460.7 per 10,000 under 18s from 2010/11 to 2011/12.
    - This is lower than the national rate but higher than the 'statistical neighbour' average.
    - It represents an increase of 18.3% compared to a fall of 4.2% at the national level.
- The number of repeat referrals to children's social care increased by 57% between 2009/10 and 2011/12.

7. Ensuring people live well and independently

- The percentage of residents who reported their health to be very bad or bad in the June 2011 Census was lower than the regional and national average.
- Oxfordshire contains a lower proportion of households with at least one adult with a long term health problem or disability (21.7%) than the South East region (23.6%) and the country (26.0%).
- The number of referrals to adult social care has grown at a higher rate than that which would be expected through the effects of an aging population.
- The proportion of Adult Social Care Users who report having enough control over their lives was 78.6% in 2011/12. This puts it in the top 25 % of local authorities nationwide.
- 62.2% of clients in Oxfordshire received self-directed support in 2011/12. This is the 18th highest proportion of all local authorities.

- Oxfordshire county council supports 4,500 people to provide unpaid care to another person.
    - The proportion of people who reported that they provide some form of unpaid care is much higher at 61,130.
    - There appear to be higher proportions of people providing unpaid care in rural areas compared with urban and suburban areas.
- 29% of people aged over 65 were living alone at the time of the census.
    - Across districts, it is estimated that this rate is highest in Oxford City, at 36% of the population.
- At 30.2 per 1000 people, the rate of people claiming disability living allowance in February 2012 in Oxfordshire was well below the national rate (50.4). Districts range from 25.9 in South Oxfordshire to 33.8 in Oxford City.
    - However, when only mental health related conditions (Psychosis, Psychoneurosis, Personality Disorder, Dementia) are considered, the rate for Oxford City (8.4 per 1000 people) is above the national rate (7.4)

8. Preventing chronic health problems and early death

- Life expectancy for both men and women in Oxfordshire is higher than the England average.
- Estimates for 2011/12 suggest that the number of adults participating in physical activity is higher in Oxfordshire (27.4%) than in the South East (24.7%) or England 22.9%.
- The rates of immunisation in Oxfordshire are significantly above the national rates.
- Hospital admissions for alcohol related harm are increasing, especially for men.
- Oxfordshire contains below average prevalence of most of the diseases in the quality outcomes framework. Out of 20 diseases recorded measured by General Practice the following conditions were more prevalent than the UK average in 2011/12:
    - Cancer, Depression, Asthma, Atrial Fibrillation, Chronic Liver Disease
- These figures may reflect the thoroughness of our GP services in identifying disease early rather than high disease rates in the population.
- The uptake of cervical cancer screening increased by 6% among younger women (25-49 yrs) and fell by 2% among older women (50-64 yrs) between 2007/08 and 2011/12. The rate remains higher for older women than for younger women although the gap is closing.
- The diagnosis and early recognition of dementia is increasing across the county and is particularly high in West Oxfordshire.

Conclusion

Analysis of the information available for this report leads to the conclusion that the priorities currently set out in the Joint Health and Wellbeing Strategy should be taken forward in 2013-14.

The 11 priority areas are:

Children and Young People

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

Adult Health and Social Care

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

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

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

Health Improvement

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

Next steps

The JSNA Steering Group will continue to develop the data collection which underpins the JSNA throughout 2013-14 in the light of feedback from commissioners and service planners. This work will include further analysis of groups with "protected characteristics" (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, sexual orientation).

Alexandra Bailey, Simon Grove-White. March 2013