

Public Document Pack

To: Members of the Oxfordshire Health & Wellbeing Board

Notice of a Meeting of the Oxfordshire Health & Wellbeing Board

Thursday, 9 November 2017 at 2.00 pm
Rooms 1&2 - County Hall, New Road, Oxford OX1 1ND



Peter G. Clark
Chief Executive

November 2017

Contact Officer: **Julie Dean, Tel: 07393 001089**
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Membership

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

Board Members:

Councillor Anna Badcock (South Oxfordshire District Council)	Chairman, Health Improvement Partnership Board
Lucy Butler	Director for Children's Services
Dr Matthew Gaw	Vice-Chairman, Children's Trust
Cllr Steve Harrod (Oxfordshire County Council)	Chairman, Children's Trust
Councillor Hilary Hibbert-Biles (Oxfordshire County Council)	Cabinet Member for Public Health & Education
Dr Jonathan McWilliam	Strategic Director for People & Director of Public Health
Dr Paul Park	Vice-Chairman, Older People's Joint Management Group
Rachel Pearce (NHS England)	Director of Commissioning Operations (South Central)
Prof George Smith	Chairman, Healthwatch Oxfordshire
Councillor Lawrie Stratford (Oxfordshire County Council)	Chairman, Older People's Joint Management Group
Kate Terroni	Director for Adult Services
Councillor Marie Tidball (Oxford City Council)	Vice Chairman, Health Improvement Partnership Board

In Attendance: Peter Clark, Chief Executive, OCC
David Smith, Chief Executive, OCCG

Notes:•Date of next meeting: 22 March 2018

County Hall, New Road, Oxford, OX1 1ND

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Declarations of Interest

The duty to declare.....

Under the Localism Act 2011 it is a criminal offence to

- (a) fail to register a disclosable pecuniary interest within 28 days of election or co-option (or re-election or re-appointment), or
- (b) provide false or misleading information on registration, or
- (c) participate in discussion or voting in a meeting on a matter in which the member or co-opted member has a disclosable pecuniary interest.

Whose Interests must be included?

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

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

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

What if I remember that I have a Disclosable Pecuniary Interest during the Meeting?

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

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

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

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

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

List of Disclosable Pecuniary Interests:

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

For a full list of Disclosable Pecuniary Interests and further Guidance on this matter please see the Guide to the New Code of Conduct and Register of Interests at Members' conduct guidelines. <http://intranet.oxfordshire.gov.uk/wps/wcm/connect/occ/Insite/Elected+members/> or contact Glenn Watson on **07776 997946** or glenn.watson@oxfordshire.gov.uk for a hard copy of the document.

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

AGENDA

1. **Welcome by Chairman, Councillor Ian Hudspeth**
2. **Apologies for Absence and Temporary Appointments**
3. **Declarations of Interest - see guidance note opposite**
4. **Petitions and Public Address**
5. **Note of Decisions of Last Meeting (Pages 1 - 10)**

To approve the Note of Decisions of the meeting held on 13 July 2017 (**HBW5**) and to receive information arising from them.

6. **Performance Report**

- (a) **Progress against Joint Health and Wellbeing Strategy Outcome Measures agreed for 2017-2018_**(Pages 11 - 26)

2:05

10 minutes

Persons responsible: Strategic Director for People & Director of Public Health, Director for Adult Services, Director for Children's Services, Oxfordshire County Council (OCC); Chief Executive, Oxfordshire Clinical Commissioning Group (OCCG)

Person giving report: Strategic Director for People & Director of Public Health

To receive an update on performance against the outcomes agreed for 2017-2018 in the Joint Health & Wellbeing Strategy (**HWB6a**).

The Board is RECOMMENDED to hold members to account for performance against key indicators.

- (b) **Accident and Emergency Delivery Board Targets_**(Pages 27 - 30)

2:15

5 minutes

Persons responsible: Chief Executive of Oxfordshire Clinical Commissioning Group and Director for Adult Services.

Person giving report: as above

Health and Wellbeing Board are asked to consider the Accident and Emergency Delivery Board Performance report and review those areas where we are performing below target.

(c) Adult Social Care Outcomes Framework Published Results for 2016-17
(Pages 31 - 36)

2.20

5 minutes

Persons responsible: Director for Adult Services.
Person giving report: as above

Each year the NHS publish the findings from the Adult Social Care Outcomes Framework. This measures how well care and support services achieve the outcomes that matter most to people. The findings for 2016/17 were published on October 25th. This paper describes how Oxfordshire performed on that framework and the key issues it raises for us

Health and Wellbeing Board are asked to consider the newly published Social Care Outcomes Framework report on data for 2016-17 as it relates to Oxfordshire and review those areas where we are performing below target.

7. Care Quality Commission (CQC) Inspection

2:25

20 minutes

Persons responsible: Chief Executive, OCCG; Chief Executive, Oxford Health Foundation Trust (OH); Chief Executive, Oxford University Hospitals NHS Foundation Trust (OUH) Chief Executive OCC and Care Governance Lead, Strategy Team, OCC
People giving the report: As above

There will be a presentation from the Chief Executives of OCCG, OH, OUH and OCC on the CQC Inspection which will take place in November 2017. The Board is asked to critically appraise the presentation in terms of content and emphasis and to recommend changes.

8. Early Lessons from the CQC reviews of Health and Social Care Systems (Pages 37 - 114)

2.45

10 minutes

Persons Responsible: Kate Terroni - Director of Adult Services
Jonathan McWilliam - Director of Public Health/ Strategic Director for People

Persons giving the report: as above

The Health and Wellbeing Board are asked to consider these two completed reviews and what lessons might be learned for the Oxfordshire system in general and the review of Health Wellbeing Board Governance in particular.

(3 papers attached)

9. Improved Better Care Fund and Delayed Transfers of Care (Pages 115 - 136)

2.55

10 minutes

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

Persons giving report: As above

The attached report (**HWB9**) aims to update the Board on developments of the improved Better Care Fund implementation and related Delayed Transfers of Care (DTOC) measurements.

The Board is RECOMMENDED to review and endorse the iBCF plan.

The Board is RECOMMENDED to note and confirm the planned DTOC trajectory set out at paragraph 8 endorsed on behalf of the Board by the Leader of the Council with the agreement of OCCG and system partners on 26th September 2017.

The Board is RECOMMENDED to endorse the planned investment of the iBCF and to note the risk to the future funding from the Government if the schemes that have been identified do not deliver a reduction in delayed discharges in line with the agreed trajectory

The Board is RECOMMENDED to critically appraise and endorse the performance measures that are proposed to be used to assure the delivery of the agreed trajectory

The Board is RECOMMENDED to agree a reporting regime to ensure effective delivery.

(2 papers attached)

10. The Oxfordshire Transformation Board

3.05

10 minutes

Person Responsible: Chief Executive, Oxford Health NHS Foundation Trust

Person giving report: as above

Stuart Bell, the Chief Executive of Oxford Health NHS Foundation Trust, will give a progress report from Oxfordshire's Transformation Board.

11. Accountable Care Systems - Update (Pages 137 - 140)

3.15

5 minutes

Persons responsible: Chief Executive and Chair, OCCG

Persons giving report: As above

The paper (**HW11**) sets out the current situation in respect of Accountable Care Systems.

The Board is recommended to consider the development of Accountable Care Systems and how the Oxfordshire Health and Wellbeing Board wishes to be involved in their development.

12. Health & Wellbeing Governance Review Proposal (Pages 141 - 142)

3.20

10 minutes

Person responsible: Dr Jonathan McWilliam, Strategic Director for People, OCC

Person giving report: As above

A report is attached at **HWB12**.

The Board is RECOMMENDED to discuss and agree to review the governance of the Health and Wellbeing Board taking into account the emerging findings of CQC reviews, current performance and outcome measures, the report on the Better Care Fund, the work of the Transformation Board and the emergence of Accountable Care Systems as set out in the preceding papers.

13. Development of a new Older People's Strategy (Pages 143 - 146)

3.30

10 minutes

Person responsible: Director for Adult Services, OCC

Person giving report: Director for Adult Services, OCC

To seek agreement to a proposed approach to developing a new Older People's Strategy (**HWB11**).

The Board is RECOMMENDED to agree the proposed approach to developing the

Older People's Strategy, including the broader focus and engagement of wider range of people and partner organisations.

14. Healthwatch Oxfordshire (HWO) - Update (Pages 147 - 152)

3.40

10 minutes

Persons responsible: Chief Executive Officer and Chairman of Healthwatch Oxfordshire (HWO)

Persons giving report: Chairman of HWO

There will be an update on HWO activities given by the Chairman of HWO Professor George Smith (**HWB14**).

The Board is RECOMMENDED to note the report.

15. Annual Reports from Adult and Children Safeguarding Boards (Pages 153 - 288)

3.50

30 minutes

Persons responsible: Independent Chairs of OSCB and OSAB

Persons giving reports: Independent Chairs of OSCB and OSAB

The Oxfordshire Safeguarding Children's Board (OSCB) and the Oxfordshire Safeguarding Adults Board (OSAB) are required to report annually on the work of the Boards and of its partners, assessing the position of the partnerships in relation to the safeguarding of children and adults at risk within Oxfordshire. Paul Burnett, Chairman of OSCB and Pamela Marsden, Chair of OSAB will present the reports (**HWB15**).

The Board is RECOMMENDED to receive the reports.

16. Director of Public Health Annual Report 2016-2017 (Pages 289 - 366)

4.20

15 minutes

Person Responsible: Director of Public Health

Person giving report: Director of Public Health

The Director of Public Health will present his Annual Report for 2016/17 (**HWB16**). It is an independent report with robust recommendations for all organisations and individuals.

The annual report summarises key issues associated with the Public Health of the

County. It included details of progress over the past year as well as specific and robust recommendations for future work.

The Oxfordshire Joint Health Overview & Scrutiny Committee and Cabinet at their meetings on 14 September 2017 and 17 October 2017 discussed the report. The comments of the Oxfordshire Joint Health Overview & Scrutiny Committee are included and comments from Cabinet will be circulated separately.

The Board is RECOMMENDED to consider the report and to advise the appropriate bodies of their responsibilities in implementing the recommendations.

17. Development of the Joint Strategic Needs Assessment for 2018-19 (Pages 367 - 368)

4.35
15 mins

Person Responsible: Director of Public Health
Person Giving Report: Director of Public Health

The Board is asked to discuss proposals for further development of the Joint Strategic Needs Assessment (JSNA) and to decide direction for 2018-19

18. Health Inequalities Commission - Implementation Plan (Pages 369 - 380)

4.50
15 minutes

Person responsible: Dr Jonathan McWilliam, Strategic Director for People & Director of Public Health

Persons giving report: Chair of OCCG, Dr Joe McManners and Dr. Jonathan McWilliam, Strategic Director for People & Director of Public Health

The report **HWB18** sets out updated action to implement the recommendations for the Commission.

An annex is available on the web site on health inequalities indicators.

The Board is asked to ensure timely implementation of this work by all partners.

19. Reports from Children's Trust, Joint Management Group for Adults and Health Improvement Partnership Board (Pages 381 - 390)

5:05

10 minutes

Attached are the written reports on activities to deliver the priorities set out in the Joint Health & Wellbeing Strategy since the last Health & Wellbeing Board in July (**HWB19**) from:

- Children's Trust Board
- Health Improvement Partnership Board
- Joint Management Group for Adults (to be circulated separately)

The Board is RECOMMENDED to receive the reports and assess progress in delivering the Joint Health & Wellbeing Strategy priorities.

20. PAPERS FOR INFORMATION ONLY (Pages 391 - 392)

The following paper is attached for the information of Board members at **HWB20**:

- Milestone report on the statutory duty to revise the Oxfordshire Pharmaceutical Needs Assessment

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OXFORDSHIRE HEALTH & WELLBEING BOARD

OUTCOMES of the meeting held on Thursday, 13 July 2017 commencing at 2.00 pm and finishing at 4.15 pm

Present:

Board Members: Councillor Ian Hudspeth – in the Chair

Dr Joe McManners (Vice-Chairman)
District Councillor Anna Badcock
Dr Jonathan McWilliam
Councillor Lawrie Stratford
Prof George Smith
Kate Terroni
Cllr Marie Tidball
Hannah Farncombe (In place of Lucy Butler)

Other Persons in Attendance: Peter Clark, OCC and David Smith, OCCG

Officers:

Whole of meeting Julie Dean, OCC

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

If you have a query please contact Julie Dean, Tel: 07393 001089 (julie.dean@oxfordshire.gov.uk)

	ACTION
1/17 Welcome by Chairman, Councillor Ian Hudspeth (Agenda No. 1)	
The Chairman welcomed all to the meeting, in particular to new members Cllr Steve Harrod in his absence, Professor George Smith, Cllr Lawrie Stratford and Cllr Marie Tidball. Cllr Hudspeth thanked Val Johnson for her invaluable work over the years in her role as partnership development manager, and wished her well in her retirement. He also thanked District Cllr Ed	

Turner, on behalf of the Board, for his hard work as Chairman and Deputy Chairman of the Health Improvement Partnership Board. He announced an item of urgent business 'Update on DTOC and Better Care Fund Planning', to be included after Agenda Item 5. Cllr Hudspeth stated that the reason for urgency was because sign off was required before the next meeting of this Board in November.	
2/17 Apologies for Absence and Temporary Appointments (Agenda No. 2)	
An apology had been received from Cllr Steve Harrod and Cllr Hilary Hibbert-Biles and Hannah Farncombe attended for Lucy Butler.	Andrea Newman
3/17 Declarations of Interest - see guidance note opposite (Agenda No. 3)	
There were no declarations of interest submitted.	Andrea Newman
4/17 Petitions and Public Address (Agenda No. 4)	
No requests to present a petition or address the meeting had been received.	
5/17 Note of Decisions of Last Meeting (Agenda No. 5)	
The note of the last meeting, which took place on 23 March 2017, was approved and signed as a correct record. There were no matters arising.	Julie Dean
6/17 Urgent Business - Update on Delayed Transfers of Care and Better Care Fund Planning (Agenda No. 5a)	
David Smith gave a brief introduction stating that the OCCG had worked together with Adult Social Care on the previous allocation of £350m, which was already in place. He pointed out that the theme of the additional provision was to assist with the reduction of the county's Delayed Transfers of Care (DTOC) statistics which remained high, with the problems sitting with the Oxford	

University Hospitals NHS Foundation Trust (OUP) and OCC's Adult Social Care. He stressed the importance of reducing the DTOC figures as a joint venture.

Kate Terroni proposed the recommendations contained in the report citing the Secretary of State for Health's statement on 3 July 2017 that urged both Health and Local Authorities to be well prepared for the coming winter, asking that they renew efforts in respect of DTOC and to refocus on priorities. She also made reference to his intention to undertake twelve Care Quality Commission (CQC) reviews, of which Oxfordshire would be one. She welcomed the external challenge that this would bring, along with a focus on learning from good practice elsewhere.

Professor Smith, Chair of Healthwatch Oxfordshire, conveyed a message to the Board from Dr Bruno Holthof, Chief Executive of the OUH who had been invited along for this item alongside Stewart Bell, Chief Executive of Oxford Health (OH), both of whom were unable to attend due to a previous engagement. Dr Holthof had agreed with HWO that joint teams comprising OUH care workers and ASC teams for home care delivery was a good idea and he looked forward to an invitation from the County Council to discuss this. Professor Smith suggested that a joint objective could be the upskilling of care workers via 'on the job' training with the support of mentors. It was his view that a high level approach was required within a climate of increasingly complex health problems. He also raised the need for more support to be given to carers in order that they may be supported in giving acute care to patients in their own home. He also stressed the requirement for good respite care.

Kate Terroni highlighted the proposals contained in the report relating to how the additional Better Care Fund monies would be spent. She cited the following provision:

- Raising the hourly rate again for care workers;
- Exit interviews to be given to people leaving their post, thus ensuring that workforce issues were cited on a constant, ongoing basis;
- The use of shared care practitioners employed by Oxford Health to upskill domiciliary care workers; and
- The use of locality-based providers – to which Dr Holthof's views would be welcomed.

Members of the Board commended the positive attitude conveyed in the report and endorsed the validity of Professor Smith's comments recognising the need for more support for carers and the importance of respite care for carers, in particular for those caring for dementia patients.

Dr McManners stated that this was a good opportunity for the integration of Health and Social Care workers on a locality basis, and furthermore, to embed social workers and carers into the locality groups. The OCCG were actively encouraging proposals to integrate GPs and community teams, working in parallel with social workers. These 'locality teams' could be integrated into locality plans. Furthermore, the OCCG would encourage any reduction in costs or extra investment to be passed on to the care workers at the hourly rate; and for all this to be tied into the appropriate training for the job and recruitment in order to reduce staff turnover, as suggested.

Other comments made and views expressed from the Board included the following:

- That a sustainable plan must be made in terms of recruitment and retention of staff;
- It was hoped that the Government would be producing national advice on particular issues such as for areas in low employment, high growth and productivity, to support the plans;
- The plans for this could be used as an opportunity to re-visit the Mental Health Concordat and to scrutinise the extent to which it had been implemented;
- Adults of Working Age and child carers should not be overlooked in plans for respite; and
- Age UK and Oxfordshire Carers Forum could give valuable input.

Dr McManners and Kate Terroni reminded the Board that it had detailed oversight of services for older people, people with mental health problems or a physical disability and adults of working age via the Health Improvement Partnership Board.

David Smith suggested that a time-limited focus group comprising OCC and the OCCG representatives could be created to take a look at what needed to be done. He also undertook to spend time talking to colleagues in other locations and looking at other systems. Kate Terroni agreed with his suggestion stating also that she was working on a clear, shared narrative and diagnostics across the system.

The Board **AGREED** to:

- (a) approve the plans for spending the Improved Better Care Fund funding as described in the report;)
- (b) approve the governance arrangements as described in the report, including delegating responsibility for)

implementing these plans to the Better Care Fund Joint Management Group; and (c) create an informal, time-limited focus group comprising OCC and OCCG representatives to look at the work that was required to be undertaken.	Director for Adult Services)))
7/17 Performance Report - Final Outcomes for 2016-2017 year end (Agenda No. 6)	
The Board received an update on performance against the outcomes in the Joint Health & Wellbeing Strategy set for 2016/17 and also considered the new outcomes for quarters 2 to 3 (HWB6). Dr McWilliam highlighted the good work undertaken by the Health Improvement Partnership Board (HIB) who typically used a workshop format together with a usual stance of 'critical friend' when a problem had been identified. This method had realised some good solutions. The Board AGREED to note the report.	Strategic Director for People
8/17 Revised Joint Health & Wellbeing Board Strategy for 2017-18 (Agenda No. 7)	
The Board considered the draft, revised Joint Health & Wellbeing Strategy (JHWBS) for 2017/18. The cover report to this document set out the process for revision and also contained the views of the Oxfordshire Joint Health Overview & Scrutiny Committee (OHOSC) put forward at its meeting on 22 June 2017. The Chairman stated that the comments of OHOSC had been noted and would be considered at the time when the Plan was implemented. He added that it had benefited greatly by the report of the Health Inequalities Commission which was an impressive testament to identifying problems and going forward. The Board AGREED to approve the outcome measures proposed in the draft Strategy and to monitor performance against those outcomes at each meeting in 2017 – 18.	Strategic Director for People

9/17 Local Digital Roadmap (Agenda No. 8)	
Stuart Bell CBE, Oxford Health and Gareth Kenworthy and Lucasz Bohman, OCCG, gave a slide presentation on action planning for digital platforms within the NHS. A cover paper was attached at HWB8, together with a copy of the presentation slides. Comments, suggestions and views were sought from the Board. These were as follows: • Should consideration be given to its use, for example, to monitor a person's weight, at home in order to reduce the need for medication? 95% of homes had broadband, and a very high number had a smart phone (although not all), could the governance be sufficiently relaxed to allow this to happen? Stuart Bell responded that a big challenge would be in how to keep pace with the range of equipment, if ipads were given. However, Skype could be used to the benefit of the patient; • Government advice regarding the planning process for designing data protection had yet to be given and there was a danger that systems would become obsolete before it was rolled out. A high level of protocol was required for the exchange of information. Oxfordshire had the potential to become a world class system, but it was being held back with the current 'siloed' system. Different organisations had different priorities and Government leadership was required to break down the siloes; • There was a need for 'hospital at home' technology ie for data to be collected and transmitted from the home environment virtually, to be rolled out. Stuart Bell responded that there were basic national expectations and requirements, and much work still needed to be done as an extension to requirements. The potential for it to be used for research purposes was high; • Whilst the principle was good, to be effective and glean results simplicity of use would be the key. There was now more IT literature for older people in existence. Furthermore, there were 'do-it-yourself advocacy organisations to assist with people if they require it; • With regard to the slide on universal capability, it would be essential to include provision for people with conditions such as autism, to ensure that the patient voice was	

captured. Stuart Bell responded that people would be able to generate their own health data and would ultimately have a fundamental impact on people's ability to change their health care. He added that a significant amount of monitoring took place in relation to Diabetes and Bipolar with more to be done on Autism and ADHD. The aim was to develop it via the citizen's interface; and Thames Valley Police, particularly the Domestic Homicide Police, could be brought on board, together with the social workers. In addition, the Hampshire Orthopaedic Society had developed an app to ensure access for autistic patients. Stuart Bell, Gareth Kenworthy and Lucasz Bohman thanked the Board for all the views and suggestions given. They were thanked by the Board for their presentation.	Chief Executive of Oxford Health
10/17 Safeguarding Boards - Impact Assessments (Agenda No. 9)	
Seona Douglas, Deputy Director, Adult Social care, and Tan Lea, Strategic Safeguarding Partnerships Manager, Oxfordshire County Council, attended for this item in place of the Chairs of the Safeguarding Boards who were unable to attend. They presented the report HWB9. The Board thanked Seona Douglas and Tan Lea for the report and AGREED to note the report.	Director for Adult Services; Director for Children's Services/Chairs of Safeguarding Boards
11/17 Health Inequalities Commission - update (Agenda No. 10)	
Dr Joe McManners, Chair, CCG and Jackie Wilderspin, Public Health Specialist, OCC presented a report on the process for implementing the recommendations from the Commission report, published in November 2016 (HWB10). The Board heard that the Commission report had been used by	

specific organisations, particularly in the voluntary sector, as evidence to support bids for work. It had also been used by the CCG for work planning and transformation purposes. The Public Health Team was working to develop an overview of indicators showing variation for different inequalities, which would be picked up as part of future planning. A further, more detailed update would be given at the Board's November meeting. The Board AGREED to note the report and to thank Dr McManners and Jackie Wilderspin for the update.	Chair, OCCG/Strategic Director for People
12/17 Healthwatch Oxfordshire (HWO) - Update (Agenda No. 11)	
Professor Smith, Chairman of Healthwatch Oxfordshire (HWO), gave an oral update on activities. He made reference to the annual report which had been circulated to all Board members. He raised the following issues: • A cut in budget allocation had led to a number of challenges. The organisation had moved to smaller premises, staff reductions had taken place and some projects had been abandoned; • Three new directors had been appointed onto the HWO Board; • Further to the Witney project, a number of other county towns had requested HWO to undertake a similar project in their town. He updated the Board on three activities in hand; • HWO had provided secretarial and administrative support to one of the locality forums. A CCG contract had now been awarded to HWO to provide the same to all six forums. An additional member of staff was to be appointed to undertake this; • Discussions were underway with the Council of Governors of two Trusts for HWO to act as a source of information to them; • HWO was also looking into the possibility of using the more advanced students at local universities as an information resource, via the generation of projects which would in turn assist with their studies and qualification; • HWO was to challenge Health and Social Care authorities	

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Health & Wellbeing Board Performance Report 2017/18 Quarter 2

Introduction

1. Annex 1 shows performance for the priorities within the Health & Wellbeing strategy for 2017/18. Priorities 1-4 are managed through the Children's Trust; priorities 5-7 is managed through the Joint Management Groups for the Pooled Budgets for adult health and care services and priorities 8-11 is managed through the Health Improvement Board.
2. The priorities in outcome 5-7 are being currently updated in light of revised guidance on reporting on the Improved Better Care Fund and some measures will be replaced in quarter 3. This includes looking at new measures including
 - a. Hospital discharges on a weekend to be at least 60% of the week day average
 - b. Increasing the amount of reablement delivered by some 30%.

Summary

3. The table below summarises performance on each priority. 60 measures are reported with 29 currently rated:
 - a. 15 (52%) are currently green,
 - b. 5 (17%) rated amber - not on target, but close to target
 - c. 9 (31%) rated red.

	Red	Amber	Green	Not Rated	Total
1. Ensuring children have a healthy start in life and stay healthy into adulthood	1	0	0	0	1
2. Narrowing the gap for our most disadvantaged and vulnerable groups	2	1	1	2	6
3. Keeping children and young people safe	3	1	0	2	6
4. Raising achievements for all children and young people	0	0	0	2	2
5. Working together to improve quality and value for money in the Health and Social Care System	1	0	5	1	7
6 Adults with long term conditions living independently and achieving their full potential	1	1	3	4	9
7. Support older people to live independently with dignity whilst reducing the need for care & support	1	0	2	6	9
8 Preventing early death and improving quality of life in later years	0	1	3	3	7
9. Preventing chronic disease through tackling obesity	0	0	0	3	3
10. Tackling the broader determinants of health through better housing and preventing homelessness	0	0	0	6	6
11. Preventing infectious disease through immunisation	0	1	1	2	4
Total	9	5	15	31	60

4. **Recommendation:** The Health and Wellbeing Board is recommended to hold members to account for performance against key indicators. Those indicators that are currently rated Red are listed in detail below.

5. The individual indicators rated as red are:
- a. Ensuring children have a healthy start in life and stay healthy into adulthood
 - i. 1.1 Waiting times for first appointment with Child and Adolescent Health Services (CAMHS). 75% of children will receive their first appointment within 12 weeks of referral by the end 2017/18.
 - b. Narrowing the gap for our most disadvantaged and vulnerable groups
 - i. 2.3 Ensure that the attainment of pupils with Special Educational Needs and Disability (SEND) but no statement or Education Health and Care Plan is in line with the national average.
 - ii. 2.6 Reduce the number of children and young people placed out of county and not in neighbouring authorities
 - c. Keeping children and young people safe
 - i. 3.4 Reduce the number of children subject of a child protection plan
 - ii. 3.5 Reduce the number of hospital admissions caused by unintentional and deliberate injuries in young people aged 0-14 (Public Health measure number 2.07i) to the national level
 - iii. 3.6 Reduce the current number of looked after children
 - d. Raising achievement for all children and young people
 - i. none
 - e. Working together to improve quality and value for money in the Health and Social Care System
 - i. 5.2 Increase the percentage of people waiting a total time of less than 4 hours in A&E.
 - f. Adults with long term conditions living independently and achieving their full potential
 - i. 6.8 Reduce the number of people with learning disabilities and/or autism admitted to specialist in-patient beds to 11 by Q4 17/18 and 9 by Q4 18/19
 - g. Support older people to live independently with dignity whilst reducing the need for care and support
 - i. 7.2 Reduce the number of older people placed in a care home from 11.25 per week in 2016/17 to 11 per week for 2017/18
 - h. Preventing early death and improving quality of life in later years
 - i. Preventing chronic disease through tackling obesity
 - i. none
 - j. Tackling the broader determinants of health through better housing and preventing homelessness
 - i. none
 - k. Preventing infectious disease through immunisation
 - i. none

Steve Thomas
Performance & Information Manager (Social Care)
October 2017

Oxfordshire Health and Wellbeing Board
Performance Report

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

Measure	Tgt	Baseline	Q1		Q2		Q3		Q4		Comment
			Fig	RAG	Fig	RAG	Fig	RAG	Fig	RAG	
1.1 Waiting times for first appointment with Child and Adolescent Health Services (CAMHS). 75% of children will receive their first appointment within 12 weeks of referral by the end 2017/18.	75%	68% (16/17)	53	R	51 (end Aug)	R					Q1 figure updated and RAG amended

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

Measure	Tgt	Baseline	Q1		Q2		Q3		Q4		Comment
			Fig	RAG	Fig	RAG	Fig	RAG	Fig	RAG	
2.1 Reduce the proportion of children with Special Educational Needs and Disability (SEND) with at least one fixed term exclusion in the academic year.	<6.7%	7.1% 15/16	8.3% (terms 1-6 16/17 ac yr)	A							
2.2 Increase the proportion of children with a disability who are eligible for free school meals who are accessing short breaks services.	>42%	57% 16/17	53%	G	55%	G					
2.3 Ensure that the attainment of pupils with Special Educational Needs and Disability (SEND) but no statement or Education Health and Care Plan is in line with the national average. Key Stage 2 Key Stage 4	16% 36.2	No baseline	9% KS2 32.8 KS4	R							Annual Figures - KS4 figure corrected
2.4 Reduce the persistent absence of children subject to a Child In Need plan.	<28%	30.4% 16/17									Annual Figure
2.5 Reduce the persistent absence of children subject to a Child Protection plan.	<29%	30.3% 16/17									Annual Figure
2.6 Reduce the number placed out of county and not in a neighbouring authority from 77 to 60	60 (9.8%)	118 17.5%	132 19%	R	139 20%	R					as at 30/09/17 figure includes: 9 children placed for adoption 37 children placed in Children's Homes 9 children placed in a kinship placement 1 child in residential school 4 mother and baby placements
2.7 Increase the % of care leavers who are in employment, education and training (17-21)	50%	48%									Annual Figure

Priority Three: Keeping children and young people safe (select measures from the OSCB dataset)

Measure	Tgt	Baseline	Q1		Q2		Q3		Q4		Comment
			Fig	RAG	Fig	RAG	Fig	RAG	Fig	RAG	
3.1 Monitor the number of child victims of crime	Monitoring only	2189 16/17	603		1125						Small rise on last year
3.2 Number of children missing from home	Monitoring only	2105	521								
3.3 Reduce the number of social care referrals to the level of our statistical neighbours	6151	6658	1679	R	3151	A					
3.4 Reduce the number of children subject of a child protection plan	609	607	585	G	657	R					Demand for services continues to rise. Front door demand is reducing, the current growth is as children stay in the system for longer
3.5 Reduce the number of hospital admissions caused by unintentional and deliberate injuries in young people aged 0-14 (Public Health measure number 2.07i) to the national level	109.6	108	122	R	119 (aug)	R					
3.6 Maintain the current number of looked after children	629	667	691	R	701	R					The number of looked after children is rising. Over ½ those coming into care this year are on care orders; UASC or disabled. Reconnection panels being set up to ensure timely return home

Priority Four: Raising achievement for all children and young people

Measure	Tgt	Baseline	Q1		Q2		Q3		Q4		Comment
			Fig	RAG	Fig	RAG	Fig	RAG	Fig	RAG	
4.1 Improve the disadvantaged attainment gap at all key stages and aim to be in line with the national average by 2018 and in the top 25% of local authorities. * Key Stage 2 * Key Stage 4	To be top quartile	31% KS2 15pts KS4									KS2 Oxfordshire gap 31% pts compared National gap 21% pts. Oxfordshire is in the bottom quartile (lowest 25%) nationally. KS4 Oxon 15 pts compared to 12.3 nationally. This means that disadvantaged pupils achieve 1.5 GCSE grades lower than non-disadvantaged pupils nationally. Oxon in bottom quartile nationally.
4.2 69% of children in early years & foundation stage reaching a good level of development, Early Years Foundation Stage Profile placing Oxfordshire in the top quartile of local authorities. Baseline is 66% from 2015.	69%	70%									Annual Figure - available in public domain in November

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

	Target	Baseline	Q1		Q2		Q3		Q4		Comment
			Fig	R A G	Fig	R A G	Fig	R A G	Fig	R A G	
5.1 Reduce the number of avoidable emergency admissions for acute conditions that should not usually require hospital admission for people of all ages	< baseline	524	511	G							Q2 not yet available
5.2 Increase the percentage of people waiting a total time of less than 4 hours in A&E. Target 95 %.	95%	86%	87.5	R	84.8	R					Figure to the end of August (July 80.76% August 84.78%)
5.3 Reduce the average length of “days delay” for people discharged from hospital to care homes	310	762	632	A	529	G					Agreed trajectory (BCF plan 31/7): Aug 558, Sep 480; Oct 434; Nov 434, Dec 434, Jan 403, Feb 336, Mar 310. Actual July: 622; Aug: 529 Sep data not yet available. Marked as on target as latest figures (August) are on target. Note measure amended to align with revised BCF
5.4 Reduce the number of people placed out of county into care homes by social care	<306	306	302	G	299	G					
5.5 Reduce the number of incidents relating to medication errors, falls and pressure ulcers											Measure to be revised at December JMG.
5.6 Ensure the proportion of (all) providers described as outstanding or good by CQC remains above the national average	> 81%	84%	87.5	G	89.4	G					
5.7 Ensure the proportion of people who use services who feel safe remains above the national average	> 69%	73.3		G		G					

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

	Target	Baseline	Q1		Q2		Q3		Q4		Comment
			Fig	R A G	Fig	R A G	Fig	R A G	Fig	R A G	
6.1 Increase the number of people with mild to moderate mental illness accessing psychological therapies, with a focus on people with long-term physical health conditions	17%	16.5	16.5	A							Q2 data not yet validated
6.2 Reduce the number of people with severe mental illness accessing Emergency Departments in acute hospital for treatment for their mental illness	tbc	tbc									This is a measure that is provided in the outcomes based contract: we do not have the baseline confirmed yet: performance will be measured from 1/10/17 annual review of contract. Will report from Oct 17
6.3 Reduce the use of s136 Mental Health Act 1983 so that fewer people are detained in police cells when they are unwell:											This measure is in 3 parts: Adults JMG will confirm the trajectory in Dec.
6.3.1 Reduction in the use of s136 (number for 10/17)		266									
6.3.2 People on s135/6 detained in police cells is a never event (number of people detained in police cell)	tbc	4	n/a		n/a						
6.3.3 Person is in health based place of safety (HBPOS) for no longer than 24 hours (number of people in HBPOS for >24 hours)		5									
6.4 Reduce the number of deaths by suicides	< baseline	9.4									Baseline is 2013-15 3 year average rate per 100k. The target tbc at Adult JMG Dec. It will be an annual measure-Q1 and Q2 is N/A.
6.5 Increase the number of people with severe mental illness in employment	16.5%	16.5%	21%	G							Q2 data not yet validated
6.6 Increase the number of people with severe mental illness in settled accommodation	70%	70%	72%	G							Q2 data not yet validated
6.7 Increase the number of people with learning disability having annual health checks in primary care to 75% of all registered patients by 2019	75%	n/a	n/a		n/a						We have not had the 1617 performance as baseline yet

6.8 Reduce the number of people with learning disabilities and/or autism admitted to specialist in-patient beds to 11 by Q4 17/18 and 9 by Q4 18/19	11	16	12	G	16	R					This measure has been extended to monitor the NHSE Transforming Care Plan target in relation to people with learning disability and/or autism. The current performance is skewed as it includes 4 patients who are on s17 leave from their in-patient bed but who have to be counted for these purposes. There are a number of discharges planned for Q3.
6.9 Reduce the number of people with learning disability and/or autism placed/living out of county	< 182	182	179	G	181	G					

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

	Target	Baseline	Q1		Q2		Q3		Q4		Comment
			Fig	R A G	Fig	R A G	Fig	R A G	Fig	R A G	
7.1 The number of home care hours purchased per week	Monitoring only	22,284	22,368		22,163						Home care hours purchased rose by 12% last year, but have remained stable this year
7.2 Reduce the number of older people placed in a care home from 11.25 per week in 2016/17 to 11 per week for 2017/18	11	11.25	13	R	12.8	R					There has been an increase in care home placements this year.
7.3 Reduce the number of permanent admissions to care homes per 100k of population	469	480	554		546						
7.4 70% of people who receive reablement need no ongoing support (defined as no Council-funded long term service excluding low level preventative service).	70%	68%	56%	R	51%						We are reviewing this target as we have a discharge to assess pathway and all people returning home are expected to go through this service. The 70% target is based on national benchmarks including people without a discharge to assess model. We will look to move to target which identifies how much we reduce the amount of care needed as people are supported to become more independent.
7.5 Increase in the number of people still at home 90 days post reablement	83%	80%									Figure available annually only
7.6 Reduce the beds days lost to delays in Oxfordshire from an average of 181 in March 2017 to an average of 99 in November and 87 by March 2018	87	181	214	R	118	G					
7.7 Reduce the average number of weekly delays attributable to the HART service from 65 in March 2017 to 41 in November and 35 in March 2018	35	65	n/a		41	G					
7.8 Reduce the average overall length of stay in health funded beds from hospital admission to final destination											OCCG seeking to measure monitor patients length of stay through the bed-based pathway: if this cannot be resolved by Dec JMG will propose alternative measure or will use the acute and community hospital

7.9 Increase the number of carers receiving a social care assessment	6000	5609	865	R	1834					We are reviewing this target in the light of feedback from carers. The assessment is not the most important thing for carers. IN the recent carers survey older carers were more likely to have accessed information and advice and more likely to rate advice as helpful
7.10 100% of patients with dementia are registered with GPs and live in Oxfordshire are known to the Dementia Support Service										We are working with GPs and Age UK (who run the dementia support service) to find a way to monitor this. If this cannot be resolved by Dec JMG will propose alternative measure.

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

	Indicator	Target	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Comments
			Fig.	RAG	Fig.	RAG	Fig.	RAG	Fig.	RAG	
8.1	At least 60% of those sent bowel screening packs will complete and return them (aged 60-74 years) - and adequately screened	60%	0.0%		0%		0%		0%		Data at least six months in arrears.
8.2	At least 95% of the eligible population 40-74 will have been invited for a health check between 1/4/2013 and 31/3/2018. No CCG locality should record less than 80%	95% over 5-year period Q1 84%, Q2 88%, Q3 92%, Q4 95%	85.2%	G	0.0%		0.0%		0%		
8.3	At least 45% of the eligible population 40-74 will have received a health check between 1/4/2013 and 31/3/2018. No CCG locality should record less than 40%.	45% over 5-year period Q1 42%, Q2 43%, Q3 44%, Q4 45%	42.3%	A	0.0%		0.0%		0.0%		
8.4	Rate of successful quitters per 100,000 smokers aged 18+ should exceed the baseline set in 2017-18	>2315	2432	G	0		0		0		
8.5	The number of women smoking in pregnancy should remain below 8% recorded at time of delivery	<8%	8.0%	G	0.0%		0.0%		0.0%		-
8.6	Oxfordshire performance for the proportion of opiate users who successfully complete treatment. KEEP UNDER SURVEILLANCE IN 2017/18	NO TARGET	7.3%		0.0%		0.0%		0.0%		
8.7	Oxfordshire performance for the proportion of non-opiate users who successfully complete treatment KEEP UNDER SURVEILLANCE IN 2017/18	NO TARGET	44.6%		0.0%		0.0%		0.0%		-

Priority 9: Preventing chronic disease through tackling obesity

	Indicator	Target	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Comments
9.1	Ensure that obesity level in Year 6 children is held at below 16% (in 2016 this was 16.0%) No district population should record more than 19% (NCMP)	<=16%					0.0%				
9.2	Reduce by 0.5% the percentage of adults classified as "inactive" (Oxfordshire baseline Nov 2016 of 17%).	Reduce by 0.5% from baseline (17%)					0.0%				
9.3	63% of babies are breastfed at 6-8 weeks of age (county). KEEP UNDER SURVEILLANCE IN 2017/18	63%	60.1%		0.0%		0.0%		0.0%		

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

	Indicator	Target	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Comments
10.1	The number of households in temporary accommodation on 31 March 2018 should be no greater than level reported in March 2017 (baseline 161 households in Oxfordshire 2016-17).	≥161			0				0		
10.2	At least 75% of people receiving housing related support will depart services to take up independent living (baseline 87.3% in 2016-17)	≥75%	0.0%		0.0%		0.0%		0.0%		
10.3	At least 80% of households presenting at risk of being homeless and known to District Housing services or District funded advice agencies will be prevented from becoming homeless (baseline 80% in 2016-17).	80%			0.0%				0%		
10.4	Ensure that the number of people estimated to be sleeping rough in Oxfordshire does not exceed the baseline figure from 2016-17 (baseline 79)	≥79					0				
10.5	At least 70% of young people leaving supported housing services will have positive outcomes in 2017-18	≤70% Aspire 95%	0.0%		0.0%		0.0%		0.0%		
10.6	At least 1430 residents are helped per year over the next 4 years where building based measures account for 25% of those interventions by the final year. KEEP UNDER SURVEILLANCE in 2017/18	NO TARGET							0		

Priority 11: Preventing infectious disease through immunisation

	Indicator	Target	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Comments
11.1	1 At least 95% children receive dose 1 of MMR (measles, mumps, rubella) vaccination by age 2 (currently 94.6%) No CCG locality should perform below 94%	95%	95.0%	G	0.0%		0.0%		0.0%		
11.2	2 At least 95% children receive dose 2 of MMR (measles, mumps, rubella) vaccination by age 5 (currently 93.1%) No CCG locality should perform below 94%	95%	93.6%	A	0.0%		0.0%		0.0%		
11.3	At least 55% of people aged under 65 in "risk groups" receive flu vaccination	≥ 55%							0.0%		
11.4	At least 90% of young women to receive both doses of HPV vaccination. KEEP UNDER SURVEILLANCE in 2017/18	≥ 90%							0%		Data available annually for school year Sept-Aug so published after September.

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Accident and Emergency Delivery Board (AEDB) Performance Report (October 2017)

AEDB provides assurance to the Oxfordshire system, NHS England and NHS Improvement that action is being taken system wide to support the delivery of the key performance measures connected to the Urgent and Emergency care (U&EC) system.

As such AEDB is one of the key delivery mechanisms that enables the Oxfordshire Health and Wellbeing Board to be assured that the Oxfordshire system is delivering for our residents.

The key measure for local urgent and emergency system performance is for patients to be seen, treated, and admitted or discharged in under four hours within A&E, but there are a number of other important and related areas that support this standard such as delayed transfers of care, ambulance response and handover.

Planning was initially against the Rapid Implementation Guidance aimed at A&E improvement but there have recently been a number of both local and national developments that have resulted in a review of the key focus areas for improvement and the development of a revised AEDB delivery plan.

We have developed a local performance report covering demand, capacity, and flow in the Oxfordshire system. AEDB consider these to be key measures of the performance of our overall system.

Recommendation

Health and Wellbeing Board are asked to consider the Accident and Emergency Delivery Board Performance report and review those areas where we are performing below target.

A&E Delivery Board Performance Report

			2016/17												Full	2017/18						YTD
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year	Apr	May	Jun	Jul	Aug	Sep	
Demand	ED attendances not above 16/17 outturn on month-by-month basis	<0	-1517	2769	1426	1214	766	787	767	452	499	73	-700	-180	6356	172	238	768	-27	5	-48	1178
	Emergency admissions not above 16/17 outturn on month-by-month basis	<0	-536	606	-48	103	28	78	180	311	306	-273	-41	462	1176	-121	-346	-245	-391	-258	-326	-712
	111 - Total Activity		14962	17609	14705	16140	14631	13941	16650	15509	19412	17523	14980	15148	191612	18545	17695	18348	17745	16204	15442	103979
	111- % Transferred to All Clinicians (5.22)	30%														31.36%	24.11%	29.74%	28.48%	28.89%	28.20%	27.54%
	111 - Number Referred to A&E	5%	1174	1408	1210	1360	1121	1172	1353	1163	1429	1293	1205	1230	15118	1420	1381	1565	1406	1287	1068	8127
	111 - % Referred to A&E		7.85%	8.00%	8.23%	8.43%	7.66%	8.41%	8.13%	7.50%	7.36%	7.38%	7.75%	8.12%	7.89%	8.37%	7.80%	8.53%	7.92%	7.94%	6.92%	7.82%
	111- % Referred to Primary Care		56.22%	57.36%	55.12%	55.28%	54.99%	55.10%	55.25%	56.48%	58.09%	57.50%	55.41%	54.92%	56.05%	57.36%	45.72%	51.34%	50.54%	51.48%	48.70%	50.95%
	GPAF: Appointments Utilised	95%								1120	1204	2012	3113	3164	10613	2872	3855	3629	3964	3883		18203
	Total 999 Incidents		6245	6792	6453	6891	6456	6472	6928	6704	7130	6766	6119	6664	79621	6440	7064	6722	6951	6650	6654	40481
Capacity	Average Daily Beds Available - Acute (G&A Only)									88	116	60	51	70	77	91	71	60	58	70	37	65
	Average Daily Beds Available - Community Beds					3.3	3.3	3.4	4.7	3.5	2.6	3.5	3.3	3.45		3.4	3.5	3.9	3.7	4	6	3.7
	Average Daily Beds Available - Intermediate Care Beds					2.5	2.8	2.4	2.1	2.9	1.9	1.5	1.7	2.2		1.8	1.6	2.3	2	2.6	1.3	2.1
	Average Daily Beds Available - Residential and Nursing home (to purchase)																				172	172
	Non-bed Capacity - HART delivered hours	8440							6116	6865	5946.5	6217.25	5491.25	6306.3	6157.05	5691	6106	6039.75	6217.95	6348	6383.5	6131
	Non-bed Capacity - Dom Care delivered hours																				22163	22163
	GPAF: Appointments Available	6211								1401	1353	2445	3931	4376	13506	3843	5108	4850	5599	5684		25084
	% of OOH Shift un-filled	2%										7.0%	9.0%	9.4%	8.5%	3.7%	5.6%	8.9%	12.1%	13.2%	8.2%	8.6%
Flow	Deliver a 15% cumulative reduction in DToC in OUHFT quarter by quarter, so 110 by Q1, 93 by Q2, 79 by Q3 and 67 by Q4		100			128			122			187				114			59			
	DToC Trajectory head count performance against trajectory (Starts in August)															154	181	178	169	114	117	
	Saturday and Sunday discharges at least 60% of Monday – Friday average															58.07%	44.23%	41.01%	54.03%	38.96%		46.83%
	CHC eligible patients moved on within 7 days of assessment decision (48 hours not yet available)															75.00%	45.45%	63.16%	54.55%			59%
	Where the patient is not fit for transfer to D2A bed CHC assessment will take place within 7 days																60.00%	77.78%	60.61%			66%
	Where the patient is fit for transfer to D2A bed the assessment will take place in that bed.																100%	100%	80%			92%
	Average Length of Stay - Acute															4.14	4.02	3.97	4.21	4.02		4.07
	Average LOS in Community Hospitals (inc DToC)	24	31	30	32	30	32	36	31	28	28	28	30	30	30.50	38	27	29	30.5	36	28	31.42
	Average Length of Stay - Intermediate Care Beds																				28	28
	Average Length of Stay - Hub																					
Additional Standards	OUHFT 4 Hour Standard Overall Performance	95%	87.55%	87.00%	88.16%	87.60%	86.60%	82.80%	73.89%	94.21%	91.05%	84.84%	82.25%	87.10%	86.07%	88.84%	86.40%	82.78%	80.76%	84.78%	82.77%	84.33%
	OUHFT Minors Performance	98%						88.50%	81.14%	95.80%	96.46%	94.47%	91.60%	92.62%	91.00%	94.72%	95.11%	93.46%	92.28%	95.48%	95.44%	94.35%
	JR Overall Performance	95%	82.60%	81.23%	83.05%	82.13%	81.29%	75.83%	63.94%	92.70%	91.30%	85.23%	81.78%	84.41%	82.47%	87.83%	83.70%	81.60%	77.81%	80.87%	80.36%	82.22%
	HGH Overall Performance	95%	87.67%	89.66%	90.02%	89.78%	87.89%	85.54%	78.10%	96.38%	91.52%	83.95%	84.15%	93.17%	88.28%	92.49%	91.51%	89.03%	86.96%	95.48%	89.81%	90.71%
	4 Hour Performance (Type 3 MIU/FAU)	95%	94.48%	95.54%	97.49%	94.96%	95.93%	97.61%	97.17%	96.67%	97.09%	98.49%	98.59%	96.41%	96.65%	96.63%	95.37%	97.14%	96.98%	97.62%	98.67%	96.63%
	Total AAU Attendances (inc EMU)							431	452	526	551	550	569	577	5896	1243	1164	1398	1261	1227	1405	7698
	Total Pick Ups - HART		183	177	196	198	160	140	175	173	162	187	133	155	2039	176	177	175	197	174	225	1124
	Red 1	75%	73.8%	74.5%	72.4%	65.6%	69.1%	63.2%	67.9%	70.7%	71.4%	71.9%	75.4%	69.9%	70.4%	75.7%	74.1%	70.4%	74.4%	70.5%	63.6%	71.4%
	Red 2	75%	74.7%	72.1%	73.4%	70.3%	72.7%	69.8%	70.8%	72.3%	70.5%	70.6%	71.7%	71.4%	71.7%	70.7%	69.9%	68.2%	70.0%	69.1%	66.8%	69.1%
	Red 19	95%	95.5%	93.8%	92.2%	91.6%	93.8%	91.8%	91.8%	92.0%	91.2%	93.1%	93.3%	94.3%	92.9%	94.1%	91.6%	91.0%	93.0%	92.4%	92.0%	92.3%
	PTS - Planned Discharges %	35%										26.6%	26.9%	25.0%	26.2%	33.9%	30.1%	29.7%	30.7%	28.5%	29.6%	30.5%
	Acute Discharges							9107	11150	5794	5896	5382	5691	7153	50173	6681	5490	6898	5477	5458	5404	35,408
	Discharges before 12noon %	33%						10.5%	10.5%	19.5%	19.0%	17.9%	17.9%	18.9%	15.5%	19.2%	19.1%	19.1%	19.5%	18.7%	21.5%	19.5%
	Conversion Rate from A&E	25%	26.4%	26.8%	26.0%	25.2%	26.3%	25.8%	25.1%	27.5%	29.8%	25.1%	26.2%	28.4%	26.5%	25.0%	23.8%	22.7%	22.3%	24.2%	23.3%	23.6%

Please note: Sept 17 data is potentially unvalidated and may be subject to change
n.b. - DToC Trajectory will begin in August

Timeline for completion	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
AEDB	20/10/17	17/11/17	21/12/17	19/01/18	15/02/18	15/03/18
OSFB	14/10/17	11/11/17	15/12/17	13/01/18	09/02/18	09/03/18
Deadline for Comments	13/10/17	10/11/17	14/12/17	12/01/18	08/02/18	08/03/18
Dashboard Produced	11/10/17	08/11/17	12/12/17	10/01/18	06/02/18	06/03/18
Deadline for Data	10/10/17	07/11/17	11/12/17	09/01/18	05/02/18	05/03/18

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HEALTH & WELLBEING BOARD – 9 NOVEMBER 2017

Adult Social Care Outcome Framework Published Results for 2016-17

1. NHS Digital has published the findings from the Adult Social Care Outcomes Framework (ASCOF) in England for the period 1 April 2016 to 31 March 2017¹. This measure how well care and support services achieve the outcomes that matter most to people.
2. The framework reports on 27 measures. Oxfordshire performs above the national average on 14 of these measures; the same as the national average on 3 measures and below the national average on 10 measures. Overall Oxfordshire remains better than average, but is no longer in the top quartile ranking 61st out of the 152 authorities.
3. The areas where Oxfordshire performs better than average include:
 - a. The number of people who use social care who say that
 - i. they were satisfied with their services
 - ii. their services meet their needs
 - iii. their services helped them feel safe
 - iv. they have choice and control over their lives
 - b. The number of informal carers who say
 - i. they have been included or consulted in discussion about the person they care for
 - ii. they find it easy to find information about support
 - c. The number of people with personal budgets and those who receive a direct payment so they can organise their own care
 - d. The number of adults receiving services who are in paid employment
 - e. The number of people receiving services in their own homes as opposed to care homes
4. Areas where Oxfordshire needs to improve include²
 - a. Reducing delayed transfers of care from hospital (2 measures)
 - b. Improving the number of people who are offered a reablement service (i.e. a short term service to help them to return to independence) and the success of these services (3 measures)
 - c. Fewer service users and their carers report they have enough social contact (2 measures)
 - d. Helping adults in contact with mental health services to live independently (1 measure)
 - e. Provision of information to service users (1 measure)
5. On 14 of the measures performance improved and on 10 performance fell. On 6 of these measures performance deteriorated and we worse than national figure. These related to
 - a. Reablement (2 of the 3 measures)

¹ <http://digital.nhs.uk/pubs/adusccoccareof1617>. published 25th October 2017

² Oxfordshire was also below average on % of service users who say services helped them feel safe, but more service users actually felt safe

- b. Service Users and carers saying they had enough social contact (2 measures)
 - c. Service users finding it easy to access information
 - d. People saying services make them feel safe
- 6. Although performance on delayed transfers of care remains poor. On the measures used in ASCOF; all delays, taken as an average of the snapshots Oxfordshire was 142 in the country; and social care delays (defined as social care and both) Oxfordshire was 136 in the country.
- 7. The percent of people over 65 who leave hospital with reablement has remained stable (2.5%), but nationally it has dropped for the second successive year.
- 8. The following tables show the best performing authorities in the areas where we are most challenged
 - a. Delayed Transfers of Care
 - b. Access to reablement
 - c. Social Contact for people who use services
 - d. Provision of information to people who use services
 - e. Overall satisfaction of carers with social services

2C(1): All delayed transfers of care from hospital, per 100,000

	Local	Nationally Best	SE Best	SN ³ best	Shire Best
Authority	Oxon	Sunderland ⁴	Wokingham	Glos	Notts
Figure	25.5	1.7	7.7	9.8	9.0
Rank	143	2	37	55	45

2B(2): The proportion of older people (aged 65 and over) who received reablement/rehabilitation services after discharge from hospital

	Local	Nationally Best	SE Best	SN best	Shire Best
Authority	Oxon	Lambeth	Brighton & Hove	Bucks	Bucks
Figure	2.5	9.4	7.7	4.3	4.3
Rank	91	1	3	21	21

1I(1): The proportion of people who use services who reported that they had as much social contact as they would like

	Local	Nationally Best	SE Best	SN best	Shire Best
Authority	Oxon	Sefton	Glos	Isle of Wight	Glos
Figure	44.9	52.9	52.8	51.5	52.8
Rank	87	1	2	10	2

³ Statistical neighbours are areas most similar to Oxfordshire. These are: Bucks; Cambs; Warwicks; Glos; Hants; Herts; Leics; Worcs; Surrey; Northants; West Susses; Essex; Suffolk; North Yorks; Somerset

⁴ Isle of Scilly reports none

3D(1): The proportion of people who use services who find it easy to find information about support

	Local	Nationally Best	SE Best	SN best	Shire Best
Authority	Oxon	Rutland	Portsmouth	Worcs	Worcs
Figure	72.5	85.0	81.1	82.3	82.3
Rank	94	1	11	6	6

3B: Overall satisfaction of carers with social services

	Local	Nationally Best	SE Best	SN best	Shire Best
Authority	Oxon	Rutland	Bracknell Forest	Warks	Warks
Figure	39.0	62.1	49.2	46.3	46.3
Rank	68	1	10	12	12

Steve Thomas
Performance & Information Manager (social care)
1st November 2017

Comparative performance 16/17 on each measure

	Oxon	SE	Shire	National
1A: Social care-related quality of life score	19.5	19.4	19.3	19.1
1B: The proportion of people who use services who have control over their daily life	82.9	80.1	79.4	77.7
1C(1A): The proportion of people who use services who receive self-directed support	92.1	93.6	89.2	89.4
1C(1B): The proportion of carers who receive self-directed support	100.0	94.6	82.8	83.1
1C(2A): The proportion of people who use services who receive direct payments	33.6	30.5	31.8	28.3
1D: Carer-reported quality of life	7.7	7.6	7.7	7.7
1E: The proportion of adults with a learning disability in paid employment	8.6	6.1	5.3	5.7
1F: Proportion of working age adults (18-69) who are receiving secondary mental health services and who are on the Care Programme Approach at the end of the month who are recorded as being employed (%)	10.0	n/a	n/a	7.0
1G: The proportion of adults with a learning disability who live in their own home or with their family	83.0	71.3	75.1	76.2
1H: Proportion of working age adults (18-69) who are receiving secondary mental health services and who are on the Care Programme Approach at the end of the month, who are recorded as living independently (with or without support) (%)	44.0	n/a	n/a	54.0
1I(1): The proportion of people who use services who reported that they had as much social contact as they would like	44.9	46.4	46.7	45.4
1I(2): The proportion of carers who reported that they had as much social contact as they would like	33.1	33.2	33.6	35.5
1J: Adjusted social care quality of life - impact of adult social care services	0.4	0.4	0.4	0.4
2A(1): Long-term support needs of younger adults (aged 18-64) met by admission to residential and nursing care homes, per 100,000 population	9.3	11.0	11.4	12.8
2A(2): Long-term support needs of older adults (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population	483.6	565.4	560.4	610.7
2B(1): The proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	79.8	80.1	81.5	82.5
2B(2): The proportion of older people (aged 65 and over) who received reablement/rehabilitation services after discharge from hospital	2.5	2.6	2.2	2.7
2C(1): Delayed transfers of care from hospital, per 100,000	25.5	16.9	17.4	14.9
2C(2): Delayed transfers of care from hospital that are attributable to adult social care, per 100,000 population	11.0	6.9	7.2	6.3
2D: The outcome of short-term services: sequel to service	68.2	80.1	82.4	77.8
3A: Overall satisfaction of people who use services with their care and support	67.6	65.9	66.6	64.7
3B: Overall satisfaction of carers with social services	39.0	37.9	38.7	39.0
3C: The proportion of carers who report that they have been included or consulted in discussion about the person they care for	72.3	70.6	70.5	70.6
3D(1): The proportion of people who use services who find it easy to find information about support	72.5	74.5	73.8	73.5
3D(2): The proportion of carers who find it easy to find information about support	64.6	63.6	63.0	64.2
4A: The proportion of people who use services who feel safe	73.6	72.1	71.4	70.1
4B: The proportion of people who use services who say that those services have made them feel safe and secure	85.6	86.3	87.3	86.4

Trend data on each measure

	Oxon			Compared to national	Direction of travel
	14/15	15/16	16/17		
1A: Social care-related quality of life score	19.2	19.3	19.5	Better	Improving
1B: The proportion of people who use services who have control over their daily life	80.6	77.1	82.9	Better	Improving
1C(1A): The proportion of people who use services who receive self-directed support	81.6	81.3	92.1	Better	Improving
1C(1B): The proportion of carers who receive self-directed support	100.0	94.6	100.0	Better	Stable
1C(2A): The proportion of people who use services who receive direct payments	31.2	34.7	33.6	Better	Dropping
1D: Carer-reported quality of life	8.0		7.7	Same	Dropping
1E: The proportion of adults with a learning disability in paid employment	8.7	7.7	8.6	Better	Improving
1F: Proportion of working age adults (18-69) who are receiving secondary mental health services and who are on the Care Programme Approach at the end of the month who are recorded as being employed (%)	9.6	8.0	10.0	Better	Improving
1G: The proportion of adults with a learning disability who live in their own home or with their family	82.5	80.1	83.0	Better	Improving
1H: Proportion of working age adults (18-69) who are receiving secondary mental health services and who are on the Care Programme Approach at the end of the month, who are recorded as living independently (with or without support) (%)	54.5	37.9	44.0	Worse	Improving
1I(1): The proportion of people who use services who reported that they had as much social contact as they would like	46.1	47.5	44.9	Worse	Dropping
1I(2): The proportion of carers who reported that they had as much social contact as they would like	38.5		33.1	Worse	Dropping
1J: Adjusted social care quality of life - impact of adult social care services	0.4	0.4	0.4	Same	new
2A(1): Long-term support needs of younger adults (aged 18-64) met by admission to residential and nursing care homes, per 100,000 population	6.5	10.1	9.3	Better	Improving
2A(2): Long-term support needs of older adults (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population	514.9	530.4	483.6	Better	Improving
2B(1): The proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	83.2	81.2	79.8	Worse	Dropping
2B(2): The proportion of older people (aged 65 and over) who received reablement/rehabilitation services after discharge from hospital	3.2	2.5	2.5	Worse	Stable
2C(1): Delayed transfers of care from hospital, per 100,000	27.2	29.4	25.5	Worse	Improving
2C(2): Delayed transfers of care from hospital that are attributable to adult social care, per 100,000 population	11.2	11.7	11.0	Worse	Improving
2D: The outcome of short-term services: sequel to service	64.1	70.9	68.2	Worse	Dropping
3A: Overall satisfaction of people who use services with their care and support	60.6	66.7	67.7	Better	Improving
3B: Overall satisfaction of carers with social services	43.6		39.0	Same	Dropping
3C: The proportion of carers who report that they have been included or consulted in discussion about the person they care for	72.2		72.3	Better	Improving
3D(1): The proportion of people who use services who find it easy to find information about support	76.5	76.7	72.5	Worse	Dropping
3D(2): The proportion of carers who find it easy to find information about support	69.2		64.6	Better	Dropping
4A: The proportion of people who use services who feel safe	70.1	71.6	73.6	Better	Improving
4B: The proportion of people who use services who say that those services have made them feel safe and secure	86.0	86.5	85.6	Worse	Dropping

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HEALTH & WELLBEING BOARD – 9 NOVEMBER 2017
Early Lessons from the CQC reviews of Health and Social Care Systems

The CQC has been asked by the Secretaries of State for Health and for Communities and Local Government to undertake a programme of local system reviews of health and social care in 12 local authority areas. Oxfordshire is one of these areas.

These reviews, exercised under the Secretaries of State's Section 48 powers, will include a review of commissioning across the interface of health and social care and an assessment of the governance in place for the management of resources.

The purpose of the CQC review is to understand how people move through the health and social care system. The CQC is focussing on the **interface between health and social care** systems during the review and looking at what improvements can be made. The **CQC want to understand the maturity, capacity and capability** of the Oxfordshire system.

The review will focus on **older people aged 65 and over**, they will not be looking at people who have a mental illness, but will review people who have a diagnosis of dementia.

The review will look at the Key Lines of Enquiry (KLOE) under the domains of **Safe, Effective, Caring, Responsive and Well-led**. There is an additional KLOE which covers **Resource Governance** that focuses on how the system partners assure themselves that resources are being used to achieve sustainable high quality care and promoting people's independence.

Clearly the early learning from these reviews will be of importance to the Health and Wellbeing Board and the Board will want to take these into account as it embarks on its own review of governance. (see proposal elsewhere on this agenda).

The CQC has completed inspections of two areas. These are Halton and Bracknell Forest. The findings from these reviews provide useful early benchmarking for the health and Wellbeing Board to consider. The reports for these two areas are attached and the summaries are below.

Recommendation

The Health and Wellbeing Board are asked to consider these two completed reviews and what lessons might be learned for the Oxfordshire system in general and the review of Health Wellbeing Board Governance in particular.

Kate Terroni - Director of Adult Services

Jonathan McWilliam - Director of Public Health/ Strategic Director for People

Summary of Findings: Halton

Is there a clear shared and agreed purpose, vision and strategy for health and social care?

- Overall, there was a strong commitment from the local authority (LA) and the clinical commissioning group (CCG) to serve the people of Halton well.
- The local authority and CCG had a clear vision for the borough that had been shared with its strategic partners and was well understood by their staff at a managerial and operational level. There were also well established, positive relationships across the health and social care system with a shared dialogue between the CCG and the local authority underpinned by a high level of trust.
- Local NHS acute trusts, although not located in the borough, participated in the wider system planning.
- As there was not yet a cohesive interface or alignment between the local authority's and CCGs vision for the borough, the Local Delivery System (LDS), the Sustainability and Transformation Plan (STP), and a developing accountable care system, there were opportunities for system partners to think more widely and include the Local Delivery System (LDS) and the Sustainability and Transformation Plan (STP) in the overall system strategy to strengthen the position of the Halton community and give local partners a stronger voice within the system footprint.
- Work was required to develop a wider system vision for the STP footprint and develop a common framework for prioritising actions, and for specifying accountabilities and shared governance arrangements.
- This was recognised by the system leaders who were working towards a more robust approach to alignment at the time of our review.
- There was agreement across partners to develop an accountable care system (ACS) in the future, however this agreement had not yet manifested into detailed plans and actions. Discussions were ongoing at the time of our review.

Is there a clear framework for interagency collaboration?

- There were well established, positive relationships across the health and social care system with a shared dialogue between the CCG and the local authority, underpinned by a high level of trust.
- The Joint Strategic Needs Assessment (JSNA) was well thought out and had underpinned operational delivery plans and desired outcomes .All partners were sighted on what was important to older people and carers when moving through the interface of health and social care. There was a specific JSNA for older people and there was good evidence of partners meeting individuals'
- needs in terms of health and wellbeing, social inclusion, social prescribing and transport. However, a joint commissioning strategy for older people's service provision had not yet been fully developed.
- There was evidence of robust analysis of need to support resource allocation and the setting of priorities within the local authority and the CCG. The local authority had a strong track record of financial management and delivering services for older people based on quality outcomes within budget.
- Joint preventative approaches were well thought through and embedded. There was a wide range of effective initiatives that were supporting people to remain socially included, maintain their own health and manage their long term conditions.

- There were some excellent examples of shared approaches and local agreements that supported local people in having timely access to services and support that met their needs in a person-centred way.
- The seven-day Rapid Access Re-ablement Service (RARS) and the five- day Rapid Clinical Assessment Team (RCAT) had been developed to reduce avoidable hospital admissions, which in 2016/17 had been above the comparator average. Similarly the numbers of delayed transfers of care were higher than the comparator average for the same period. System leaders were confident that the recently implemented RARS and RCAT teams' approach, coupled with the implementation of elements of the high impact change model, would secure improved performance in respect of avoidable admissions and further reductions in the numbers of delayed transfers of care.
- It was evident from the range of joint initiatives from the local authority and the CCG that there was a shared understanding and collective responsibility for meeting the needs of the local population. There was a strong commitment from partners to work collaboratively and efficiently for the benefit of local people.
- We found that the Health and Wellbeing board provided senior officers with high levels of support. However, as a forum to challenge and support the system's joint strategic approach, the Health and Wellbeing Board lacked rigour and required improvement to support and challenge the local system's transformation agenda and monitor progress more robustly.
- We found examples of poor monitoring of commissioned services which were having an impact on the quality of service provision, such as the intermediate care service provided at Warrington and Halton NHS Foundation Trust.
- Initiatives were not always connected and joined up to inform whole system performance. For example, GP practices were not always aligned with the system wellbeing strategies for example the enhanced care home model was not fully embedded with all GP practices
- Although recent DTOC figures were improving (figures for June 2017 indicate that the average daily rate of delayed transfers of care in Halton had dropped to 8.8 delayed days per 100,000 population,
- below the England figure of 13.8 and below Halton's comparator average of 10.80), there were a number of challenges in the timely provision of appropriate rehabilitation services and intermediate care to support and maintain further reduction. Some people with complex needs were experiencing considerable delays.
- The local authority and CCGs had transformation plans for domiciliary care and care home provision in Halton. Both these elements of provision were challenged in terms of their capacity to meet demand

How are interagency processes delivered?

- The framework for interagency working was supported by separate organisational strategies; however we did not find evidence of this being co-ordinated into a system wide approach by the STP.
- There were shared performance metrics between the local authority and the CCG which were scrutinised at the Executive Partnership Board. However these were not aligned with all system partners.

What are the experiences of front line staff?

- Senior leaders were visible, accessible and approachable.

- Staff felt supported by their line managers and were encouraged to influence the design and delivery of services.
- There were systems and processes in place to support staff development and professional competence.
- There was work planned with staff in the independent sector in terms of promoting peoples safety and injury prevention.
- There was good support available to staff underpinned by regular training to manage adult safeguarding issues including issues of abuse and neglect.
- From interviews with system leaders and operational staff it was evident that leaders across respective agencies were working together to implement systems to support interagency and multi-disciplinary working and encourage staff to work in cohesive teams.
- We found a range of support services that encouraged staff to work across
- organisational boundaries to better provide holistic care to people requiring services

What are the experiences of people receiving services

- The experiences of people receiving services in Halton varied.
- We found a very positive approach to maintaining people's health and wellbeing in their own homes and services designed for older people to keep them socially included, active and able to manage their long term conditions.
- There were some excellent examples of social prescribing that helped people deal with bereavement, loneliness and concerns about their safety at home.
- We observed a number of assessments carried out by different teams during the course of the review. We saw good examples of person-centred assessments, including those for people experiencing memory loss. Clinical, social and cultural information was included in assessments which covered all aspects of what was important in people's lives. Care plans were developed with the inclusion of the person, their families and carers.
- Halton had a high uptake of personal health budgets and direct payments for all adults compared to the England average and Cheshire and Merseyside regional average. The Halton Disability Partnership delivered a service to support people through the process of accessing and using direct payments.
- The local authority provided good support to carers with input from the carer's centre that supported approximately 5000 carers, including 528 carers supporting people living with dementia.
- However, some older people from the Halton area had less satisfactory experiences when they were admitted to hospital; they were often experiencing long waits in A&E before being admitted to a ward.
- Once ready for discharge, some older people were subject to delays in their transfer home or to a new place of residence. In some cases people had suffered avoidable harm or detriment as a result of the delays, such as the development of a pressure sore. In the main, delays were attributed to the lack of provision of care packages in the community or the availability of long term care placements.
- In response there were a number of new initiatives planned to improve the experience of older people and at the time of our review performance in delayed transfers of care was improving. Nevertheless further work was required to maintain this improvement and ensure that delays did not increase as a result of winter pressures.

- Continuing Healthcare (CHC) was provided through a joint local authority and CCG budget that had been established for a number of years. Securing CHC funding was not considered to be a primary cause of delayed transfers of care. The NHS CHC figures for all adults showed that in Q1 2017/18 both the referral conversion rate (% of newly eligible cases of total referrals completed) and assessment conversion rate (% newly eligible cases of total cases assessed) were higher than the England and Cheshire and Merseyside regional averages. This indicated that Halton's processes for identifying people eligible for CHC were working well. However, there were delays in completing the process as the data for all adults in Q1 2017/18 also showed that for Halton CCG 25% of referrals for standard CHC were completed within 28 days, lower than the England average of 57% and the Cheshire and Merseyside regional average of 73%.

Summary of Findings: Bracknell Forest

Is there a clear shared and agreed purpose, vision and strategy for health and social care?

- There was a system-wide commitment to serve the people of Bracknell Forest well. There was a shared understanding across system partners of the challenges the system faced, and a willingness to work together to achieve solutions.
- Bracknell Forest was part of an agreed accountable care system (ACS) centred on the Frimley Health and Care Partnership and led by the Chief Executive Officer (CEO) of Frimley Health NHS Foundation Trust (FHFT). There was vertical and horizontal alignment of a system wide vision that was centred on the Sustainability and Transformation Partnership (STP) plans and the Better Care Fund (BCF) plans. The STP was recognised as a driving force for culture change across the system and instrumental in supporting integrated working.
- All staff within the system, from front line staff to the leadership teams, demonstrated knowledge of STP plans and voiced their commitment to its aims.
- The Health and Wellbeing Board (HWB) was well established, mature and functioned effectively by monitoring planning, delivery and outcomes for local people. The HWB was made up of representatives from across the system including the acute, community and voluntary sector. There were clear lines of responsibility and accountability.
- It was evident from our review that partners across the system were responsive to each other's challenges, while ensuring that responsibilities relating to their own organisations were not compromised by joint working.
- Aligned with the Bracknell Forest health and wellbeing strategy, there were joint strategic priorities in place. These focused on providing older people with preventative services and support to stay well, and on enhancing the capacity in the domiciliary and care home sectors to manage the current and projected shortfalls in these services.

Is there a clear framework for interagency collaboration?

- The Joint Strategic Needs Assessment (JSNA) was robust, well considered and underpinned by clear delivery plans and outcomes. All partners were sighted on what was important to older people, their families and carers when moving through the interface of health and social care.
- Governance arrangements, as set out in the BCF plan, included community, professional and clinical leadership and were collaborative with decisions made at local level. The BCF board had oversight on the alignment of the various strategies, including the joint commissioning strategy for intermediate care, joint commissioning strategy for people in an unpaid caring role, and the commissioning strategy for older people, together with the pooled budget and associated risks.
- The BCF plan built on a history of successful integration between Bracknell Forest Council (the local authority) and Bracknell and Ascot Clinical Commissioning Group (the CCG). Intermediate care and reablement services were jointly funded through a Section 75 pooled budget agreement and had run in partnership between the local authority and the NHS for ten years. This integrated service was hosted by Bracknell Forest Council with Berkshire Healthcare NHS Foundation Trust providing supplementary community nursing and therapy.

- There were positive examples of shared approaches and initiatives that supported local people to have timely access to services and support that met their needs in a person-centred way.
- There was evidence of effective risk sharing across partners. For example, there were plans for the local authority to administer personal health budgets on behalf of the CCG. A shadow control budget was also in place.
- The system was willing to take collective risks to transform the provider market to meet the needs of the local population. For example, the local authority was using outcomes-based contracts that incentivised new domiciliary care providers to put reablement at the centre of their activities, and in turn challenge local people to rethink how care at home could be used.

How are interagency processes delivered?

- Partnership working across the system was supported through a range of joint partnership boards. Boards were well attended and encompassed a comprehensive range of stakeholders including housing, voluntary services and the out-of-hours (OOH) service. Key issues were discussed and actions agreed, implemented and performance monitored.
- A programme delivery board had been established to monitor and support STP delivery and progress which reported to the Frimley STP Board.
- As part of the STP, integrated decision-making hubs were being developed to support people who were frail or had complex needs through advance care planning and social prescribing to promote independence, wellbeing and social inclusion.
- Winter plans covering the resilience arrangements across the system had been formalised and agreed. While the CCG led on the plans, we found that all system partners including frontline staff across primary and secondary care were aware of the plans and had contributed to the planning processes.

What are the experiences of front line staff?

- Staff benefitted from strong visible leadership and clear direction. We found that a collaborative multi-agency approach was already embedded.
- Feedback from front line staff was, in the main, very positive. Staff felt that leaders were responsive and inclusive. Staff generally communicated well across agencies. However, some social care staff reported that they were not always kept informed when people in their care had been admitted to hospital.
- Workforce issues were identified across the whole health and social care system, and particularly in the recruitment and retention of carers that provided care to people in their own homes. There were comprehensive system-led plans in place to mitigate risks associated with these issues; however most of these had not been implemented at the time of the review and we were therefore unable to assess their impact. The plans in place to support the up-skilling of staff and the development of cross-boundary roles were welcomed by the staff we spoke with.
- Staff told us that there was an opportunity for improving the care and support to people with moderate to severe dementia within acute hospital settings.

What are the experiences of people receiving services?

- The majority of older people living in Bracknell Forest received good quality health and social care services in a timely way. Most people using services told us they felt included in decision making about their care.

- Local people benefitted from access to direct payments. We heard positive feedback from people and their carers about how this enabled them to have control over their care, and be more involved in their care planning.
- There was an agreement between the local authority and the CCG for the local authority to procure continuing healthcare (CHC). NHS and the Emergency Duty Service (EDS) CHC quarterly figures for April to June (Q1) 2017 showed that the CCG had a standard NHS CHC assessment conversion rate for all adults (percentage of newly eligible cases of total assessments) of 50%. This was high compared to the England average (31%) and the South Central regional average (35%).
- We found a multidisciplinary, integrated approach to delivering a number of key services including the assessment and discharge team who were proactive and solution-focused. The EDS was well integrated and worked well with the integrated intermediate care team. All these services were having a positive effect on reducing delayed transfers of care (DTOC). Our analysis showed that Bracknell Forest had an average of 14.5 daily delayed days in July 2017 compared with a peak of 22.5 daily delayed days in March 2017. Local system leaders were confident that this level of performance could be further improved.
- However, in both acute hospitals there were some issues around the timely provision of hospital transport and medicines and these were contributing to delayed transfers of care and a poor experience for some people.
- People who used services, their families and carers were engaged in developing and improving the health and social care interface. There was regular engagement and co-production with older people via a range of panels and groups.
- There was scope to increase the effectiveness of local engagement by working better with Healthwatch Bracknell Forest.

Halton

Local system review report Health and Wellbeing Board

Date of review:
21-25 August 2017

Background and scope of the local system review

This review has been carried out following a request from the Secretaries of State for Health and Communities and Local Government to undertake a programme of 20 targeted reviews of local authority areas. The purpose of this review is to understand how people move through the health and social care system with a focus on the interfaces between services.

This review has been carried out under Section 48 of the Health and Social Care Act 2008. This gives CQC the ability to explore issues that are wider than the regulations that underpin our regular inspection activity. By exploring local area commissioning arrangements and how organisations are working together to develop person-centred, coordinated care for people who use services, their families and carers, we are able to understand people's experience of care across the local area, and how improvements can be made.

This report is one of 20 local area reports produced as part of the local system reviews programme and will be followed by a national report for government that brings together key findings from across the 20 local system reviews.

The review team

Our review team was led by:

Delivery Lead: Ann Ford, CQC

Lead Reviewer: Wendy Dixon, CQC

The team also included:

- Members of the executive team
- Three CQC reviewers,
- Two CQC strategy leads,
- One CQC analyst,
- One CQC Expert by Experience; and
- Three specialist advisors (two former local government directors of social service and one Clinical Commissioning Group board member).

How we carried out the review

The Local System Review considered system performance along a number of ‘**pressure points**’ on a typical pathway of care with a focus **on older people aged over 65**.

We also focussed on the interface between social care, general medical practice, acute and community health services, and delayed transfers of care from acute hospital settings.

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across three key areas:

1. Maintaining the wellbeing of a person in usual place of residence
2. Crisis management
3. Step down, return to usual place of residence and/ or admission to a new place of residence

Across these three areas, detailed in the report, we have asked the questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive?

We have then looked across the system to ask:

- Is it well led?

Prior to visiting the local area we developed a local data profile containing analysis of a range of information available from national data collections as well as CQC’s own data. We requested the local area provide an overview of their health and social care system in a bespoke System Overview Information Return (SOIR) and asked a range of other local stakeholder organisations for information. We also developed two online feedback tools; a relational audit to gather views on how relationships across the system were working, and an information flow audit to gather feedback on the flow of information when older people are discharged from secondary care services into adult social care¹.

During our visit to the local area we sought feedback from a range of people involved in shaping and leading the system, those responsible for directly delivering care as well as those who use services, their families and carers. The people we spoke with included:

- Staff members including social workers, GPs, discharge coordinators, therapists and nurses
- Senior leaders and managers in the local authority, the Clinical Commissioning Group (CCG), Warrington and Halton Hospitals NHS Foundation Trust, St Helen’s and Knowsley Teaching Hospitals NHS Trust, Bridgewater Community Healthcare NHS foundation Trust, the North West Ambulance Service and North West Boroughs

- Local Healthwatch, voluntary and community sector (VCS) services
- Local Residents attending the Halton Direct Link service (the local authority's walk in advisory service)
- Service users in the acute hospitals in both A&E and the discharge lounges

We reviewed 26 care and treatment records and visited nine services in the local area including acute hospitals, intermediate care facilities, a hospice, a care home, a nursing home and 2 GP practices.

The Halton context

Demographics

- 15% of the population is aged 65 and over.
- 98% of the population is categorised as White.
- Halton is in the most deprived 20% of local authorities in England.

Adult Social Care

- 18 active residential care home locations:
 - 17 rated good
 - 1 rated requires improvement
- 8 active nursing care home locations:
 - 5 rated good
 - 3 rated requires improvement
- 5 active domiciliary care agencies:
 - 4 rated good
 - 1 rated requires improvement

GP Practices

- 12 GP practices rated good
- 1 GP practice rated outstanding
- 2 are currently unrated

Acute and community Healthcare

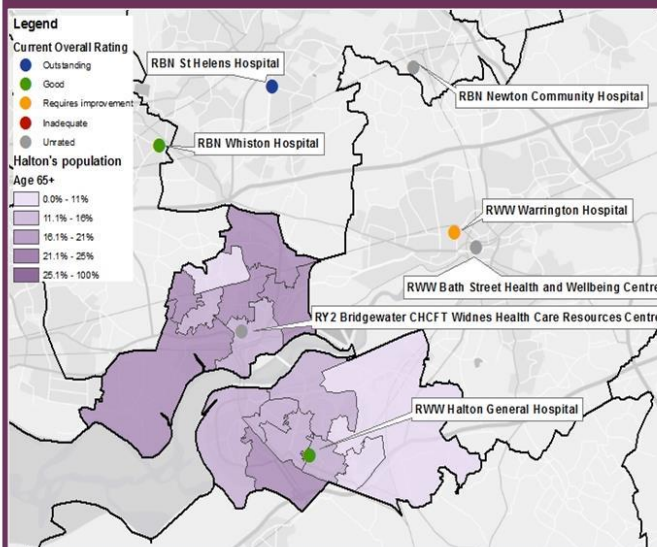
Hospital admissions (elective and non-elective) from Halton are largely split between two NHS acute hospital trusts:

- Warrington and Halton Hospitals NHS Foundation Trust (RWW)
 - Receives 49% of Halton's admissions
 - Admissions from Halton make up 25% of the trust's admissions
 - Currently rated Requires Improvement overall
- St Helens and Knowsley Teaching Hospitals NHS Trust (RBN)
 - Receives 43% of Halton's admissions
 - Admissions from Halton make up 16% of the trust's admissions
 - Currently rated Good overall

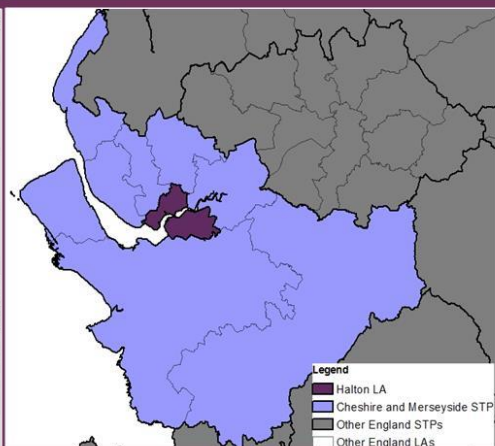
Community services are provided by:

- Bridgewater Community Healthcare NHS Foundation Trust (RY2) - currently rated requires improvement overall.

*Acute and Community hospital locations as at 29/09/2017; ASC and PMS locations as at 29/09/2017
Admissions percentages from 2015/16 Hospital Episode Statistics.*



Map 1: Population of Halton aged 65+ and location and current rating of acute and community healthcare organisations serving Halton.



Map 2: Location of Halton LA within Cheshire and Merseyside STP. Halton CCG and the HWB cover an almost identical footprint.

Summary of findings

Is there a clear shared and agreed purpose, vision and strategy for health and social care?

- Overall, there was a strong commitment from the local authority (LA) and the clinical commissioning group (CCG) to serve the people of Halton well.
- The local authority and CCG had a clear vision for the borough that had been shared with its strategic partners and was well understood by their staff at a managerial and operational level. There were also well established, positive relationships across the health and social care system with a shared dialogue between the CCG and the local authority underpinned by a high level of trust.
- Local NHS acute trusts, although not located in the borough, participated in the wider system planning.
- As there was not yet a cohesive interface or alignment between the local authority's and CCGs vision for the borough, the Local Delivery System (LDS), the Sustainability and Transformation Plan (STP), and a developing accountable care system, there were opportunities for system partners to think more widely and include the Local Delivery System (LDS) and the Sustainability and Transformation Plan (STP) in the overall system strategy to strengthen the position of the Halton community and give local partners a stronger voice within the system footprint.
- Work was required to develop a wider system vision for the STP footprint and develop a common framework for prioritising actions, and for specifying accountabilities and shared governance arrangements.
- This was recognised by the system leaders who were working towards a more robust approach to alignment at the time of our review.
- There was agreement across partners to develop an accountable care system (ACS) in the future, however this agreement had not yet manifested into detailed plans and actions. Discussions were ongoing at the time of our review.

Is there a clear framework for interagency collaboration?

- There were well established, positive relationships across the health and social care system with a shared dialogue between the CCG and the local authority, underpinned by a high level of trust.
- The Joint Strategic Needs Assessment (JSNA) was well thought out and had underpinned operational delivery plans and desired outcomes. All partners were sighted on what was important to older people and carers when moving through the interface of health and social care. There was a specific JSNA for older people and there was good evidence of partners meeting individuals'

needs in terms of health and wellbeing, social inclusion, social prescribing and transport. However, a joint commissioning strategy for older people's service provision had not yet been fully developed.

- There was evidence of robust analysis of need to support resource allocation and the setting of priorities within the local authority and the CCG. The local authority had a strong track record of financial management and delivering services for older people based on quality outcomes within budget.
- Joint preventative approaches were well thought through and embedded. There was a wide range of effective initiatives that were supporting people to remain socially included, maintain their own health and manage their long term conditions.
- There were some excellent examples of shared approaches and local agreements that supported local people in having timely access to services and support that met their needs in a person-centred way.
- The seven-day Rapid Access Re-ablement Service (RARS) and the five- day Rapid Clinical Assessment Team (RCAT) had been developed to reduce avoidable hospital admissions, which in 2016/17 had been above the comparator average. Similarly the numbers of delayed transfers of care were higher than the comparator average for the same period. System leaders were confident that the recently implemented RARS and RCAT teams' approach, coupled with the implementation of elements of the high impact change model, would secure improved performance in respect of avoidable admissions and further reductions in the numbers of delayed transfers of care.
- It was evident from the range of joint initiatives from the local authority and the CCG that there was a shared understanding and collective responsibility for meeting the needs of the local population. There was a strong commitment from partners to work collaboratively and efficiently for the benefit of local people.
- We found that the Health and Wellbeing board provided senior officers with high levels of support. However, as a forum to challenge and support the system's joint strategic approach, the Health and Wellbeing Board lacked rigour and required improvement to support and challenge the local system's transformation agenda and monitor progress more robustly.
- We found examples of poor monitoring of commissioned services which were having an impact on the quality of service provision, such as the intermediate care service provided at Warrington and Halton NHS Foundation Trust.
- Initiatives were not always connected and joined up to inform whole system performance. For example, GP practices were not always aligned with the system wellbeing strategies for example the enhanced care home model was not fully embedded with all GP practices
- Although recent DTOC figures were improving (figures for June 2017 indicate that the average daily rate of delayed transfers of care in Halton had dropped to 8.8 delayed days per 100,000 population,

below the England figure of 13.8 and below Halton's comparator average of 10.80), there were a number of challenges in the timely provision of appropriate rehabilitation services and intermediate care to support and maintain further reduction. Some people with complex needs were experiencing considerable delays.

- The local authority and CCGs had transformation plans for domiciliary care and care home provision in Halton. Both these elements of provision were challenged in terms of their capacity to meet demand

How are interagency processes delivered?

- The framework for interagency working was supported by separate organisational strategies; however we did not find evidence of this being co-ordinated into a system wide approach by the STP.
- There were shared performance metrics between the local authority and the CCG which were scrutinised at the Executive Partnership Board. However these were not aligned with all system partners.

What are the experiences of front line staff?

- Senior leaders were visible, accessible and approachable.
- Staff felt supported by their line managers and were encouraged to influence the design and delivery of services.
- There were systems and processes in place to support staff development and professional competence.
- There was work planned with staff in the independent sector in terms of promoting peoples safety and injury prevention.
- There was good support available to staff underpinned by regular training to manage adult safeguarding issues including issues of abuse and neglect.
- From interviews with system leaders and operational staff it was evident that leaders across respective agencies were working together to implement systems to support interagency and multi-disciplinary working and encourage staff to work in cohesive teams.
- We found a range of support services that encouraged staff to work across organisational boundaries to better provide holistic care to people requiring services

What are the experiences of people receiving services

- The experiences of people receiving services in Halton varied.
- We found a very positive approach to maintaining people's health and wellbeing in their own homes and services designed for older people to keep them socially included, active and able to manage their long term conditions.
- There were some excellent examples of social prescribing that helped people deal with bereavement, loneliness and concerns about their safety at home.
- We observed a number of assessments carried out by different teams during the course of the review. We saw good examples of person-centred assessments, including those for people experiencing memory loss. Clinical, social and cultural information was included in assessments which covered all aspects of what was important in people's lives. Care plans were developed with the inclusion of the person, their families and carers.
- Halton had a high uptake of personal health budgets and direct payments for all adults compared to the England average and Cheshire and Merseyside regional average. The Halton Disability Partnership delivered a service to support people through the process of accessing and using direct payments.
- The local authority provided good support to carers with input from the carer's centre that supported approximately 5000 carers, including 528 carers supporting people living with dementia.
- However, some older people from the Halton area had less satisfactory experiences when they were admitted to hospital; they were often experiencing long waits in A&E before being admitted to a ward.
- Once ready for discharge, some older people were subject to delays in their transfer home or to a new place of residence. In some cases people had suffered avoidable harm or detriment as a result of the delays, such as the development of a pressure sore. In the main, delays were attributed to the lack of provision of care packages in the community or the availability of long term care placements.
- In response there were a number of new initiatives planned to improve the experience of older people and at the time of our review performance in delayed transfers of care was improving. Nevertheless further work was required to maintain this improvement and ensure that delays did not increase as a result of winter pressures.
- Continuing Healthcare (CHC) was provided through a joint local authority and CCG budget that had been established for a number of years. Securing CHC funding was not considered to be a primary cause of delayed transfers of care. The NHS CHC figures for all adults showed that in Q1 2017/18 both the referral conversion rate (% of newly eligible cases of total referrals completed) and assessment conversion rate (% newly eligible cases of total cases assessed) were higher than the

England and Cheshire and Merseyside regional averages. This indicated that Halton's processes for identifying people eligible for CHC were working well. However, there were delays in completing the process as the data for all adults in Q1 2017/18 also showed that for Halton CCG 25% of referrals for standard CHC were completed within 28 days, lower than the England average of 57% and the Cheshire and Merseyside regional average of 73%.

Are services in Halton well led?

Is there a shared clear vision and credible strategy which is understood across health and social care interface to deliver high quality care and support?

As part of this review we looked at the strategic approach to delivery of care across the interface of health and social care. This included strategic alignment across the system, joint working, inter-agency and multi-disciplinary working and the involvement of people who use services, their families and carers.

We did not find a cohesive interface between the local authority's and CCG vision for the borough, the Local Delivery System (LDS), the Sustainability and Transformation Plan (STP), and the emergent accountable care system (ACS).

The local authority and CCG had a clear vision for the borough that had been shared with its strategic partners and was well understood by its staff at a managerial and operational level. There was a strong commitment to joint working across the health and social care system. Leaders were visible and accessible, staff felt engaged and included in planning for the future. They were well supported by leaders in the development and design of services.

Strategy, Vision and partnership working

- We did not find a cohesive interface between the local authority's and CCGs vision for the borough, the Local Delivery System (LDS), the Sustainability and Transformation Plan (STP), and the emerging plans for an accountable care system (ACS).
- There were opportunities for partners to think more widely and include the Local Delivery System (LDS) and the Sustainability and Transformation Plan (STP) in the overall system strategy to strengthen the position of the Halton community and give local partners a stronger voice within the wider system.
- There were a range of plans across different organisations that were targeted at achieving the strategic aims in addition to the action plan within the wellbeing strategy.
- The local authority and CCGs had a clear vision for the borough. System leaders were working to promote a wider shared vision but there was a lack of clarity on the wider system interface; some leaders referred to the vision for the borough, others to the LDS and the STP.

- Interviews with system leaders indicated that partnerships and relationships at a local level were strong, particularly between the local authority and the CCG. Primary care engagement had previously been challenging but was seen to be improving, facilitated by the GP Federations. However, improvement was needed across the system in terms of understanding the role and potential of the federations.
- A review of the minutes of the Health and Wellbeing Board and discussions with senior leaders indicated that the function of the Health and Wellbeing Board could be improved as a forum to challenge and support the system's joint strategic approach and drive changes in practice.
- There was further work to be done to strengthen the HWB Board's challenge function to ensure the change agenda is developed and implemented in a timely way.
- Capacity and demand within the hospital system was overseen at an LDS and A&E Delivery Board level. This involved predictive modelling of activity, links to the A&E work streams and the wider out of hospital demand management work within the Local Alliance. The Local Delivery System (LDS) is the system that will deliver the Sustainability and transformation plans (STPs) developed for the area of Halton and make them operational.
- Planning for winter pressures was aligned with the North West boroughs and local plans had started via the A&E Delivery Board in the weeks prior to our visit. The local authority's divisional manager was also the urgent care lead for the local authority and the CCG, and was an active member of the Mid Mersey A&E Delivery Board, representing both organisations. This appointment was well received at an operational level and the divisional manager was seen as visible and supportive across the CCG, local authority and local NHS Trusts. There was an opportunity to replicate these joint posts at a more strategic level to better support the alignment of plans and the integration of services as well as establish joint governance and performance management arrangements.
- Winter planning was underway in all partner organisations however though we found a winter plan was being developed at a strategic level we found no evidence of this being shared to system partners
- Winter plans across different organisations were collated at the A&E Delivery Board, however, operational staff in services felt that overarching plans were not fed back to them and consequently they were only aware of their own operational plans and not the wider support for winter pressures planned across the system.

Involvement of service users, families and carers in the development of strategy

- Halton OPEN (Older People's Empowerment Network) was a network of over 1000 older people that was established in 2001 and had become the collective voice of people aged 50 and over who live and work in Halton. The network was designed to support older people to influence and

encourage the development of services that can help to improve the quality of life and wellbeing of all older people in Halton.

- Halton OPEN members were engaged in new approaches and represented on boards for frailty pathway; Older People's Delivery Board and GP patient participation group boards. The network was also engaged in the process for transforming domiciliary care and will also have representation on the forthcoming Domiciliary Care Board.
- Halton OPEN has been engaged in discussions about health and wellbeing, finances, public transport, information provision, and reducing social isolation. The Director of Adult Social Services (DASS) met with the group regularly.
- Halton Carers Centre was used to gather carers' views and has fed into work such as the development of Halton's dementia strategy and associated implementation plan.
- Halton People's Health Forum was a key group supporting local engagement and involvement in service redesign. They have supported the development of the urgent care centres and aspects of enhancing healthcare in care homes, particularly with regard to GP realignment.
- The local authority started work on the development of an end-to end-pathway of care for frail older people, as part of the 'One Halton' approach.
- Older people have been involved in the development in the needs gap analysis for the older people's pathway, 'Living and Aging Well in Halton'.
- The Bridgewater Community NHS FT that serves the Halton area had undertaken engagement activities with local populations and staff on the future of community health services, which included a 'Big Conversation' event.
- North West Boroughs Healthcare NHS Foundation Trust undertook an engagement exercise in respect of changes to the bed provision for people with dementia. Plans were changed as a result of this engagement, ensuring better travel arrangements, improved community services as well as a more flexible approach to bed based service provision for older people.
- The information gathered as part of the consultation on 'Living and Aging Well in Halton', along with national best practice guidance was used to underpin the development of an overarching integrated 'Older People's Pathway'. This outlined the expected interventions, standards and aims to the approach for supporting older people across the whole system.
- It was evident that system partners understood the importance of including and involving people who use services, their families and carers in developing their strategic approach to managing the quality of the interface of health and social care.

Promoting a culture of inter-agency and multi-disciplinary working

- From interviews with system leaders and operational staff it was evident that leaders across respective agencies were working together to implement systems to support inter-agency and multi-disciplinary working.

The framework for interagency working was supported by separate organisational strategies; however we did not find evidence of this being co-ordinated into a system wide approach. There were shared performance metrics between the local authority and the CCG which were scrutinised at the Executive Partnership Board. However these were not aligned with all system partners.

- We found a range of support services that encouraged staff to work across organisational boundaries. Examples included:
 - ⇒ A new contract from the CCG that will see all GP practices aligned to individual care homes – every care home will now have a designated GP practice.
 - ⇒ Social workers embedded within GP practices.
 - ⇒ The continued development of the multi-disciplinary team (MDT) approach at primary care level offered a medical, nursing and a social care service as well as a multi-disciplinary prevention and wellbeing approach.
 - ⇒ District nurses working together with local pharmacies to support effective medicines management and mitigate risk to safety to enable people to be maintained in their usual place of residence.

Learning and improvement across the system

- The CCG and the local authority are engaged with the STP and LDS and the Liverpool City Region Combined Authority which enabled them to transfer and apply learning from outside their local area.
- There was some evidence of learning being shared across agencies to improve quality and safety of care, for example, the CCG has worked with operational staff in hospices and hospitals to improve the quality of discharge information.
- We found evidence of learning at an organisational level regarding lessons learned however it was less apparent that this learning was being shared across organisations within the local area.

What impact is governance of the health and social care interface having on quality of care across the system?

We looked at the governance arrangements with the system, focusing on collaborative governance, information governance and effective risk sharing.

We found governance arrangements had been developed across the system to support partners to

collaboratively drive and support quality of care across the health and social care interface.

The overarching forum for system leaders to jointly plan how best to meet local health and care needs, and to commission services accordingly was the Health and Wellbeing Board (HWB). However there was little evidence of shared success criteria between the local authority and CCG commissioners and providers, underpinned by shared key performance metrics outside of the BCF

Overarching governance arrangements

- Governance arrangements had been developed across the system to support partners to collaboratively drive and support quality of care across the health and social care interface. Governance for the local authority and CCG's Section 75 partnership agreement was through a shared Executive Partnership Board (EPB) with an Operational Commissioning Committee (OCC) undertaking the detailed work of the agreement.
- The Health and Wellbeing Board was described as the overarching forum for system leaders to jointly to plan how best to meet local health and care needs, and to commission services accordingly. Partners were already engaged in system wide dialogue regarding the development of an accountable care system however these discussions had not yet manifested into detailed planning arrangements. Partners were committed to moving this work forward over the coming months
- Individual organisational governance arrangements were supported by well-developed committee structures in each of the system partner organisations. Strategic objectives were linked appropriately to organisational priorities. Organisational performance dashboards were shared and understood across partners and focussed on service quality and delivery.
- System partners acknowledged that pathways of care across organisational boundaries continued to challenge the system and required additional work regarding governance arrangements as well as future contracting and commissioning arrangements to ensure a truly collaborative and shared approach.
- There was a good process for agreeing Better Care Fund (BCF) allocations and responsibilities were agreed, shared and understood across the local authority and the CCG, and this was built on a pooled budget. However, the NHS trusts were not fully engaged
- There was not a collective governance framework that culminated in a series of agreed or shared performance metrics that were robustly monitored at the Health and Wellbeing Board. From the minutes of its meetings, and from our discussions with senior leaders, we found that the Health and Wellbeing Board had extensive membership and good rates of attendance. However the minutes indicated positive stakeholder engagement rather than a forum for strategic leadership and robust governance. There was a lack of challenge around performance for the system through the Health and Wellbeing Board.

- There was a history of joint working across health and social care, with some joint posts established, for example, the local authority's divisional manager is also the urgent care lead for the local authority and the CCG, and is an active member of the Mid Mersey A&E Delivery Board, representing both organisations. This appointment was well received at an operational level and the divisional manager was seen as visible and supportive across the CCG, local authority and local NHS Trusts. There was an opportunity to replicate these posts at a more strategic level to better support alignment and the integration of services as well as establish joint governance and performance management arrangements.
- In addition there was an agreement for a single executive lead for the development and delivery of older people's services supported by the chief nurse.

The governance of data collection systems were not always aligned to inform performance, which meant that information could not be effectively monitored across the system. For example, information from the discharge lounge at Warrington Hospital was not being used to improve the effectiveness of discharge lounge processes.

Information governance arrangements across the system

- Better Care Fund returns for 2016/17 indicated that the area was meeting the national conditions around data sharing. This included confirmation that they are using NHS numbers as the consistent identifier for health and care services. The local authority and the CCG are pursuing interoperable Application Programming Interfaces (APIs) – systems that can exchange and make use of information – with the necessary security and controls, ensuring appropriate information governance controls for information sharing, in line with national guidance. This approach supports people having clarity about how their data is used, who may have access to it, and how they can exercise their legal rights.
- The system has agreed to undertake work to improve information sharing and is transferring urgent care centres and community services onto 'EMIS Web' which will allow access to shared records with out of hospital services. This approach (due to be fully implemented in 2020) aims to promote seamless transfer of information across the system and reduce duplication of effort.
- All organisations within the system had robust policies regarding personal information and a person's right to confidentiality and privacy.

Risk sharing

- Work is required at a system level to articulate and mitigate wider system risks; this process was not yet fully developed across the STP and LDS or the emerging ACS
- We found no evidence (either during on site activities or through reviewing minutes from Health and Wellbeing Board meetings) of risk management arrangements across the system, however these were in place at an organisational level.

- All partners in the system were experiencing complex financial challenges. Partners were transparent and open with each other in sharing information about their own risks as to the impact this was having on decision making in respect of resource allocation and the setting of priorities.
- There was a shared understanding regarding risk mitigation in respect of the new approach to domiciliary care provision between the local authority and the preferred provider.

To what extent is the system working together to develop its health and social care workforce to meet the needs of its population?

We looked at how the system is working together to develop its health and social care workforce, including the strategic direction and efficient use of the workforce resource. In Halton we found system leaders acknowledged a number of workforce issues across the health and social care system. Workforce challenges in the NHS were most prevalent in the availability of medical staff in hospitals, general practice and urgent care. In adult social care the biggest challenge was in the recruitments and retention of domiciliary care staff. Robust actions had been taken by each organisation to address vacancies however this had not yet resulted in a system-wide workforce strategy that supported the system to determine joint investment in a future workforce.

Workforce planning and development

- With the exception of the acute trusts we met with system leaders responsible for workforce planning. All participants indicated that there were strong personal relationships across the system and a shared understanding that workforce issues were a risk to high quality, timely service delivery. Most partners had an organisational workforce strategy however; we found little evidence of a cross sector analysis of workforce challenges or joint plans to address them.
- Individual partners in the system had an organisational workforce strategy. However, there was not a joint workforce strategy for the Halton footprint that was shared and governed across the health and social care system.
- System leaders acknowledged a number of workforce issues across the health and social care system. Workforce challenges in the NHS were most prevalent in the availability of medical staff in hospitals, general practice and urgent care.
- Actions had been taken by each NHS acute trust to address hospital-based nursing vacancies; however this remained an ongoing challenge and there were rolling programmes in place to secure nursing staff and manage turnover.
- Within social care, analysis of Skills for Care data from 2013-14 to 2015-16 indicated that staff turnover and vacancies in Halton were below national and comparator group averages. During our visit we found there were no social worker vacancies, the greatest challenges related to the recruitment and retention of domiciliary care workers.

- The increased skill expectation of care and nursing staff in the independent care sector was having an impact on capacity, demand and the delivery of high quality care. These matters also had an impact on the ability of community services to respond to the changing pattern of demand and the desire to deliver older peoples' care closer to and in their own home.
- The local authority and in some areas the CCG, had started work to support care and nursing staff in the independent sector through the transformation of domiciliary care and the support to care homes projects. This involved initiatives such as apprenticeships, and training and development programs to support staff development and retention in these areas.
- We found that there was a collaborative agreement across the whole system, including Health Education England, to work with the developing Health Academy to help address staffing challenges within health and social care and to adopt a more collegiate and strategic approach to manage workforce across the local authority footprint.
- Work was also underway to develop the skills of the existing workforce to help manage gaps. Partners were looking at ways to increase the numbers of advanced nurse practitioners and nurse prescribers to support timely interventions and improved access in both primary and secondary care.
- We found little evidence of a cross sector analysis of need regarding the workforce and no joint strategic action plan to support the anticipated increased demand as winter approached.
- However, there were positive steps being taken at an organisational level to support the maximisation of the existing workforce through work-related wellness campaigns and immunisation projects that included staff in the independent sector who were involved in direct care.

Is commissioning of care across the health and social care interface, demonstrating a whole system approach based on the needs of the local population? How do leaders ensure effective partnership and joint working across the system to plan and deliver services?

We looked at the strategic approach to commissioning and how commissioners are providing a diverse and sustainable market in commissioning of health and social care services.

There was evidence that the local authority and the CCG worked positively together to develop the JSNA over a number of years. Commissioning strategies were underpinned by the JSNA and were regularly reviewed and evaluated.

There was a specific JSNA for older people and good evidence of partners meeting people's needs in terms of health and wellbeing, social inclusion, social prescribing and transport; however a joint

commissioning strategy for older people's service provision had not yet been fully developed.

There was acknowledgement, particularly by the local authority, that work was needed to strengthen and diversify the range and nature of support services particularly domiciliary and care home provision to meet the needs of older people.

Strategic approach to commissioning

- Commissioners in the local authority and the CCG had carried out a comprehensive needs assessment and had used this to determine commissioning priorities at the interface of health and social care.
- To secure improved outcomes for older people commissioners had initiated several large-scale, long-term commissioning initiatives that were in the early stages of development and implementation. For example the 'Healthy New Town' project that aimed to improve peoples' experience by providing housing with health and wellbeing services that were easily accessible and co-located. This initiative also aimed to address staffing shortages in health and social care.
- A JSNA for older people had been completed however a joint commissioning strategy for Older People had not yet been formalised at the time of our review.
- There was evidence of consultation and inclusion of older people in the assessment process.
- One of the issues raised by users was they often felt unprepared for discharge from hospital and that the discharge process was not always well managed, especially for those older people who lived alone.
- Partners had responded positively to improving older people's experiences in this regard; this was one of the main areas identified to shape future service commissioning
- The local authority acknowledged that patients being able to exercise a choice regarding which care home to move to was leading to delays, patients were given the full range of care homes in the borough and not just a list of those care homes with vacancies. This meant that if a patient chose a home without vacancies their transfer of care could be delayed. The rationale for this was that the local authority wanted to provide information on all care homes within the area to ensure people in the borough received their care in a place of their choice. However there was a choice policy in place at Warrington and Halton NHS FT intermediate care unit that would have mitigated this issue, by a service user choosing their long term home but waiting in the interim in another care home however, we did not see evidence this was being implemented
- There were joint commissioning initiatives for older people based on robust analysis and evidence-based commissioning principles to keep people well and when they experienced a crisis, focussed on recovery. These were not yet fully implemented and embedded at the time of our review but included:

- ⇒ The development of multi-agency guidance regarding the early recognition of frailty across health and social care sectors
 - ⇒ Rapid assessment 'close to home' and at hospital including management of frailty and improved discharge processes
 - ⇒ Review of capacity, demand and models in intermediate care provision
 - ⇒ Outcome-based domiciliary care commissioning and contracting
 - ⇒ Strengthening of the existing primary and secondary falls prevention work
- There was one A&E Delivery Board for covering both St Helens and Knowsley NHS Trust and Warrington and Halton NHS Foundation Trust. The A&E Delivery Board met regularly and supported system resilience planning across the system including capacity planning and out-of-hours planning, however joint winter plans were still being developed at the time of the review. Pooled budgets had been in place since 2013, for example the continuing healthcare budget. Other initiatives included the use of embedded Social Care in Practice (SCIP) workers who worked across the primary care and social care interface.
 - The joint commissioning of new services and the implementation of some key initiatives was already underway, for example the development of a frailty pathway.
 - Changes to domiciliary care provision proposed by the local authority were agreed and due for full implementation by November 2017.

Market shaping

Our analysis showed that, per population aged 65+, there are fewer residential and nursing care home beds in Halton compared to comparator areas and the England average. Furthermore, our analysis identified that the number of residential care home beds had decreased by 9% since April 2015, meanwhile nursing home beds had decreased by 13%. However the vacancy rates in care homes was below the England average and that of comparator areas.

- There was an acknowledgement, particularly by the local authority, that work was needed to strengthen and diversify the range and nature of support services *particularly domiciliary and care home provision* to meet the needs of older people. Partners had an understanding of the changing environment of the adult social care provision and a subsequent risk assessment has been used to inform the 'Transforming Domiciliary Care' project.
- Commissioners were using long term contracts and risk sharing to address the challenges in the market. For example, through the Transforming Domiciliary Care project a long term contract was offered to a sole provider. The contract had an associated risk mitigation process, allowing the provider to sub-contract to meet identified and anticipated increased need, if required.

- The local authority had agreed to expand its in-house service provision by recommissioning long-term care beds for the provision of intermediate care.
- LDS partners had worked together to agree the key characteristics of a high performing out-of-hospital system, undertaking a baseline assessment and identifying the areas for improvement. Implementation of the following would commence in September 2017:
 - ⇒ Halton's GP Forward View and the local strategy for primary care. These outlined the plans to manage the increasing demand for local medical services and primary care through service redesign.
 - ⇒ Work to strengthen the domiciliary care and care home sector as part of Halton's BCF plan.
 - ⇒ A single contract for care home provision was developed by the local authority and the CCG as part a Section 75 agreement, following a consultation on the cost of care.
 - ⇒ The transformation of domiciliary care and the re-procurement of domiciliary care which sought to strengthen the market and plan for future demand. This would be done through using long term contracts, more efficient care delivery, and greater utilisation of the third sector to support older people in their own homes.
 - ⇒ Developing existing multi-disciplinary teams, wrapped around primary care and supporting better self-care through technology.
- Developing an ACS will go some way to managing competitive elements with the health and social care system, however at the time of our review this work was in its very early stages.

Do commissioners have the right range of support services in place to enable them to improve interface between health and social care?

- An assistive technology program (telemedicine) was well established in Halton with approximately 3,000 people currently using the service that included a 24-hour response service.
- Community wardens responded to calls within approximately 30 minutes and were actively involved in the falls prevention programme.
- There was evidence emerging locally that the falls reduction programme was having a positive impact in reducing the number of domestic admissions to hospital as a result of falls.
- There was a single team approach in the falls team with good communication and support between teams and single senior management oversight of operational provision of this valued service.
- Halton Direct Link services, supported by partners in the voluntary sector, provided two centres in Widnes and Runcorn for people to access or be signposted to services that supported health and wellbeing and avoid medical intervention. Support was also available for people to access an appropriate assessment of need. People also had access to social prescribing and productive activities to maintain the wider determinants of health such as housing and social isolation.

- In addition, a member of the wellbeing service team was based at each GP practice; people could be referred directly to wellbeing services at the point of GP contact. Feedback from service users was very positive about these services and they felt valued and included as a result. Feedback from GPs indicated that this service was successful at preventing older people becoming lonely, demotivated and suffering from related conditions such as depression and anxiety.

Contract oversight

- The local authority had systems and processes in place to review the impact and quality of service provision through close working with the CCG in respect of contract renewal. This was particularly evident in the recent work regarding the transformation of domiciliary care and care home provision in the borough.
- More widely, all service commissioners had systems in place to review contractual arrangements as part of a rolling programme. However we found that some quality monitoring arrangements relating to commissioning contracts would benefit from a more proactive approach, for example in primary care and the performance of the intermediate care services provided by Warrington and Halton Hospitals NHS FT.

How do system partners assure themselves that resources are being used to achieve sustainable high quality care and promoting peoples' independence?

We looked at resource governance and how systems assure themselves that resources are being used to achieve sustainable high quality care and promote peoples' independence.

We found that the assurance and governance process across the system would benefit from the addition of agreed performance metrics underpinned by a continuing challenge and scrutiny function from the HWB. Partners met regularly to share information, discuss key issues and adopt a problem solving approach. However not all partners felt fully involved in determining how resources were allocated, primarily the NHS trusts, and in particular with regards to the resource allocation for the Better Care Fund. We found performance dashboards in place to monitor resource capacity and predict demand. Performance metrics were shared and a problem solving approach adopted, particularly by the local authority and the CCG.

- The Health and Wellbeing Board had ultimate oversight of the work of the Operational Commissioning Committee, the forum undertaking the detailed work of the pooled budget agreement which included the BCF. Governance of this was through a shared Executive Partnership Board (EPB). However, not all partners felt fully engaged in this process, particularly the NHS Trusts.
- The assurance and governance process across the system would benefit from the addition of agreed performance metrics underpinned by a continuing challenge and scrutiny function from the HWB.
- The CCG and the local authority held monthly joint meetings of the Executive Board of the Council

and the Executive Management Team of the CCG, to share information and discuss key issues.

- There were a number of joint management team meetings that included the local authority, CCG and NHS Trusts that supported an open culture and problem solving approach.
- There were performance dashboards in place to monitor resource capacity and predict demand. Resource allocation and effective financial management was scrutinised through an embedded committee structure that called senior officers to account in their respective organisations.
- In respect of the BCF, joint consideration had been given and agreed by the local authority and the CCG as to where the investment of the fund would have the biggest impact on improving the care for older people and reducing DTOC.
- Work was planned and underway in respect of:
 - ⇒ Investment in re-ablement as the first approach on discharge from hospital, rather than a reliance long-term domiciliary care
 - ⇒ Investment in the transforming domiciliary care project
 - ⇒ The development of improved technology such as telecare
 - ⇒ The development of a social care Trusted Assessor model
 - ⇒ Improved information systems within the hospital to support discharge choices/ pathways
 - ⇒ Enhancing health in care homes, working with providers to develop an alternative commissioning and delivery model
- Expected outcomes were to:
 - ⇒ Meet adult social care needs in a timely way
 - ⇒ Reduce pressures on the NHS. There is an expectation that additional funding will reduce DTOC in accordance with national expectations
 - ⇒ Stabilise the social care provider market to support a wider range of support in the community
- Associated action plans had been developed to ensure that these initiatives would be implemented during 2017/18. A review of the outcomes and financial impact achieved was scheduled for completion at the end of 2017/18, and would form the basis of recommendations for further initiatives/developments for 2018/19 and 2019/20.
- The local authority worked with the CCG to complete the Urgent & Emergency Care Milestone Tracker that indicated positive progress in relation to the implementation of the high impact change model. However, the trusted assessor element of the model had yet to be implemented.
- We saw evidence of where resources were not being managed effectively. For example, some people being cared for in hospital were also being funded for a residential care home bed, when it

was apparent their needs had changed and they would require more intensive support ,for example a nursing home placement and consequently would not be eligible to return to their usual place of residence.

- Halton had one of the highest costs per patient with regards prescriptions in the country. To reduce the costs and optimise medication use in the system, the CCG medicine team were beginning to review cases where older people were prescribed large numbers of medicines in care homes. However this work needed a more system wide approach as the team were struggling to reach all GPs to identify cases for review.

Do services work together to keep people well and maintain them in their usual place of residence?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: maintaining the wellbeing of a person in usual place of residence

Are services in Halton Safe?

Strategies and initiatives have been developed and put in place to prevent avoidable harm.

- Each GP practice held monthly MDT meetings targeted at people with complex needs and those at risk of deterioration. These meetings were attended by a range of health and social care professionals to develop a person centred approach to case management.
- Systems were in place across the health and social care interface to safeguard people from avoidable harm, abuse or neglect. Halton's Safeguarding Adults Board was well established and was supported by its member agencies including the local authority, Halton CCG, North West Ambulance Service (NWS), the local acute trusts, NHS England, Cheshire Probation Service, Halton Housing Trust and Cheshire Fire and Rescue.
- Providers were supported to identify people who were frail and with complex needs. A frailty pathway had been developed with input from all partners in the system. This included assessments being developed and rolled out across health and social care teams to facilitate the early identification of frailty, and timely access to support and interventions.
- Systems were in place to support the management of medicines. Pharmacy support was provided to reduce polypharmacy related risks, including falls prevention. The CCG medicines management team were working with the falls team to proactively address medication prescription and polypharmacy issues to support falls prevention for people living in care homes.

- Domiciliary care providers were working with their commissioners to assess risk to people using their services. Risk assessments were in place for each service user that could be reviewed on a regular basis. The domiciliary care provider proactively raised concerns to the local authority where there were mental capacity concerns that had not been communicated by the Acute Trust. In these instances a Mental Capacity Act assessment was subsequently completed, however we were told this could sometimes be delayed.

Are services in Halton Effective?

Halton had a high rate of attendance at A&E for older people. Joint initiatives had been developed across the health and social care system to maintain people in their usual place of residence. However these were not always fully coordinated and evaluated, meaning they might not always be used to their maximum benefit.

- Our analysis showed that Halton had a significantly higher rate of attendance at A&E of people aged 65+ than the England average and their comparator areas.² Analysis also showed a comparatively high number of hospital admissions from care homes, with a diagnosis associated with accidents and injury³.

A high number of falls in Halton had been identified as a challenge by the system, and a joint strategy involving public health, the CCG and the fire service had been put in place to prevent falls. There was multi-agency working to prevent falls including the falls team working with care homes to train staff, and the fire service conducting falls risk assessments in domestic premises. The system reported that the number of admissions to hospital as a result of falls has since reduced.

- The planned enhanced care home model, involving the CCG, local authority and GPs, will support care home staff to have the skills and confidence to make care decisions that avoid hospital admission. However this initiative will not be embedded to support the anticipated increase in service demand over this winter.
- An Older Peoples' Pathway had been jointly developed across the system with an emphasis on reducing the dependency culture for older people and supporting them to remain independent. The pathway had nine elements, including staying healthy, living well and rapid support to avoid admissions.
- We found that many older people had access to a range of services to help them remain healthy and socially included. Service user satisfaction rates remained high with over 90% of older people who responded to the local authority satisfaction survey saying the services were effective.
- Rapid and out of hours support in Halton included the Rapid Clinical Assessment team (RCAT) and

² Hospital Episode Statistics April 2015-March 2016.

³ Hospital Episode Statistics October 2015- September 2016. Analysis based on attendances from postcodes containing a registered care home. Data could pertain to other addresses within the postcode. Postcodes containing more than one care home have been excluded from analysis.

Rapid Access Rehabilitation Service (RARS) services. Across stakeholders, the RCAT service was regarded as an effective and valued service; an unpublished exploratory study conducted locally identified that RCAT successfully avoided admissions for 85% of cases referred to it.

- However, the RCAT service was underutilised due to low referral numbers (196 in 2016/17). A recent (June 2017) report commissioned by the local authority identified the reasons for this as being gaps in GPs' knowledge of the service, inadequate communication between system partners, and a lack of shared understanding as to the capacity of the service and its availability out of hours. The recommendations made following the report were yet to be agreed and implemented by partners. The number of referrals to RCAT was being monitored as part of shared BCF Key Performance Indicators.
- In the RARs service there was historical evidence of a formal commissioning process and agreed performance criteria. However operational staff were unable to articulate this when asked

Are services in Halton Caring?

People and their carers are supported and involved in the planning and delivery of their care. There was good evidence of support services for carers that met their individual needs and preferences; however the assessment process for carers was duplicated.

- We observed a number of assessments carried out by different teams during the course of the review. We saw good examples of person centred assessments, including for people experiencing memory loss. Clinical, social and cultural information was included in assessments which provided all aspects of what was important in people's lives.
- Halton CCG had a high uptake of personal health budgets and direct payments. Cumulative activity through Q1 2017/18 showed their rate of personal health budgets for all adults was 27.7 per 50k, compared to the England average of 5.82 and the average across Cheshire and Merseyside of 7.44. Their number of direct payments for all adults was 11.18 per 50k, compared to the England average of 3.63 and Cheshire and Merseyside region average of 3.79. The Halton Disability Partnership delivered a service to support people through the process of accessing and using direct payments. Direct payments can empower people to make decisions about their future care and manage their health and wellbeing.
- Carers were well supported in Halton, with input from the Carer's Centre that reached approximately 5000 carers, including 528 carers supporting people with dementia. The centre had a carers support group specifically for people living with dementia which had 20 members. The centre considered the wishes and aspirations of carers and held a well-attended quarterly forum to seek feedback to ensure that they were meeting carers' needs.
- However, there was some duplication of assessments for service users between system partners and the local authority. There was an opportunity to streamline the assessment processes and reduce the number of times service users have to tell their story in order to receive support.

Are services in Halton Responsive?

People are assessed and receive care and treatment at the right place and the right time to maintain them in their usual place of residence. However, data showed that there were challenges in Halton in avoiding admission and readmission to A&E.

- Work was being undertaken to reduce A&E attendance by increasing the capacity within care homes to be more responsive to the needs of residents. The care home support team, and mental health care home liaison team supported care homes to prevent hospital admissions and improve the quality of care. There were plans to link each care home to a named GP, due to begin in September 2017 and be completed by December 2017.
- People in Halton could contact the local authority Contact Centre or attend the Direct Link services which were available to signpost and support people to make decisions about their care. Direct Link hosted health improvement and prevention programmes to keep people well, such as stop smoking groups and diet and nutritional advice.
- Direct Link could refer people to the local authority Contact Centre for pendant alert system services and blue badge applications, the Citizens Advice Bureau, and the Sure Start to Later Life service (offering information and activities for people over 55) . However, staff at Direct Link felt that by taking a greater role in referral process they could be more responsive to people's needs. Staff at the Direct Link centre had not received dementia training, meaning that there was a risk that people with dementia were not having their needs identified.
- Halton had a range of services designed to enable people to receive the right care in the right place at the right time to maintain them in their usual place of residence. This included:
 - ⇒ The 24-hour assistive technology service
 - ⇒ Community wardens working to a 30 minute response from referral time
 - ⇒ The Initial Assessment Team, RCAT and RARs services working to a same day response from referral target
 - ⇒ Community equipment provided within five days and emergency equipment available for teams as needed
 - ⇒ Strong and bespoke support for carers.

Do services work together to manage people effectively at a time of crisis?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: crisis management

Are services in Halton Safe?

Partners were working together to implement initiatives to assess risk and reduce avoidable harm, however there are still challenges in meeting the needs of older people at a time of crisis, particularly in relation to patients moving to intermediate care.

- There were systems and processes in place across the system to safeguard people from avoidable harm at a time of crisis. For example, NWS had worked with the CCGs to reduce the number of A&E admissions from people who call the emergency services. NWS deployed a 'falls care' process to incidents where an older person had fallen to give specific care and support to prevent a direct A&E admission.
- Our analysis of waiting times in A&E from 2014/15 to 2016/17 showed that both trusts were performing below the national expectation. In Whiston Hospital (St Helen and Knowsley Teaching Hospitals NHS Trust) an increasing percentage of people arriving at A&E had to wait longer than four hours year-on-year, with only 85% seen within four hours in 2016/17. At the two hospitals in Warrington and Halton Hospitals NHS Foundation Trust, 90% were seen within four hours in 2016/17.
- Risk assessments and escalation pathways were in place to mitigate avoidable harm for people who use services during a crisis. These included pressure area management and falls prevention. However, due to the extended waits for some patients to access intermediate care at Warrington and Halton Hospitals NHS FT we found evidence of avoidable harm to people.
- The CCG and local trusts had shared key performance indicators around quality, safety and experience of care, these look at recurrent trends for incidents and falls. Incidents were reported and discussed at the Quality Surveillance Group (QSG).
- Staff in A&E departments displayed an awareness of how to identify and manage safeguarding concerns, however further training in safeguarding awareness was identified as a need. Halton Adult Social Care was recognised in the system as providing high quality safeguarding training, and had been requested to deliver training to NHS staff.

- At Whiston Hospital GP streaming had been in place since June 2017 WHFT was due to have front door clinical screening provided by GPs in place by October 2017, this would allow the emergency departments to focus on caring for people with the highest needs, including older people.

Are services in Halton Effective?

We found evidence that the urgent care system was effectively managing the flow of people at a time of crisis, including through effective joint working in the emergency departments.

- There were good examples of effective system working at the Urgent Care Centres (UCCs) in Widnes and Runcorn. The UCCs were aligned in their approach, using a shared care pathway to deliver a consistently high standard of care across both sites.
- Systems were in place to support the effective collaboration and information sharing between professionals and organisations to meet the needs of the people who used services. Both UCCs had access to a record sharing system that included a summary care record, information about allergies, medications, and risk management.
- Diagnostic testing such as scans and blood tests could be carried out in the centres and the person's care and treatment plan was sent to their GP by 8am the following morning. Multi-disciplinary assessments were carried out by the appropriate professionals, as therapy staff were co-located at the centres. Referrals could be made to community services, district nurses, or when appropriate local safeguarding teams.

Are services in Halton Caring?

People and their carers are involved in their care and supported to make informed choices during a time of crisis. However people indicated that the discharge process could be more informative.

- In the discharge lounge people told us they had been given information about their care and treatment options and that the process had been explained in a way that they could fully understand. There was a wide range of information available in the departments for people to take away regarding the management of their condition and discharge options. However, there were also some people who indicated that the discharge process could be more informative.
- A survey carried out by the discharge teams at WHFT in 2016/17 was generally positive and people felt assessment and discharge was a smooth process, however, 10% of people and their carers who took part in the survey felt they weren't given enough time to prepare for the change in care arrangements.

Are services in Halton Responsive?

Services have been developed and planned in consultation with the local population. People are managed well through their admission and assessment in acute settings. However some people remain in acute care longer than necessary while waiting for intermediate and re-ablement services.

- Operational and management staff acknowledged that there was a challenge around delayed discharge due to a lack of care home placement and domiciliary care packages. During our site visit to Warrington hospital we saw examples of people who had been assessed as no longer requiring an acute bed remaining in hospital because an enablement /intermediate care bed was not available. There was evidence to suggest that one patient had suffered avoidable harm because of this.
- Data for 2016/17 showed an improvement in reaching the four hour treatment expectation at Warrington and Halton Hospitals NHS FT; however performance was still below the national expectation, and at St Helen and Knowsley Teaching Hospitals NHS Trust performance had been declining each year and in 2016/17 was below the expectation and the national average. The system attributes the improvement at Warrington and Halton Hospitals NHS FT to the RCAT and RARs services.
- At Q4 2016/17, 95.4% of the 718 available overnight beds at St Helens and Knowsley Hospital NHS Trust were occupied and throughout 2016/17 occupancy had remained above 90% at the trust. Although optimum occupancy rates for hospital beds may vary according to type of services offered, hospitals with average bed-occupancy levels above 85% are likely to face regular bed shortages, periodic bed crises and increased numbers of health care-acquired infections. At Warrington and Halton Hospitals NHS Foundation Trust, 86.9% of the 613 available overnight beds were occupied in Q4 2016/17 and occupancy had stayed close to the optimal 85% level throughout the year.
- We found positive examples of effective discharge planning when we sampled records in Whiston hospital and Warrington hospital A&E and discharge lounges. There was evidence of people progressing through the system with a multi-disciplinary focus on assessment and discharge planning.
- There was a challenge around the sharing of relevant service user information in a timely way across organisations with different IT systems. This was identified as causing delays to the process, duplication of effort, and impacting effective decision making.
- Halton operated a borough based urgent care system review using daily information on capacity and demand in hospitals, intermediate care, and care home and domiciliary care provision. This information supported operational teams to identify gaps and direct existing resources (finance and staffing) accordingly. This also fed into longer term trend analysis used for the commissioning of additional capacity and alternative forms of care as well as for seasonal planning.

Do services work together to effectively return people to their usual place of residence, or a new place that meets their needs?

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: step down, return to usual place of residence and/ or admission to a new place of residence

Are services in Halton Safe?

There was a shared view of risk management across staff, however there were sometimes difficulties with joined up working between health and social care when people are returned to their usual place of residence, or a new setting.

- Our analysis of emergency readmissions within 30 days of discharge during 2015/16 showed that Halton was in line with the England and comparator averages. However, the rate of emergency readmissions from care homes was significantly higher in Halton than the England average (28% in Q1 2016/2017 compared to 20%) and was also higher than the comparator group average (22%).
- A lack of communication between hospital social work teams and domiciliary care agencies during the discharge process was sometimes leading to people being discharged to their usual place of residence without all aspects of packages of care in place. The system in place for the domiciliary care provider to contact the social work team to address any issues was not always effective.
- There was an agreed view on risk across professions within the intermediate care team; that people should be facilitated to take ownership over their risk management plans. From a number of years of health and social care services working together a shared understanding of risk management had developed, this was well embedded and GPs trusted the system and used it to inform decisions as to whether a hospital re-admission was necessary.

Are services in Halton Effective?

There were a number of discharge pathways and plans in place involving partners across the system to effectively enable people to return to their usual place of residence. However these were not always able to be carried out effectively due to a lack of social care availability and poor information flow.

- We observed people experiencing delayed discharges on the review: one person waiting for a care home placement, one person waiting for intermediate care and another waiting for a domiciliary package of care. We saw the negative impact of delayed discharge; one person developed a pressure ulcer and another experienced an increase in clinical symptoms.
- Both our analysis and the analysis conducted by the Department of Health indicated that Halton

had comparatively longer length of stay in acute hospitals for older people. Across Halton's comparators, 90% of people aged 65+ who were admitted as an emergency were discharged within 19 days, however in Halton this figure was 23 days.

- At the time of our review the length of stay at the intermediate care unit at Warrington hospital was more than 50 days. The reasons cited by senior leaders and operational managers for these delays were the challenges in the care home and domiciliary care market including volume and capacity and quality issues.
- Analysis of Adult Social Care Outcome Framework (ASCOF) reablement measures for 2015/16 showed that Halton had a significantly lower percentage of people aged 65+ still at home 91 days after discharge from hospital into a reablement service (63.3%) compared to the England average (82.7%) and comparator areas (81%). Analysis of the longer term trend between 2011/12 to 2015/16 showed that the proportion had been consistently lower in Halton relative to the national and comparator averages and had decreased over that period. The rationale for this of the Local Authority was to respect people's choice if they wanted to return to their usual place of residence, sometimes against professional advice. This resulted in a higher percentage of people being transferred to a more suitable care environment.
- The quality of discharge summaries was raised as a concern across professional groups. Poor quality discharge summaries sometimes impacted on providers' ability to meet the needs of people when they return to their usual place of residence or a new setting. This was a particular issue with regard to quality of information around medications. It was acknowledged at a senior level that there was a lack of understanding about the importance of the quality of discharge information and actions were in place to help address the issue. These included the introduction of compulsory fields on electronic discharge forms.
- Our analysis showed there were fewer care home beds available in Halton compared to similar areas and recent care home closures had contributed to this. The local authority had worked with an external consultancy firm to assess the reasons for closures and develop early warning indicators before services closed. This had been fed into the care homes transformation programme and the local authority was also in the processes of purchasing a care home at risk of closure to secure these placements.
- Although both the domiciliary care and care home transformation plans appeared robust they were not in place at the time of the review. At the time of the review was that there were no new domiciliary care placements available and people had to stay in hospital until capacity became available. This meant that people were having extended length of stays in intermediate care. We also saw examples of people waiting in acute hospital beds to go into intermediate care.
- It was acknowledged across the system that there was a shortage of care home placements for people living with dementia. This was being addressed through the care home transformation programme, however this was not due to fully implement until 2018. It was not possible to assess if either of these programmes would be effective in dealing with the increased demand over winter.

Are services in Halton Caring?

People using services, their families and carers felt included and involved in care planning. However the co-ordination of care and content of needs assessment was not always consistent across services

- Feedback from people in the Halton Borough Council satisfaction survey who had received a service (approximately 4,500) was positive overall with 58% of people responding:
 - ⇒ 96% of people said that they felt that staff treated them with respect and dignity all of the time.
 - ⇒ 100% of people outlined that they fully understood the information given to them about their care.
 - ⇒ .
 - ⇒ 96% of the people said they were either likely/extremely likely to recommend the service to a friend.
 - ⇒ 100% of people were either satisfied/very satisfied with the care they received.
- We reviewed eight assessments and discharge plans at Whiston, Warrington and Halton hospitals and found they varied in content and quality. There was evidence of people progressing through the system with a MDT approach to discharge planning. However in records reviewed at Halton hospital we found no evidence of involvement from people, their family or carers in terms of discharge planning and preferred place for discharge.
- In our review of case notes we saw examples of repeated assessments; in one case a person had received five assessments by different professionals in two weeks. The person had some cognitive impairment and had become distressed at the number of questions they were being asked and the number of people visiting them. This had also led to duplication of effort across professionals. The reoccurrence of such situations may be reduced by the planned implementation of the trusted assessor component of the high impact change model; however this had not been implemented at the time of our review.
- Case note review and dip sampling showed that people who used services and their relatives were involved in the development of care plans and discharge arrangements. We also saw evidence that GPs had discussion post admission with families about their choices and future planning, for example around further hospital admissions.
- However, involvement of people who use services, their families and carers was not consistent across Halton, and in some records we saw no evidence of their involvement in terms of discharge planning and preferred place of discharge. This was more significant in records reviewed from Warrington and Halton hospitals.

Are services in Halton Responsive?

Partners are working together to enable people to be discharged at the right time and to the right place, however, there are significant challenges with delayed transfers of care that had a negative impact on people.

- The capacity challenges in the care home, nursing home and domiciliary care market was widely recognised at operational and management levels at both hospitals as a key contributor to delayed transfers of care.
- The length of stay at the Warrington and Halton Hospitals NHS FT intermediate care unit (HICU/ B1) was at an average of 48 days for 2016/17, on the day we visited this had risen to 67 days. Staff dealing with discharges did not routinely attend the length of stay weekly meetings at Warrington hospital in person and any delayed transfers of care would be reported by phone.
- When reviewing six sets of case notes, the most common reasons for delayed discharge were people waiting for care packages, either domiciliary care provision or a care home placement.
- Senior leaders in the local authority and CCG had instigated the plans to transform provision in both domiciliary and care home settings, however these plans were untested and therefore the impact could not be measured as to see how they would increase capacity in the system and address the increased pressures during winter
- Analysis of DTOC figures from April 2015 to April 2017 showed that the rate of delays had been increasing within Halton and after October 2016 had remained higher than both national and comparator area averages. Although recent DTOC figures were improving (figures for June 2017 indicate that the average daily rate of delayed transfers of care in Halton had dropped to 8.8 delayed days per 100,000 population, below the England figure of 13.8 and below Halton's comparator average of 10.80), there were a number of challenges in the timely provision of appropriate rehabilitation services and intermediate care to support this reduction. Patients with complex needs were experiencing some considerable delays.
- Our analysis of delayed transfers of care showed that one of the main reasons reported for delayed discharges was 'patient or family choice', accounting for 35% of delays in the area. We were informed at the Warrington and Halton NHS FT intermediate care unit that people awaiting discharge to a care home were provided with information about all homes within the area, even those that did not have availability. This could result in delays if people and their families chose to wait for a bed in their preferred home. There was a choice policy in place at Warrington and Halton NHS FT intermediate care unit, we did not see evidence this was being implemented. The local authority acknowledged that people choice was leading to delays; however they wanted to provide the information to enable people to choose the right provision for them.
- Halton has comparatively longer lengths of stay in hospital for older people than the England average and that of its comparators. Analysis produced by the Department of Health showed that

across Halton's comparators, 90% of people aged 65+ who were admitted as an emergency were discharged within 19 days, however in Halton this figure was 23 days⁴. Additionally, our analysis showed that during 2015/16 33% of people aged 65+ who were admitted stayed in hospital for over a week, compared to the national average of 32% and comparator average of 30%.

- We held discussion with members of staff who dealt with discharges from the two acute hospitals and the intermediate care units. Staff from Whiston hospital had a good overview of how many delayed transfers of care they were managing that week. However staff covering Warrington and Halton were less clear because of a lack of robust managerial oversight.
- Continuing Healthcare (CHC) was provided through a joint local authority and CCG budget which had been established for a number of years. Staff did not recognise CHC as being a primary cause of delays. However, NHS CHC figures for all adults (NHS England) for Q1 2017/18 showed that for Halton CCG 25% of referrals for standard CHC were completed within 28 days, lower than the England average of 57% and the Cheshire and Merseyside regional average of 73%.
- The same data (NHS CHC figures for all adults for Q1 2017/18) showed that Halton CCG had a standard NHS CHC referral conversion rate (% of newly eligible cases of total referrals completed) of 43%. This was high compared to the England and Cheshire and Merseyside regional averages of 25%. Their assessment conversion rate (% newly eligible cases of total cases assessed) was also higher. This indicates that Halton's processes for identifying people eligible for CHC are working well and a lower proportion of people and their families entered the CHC process to be then denied CHC funding.

⁴ Department of Health analysis of Hospital Episode Statistics - March 2016 – February 2017

Maturity of the system

What is the maturity of the system to secure improvement for the people of Halton?

- Relationships were strong with a high level of mutual trust and a culture of openness and transparency. There was a shared understanding of system challenges and a willingness to work together to achieve a solution, coupled with a strong commitment to serve the people of Halton well.
- Partners in the Halton system had a longstanding history of working together effectively for the benefit of the people living in the borough.
- There were some excellent examples of shared preventative approaches and local agreements that supported local people in having timely access to services and support that met their needs in a person centred way.
- However, there was still work required in relation to developing a wider system vision for the STP and ACS footprint and the development of a common framework for prioritizing actions, accountabilities and governance arrangements.
- Although managed well at a local level, the system had work to do to develop a strategic approach to workforce planning and development.
- In addition, the allocation of resources within a financially challenging environment and managing system wide performance would benefit from a more robust approach to risk sharing and shared success criteria.
- Work was underway to allow access to shared records with out of hospital services. This approach (due to be fully implemented in 2020) aims to promote seamless transfer of information across the system and reduce duplication of effort.
- This approach to records and information sharing should be part of a wider IT strategy that supports compatibility across partner IT systems to ensure that all parties have access to a full range of a person's record.
- Strengthening these key elements of system wide working would support the area to understand its future priorities and direction of travel more comprehensively and support improved outcomes for local people in a timely and effective way.

Areas for improvement

- The Health and Wellbeing Board would benefit from increased vigour in calling system leaders to account to ensure that agreed plans and service improvements are delivered at pace.
- A cohesive interface and robust alignment between the local authority's and CCGs vision for the borough, the Local Delivery System, the STP and planned ACS should be developed. This alignment should be underpinned by shared success criteria, key performance metrics and formal joint governance arrangements so that the all partners have a voice and appropriate recognition in wider system planning.
- While the local authority and the CCG work effectively together as commissioners in the borough, commissioning activity would benefit from increased care provider engagement including local NHS trusts and the GP Federations.
- The implementation of local strategies and plans to reduce avoidable admissions to hospital and improve delayed transfers of care should continue at pace.
- Plans to meet winter pressures should be aligned and coordinated at a system level to ensure that actions between key partners, staff, and people are effective and communications with the public to deter hospital attendance are clear, helpful and consistent.
- Further oversight and monitoring of commissioned services, particularly the intermediate care service provided at Warrington and Halton NHS FT should be put in place by both the service provider and the service commissioner so that poor performance is actively managed and patient experience improved.
- Data collection in different assessment processes across the system should be reviewed to avoid duplication this was particularly evident in assessment of people living with dementia and in the carer's assessment process.
- Now that strategic plans have been developed, strategic leaders should focus on delivery at the front line to improve outcomes for people in Halton.

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Bracknell Forest

Local system review report Health and Wellbeing Board

Date of review:
4-8 September 2017

Background and scope of the local system review

This review has been carried out following a request from the Secretaries of State for Health and for Communities and Local Government to undertake a programme of 20 targeted reviews of local authority areas. The purpose of this review was to understand how people move through the health and social care system with a focus on the interfaces between services.

This review has been carried out under Section 48 of the Health and Social Care Act 2008. This gives the Care Quality Commission the ability to explore issues that are wider than the regulations that underpin our regular inspection activity. By exploring local area commissioning arrangements and how organisations are working together to develop person-centred, coordinated care for people who use services, their families and carers, we are able to understand people's experience of care across the local area, and how improvements can be made.

This report is one of 20 local area reports produced as part of the local system reviews programme and will be followed by a national report for government that will bring together key findings from across the 20 local system reviews.

The review team

Our review team was led by:

Delivery lead: Ann Ford, CQC

Lead reviewer: Julia Daunt, CQC

The team also included:

- One CQC reviewer
- Two CQC strategy leads
- One CQC analyst
- Three specialist advisors (with backgrounds in older people, primary care, and adult social care)
- Two Experts by Experience

How we carried out the review

The local system review considered system performance along a number of **'pressure points'** on a typical pathway of care with a focus **on older people aged over 65**.

We also focussed on the interfaces between social care, general medical practice, acute and community health services, and delayed transfers of care from acute hospital settings.

Using specially developed key lines of enquiry, we reviewed how the local system was functioning within and across three key areas:

1. Maintaining the wellbeing of a person in usual place of residence
2. Crisis management
3. Step down, return to usual place of residence and/ or admission to a new place of residence

Across these three areas, detailed in the report, we have asked the questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive?

We have then looked across the system to ask:

- Is it well led?

Prior to visiting the local area we developed a local data profile containing analysis of a range of information available from national data collections as well as CQC's own data. We asked the local area to provide an overview of their health and social care system in a bespoke System Overview Information Request (SOIR) and asked a range of other local stakeholder organisations for information. We also developed two online feedback tools; a relational audit to gather views on how relationships across the system were working, and an information flow tool to gather feedback on the flow of information when older people are discharged from secondary care services into adult social care.

During our visit to the local area we sought feedback from a range of people involved in shaping and leading the system; those responsible for directly delivering care as well as those who use services, their families and carers. The people we spoke with included:

- Senior leaders from across the health and social care system, including housing and public health
- Health and social care providers and commissioners
- Front line staff from acute, primary and community care providers including therapy specialists, bed managers, discharge teams, nurses and GPs
- Voluntary and community (VCS) sector representatives, Healthwatch Bracknell Forest, people who use services, their carers and people who are close to them

We also met people using services in the emergency departments and the discharge lounges of Frimley Park Hospital and the Royal Berkshire Hospital.

We tracked the journey of five people through the health and social care pathway by looking at their care and treatment records and we visited eight services in the local area including the out-of-hours GP service, an urgent care centre, a nursing home, a domiciliary care agency and a GP practice.

The Bracknell Forest context

Demographics

- 12% of the population is aged 65 or over
- 91% of the population identifies as white
- Bracknell Forest is in the least deprived 20% of local authorities in England

Adult Social Care

- 12 active residential care homes:
 - One rated outstanding
 - Eight rated good
 - Three currently unrated
- Three active nursing care homes:
 - one rated outstanding
 - two rated good
- 17 active domiciliary care agencies:
 - 12 rated good
 - one rated inadequate
 - four currently unrated

GP Practices

- 16 active locations
 - 15 rated good
 - one rated requires improvement

Acute and community healthcare

Most hospital admissions (elective and non-elective) of people living in Bracknell Forest are to Frimley Health NHS Foundation Trust:

- Receives 80% of admissions of people living in Bracknell Forest
- Admissions from Bracknell Forest make up 11% of the trust's total admission activity
- Currently rated outstanding overall

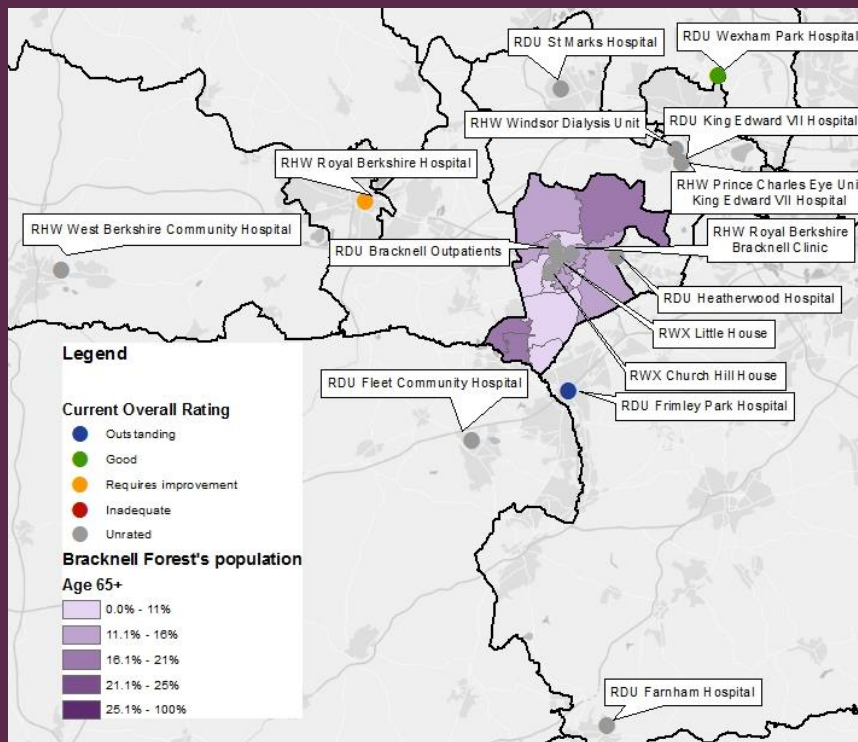
The second main trust used by people living in Bracknell Forest is Royal Berkshire NHS Foundation Trust:

- Receives 11% of admissions of people living in Bracknell Forest
- Admissions from Bracknell Forest make up 5% of the trust's total admission activity
- Currently rated requires improvement overall

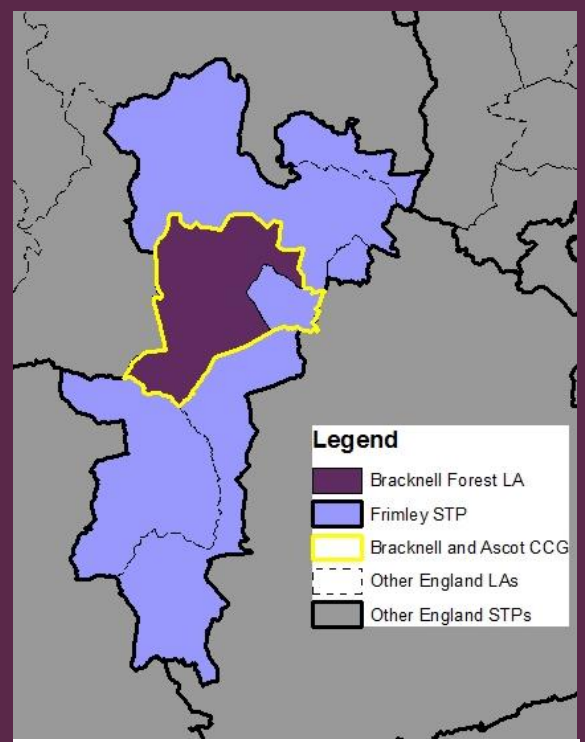
Community services are provided by:

- Berkshire Healthcare NHS Foundation Trust - currently rated good overall
- The trust is also the main provider of mental health services for Bracknell Forest

All location ratings as at 29/09/2017. Admissions percentages from 2015/16 Hospital Episode Statistics.



Map 1: Population of Bracknell Forest shaded by proportion aged 65+ and location and current rating of acute and community NHS healthcare organisations serving Bracknell Forest.



Map 2: Location of Bracknell Forest LA within Frimley STP. Bracknell and Ascot CCG is also highlighted.

Summary of findings

Is there a clear shared and agreed purpose, vision and strategy for health and social care?

- There was a system-wide commitment to serve the people of Bracknell Forest well. There was a shared understanding across system partners of the challenges the system faced, and a willingness to work together to achieve solutions.
- Bracknell Forest was part of an agreed accountable care system (ACS) centred on the Frimley Health and Care Partnership and led by the Chief Executive Officer (CEO) of Frimley Health NHS Foundation Trust (FHFT). There was vertical and horizontal alignment of a system wide vision that was centred on the Sustainability and Transformation Partnership (STP) plans and the Better Care Fund (BCF) plans. The STP was recognised as a driving force for culture change across the system and instrumental in supporting integrated working.
- All staff within the system, from front line staff to the leadership teams, demonstrated knowledge of STP plans and voiced their commitment to its aims.
- The Health and Wellbeing Board (HWB) was well established, mature and functioned effectively by monitoring planning, delivery and outcomes for local people. The HWB was made up of representatives from across the system including the acute, community and voluntary sector. There were clear lines of responsibility and accountability.
- It was evident from our review that partners across the system were responsive to each other's challenges, while ensuring that responsibilities relating to their own organisations were not compromised by joint working.
- Aligned with the Bracknell Forest health and wellbeing strategy, there were joint strategic priorities in place. These focused on providing older people with preventative services and support to stay well, and on enhancing the capacity in the domiciliary and care home sectors to manage the current and projected shortfalls in these services.

Is there a clear framework for interagency collaboration?

- The Joint Strategic Needs Assessment (JSNA) was robust, well considered and underpinned by clear delivery plans and outcomes. All partners were sighted on what was important to older people, their families and carers when moving through the interface of health and social care.
- Governance arrangements, as set out in the BCF plan, included community, professional and clinical leadership and were collaborative with decisions made at local level. The BCF board had oversight on the alignment of the various strategies, including the joint commissioning strategy for intermediate care, joint commissioning strategy for people in an unpaid caring role, and the commissioning strategy for older people, together with the pooled budget and associated risks.
- The BCF plan built on a history of successful integration between Bracknell Forest Council (the

local authority) and Bracknell and Ascot Clinical Commissioning Group (the CCG). Intermediate care and reablement services were jointly funded through a Section 75 pooled budget agreement and had run in partnership between the local authority and the NHS for ten years. This integrated service was hosted by Bracknell Forest Council with Berkshire Healthcare NHS Foundation Trust providing supplementary community nursing and therapy.

- There were positive examples of shared approaches and initiatives that supported local people to have timely access to services and support that met their needs in a person-centred way.
- There was evidence of effective risk sharing across partners. For example, there were plans for the local authority to administer personal health budgets on behalf of the CCG. A shadow control budget was also in place.
- The system was willing to take collective risks to transform the provider market to meet the needs of the local population. For example, the local authority was using outcomes-based contracts that incentivised new domiciliary care providers to put reablement at the centre of their activities, and in turn challenge local people to rethink how care at home could be used.

How are interagency processes delivered?

- Partnership working across the system was supported through a range of joint partnership boards. Boards were well attended and encompassed a comprehensive range of stakeholders including housing, voluntary services and the out-of-hours (OOH) service. Key issues were discussed and actions agreed, implemented and performance monitored.
- A programme delivery board had been established to monitor and support STP delivery and progress which reported to the Frimley STP Board.
- As part of the STP, integrated decision-making hubs were being developed to support people who were frail or had complex needs through advance care planning and social prescribing to promote independence, wellbeing and social inclusion.
- Winter plans covering the resilience arrangements across the system had been formalised and agreed. While the CCG led on the plans, we found that all system partners including frontline staff across primary and secondary care were aware of the plans and had contributed to the planning processes.

What are the experiences of front line staff?

- Staff benefitted from strong visible leadership and clear direction. We found that a collaborative multi-agency approach was already embedded.
- Feedback from front line staff was, in the main, very positive. Staff felt that leaders were responsive and inclusive. Staff generally communicated well across agencies. However, some social care staff reported that they were not always kept informed when people in their care had been admitted to hospital.

- Workforce issues were identified across the whole health and social care system, and particularly in the recruitment and retention of carers that provided care to people in their own homes. There were comprehensive system-led plans in place to mitigate risks associated with these issues; however most of these had not been implemented at the time of the review and we were therefore unable to assess their impact. The plans in place to support the up-skilling of staff and the development of cross-boundary roles were welcomed by the staff we spoke with.
- Staff told us that there was an opportunity for improving the care and support to people with moderate to severe dementia within acute hospital settings.

What are the experiences of people receiving services?

- The majority of older people living in Bracknell Forest received good quality health and social care services in a timely way. Most people using services told us they felt included in decision making about their care.
- Local people benefitted from access to direct payments. We heard positive feedback from people and their carers about how this enabled them to have control over their care, and be more involved in their care planning.
- There was an agreement between the local authority and the CCG for the local authority to procure continuing healthcare (CHC). NHS and the Emergency Duty Service (EDS) CHC quarterly figures for April to June (Q1) 2017 showed that the CCG had a standard NHS CHC assessment conversion rate for all adults (percentage of newly eligible cases of total assessments) of 50%. This was high compared to the England average (31%) and the South Central regional average (35%).
- We found a multidisciplinary, integrated approach to delivering a number of key services including the assessment and discharge team who were proactive and solution-focused. The EDS was well integrated and worked well with the integrated intermediate care team. All these services were having a positive effect on reducing delayed transfers of care (DTOC). Our analysis showed that Bracknell Forest had an average of 14.5 daily delayed days in July 2017 compared with a peak of 22.5 daily delayed days in March 2017. Local system leaders were confident that this level of performance could be further improved.
- However, in both acute hospitals there were some issues around the timely provision of hospital transport and medicines and these were contributing to delayed transfers of care and a poor experience for some people.
- People who used services, their families and carers were engaged in developing and improving the health and social care interface. There was regular engagement and co-production with older people via a range of panels and groups.
- There was scope to increase the effectiveness of local engagement by working better with Healthwatch Bracknell Forest.

Are services in Bracknell Forest well led?

Is there a shared clear vision and credible strategy which is understood across health and social care interface to deliver high quality care and support?

As part of this review we looked at the strategic approach to delivery of care across the interface of health and social care. This included strategic alignment across the system, joint working, multi-agency and multi-disciplinary working and the involvement of people who use services, their families and carers.

There was a collaborative leadership approach across all system partners with a coherent vision and strategy that could be articulated by people across the system. Public engagement and partnership working could be further improved, but there was a clear sense of shared endeavour. This was supported by the alignment of Bracknell Forest's BCF plans and the wider STP plans.

Strategy, vision and partnership working

- The health and wellbeing strategy, *Seamless Health 2016-2020*, was supported by an up to date JSNA and focused on providing joined up health and social care services to keep people well and to reduce the confusing multiple points of entry into the system when people become unwell.
- The local authority and CCG delivery plans and transformation programme were in alignment with the STP, BCF plans, and the health and wellbeing strategy. There was vertical and horizontal alignment of strategy and vision, centred on the STP. All staff working in the system, from front line staff to the leadership teams, demonstrated knowledge of STP plans and voiced their commitment to its aims.
- The STP was recognised as a driving force for cultural change across the system, supporting more integrated working.
- There was an effective multidisciplinary approach to delivering services. For example, the Frimley Park Hospital assessment and discharge team worked well with the local authority social care team.
- The CQC relational audit, completed by 18 people across the system, found that overall relationships were positive. While the number of respondents was small, the findings of the audit were corroborated during our review visit, where cross agency relationships were described positively.
- Partnership working across the system was supported through governance, where there was involvement and representation of a wide membership on a variety of partnership boards, for example housing, voluntary services and the out-of-hours (OOH) service.
- Front line interagency and multidisciplinary teams were supporting people to move through the health and social care system smoothly and seamlessly; evidence that joint working at leadership level was effective. For example, the local authority hosted a hospital equipment site on behalf of three councils, enabling people to gain access to equipment that supported timely discharge from hospital.

- There was a joined up approach to winter planning, using lessons learnt to inform this year's plan. Two-day workshops were held annually, where discussions took place between primary and secondary care and the CCGs based on the previous winter's outcomes.
- Partnership working could be further improved by ensuring all partners were kept informed and able to influence the strategic direction and share associated risks. Adult social care providers felt underrepresented at some forums. One of the acute trusts serving the area was unaware of the local authority's plans for reducing the number of domiciliary care agency providers and subsequent re-tendering of contracts and therefore was not prepared for the increased delayed discharges that took place in March 2017.
- The voluntary and community sector played a prominent role in supporting health and social care in Bracknell Forest and saw themselves as service partners. Although they felt they were currently engaged and included, they were also keen to ensure that the sector was fully utilised as part of future planning.

Involving people who use services, their families and carers in the strategic approach to managing quality at the interface of health and social care

- There was evidence that people who used services, their families and carers were engaged by partners in developing and improving the health and social care interface:
 - There was regular engagement and co-production with older people via a range of panels and groups, for example the Dementia Action Alliance, which included people with dementia;
 - There were examples of where engagement had informed service specifications. For example, the CCG commissioned a programme of stakeholder engagement to co-design the GP extended hours services, with service users defining key outcomes and priorities for the service;
 - A programme of engagement also informed the specification of the new domiciliary care contract.
- However, feedback from providers and Healthwatch Bracknell Forest indicated that engagement could be improved by ensuring their timely and consistent involvement in key meetings and by focusing on widening participation to a more diverse representation of residents.
- The Chief Executive of the local authority told us that the council received twenty times more compliments about services, than complaints. The 2015/16 ASCOF measure of 'Overall satisfaction of people using adult social care services with their care and support' showed that 69.5% of respondents in Bracknell Forest who were aged 65+ were satisfied with their care and support, higher than the national average of 61.7%.

Sharing learning and improvement across the system

- Learning and improvement took place and was shared across the system. For example, there was a clinical concerns system in place that enabled issues to be raised by GPs to the quality team at the CCG. Concerns were collated and common themes identified which resulted in shared actions and learning across wider partner organisations including through quality forums in the secondary

sector. There were plans to adopt this system in secondary care to feedback concerns to primary care partners.

- Best practice ideas were sought and implemented from elsewhere. For example, Frimley Park Hospital staff visits to other trusts resulted in the development of a frail elderly pathway involving rapid assessment in A&E and treatment within 48 hours.
- There was a longstanding GP council in place where GPs, practice staff and social workers came together to discuss concerns and share learning.

What impact is governance of the health and social care interface having on quality of care across the system?

We looked at the governance arrangement with the system, focusing on collaborative governance, information governance and effective risk sharing.

There was effective board leadership and information sharing so that senior teams were held to account for the delivery of their strategies and the management of risk to quality service delivery. Strong relationships supported the effective interface between systems.

Overarching governance arrangements

- There were local governance arrangements agreed by all partners through the HWB with clear lines of accountability. Partners across the system recognised their own duties and accountabilities to their own organisations, and ensured that these were not compromised through joint working.
- The governance arrangements, as set out in the BCF plan, included community, professional and clinical leadership and were collaborative with decisions made at local level. The BCF board had oversight of the alignment of the various strategies, including the joint commissioning strategy for intermediate care and the joint commissioning strategy for people in an unpaid caring role, together with the pooled budget and associated risks. The BCF steering group led the delivery of the strategies; and held the lead groups for each of the initiatives to account. The HWB chair stated that the board had oversight of the BCF plan and had a role in holding the organisations to account if targets were not being met. This was corroborated with the HWB vice chair and reiterated through the observed BCF steering group.
- Winter plans covering resilience arrangements across the system had been approved by NHS England. While the CCG led on the plan, we found that all system partners, including frontline staff across primary and secondary care, were aware of the plans and felt they had contributed to the planning. There was on-going scrutiny and challenge from the HWB and monitoring of hospital length of stay fed into the board to further support their overview.
- Quality monitoring and evaluation of impact throughout the health and social care system was undertaken through several audit activities. For example an audit of the effectiveness of seven day services in March 2017 undertaken by FHFT produced comprehensive recommendations. This included ensuring all Friday ward rounds resulted in a weekend plan.

- The Bracknell Forest Safeguarding Adults Partnership Board worked within a newly-developed quality assurance framework. Alongside this, a safeguarding sub group utilised a self-assessment audit tool to monitor performance and provide assurance to the board. The discharge and assessment team were clear that Bracknell Forest local authority had the best safeguarding adult board. They stated that the chair of the board was inclusive and ensured any actions taken were fed back to the board.

Information governance

- Improved information sharing was under development in Bracknell Forest. In the 2016/17 BCF return the HWB confirmed it was working towards better data sharing between health and social care, based on NHS number. The Berkshire Connected Care programme had started to provide a system for sharing information across health and social care, allowing for instant access to patient and social care information and enabling people to access their own records.
- Frontline staff, particularly those working across the community, gave us very positive feedback about this system. Bracknell Forest was the first social care service within East Berkshire to take part in the Connected Care programme.

Risk sharing

- Commissioners and the vice chair of the HWB told us that there was a well-developed process of scrutiny and quality assurance around joint working. This was led by clinical representation on the BCF board and the care governance board.
- The BCF plans were facilitating elements of risk sharing between partner organisations. The BCF Programme Manager maintained a risk register and monitored and escalated risks to the BCF Programme Board and HWB for consideration and action. Identified risks included workforce development and increasing demand for services. The HWB received a quarterly report on budget spend. A monthly report was produced for the BCF steering group and the BCF board with a Red Amber Green (RAG) rating for risk.
- There was evidence of effective risk sharing across partners. For example, the local authority was planning to administer personal health budgets on behalf of the CCG. A joint agreement was in place across health and social care to buy a dual registered care facility called Heathlands. A shadow control budget was in place.

To what extent is the system working together to develop its health and social care workforce to meet the needs of its population?

We looked at how the system is working together to develop its health and social care workforce, including the strategic direction and efficient use of the workforce resource.

Developing the capacity and capability of the health and care workforce was recognised as a key challenge for Bracknell Forest, posing a risk to the future delivery of plans. However, there was a comprehensive system-wide strategy in place, as part of the health and wellbeing strategy, BCF and STP, to ensure the system had sufficient numbers of a suitably skilled staff.

- The recruitment and retention of sufficient numbers of health and care staff was widely recognised as a challenge for the system. Bracknell Forest is an affluent area with low unemployment and high cost of living and providers faced increasing competition for staff following the recent regeneration of the town centre, which created thousands of new jobs locally. A shortage of suitably skilled social care staff, together with a lack of therapists (e.g. occupational therapists), was impacting on people's discharge from hospital where they required support in their own homes.
- Our analysis of Skills for Care workforce estimates showed that between 2014/15 and 2015/16 staff turnover rates in adult social care reduced significantly from 28.8% to 19.8% and the proportion of vacancies also fell significantly from 6.5% to 1.7%. However, this may be attributed to the 58% reduction shown in our analysis of nursing home beds between April 2015 and April 2017, as well as a 5% reduction in residential care home beds.
- Within the BCF plan and linked to the Bracknell Forest health and wellbeing strategy for 2016 to 2020 there was a comprehensive plan to address workforce issues which had been developed by system partners.
- The STP plans had a workforce work stream that was focused on recruitment and retention, training and development, and supporting new ways of working; for example developing passports so staff could work across health and care. The plans also included a pilot project to develop a new Nursing Associate role. Nursing Associates would be equipped with the knowledge, skills and behaviours that would enable them to support the delivery of nursing care in and across a wide range of health and care settings. There were also plans to work with local colleges to develop the future workforce.
- These plans were at an early stage at the point of the review and work streams needed to be developed further. There was evidence of joint working to address recruitment challenges including a recent joint recruitment fair for health and social care. There was also work being carried out in relation to developing an agreement with neighbouring boroughs around managing recruitment from the same small pool of potential staff. The local authority was also in early stage talks with FHFT around the recruitment and training of staff who had been made redundant in another service and allowing them to rotate into domiciliary care.
- Plans were in place to change ways of working by increasing integration and focus on reablement and outcome-based commissioning. There was positive feedback from staff about this new way of working and the opportunity it afforded them to gain enhanced skills.

Is commissioning of care across the health and social care interface, demonstrating a whole system approach based on the needs of the local population? How do leaders ensure effective partnership and joint working across the system to plan and deliver services?

We looked at the strategic approach to commissioning and how commissioners are providing a diverse and sustainable market in commissioning of health and social care services.

There was a whole system collaborative approach to commissioning in Bracknell Forest. Partners saw the provision of high quality commissioning for local people as an ongoing process, and placed a significant focus on setting up systems that enabled them to capture accurate and meaningful data on the needs of the people they served.

- The health and wellbeing strategy focused on joint working to provide people with a seamless service and value for money. There was a history of effective collaboration around integrated commissioning which was embedded into the system. There had been joint commissioning posts that focused on integration, in place for seven years. The intermediate care and reablement services had been jointly funded (via a section 75 agreement), and delivered for ten years. This integrated service was hosted by the local authority with Berkshire Healthcare NHS Foundation Trust (BHFT) providing supplementary community nursing and therapy. This fully integrated team worked closely with the three acute hospitals used by Bracknell Forest residents.
- The BCF and STP plans demonstrated a focus on joint planning and working to commission services for people who move through the health and social care interface. The BCF plan set out the large number of joint commissioning strategies. Many of these strategies had been updated since the original BCF submission, following consultation with stakeholders, people who use the services and people working in health and social care. This included supporting people in an unpaid caring role, intermediate care and the strategy for dementia.
- There was a will to expand joint commissioning. However, commissioners were clear that identifying commissioning gaps would be an ongoing process and this would be supported by the development of a digital platform and by the data gathered from direct payment assessments.
- The voluntary sector was commissioned to provide support across the system, for example a BCF funded British Red Cross “Home from Hospital” service, operated from Frimley Park Hospital seven days a week. This service provided low level support, such as shopping and collecting prescriptions for people, for up to six weeks after hospital discharge. The team was co-located with the adult social care and hospital in-reach nursing, supporting an integrated approach with the wider hospital discharge team.
- The local authority had set out their future ambition to end grant funding to the voluntary and community sector (VCS) and develop the capacity and sustainability of the market through a digital platform. The digital platform would be used to generate data on unmet need in the community which could then be used by the VCS to develop services. The digital platform would also enable individuals with similar needs to pool direct payments and buy services collectively. However,

voluntary sector representatives expressed some concern that the plans to remove grant funding from local voluntary groups and ask people instead to use their direct payments to pay for services could mean people would be less willing to use them.

- There was an aspiration to move from commissioning criteria-based services to commissioning needs-based services and commissioners encouraging their community teams to think about how to meet people's needs using a whole system approach. This was also reflected in the focus groups held with frontline staff. For example, we were told about a bariatric patient that needed to be seen at a leg ulcer clinic; staff worked with other system partners such as South Central Ambulance Service (SCAS) to find the best way of achieving it.
- The CCG were clear that they needed to improve how they worked with acute services for the support of people with dementia and would benefit from strengthening the relationship with the adult mental health team. The Carers Forum also highlighted that acute care provision for people with dementia needed improvement. This was reflected as an action in the dementia strategy action plan.
- The local authority told us that commissioning for dementia placements in the community could be a challenge. This was corroborated by A&E staff at Frimley Park Hospital who told us that finding appropriate placements for people with moderate to severe dementia was difficult. However, the new model of joint funding with the three CCGs and local authority partners to finance a care home called Heathlands, which would have a number of Elderly Mentally Infirm (EMI) beds, was seen as a step in the right direction.
- The local authority aimed to stabilise the care market by reducing the number of domiciliary care providers and, through the contract, incentivising providers to put reablement at the centre of their activities. There was positive feedback about the retendering process; domiciliary care providers felt well informed throughout with clear objectives set around providing a needs-based service. However, the local authority need to ensure there is robust monitoring of quality to mitigate the risk of a failing service that would have a much larger impact given the smaller number of providers.
- The local authority included standards in their contracts and there were processes in place to monitor quality and take action if these standards were not met. For example, services were given a quality 'RAG' rating. Services with a red 'flag' would be reported to and monitored by the Care Governance Board. The local authority also worked with poor performing services to support improvement. The local authority Chief Operations Officer (COO) stated that the board would expect to see sustained improvement over a minimum of three months before the red flag was removed.
- Provider forum representatives expressed concern that the local authority could be over zealous in its approach to quality monitoring and slow in removing the 'red flag'. While acknowledging that this may have been the case in the past, the COO told us that they now worked well with providers but they needed to be confident that improvement was sustainable before removing the red flag. There was no evidence that poor quality care homes had an impact on delayed discharge. Our analysis showed that the CQC overall ratings score for adult social care locations in Bracknell Forest local authority was the best nationally. A focus group of providers were positive in their feedback about their relationships with the local authority and commissioners.

How do system partners assure themselves that resources are being used to achieve sustainable high quality care and promoting peoples' independence?

We looked at resource governance and how systems assure themselves that resources are being used to achieve sustainable high quality care and promote peoples' independence.

We found a shared understanding and whole system view of the challenges and priorities for using resources to achieve high quality care and promote people's independence. Key strategies focused on: prevention and support to stay well, availability of care home beds and homecare packages, provision of good quality dementia care and support in the community. There was joint working between the system partners to manage demand and govern resources. However, there was still a concern from front line staff and the older person's representative that capacity would not match demand, in particular for people with dementia. Many of the market stabilising plans were in their infancy, and their success could not be measured at the time of the review.

Effective use of information to prioritise improvement

- The system reported that the imbalance between supply and demand in long term care placements was such that placement costs were becoming unsustainable. As such, finding suitable care for people with complex needs, especially for people with dementia, was an increasing problem. An analysis of placements, undertaken as part of the JSNA between December 2016 and May 2017, indicated that the average cost of a weekly placement was now £801.89 for residential beds and £937.12 for nursing beds.
- To counteract this, the local authority developed a framework arrangement to stabilise the domiciliary care market (co-produced with providers and customers); reducing the number of domiciliary care providers whilst increasing the locations by 7% since 2015, and were working with new providers on a recruitment strategy.
- The SOIR stated that the iBCF additional grant was being invested to build on the DTOC 'deep dive' that the local authority undertook during June 2017, to look at the causes and factors associated with an increase in DTOC during 2016/17.
- The Department of Health's analysis of DTOC between February and April 2017 showed that the average daily rate of delayed days per 100,000 adults was higher in Bracknell Forest (18 days) than the England average (14 days) or comparator group average (15 days). Our monthly analysis of DTOC figures showed an increasing trend of delays in Bracknell Forest since April 2015, leading up to a spike in March 2017, (where the average daily rate of delayed days was 22.5). The main reason cited for this spike was the introduction of the new domiciliary care model and the invitation to tender in January 2017. This resulted in a period of uncertainty among providers and influenced their decision to accept new packages of care. Since March 2017, our analysis showed that DTOC had dropped in Bracknell Forest and at July 2017 were more consistent with England and comparator average rates.

Integrated commissioning arrangements

- The BCF plans built on a history of successful integration between the local authority and the CCG. The partners' next step would be developing a fully pooled budget and we were told that these

conversations were happening throughout the system.

- A Memorandum of Understanding (MoU) for the joint purchase of Heathlands had been signed by partners and a capital bid submitted to realise this ambition. There was also a proposal being considered to refurbish another site as a bridging venue until the new build was up and running. Extra iBCF money was being used to support this approach. The intended use of both sites was for an integrated community resource centre, with assistive technology showroom, sensory needs and group therapy clinics and to provide winter pressure capacity.
- The local authority had sought to address challenges with capacity in the provider market by commissioning a block contract of 20 beds with a residential care service, to include step up and step down beds. The CCG were also working collaboratively with the East Berkshire CCGs to ensure there was additional capacity available in the local area.
- The agreement of a shared control total was supporting the governance of resources between NHS community and acute services, and the commissioning and provision of services at the interface between health and social care at the right place and time. This was supported by the development of a high-level dashboard looking at mortality, satisfaction and service user outcomes.

Managing the market to ensure the system has capacity

- The Bracknell Forest BCF plan stated that they had operated a 'Home First' policy since 2010. Our analysis showed that the number of domiciliary care agency locations within the area increased by 7% between April 2015 and April 2017, (although the number of providers was reduced as part of the local authority's plans to stabilise the market), suggesting increased capacity in community-based care. However, this may not be sufficient to match demand as our analysis showed that the number of nursing home beds had reduced by 58% between April 2015 and April 2017 and the number of residential home beds had reduced by 5% over the same period. ASCOF data for 2014/15 and 2015/16 indicated that admissions to care homes in Bracknell Forest were increasing, (from 475 per 100,000 aged 65+ to 719 per 100,000 aged 65+), and as the percentage of Bracknell Forest's population aged 40-64 is above the England figure (34.2% compared to 32.7%), it is likely the area will face increased demand for social care services in the coming years.
- In recognition of this, the local authority have acknowledged in the BCF plan that as well as focusing on strategies to keep people well and in their usual place of residence they will also need to increase care home capacity to meet current demands and future projected shortfalls. The local authority increased council tax by 3% in 2017-18 through the adult social care precept. The additional 2017-18 funding for adult social care, (as announced in the Spring Budget 2017), will be used to increase capacity in adult social care by refurbishing a bridging venue until Heathlands is operational as well as spot purchasing.
- Despite the plans to fund a new care home with EMI beds there was still a concern among front line staff and the elected older person's representative that there would not be enough support in the community for people with dementia. It was felt that more needed to be done to provide a safe and secure home for people in the advanced stages of dementia. The voluntary sector felt that they could be better utilised in this area.

- System leaders acknowledged that relationships with the voluntary sector were not particularly mature however, the local authority was engaging with voluntary providers to develop a sustainable sector. For example, a voluntary sector partnership event was held in July of this year where the strategic plans were shared and the local authority set out its sustainability offer. Further events were planned to promote integrated working with the voluntary sector.
- The local authority had also put measures in place to engage with providers in the residential care home and the domiciliary care markets. This included a series of market shaping events that took place in association with the domiciliary care re-tendering exercise, as well as extensive discussions with providers within the residential, nursing and dementia care home market, with a view to entering into a block contract.

Maintaining people in their usual place of residence

Do services work together to keep people well and maintain them in their usual place of residence?

Safe

There was a system-wide commitment to maintaining people in their usual place of residence and preventing avoidable harm. The evidence showed that people in care homes were supported to stay well and avoid hospital admission. However, A&E attendance for older people was higher than the national average. Plans were in place to further support people to be safe in their usual place of residence using falls prevention and frailty pathways; however, these plans were yet to be evaluated.

- There were joint strategies to support people to remain living in their usual place of residence safely. A local self-care strategy, based on the JSNA, was in its third year of delivery. This covered areas such as arrhythmia, blood pressure, chronic obstructive pulmonary disease and obesity. The East Berkshire Cardiology Update report (2017) outlined joint working taking place between the community trust and CCGs to improve detection and control of risk factors such as hypertension and atrial fibrillation. This included a campaign called 'Missing a Beat' to increase public awareness of symptoms. The CCG informed us that they were starting to see the impact of this in reducing hospital attendances.
- However, our analysis of A&E attendance rates between April 2015 and March 2016 for people 65 and over showed that attendance levels for Bracknell Forest residents were higher than the national average, and the average of their comparator areas throughout the year. The total rate in 2015/16 of A&E attendance for people aged over 65 in Bracknell Forest was 480 per 1000 people, compared to the average across their comparators of 385 per 1000, and a national average of 414 per 1000. More recent data provided by FHFT during the review showed that there had been no significant reduction in the attendance rate at Frimley Park Hospital since July 2016.
- Our analysis showed that during 2015/16 there were significantly lower rates of A&E attendance

from people aged over 65 living in care homes in Bracknell Forest compared to the England average (10 per 1,000 compared to 36 per 1,000). Of those older people in Bracknell Forest attending A&E from a care home, a significantly high percentage were referred there by a GP (21% compared to England average of 6%) and of those referred by a GP, a significantly lower percentage were discharged without follow-up, (i.e. not admitted), compared to the England average. This meant that GPs in Bracknell Forest were referring only those older care home residents that required acute care.

- Since 2014, the local authority had worked with the CCG to develop a Care Home Quality Programme, which reported to the BCF board monthly. Since May 2017, the three East Berkshire CCGs had collaborated to appoint an East Berkshire-wide Care Home Quality Lead. A specific aim of this programme was ensuring all homes had adequate GP availability and that good practice check lists for certain common conditions, such as urinary tract infections, were adopted.
- Bracknell Forest residents did not always have access to a full provision of GP services at the time of the review. Analysis of survey data from March 2017 indicated that a comparatively low percentage of GP practices in Bracknell Forest offered full provision of extended access to pre-bookable appointments outside of core contractual hours, (7.7% of the 13 practices surveyed, compared to 22.5% across England and 16.4% across comparator areas).
- The integrated care team produced a Crisis Escalation Plan when they undertook assessments of people referred to them. This aimed to mitigate against lifestyle or health risks for the individual, to reduce the occurrence and severity of crisis and prevent avoidable admissions. These plans were shared with acute and out-of-hours providers, GPs, social care and other relevant professionals to ensure an appropriate and informed response.
- Falls prevention and frailty identification was a key focus of the STP, Bracknell Forest Adult Social Care Transformation Plan and the health and wellbeing strategy. Our analysis of admissions from care homes between October 2015 and September 2016 indicated that admissions due to accidents and injuries were comparatively low in Bracknell Forest (135 per 100,000 aged over 65, compared to comparator group average of 367 per 100,000 and England average of 392 per 100,000). The Health and Wellbeing Development Programme (2016/2017) cited the development of a new integrated falls prevention pathway. An STP investment proposal through the Urgent and Emergency Care Transformation Fund was recently submitted. The proposal focused on a system-wide approach with an integrated specialty frailty team, safe and well home visits and extended GP access.
- There were systems in place to identify frail and complex people who were at risk of deterioration. Multidisciplinary team (MDT) meetings were held around clusters of GP practices, bringing together a range of professionals to discuss these cases and coordinate care and support. As part of the STP initiatives, integrated decision-making hubs were being developed to support people who were frail and suffering from complex conditions, by using advance care planning and social prescribing to promote independence.
- The Rapid Assessment Community Clinic (RACC) ran two days a week to provide assessment and

treatment for people with complex health and social care needs in times of mild to moderate health deterioration. There was some evidence of the effectiveness of this service; referral data shown to us on review from January to March 2017 showed that of the 26 people referred to RACC, 20 avoided admission to hospital. However not all GPs in Bracknell Forest used this service regularly.

- To develop a coordinated response to complex and challenging cases within the community, a multi-agency Community Problem Solving Group was in place. This was chaired by the police and brought together the ambulance service, social care, general practice and housing. We were given several examples of the positive impact of this group including one involving the coordinated effort between partners to enable a person with significant challenges to improve the quality of their life.
- The local authority was embracing the use of technology to keep people safe at home. Forestcare, a 24-hour telecare response service, provided Lifelines, care calls and emergency responders service to their subscribers. They could also supply a 'Pocket Pal'; a device which utilised GPS technology to locate a person and detect falls. There was buy-in for the service across the hospital discharge team and the intermediate care team, with the latter planning to recruit a technology specialist to increase awareness and uptake.
- There were initiatives in place to support the management of medicines so that people could medicate safely in the community. The CCG pharmacy team ran polypharmacy clinics in GP practices. We were also told that CCG pharmacy staff were working in care homes, some as independent prescribers, supporting care home staff with medicines management.
- However, carers of people who used services indicated that there were still areas for improvement in keeping people safe through effective medicines management in the community. Several people had experienced errors in the administration of medication, and delays in prescriptions at the community pharmacy.

Effective

Bracknell Forest had embedded systems as well as new projects and initiatives aimed at keeping people well in their usual place of residence. However, the full effectiveness of new initiatives could not be measured at the time of the review. There was an opportunity for the local authority to work with providers and community partners to further enhance the skills and confidence of the social care workforce.

- Our analysis showed that between 2014/15 and 2015/16 there was a sharp increase in the rate of admission to residential and nursing care homes for people aged over 65 in Bracknell Forest (from 475 per 100,000 to 719 per 100,000). This increase put Bracknell Forest at a higher rate of admission than their comparators and the England average.
- Bracknell Forest had multiple initiatives in place to keep people well at home. For example:
 - ⇒ An integrated pilot project between community and mental health teams (2016) to provide trans-diagnostic cognitive behaviour therapy for people with long term conditions, depression and anxiety. People who accessed this service reported improved health and wellbeing with fewer visits to the hospital or GP. This service has been extended to the whole of East

Berkshire offering home visits to those who were housebound due to multiple health conditions or having mobility or communication difficulties.

- ⇒ A Patient Education Centre, based at the Berkshire Urgent Care Centre, provided health education information to people triaged at the service. While the management team did not have any evidence of how this impacted on people's health and wellbeing, they had begun to audit staff to confirm that people had been given written and verbal information.
- ⇒ The publication of an annual 'Helping you Stay Independent' guide.
- ⇒ The BCF funded Forestcare responder service – providing personal care and assistance in the event of a fall.

- Bracknell Forest had an active voluntary and community sector offering schemes to reduce social isolation and loneliness among older people and their carers. For example: Age Concern ran coffee mornings; the Alzheimer's Society hosted a memory café; the local authority funded Involve, a voluntary service, to run a befriending service; and a volunteer transport service enabled people to get out into the community.
- Plans were in place to develop the capacity and sustainability of the VCS through a digital platform and enhance the sector's role in keeping people well and independent. Through the BCF, 'community connector' roles were being funded and three posts were being advertised at the time of the review. Community connectors would sit within a connections hub and be co-located with the local authority's brokerage team, working closely with the VCS sector to identify support for people and their families. Work undertaken by public health to map the VCS sector, and the forthcoming digital platform also aligned with this work.
- There were initiatives to develop the workforce to have the right skills to support the maintenance of people in their usual place of residence. A new project entitled 'Conversations' had begun. By providing training to health and social care staff, 'Conversations' aimed to facilitate a culture change in the way that staff interacted with people, encouraging more meaningful interactions, driven by the needs of the person rather than what staff wanted to ask. Results from the pilot were encouraging, with 73% of the people who contacted the local authority having their cases concluded at the first conversation.
- Independent social care providers reported that the local authority was supporting their workforce through regular training and learning events. As part of the proposed enhanced frailty pathway there were plans to implement a competency framework and training programme to up-skill the workforce around frailty.
- However, there was still a concern from providers and the OOH service that some care home, nursing home and community staff lacked the skills and confidence necessary to make care decisions and provide support to people to avoid admission to hospital.
- The use of locum GPs at the OOH service was also cited as a factor for people being admitted to

hospital when they didn't need to be; GPs who were not familiar with the person and their needs could be more risk adverse in their assessments. The OOH service told us that they tended to use the same locum GPs each time so that they could become familiar with the area. From our analysis of the data there were low numbers of people being referred to A&E from care homes and of those who were referred the majority required hospitalisation.

- There was evidence of the workforce effectively collaborating and sharing information to ensure that people had the right care and support to maintain them in their usual place of residence. The integrated care team held virtual MDT meetings, including a link social worker, where they discussed people who were at high risk of deterioration and developed an action plan.
- The introduction of Connecting Care, a digital system that allowed the sharing of a person's information across professionals, was well received across the system and was supporting integrated working. To date the local authority, all GP practices, one acute trust and the community trust had signed up to this system. Use of Connecting Care had increased month-on-month, enabling the sharing of records across organisational boundaries and reducing the duplication of assessments.

Caring

Bracknell Forest had current initiatives and clear strategic ambitions to support people, their families and carers to take the lead in keeping themselves well and planning their care, with the support of statutory and VCS services. However, some of these plans were at early stages at the time of review.

- Bracknell Forest, through its health and wellbeing strategy, had a clear strategic direction to support people to remain in their usual place of residence. The focus was on empowering people to play the lead role in managing their own health and wellbeing and to be active decision makers in their care, support and treatment.
- A self-care strategy was in place to support people to manage their own conditions. For example, through the strategy, and in collaboration with system partners, a volunteer-led peer support scheme for people with long term conditions called 'Healthmakers' had been developed. The scheme offered support and advice on managing conditions and access to a six week self-management course.
- A programme of culture change was being initiated among staff, following the 'Making Every Contact Count' approach to encourage health and care staff to have conversations that empowered people to take responsibility for keeping themselves well.
- Representatives from the Support Care Workforce Board told us that Bracknell Forest had a comparatively good uptake of direct payments, which enabled people to take control over how their care was provided. The ASC Health and Housing Quarterly Service report for 2016-17 Q3 showed that the percentage of people using social care who received direct payments had increased from 21.9% in Q1 2016/17 to 24.2% in Q4. People and their carers who were using direct payments told us this enabled them to have a say and control over their care, and to be more involved in their care plans and reviews. Continuity of care across local authority and CCG funded care was supported by the ongoing promotion of personal healthcare budgets.

- This year the opportunity for people to make informed choices would be further enhanced through the release of the digital online marketplace. Here information on personal healthcare budgets, direct payments and groups and activities to promote independence and wellbeing would be made available via a digital platform. The marketplace would also provide a facility for individuals to pool their direct payments and jointly purchases services. A community asset map, produced by the public health team, was also available to direct people and staff towards services, activities and societies.
- Data collected by CQC suggested that Bracknell Forest had a high proportion of people fully self-funding their care home placement compared to the England average (66% compared to 37%), although the data collected for Bracknell Forest suffers from data completeness issues. There were mixed views as to whether self-funders received sufficient support to make decisions about their care. However, the introduction of the online market place would enable self-funders to have access to comprehensive information on services available.
- On review, we saw a person-centred approach to care and support planning being employed across staff groups. For example, the social work team tried to provide a consistent social worker point of contact from the point of assessment through to the planning and management of the case. The community multidisciplinary team used an 'I statement' approach to understand people's individual needs and ensure that their preferences were known and catered for.
- The Carers Forum was regarded as a strong community asset, providing a support network to carers and an information point for access to service and support. However, the Forum felt that there was scope to increase the number of referrals received from the local authority to their support group, which was local authority funded.
- Social work leads said that carers were offered separate carers assessments. A red card scheme for carers was also being promoted across the area.

Responsive

People's individual needs were assessed; their risks identified and proactively responded to in order to help maintain them in their usual place of residence. Signposting systems for people played a key part in enabling timely access to the right support in the right place.

- Services were in place to proactively maintain people in their usual place of residence. The self-care agenda in Bracknell Forest was playing a key role, as was the investment in preventative, community-based provision through the community asset mapping and online marketplace.
- Practices in the GP federation were pooling resources to ensure that the primary care system had the capacity to provide the services that kept people well, such as flu vaccinations. We were also told that flu vaccinations were being taken to carers at the carers groups. However, we received feedback from carers that annual health checks were no longer being routinely undertaken by their GP, and were difficult to arrange.

- There were processes to ensure people's needs were promptly identified and actions put in place to meet these across the health and care system. Integrated care teams, based around three clusters of GP practices, provided timely support to people with a long-term condition and frail elderly people to effectively manage their condition(s) and improve their outcomes and experience. People who were having difficulty in managing their conditions were referred to the team for a short period of time to stabilise their health. Data from the GP patient survey 2016/17 showed that 69% of people with long-term conditions in Bracknell Forest felt supported compared to the England average of 67% and the comparator average of 68%.
- To be more proactive in responding to those people more at risk of deterioration and hospital admission the OOH service supplied GP practices with cards displaying the OOH direct line number. GPs gave these cards to the people they felt were most at risk and asked them to ring the number if they needed medical advice or support out of hours. The impact of this initiative had not been measured at the time of the review.
- There was work being done to reduce the number of points of entry into the system for people, and signpost them to the right services and support. The recently established Berkshire Health Hub, provided by BHFT, gave a single point of access for the public and health and social care professionals and was streamlining the referral process by replacing multiple referral routes and points of entry. A voluntary organisation commissioned by the local authority called Bracknell Forest Signal 4 Carers was in place. Trained staff were available to signpost carers and offer them support and advice. The new community connectors' role would provide further signposting support.

Crisis

Do services work together to manage people effectively at a time of crisis?

Safe

There was effective multi-agency communication during a health or social care crisis enabling people to be kept safe as they moved across the health and social care system. However, access to support for carers in a crisis could be further improved.

- As part of the STP plans for frailty management, an investment proposal had been submitted via the Urgent and Emergency Care Transformation Fund to establish an integrated frailty liaison service. This service aimed to ensure a comprehensive review of needs was undertaken, and enable a timely return to the community with support in place to avoid readmission.
- There were formal methods to share information around risks to people's care and treatment across the system through the Quality Surveillance Groups. Representatives from Bracknell and Ascot CCG alongside the neighbouring CCGs attended the meetings regularly, as did the HWB. We were told that local authority attendance was more sporadic and tended to be linked to when there was a particular issue around the Bracknell Forest system. It was confirmed that when concerns or a crisis occurred, the CCG worked closely with the local authority to resolve them.

- There were systems and processes to safeguard people from avoidable harm at the point of crisis. For example, we tracked a case where a person was unable to get out of bed, and used their Lifeline to alert the emergency services. The paramedic made a safeguarding referral; this was followed up at an MDT meeting and led to a homecare package being put in place.
- The Berkshire Health Hub provided a single point of access for people, their carers and professionals in times of crisis. For example, health and social care professionals could call the Berkshire Health Hub and ask for an urgent occupational therapy assessment and any equipment necessary to keep people who were at risk of deterioration safe in their home. A person who cared for their partner with dementia told us they had called the hub, on the advice of the Berkshire Carers Centre, following a crisis episode. A specialist team arrived to take the person to hospital and carried out a full assessment and medication review. The carer reported that they were pleased with the actions taken and the person in their care had not experienced a crisis episode since.
- However, concerns were expressed by a carers' focus group that when there was a crisis for the carer, and they may need hospitalisation, there were not sufficient respite services available. Bracknell Forest does have a carers' emergency respite scheme that carers can sign up to, taking an assessment to create an emergency plan; however, the perception was by some carers that this was not sufficient.
- Residents of Bracknell Forest received a better than England average emergency ambulance service. Our analysis showed that between June 2016 and May 2017 SCAS performance for Red 1 and Red 2 priority calls was above the England average and for the six months from December 2016 to May 2017 was consistently meeting the national target figure.

Effective

During a health or social care crisis people's needs were effectively assessed by a skilled workforce. Information was shared across the system to enable people the ability to make choices and maintain their independence. There was an opportunity to further improve dementia care in the acute setting through encouraging MDT working and ensuring a robust and disseminated dementia pathway in A&E.

- The Berkshire EDS provided an OOH crisis social care service to Bracknell Forest. The service had evolved over time and it now also provided intermediate care services to avoid people being moved into care homes and the trusted assessor role to assist with safe hospital discharges.
- There was a single assessment process in place during a time of crisis. Three trusted assessors were operating as part of the EDS. They could visit people in their home and undertake the necessary assessments. Reports from our interviews and focus groups suggested there was system-wide trust in these roles and the assessments produced.
- The effectiveness of the service was evident from the EDS referral outcomes audit in 2016/17, where it was found that out of 627 referrals, 325 avoided hospital admissions and 41 were supported to have a safe early discharge. We were also given a case study which described an

occasion when a person's behaviour had deteriorated due to their dementia and their carer needed support. Through the EDS a GP, community mental health specialist and occupational therapist visit was organised. A care package was put in place through the integrated care team and technology installed to support the carer and keep the person safe at home.

- There were multidisciplinary professionals, including a social worker, working in the A&E departments to prevent avoidable admissions and improve flow. Frimley Park Hospital had a senior nurse in place in A&E who would, alongside an initial assessment, also offer patient education with a focus on self-care.
- However, the team in Frimley Park Hospital did not appear to have strong links with the mental health liaison team. There was a lack of clarity around the pathway for dealing with patients who had moderate to severe dementia when they presented at the department. The A&E staff also told the review team that the mental health liaison officer was not involved in their MDT meetings.
- The hospital bed managers had a hub meeting once a month to which system partners were invited and there was a discussion about new strategies or initiatives being introduced. It was felt that this was a good way of networking and communicating and a means to meet people working in other disciplines and build relationships with them.
- People with minor illnesses or injury could attend the Berkshire Urgent Care Centre (UCC). Staff at the UCC could access people's key health information through Connected Care. There were still improvements to be made in the ease of accessing information as Connected Care was due to be fully embedded into their system later this year. To assess if people were being seen in the right place and by the right people, the UCC undertook regular audits of their performance looking at referrals to A&E and whether they were appropriate. The findings from the last quarter were that 77% of referrals were appropriate. Inappropriate referrals were collated and lessons learnt disseminated to the team.

Caring

People, their family and carers told us that they were at the centre of decision making during times of crisis. Support from the VCS was praised by all the people we spoke with.

- There were multiple points of entry to the system at a time of crisis, which could be confusing for people who used services, their families and carers. Work was being undertaken to streamline access through the Berkshire Health Hub. The hub provided people, their families and carers with a single point of entry to the system, from which their care could be coordinated, providing them with a joined up and seamless experience. However, some carers indicated that they would feel unsupported if they were to have a crisis.
- From our visits to carers groups the majority of people we spoke with felt that they had been included in decision making about their health during a crisis. This was corroborated by our review of a sample of case notes, which indicated that families were informed at the point of crisis.

- People told us that voluntary groups, such as the dementia alliance, were extremely helpful in offering a single point of access for support, signposting and advice during times of crisis.
- The introduction of a trusted assessor role as part of the EDS was reducing the number of assessments people received at a time of crisis, and the number of times they had to tell their story to different professionals.

Responsive

At times of crisis services and staff were in place to respond to people in a timely way. Both acute hospitals had systems in place to improve patient flow and reduce avoidable admissions.

- There were systems in place to ensure that people received care in the right place, at the right time and to avoid admission to hospital at a time of crisis. The Berkshire Health Hub single point of access, EDS, Forestcare assistive technology service for people at risk of falls, and the Urgent Care Centre all assisted in supporting people in crisis.
- The OOH provider told us that one of their biggest challenges in preventing people from requiring hospitalisation was that there was not an OOH catheter service. This was placing pressure on the OOH services and meant that people with specific catheterisation needs required hospitalisation instead of being able to stay in their usual place of residence. BHFT and the CCG informed us that they were currently looking at introducing a 'catheter passport' as a pilot. This would include having a detailed catheter care plan to support community nurses and avoid unnecessary hospital admissions.
- We saw that Royal Berkshire Hospital and Frimley Park Hospital had allied health professionals working at the front door to prevent people from being admitted unnecessarily and improve patient flow. BHFT had established a community matron that reached into FHFT. There had been investment in this role to improve the discharge flow and to prevent inappropriate admissions.
- In the last three years, both FHFT and RBFT had performed better than the England average in terms of the percentage of people being seen, treated and either admitted or discharged within four hours in A&E, although performance at both trusts declined in 2016/17 to 91.6% at Frimley Park Hospital and 92.3% at Royal Berkshire Hospital.
- FHFT had a higher occupancy rate than the RBFT. At Q4 2016/17, 95.1% of the 1390 available overnight beds at Frimley Health NHS Foundation Trust were occupied and throughout 2016/17 occupancy had remained above 90%. Although optimum occupancy rates for hospital beds may vary according to type of services offered, hospitals with average bed-occupancy levels above 85% are likely to face regular bed shortages, periodic bed crises and increased numbers of health care-acquired infections. At Royal Berkshire NHS Foundation Trust, bed occupancy was in line with the optimal 85% level throughout the year.
- To improve the flow of people through the A&E departments and hospitals, the community discharge team met three times a week with partnership agencies to understand how the acute system was working, identifying people for discharge and where there were delays. Frimley Park

Hospital used historical data to model the predicted number of admissions, and planned their capacity accordingly.

- As part of the frail elderly pathway, the discharge and assessment team at Frimley Park Hospital had looked to other trusts to seek out best practice models in responding to people who were admitted through A&E. They were looking at implementing a rapid assessment and treatment strategy that could oversee treatment within 48 hours. There was a consultant allocated to this project who was responsible for developing the pathway and looking at the resources needed.
- Systems were in place to ensure people underwent a timely assessment and review seven days a week. FHFT undertook a seven-day service audit in March 2017. It showed that 95% of people were seen within 14 hours of admission, a figure maintained over the weekends. Also 100% of people received a twice daily review. A FHFT senior leader told us that they had increased the number of specialists working over the weekends.

Return

Are services working together to return people to their usual place of residence, or a new place that meets their needs?

Safe

When people returned to their usual place of residence or an alternative setting there were systems and processes in place to do so safely for the most part. However, further work was needed to ensure the relevant people had timely access to sufficient discharge information. Medicines management processes could be further improved to support a safe return home. People living with moderate to severe dementia needed to be able to access the right level of care and support when leaving hospital. Emergency readmission rates for Bracknell Forest's older people had improved and were now lower than the England average. However, the proportion of people still at home 91 days after reablement was significantly lower than England average.

- The number of older people in Bracknell Forest requiring emergency readmission once discharged had decreased. Our analysis showed that during 2015/16, Bracknell Forest's emergency readmission rates occurring within 30 days of discharge for people aged 65+ were slightly higher than the England average and comparator average at 17%. However, in the last quarter rates had dipped below comparator and England averages.
- The Forestcare assistive technology service provided 'takeaway bags' to support people with a safe discharge. The takeaway bag service was introduced two years ago and contained a Lifeline and instructions on installing the equipment. The service was provided as a six week free trial service, funded through the BCF. Following discharge a visit from an assessment and advice officer was provided to check for other assistive technology needs, such as an emergency response service.
- Frimley Park Hospital were piloting a scheme where they gave SCAS crew the direct number of the assessment and discharge team so that they could be informed if the crew arrived at someone's

home and found that there were safety concerns with their home environment. The team could then coordinate appropriate support for the person on discharge.

- Feedback around the quality and availability of discharge information was variable. A GP practice told us that while discharge summaries from FHFT and RBFT used to be of variable quality, they had recently improved due to feedback sent through the clinical concerns system, and most were now sent electronically. We heard from seven registered managers of social care providers, (care homes and domiciliary care), via our online feedback tool which asked about the quality of discharge information; four of seven respondents indicated that they received a discharge summary less than 75% of the time.
- The carers' forum told us that medication and discharge process concerns were a significant barrier against people returning home safely. Some reported that changes to medication had not been highlighted. Others stated that waiting for the discharge letter to reach the GP meant that there were delays in receiving the correct medication, or that people were left without a discharge letter and therefore social care was not able to be put a care package in place.
- These findings were supported by the responses to our online feedback tool around the discharge information flow, which found that while social care providers were largely positive regarding receipt of a discharge summary with 24 hours, some were less positive about receipt of discharge information that provided comprehensive information on details of medications and prescriptions.
- At Frimley Park Hospital processed were in place to support timely medicines management on discharge. When people were admitted, a log was made of what medication they were taking and passed to the pharmacy technician. The technician then liaised with the person's GP. A draft of any changes was made and reviewed throughout their stay with the aim to provide an accurate final medicine record on discharge.
- Availability of dementia placements in the community was an ongoing challenge and was compromising the safety of people in hospital at times. The Frimley Park Hospital assessment and discharge team had concerns that people with serious dementia needs were not having them met. This had led to safeguarding concerns when people with dementia and behavioural issues were cared for on a general medical ward. This was attributed to a lack of EMI bed availability. It was anticipated that the Heathlands project, which would have a number of EMI beds, should help with this.
- The percentage of people in Bracknell Forest who required readmission to hospital after discharge from reablement services was higher than the England average. The Department of Health's analysis of ASCOF reablement figures for 2015/16 showed that Bracknell Forest had a significantly lower percentage of people aged 65+ still at home 91 days after discharge from hospital into reablement services (58.2%) compared to the England average (82.7%) and comparator group average (85.1%). Our analysis of this measure showed a trend of declining performance in Bracknell Forest from a position in 2011/12 and 2012/13 where their performance was higher than the England and comparator average. The data also showed a decreasing trend between 2011/12 and 2015/16 in the percentage of people aged 65+ being offered reablement services in Bracknell

Forest.

- People discharged from intermediate care would receive a 91 day follow up appointment. The intermediate care team felt that there was scope to further safeguard these people from risk of readmission by carrying out reviews earlier, and were exploring ways to increase capacity in the service to enable them to do this as well as promoting the use of assistive technology to keep people safe at home.

Effective

There were some effective systems and processes in place to enable people to return to their usual place of residence. Market shaping, in the form of purchasing a care facility and agreeing a block contract of beds, was taking place to reduce delayed discharges

- There were multidisciplinary assessment and discharge teams in place to facilitate a smooth and timely transition of care. Social workers were linked into the hospital discharge teams through co-location and embedded into the discharge planning processes. The discharge team were clear that having a social worker in situ had improved the speed at which people could be assessed and sent home.
- Good working relationships between the FHFT hospital discharge team and the local authority social care team were seen to facilitate timely discharge from hospital. The discharge teams stated that there was a shared ethos of employing a solution-focused approach to getting people who were ready for discharge out of hospital as quickly as possible.
- There was mixed feedback about communication between care providers and hospital staff. Social care providers in a focus group stated that they had concerns about communication between themselves and secondary care staff when people's needs had changed. They felt that further work was needed regarding the assessment and communication of people's needs prior to discharge so that the person was moved into an appropriate setting with the support they needed in place.
- The discharge and assessment teams and social work teams we spoke with were clear that they felt they communicated well with social care providers, however conceded that there must still be room for improvement if a perception of poor communication was held by some providers.
- It was evident that people received seven-day care while in hospital. Analysis undertaken by the Department of Health showed the percentage of discharges of Bracknell Forest residents that took place at the weekend was 19% between October 2015 and September 2016. This was similar to the comparator areas. The availability of occupational therapists and access to equipment within the community was also given as evidence that seven day working was being supported.

Caring

We saw a strong commitment among operational staff to delivering a person-centred approach when managing how people returned to their usual place of residence or to step down care. However, transport delays meant that some people had a poor experience.

- We heard from operational staff that in addition to the trusted assessors in the EDS, a trusted assessor role was operating informally in some places, which reduced duplication of assessments and people having to tell their story multiple times.
- People were referred to VCS organisations to support their transition to their usual place of residence, for example the Red Cross support at home service. However, these organisations felt there was further scope to make use of them as a resource to support people to return home safely and support people's wellbeing.
- Staff across agencies displayed a willingness to discharge people home with a package of care when this was their wish, even if they were likely to require residential or nursing care in the longer term. Bed managers said that honest conversations with family took place early in the discharge process to ensure families were involved, and enable them to fully consider the options available with the person.
- Healthwatch Bracknell Forest's Hospital Discharge Survey June 2017 reported that the majority of people who responded felt that they were involved in decisions about their discharge and that the plan met their needs.
- However, delays to discharge from hospital meant that not all people were being treated with dignity, respect and compassion. We were told of some people with dementia having to wait for long periods in the discharge lounge. We were also given an example of transport delays leading to a poor experience for a person who was near the end of their life. The person had been scheduled to return to their nursing home in the early afternoon. Despite the nursing staff chasing up the issue several times the transport did not arrive until 17:30. The nursing home refused to accept the person after 17:00 and the person had to be readmitted to the ward, causing them distress.

Responsive

There were some systems and processes in place to enable a timely return for people to their usual place of residence or an alternative setting. However, a number of people experienced delays in their discharge due to medicines issues, transport delays and a lack of community health and social care support, including reablement beds, care packages and nursing home beds.

- Our analysis showed that, in contrast to the national picture and the average across comparators, fewer delayed transfers of care were attributable to the NHS than were attributable to social care in Bracknell Forest between February and April 2017. The main reason recorded for delayed transfers in Bracknell Forest over this period was 'awaiting care package in own home'.
- Lack of availability of adult social care beds and services was also a challenge for Bracknell Forest. Our analysis of data from July 2017 showed that provision of residential and nursing care home beds appeared to be lower per population in Bracknell Forest compared to comparator areas and the England average. The number of beds appeared to have decreased since April 2015, particularly in nursing care which saw a 58% reduction in beds.

- The local authority acknowledged that one of the capacity challenges they faced was a lack of access to local step up/step down beds to prevent admission and facilitate timely discharge. Beds were available in other areas such as Maidenhead and Slough but public transport links were poor, creating difficulties for family visiting. However, they were working with FHFT and the CCG to look at delivering an Integrated Community Hub at Bridgewell, incorporating step up/step down beds and discharge to assess (D2A) capacity. Bridgewell is a care home run by the local authority that currently provides short term care for people to support them returning to their home. The local authority was also negotiating a block contract of 20 beds to include step up/step down beds.
- Adult social care providers cited a concern that certain providers were not approached by social workers and commissioners when looking to discharge someone to a residential or nursing home from hospital, because of their higher price point. However, this was disputed by the commissioners and social workers who all explained that they would negotiate, and if the prices were deemed high, they would send this to panel for approval. They stated that this would not be a cause for delayed discharge. All agreed, however, that this difference of perception was evidence of a communication breakdown in the system.
- There were systems in place for the brokerage team to manage discharge issues raised by domiciliary care agencies. When there was a concern, the care home manager contacted the brokerage team and fed back to them. Case notes were updated to catalogue this, however there was little evidence that learning was taken from this.
- Aside from the primary reason cited in the data for delayed transfers of care (waiting for packages of care), two further issues were highlighted across stakeholders as contributing to delays; these were medicines management and transport.
- A social care provider said that medicines availability at both hospitals was a barrier to being discharged on time. We were told by social care providers and carers groups that a person could be ready to be discharged on one day but it might not be until the following day that the medication was available and they were able to leave hospital. In Healthwatch Bracknell Forest's Hospital Discharge Survey June 2017, 61% of respondents reported that their discharge was delayed, with the most common reason given as 'waiting for medication'. However, while waiting for medicines resulted in delayed discharge, evidence provided on the review from pharmacy staff suggested that the cause was more likely to be waiting for the doctor to write the prescription rather than waiting for the prescription to be filled by pharmacy.
- There were schemes in place to address medicines management. FHFT had a band 6 or 7 nurse and senior house officer undertaking 'ward rounds' to ensure medicines were written up in time for discharge, and a pharmacist independent prescriber had been employed to focus on prescribing for discharge.
- Issues with delayed transport at both hospitals were raised by stakeholders across the system. Once a SCAS key performance indicator (KPI) for collecting people with a planned discharge, (90% of people had a 45 minute or less pick up time), had been missed, frontline staff told us there was little incentive to go back to collect the person, instead they were 'bumped' down the list so that

they didn't impact on other people's wait times. However, we were told that a new KPI system was now in place that would prevent this.

- Transport for same day discharges were prioritised meaning that people with a planned discharge experienced a poorer service and delays. The SCAS transport KPI data for Bracknell Forest showed that, whereas same day discharge KPI was, on the whole, being met at 100%, those with planned discharge times had an average KPI of 70% between April and June 2017, increasing to 83% in July 2017.
- The scale and impact of transport issues was not being fully recorded which may have contributed to the fact that SCAS stated they were not aware of any significant concerns around delayed transport when the review team spoke with them. The hospital staff told us that they didn't always record their concerns because the system for logging and reporting them was too onerous and the number of delays too frequent. The relationship between transport and hospital staff was seen as needing further development and the monthly meetings held between the two groups could be at times adversarial rather than productive. However, it was reported that this had started to improve following some frank and open discussion.
- The local authority was working with Frimley Park Hospital to provide a D2A pathway. This would be a joint approach with the aim of addressing immediate need through practitioner autonomy. The planned outcome was a reduction in people remaining in hospital who were fit for discharge.
- In two of the people's records whose pathway we tracked, there was evidence that discharge planning started on admission.
- NHS continuing healthcare (CHC) quarterly figures for all adults (NHS England) for Q1 2017 showed that Bracknell and Ascot CCG had a standard NHS CHC assessment conversion rate for all adults (% of newly eligible cases of total assessments) of 50%. This was high compared to the England average (31%) and the South Central regional average (35%). Their referral conversion rate for all adults (percentage of newly eligible cases of total referrals completed) was also higher. This suggested that processes for accurately identifying people for CHC were working well and a lower proportion of people were entering into the CHC process to subsequently be denied funding. Front line staff told us that there were CHC specialists in all the discharge teams which helped them better understand the requirements of CHC and reduced the number of inappropriate referrals.
- In the same quarter, analysis for Bracknell and Ascot CCG showed that the 67% of referrals for all adults for standard CHC were completed within 28 days, higher than the England average of 57% and the South Central regional average of 33%. In our interviews, it was also confirmed that waiting for a CHC assessment and funding would not delay people's discharge. If an immediate care need was identified, the local authority would meet that need to get the person discharged while waiting for CHC funding to come through.
- However, we were told it was more challenging for people with mild dementia; people without a confirmed dementia diagnosis could find it challenging to obtain CHC funding. The discharge and

assessment team informed us that they spent a lot of time dealing with the funding issue and getting people with dementia discharged and supported in community. The integrated care team stated that people with mild dementia could stay in hospital for extended periods of time – for example waiting for a CHC funding decision which could take up to 28 days – and then spend further time in hospital for their care and support planning to be taken up by social services. There was no dementia specialist nursing post within the integrated care team which prevented them from taking on the more complex cases.

Maturity of the system

What is the maturity of the system to improve for the people of Bracknell Forest

- Overall, we found evidence of good strategic leadership supported by positive cross agency relationships that were strong enough to lead a whole system approach.
- System leaders were working collaboratively to agree and shape a structure of services that were sustainable and responsive to the needs of the local population and in particular to manage the needs of an aging population.
- The HWB had a well-developed health and wellbeing strategy. There were joint strategies aligned with local commissioning intentions and the STP and BCF.
- Within the BCF plan and linked to the health and wellbeing strategy for 2016 to 2020 there was a comprehensive plan to address workforce issues which had been developed by system partners. The resulting outcome for people is still to be tested given the early stage of the initiatives at the time of the review.
- There were well-developed joint processes for decision making, robust governance structures, and agreed performance measures that enabled partners to hold each other to account for the performance and delivery of the agreed strategies.
- The stabilising and shaping of the adult social care market through initiatives such as joint funding of a care facility, establishing a new domiciliary care agency contract and procuring a block contract of care home beds was either in the planning stage or just commenced and therefore at an immature stage.
- We found a very positive culture across the system with good use of shared learning and improvement opportunities. Leaders and managers provided encouragement and support for integrated and collaborative activities that improved outcomes.
- The Berkshire Connected Care programme had started to provide a system for sharing information across health and social care, allowing for instant access to patient and social care information and

the ability for people to access their own records. The local authority was the first social care service within East Berkshire to take part in the Connected Care programme.

Suggested areas for future focus

- Continue to ensure there is the right level of scrutiny and challenge in place across all partnerships. Consider the development of a partnership framework to support the governance of partnership working.
- Ensure there are robust and regularly evaluated plans to manage the current and projected shortfall of care home provision and the provision of high quality dementia care.
- Ensure there is robust contract monitoring and close partnership working with the newly tendered domiciliary care providers to mitigate risks during implementation and ongoing delivery.
- Prioritise workforce development and continue to work collaboratively to deliver an integrated, skilled and competent workforce.
- Ensure there is a consistent whole system and evaluated approach to best practice medicines management where medicine procedures are designed around a person's discharge needs from the point of admission.
- Continue to ensure that public engagement remains a priority alongside regular evaluation of effectiveness.
- Ensure there are robust and regularly evaluated plans in place with a whole system approach to reduce the number of people readmitted into hospital within 91 days post reablement.
- Ensure there are plans in place to reduce transport delays from hospital.

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Agenda Item

Division(s): N/A

HEALTH & WELLBEING BOARD – 9 November 2017

Delivering against the challenge: Better Care Fund, Improved Better Care Fund, and Delayed Transfers of Care Plans

Report by the Director for Adult Services and the Chief Executive of Oxfordshire Clinical Commissioning Group

Summary

1. The Better Care Fund is a programme spanning the NHS and local government which seeks to join-up health and care services, so that people can manage their own health and wellbeing, and live independently in their communities for as long as possible. This includes the Improved Better Care Fund which is paid to local government for funding of local care services and reducing pressures on the NHS.
2. The Better Care Fund is investing £40.9m in the Oxfordshire system in 2017/18 to improve health and social care outcomes for local people. In 2017/28 Oxfordshire County Council was allocated £6.3m from the Improved Better Care Fund.
3. Currently under the Section 75 NHS Act, the Joint Management Group between the Council and Oxfordshire Clinical Commissioning Group manages the Better Care Fund and reports to the Health and Wellbeing Board. This paper brings an update regarding Better Care Fund spend and progress.
4. The new pooled budget section 75 structure agreed for 2017/18 demonstrates positive intent for health and social care partners to work together locally and provides an opportunity to improve flow through the whole health and social care system. The Section 75 Report (Item 59/17) to Cabinet on 18 July 2017 set out the Council's outline agreement with Oxfordshire Clinical Commissioning Group for the pooled budget arrangements for 2017/18 to 2018/19. Agreement has now been reached between the County Council and the Clinical Commissioning Group on the contributions and risk shares. Appendix 1 sets out the contributions and summarises the planned use of the Better Care Fund and improved Better Care Fund grant funding in 2017/18.
5. The Joint Management Group's aim has been to deliver the outcomes under Priorities 5 to 7 of the Health and Wellbeing Strategy, and plans for the Improved Better Care Fund align to these desired outcomes. This paper provides an update on the outcomes and priorities agreed.

Background

Delayed Transfers of Care (DTOC)

6. Oxfordshire has had a long term problem with delayed transfers of care. In 2016/17 over 51,000 beds days were lost to delays, which, while a 13.55% improvement on the previous year (59,000 bed days lost), was still the 4th highest rate in the country and remains approximately twice the national average (August 2017 figures).
7. Government scrutiny on DTOC remains high with authorities in the bottom quartile nationwide (which includes Oxfordshire) asked to account for underperformance and informed that they will be subject to greater scrutiny regarding DTOC performance against targets.
8. Local health and social care systems have been asked to agree local targets for DTOC reduction as one of the BCF requirements for 2017-18. As part of a conversation with NHS England regarding local targets, in September it was agreed that the Oxfordshire system would reduce the average weekly overall headcount delays to 99 by November and 83 by March 2018. Figures for July indicate that progress has been made towards this target and figures for August and September suggest that progress remains ahead of the required trajectory. The early figures for October suggest that there is a risk in respect of the November milestone.
9. NHS England and the Local Government Association are requiring local systems to use the Eight High Impact Change Model to support local health and care systems to manage patient flow and discharge. The model identifies eight system changes which will have the greatest impact on reducing delayed discharges:
 - early discharge planning
 - systems to monitor patient flow
 - multi-disciplinary/multi-agency discharge teams, including the voluntary and community sector
 - home first/discharge to assess
 - seven-day services
 - trusted assessors
 - focus on choice
 - enhancing health in care homes
10. The DTOC Control Group (made up of officers from across the Oxfordshire health and social care system) has used the model to self-assess how the local care systems are working now, and to reflect on, and plan for actions to reduce delays throughout the year. The updated self-assessment is attached at appendix 2.

Home Assessment & Reablement Team (HART)

11. The report to Health & Wellbeing Board in July 2017 explained that the HART service began in October 2016 to deliver a single service supporting discharges from hospital through a reablement and discharge to assess model. HART is

delivered by Oxford University Hospitals NHS trust. At this time performance of the HART service was at 67% of contracted levels and an action plan was in place to address this.

12. Whilst the HART service has seen a marginal improvement to 71% of contracted levels, this remains short of contracted expectations. To assist with performance, a temporary adjustment to the delivery of this service has been agreed. With effect from October 2nd 2017, Oxford Health NHS Foundation Trust is delivering reablement episodes to people referred to the service from community (to avoid hospital admission). This will enable Oxford University Hospitals NHS Trust to focus on the delivery of reablement episodes to people to facilitate their discharge. This is one of a number of mitigation measures agreed by the Accident & Emergency Delivery Board to support delivery of reablement and discharge home to assess. Some of these are funded from the iBCF (see below).

iBCF spending

13. In 2017/2018 Oxfordshire County Council was allocated £6.3m to support adult social care. This additional funding is being spent on adult social care and used for the purposes of meeting adult social care needs in order to reduce pressures on the NHS. A detailed plan with outline costings is shown as appendix 3. This funding is designed to run through to September 2019. The Secretaries of State for the Department of Communities and Local Government and the Department of Health have written to the Council on October 10th setting out the national expectation for the impact of this funding in supporting system flow and highlighting the potential risk to the funding in 2018-19 if the delayed discharge trajectory is not achieved.
14. The planned iBCF investment is divided into four main areas – improving flow, market resilience, market capacity, and additional provision. Overall these work streams focus on delivering a sustainable interface between health and social care, stabilising the social care provider market and mitigating discharge pathway blockages to support delivery of the DTOC trajectory. As successive national visits to the Oxfordshire system have emphasised, “DTOC” is not simply a number that needs to be reduced to ensure system flow, but is also primarily about how we look after people under our care, and managing risks to their health and wellbeing. We are undertaking a range of system wide activities described below that are designed to improve the care that we offer by easing pressure throughout the system.

Improving Flow

15. We are investing £1.2m in social work capacity to support flow in the hospital system. This includes 7 day front door prevention work in emergency departments. This aims to avoid unnecessary admissions to hospital wards and support step down from acute and community hospital wards back to people’s own homes or to appropriate alternative long-term settings. This funding is committed for all three years of the iBCF to enable the recruitment of permanent staff and ensure effective use of resources.

16. Additional staff have now been recruited and are based in the Rapid Response Reablement Outreach Team and the Hub team. These staff will support the intermediate care system by improving flow and managing demand for long term care for people discharged from intermediate care (including HART) services. The impact of these staff will be measured by improved flow through the system, including reduced length of stay in intermediate care pathways and reduced demand for long term services. Data available so far shows that the Rapid Response Reablement Outreach team has successfully saved 312 hours per week (April – September 2017) by reducing the size of packages referred out of the HART service.
17. In total an additional 14 social work and occupational therapy staff now in post, with an extra 5 social work & therapy staff joining the team throughout October & November. Recruitment is still underway for a further 5 social work & therapy staff.
18. By improving flow and reducing the length of stay in these services, capacity for additional referrals will be generated. Performance measures regarding the flow and length of stay will be reported to and monitored by the Joint Management Group.

Market Resilience

19. We are investing in increased funding (£2.171m) for home care and care homes. We have committed the funding from the iBCF grant for the three years that we expect to receive this, and this will then be managed through the Council's medium term financial plan.
20. This funding has been spent on increasing the lowest level fees paid to home care agencies and care homes and is intended to contribute to market stability and provider resilience. Decisions regarding the amount paid through this process were taken following consultation with providers who were invited to submit their views on the Council's proposals; cost breakdowns showing the actual cost of service delivery; and the opportunity to meet with the Council to discuss any relevant financial matters. 21 out of 34 home care providers received an increased rate, which amounts to 27% of purchased hours. 22% of Council funded care home placements received an increased amount.
21. The market has not experienced the same level of provider failure as was experienced during the latter part of 2016-17. Through the spending on market resilience we aim to consolidate the market by working with providers to prevent provider failure and reports on this will be taken to the Joint Management Group.

Market Capacity

22. We are investing £0.5m in support work to increase market capacity. This includes work jointly undertaken by Oxfordshire Clinical Commissioning Group and the County Council to review the capacity of home care providers to deliver delegated health tasks. This is a longstanding arrangement in Oxfordshire to allow staff to deliver lower level health tasks. We are reconsidering the tasks that staff can undertake and the way they are trained to do this which may include recommendations to invest in provider training and support.

23. We are investing £0.2m in improving the capacity of care homes to support people with dementia via additional dementia specialist nurses in the Care Homes Support Service. £0.08m of this will be spent in 2017-18 with the remainder in 2018-19. The Care Home Support Service is provided by Oxford Health NHS Foundation Trust and their staffing complement will be supplemented by 4 full time posts specifically to support people with dementia returning to / being admitted to care homes. The staff will come into post in November. This is planned as a pilot project, the success will be measured by reduced length of hospital stay for people on this pathway. Reports on this will be provided for review by the Joint Management Group.
24. There are also a range of pilot projects currently being scoped to increase community capacity. These include different models to deliver community based support and support for people leaving hospital and are intended to supplement the traditional home care model and access different areas of the population to provide a workforce.
25. We have created a dedicated direct payments support function, enabling people to use direct payments effectively to purchase their own care. This includes support to employ staff and set up payment models.

Additional capacity to mitigate lack of HART performance

26. We are investing £0.9m for additional care home placements - 40 beds to provide additional post hospital capacity to improve hospital flow. 30 of these are beds are designed to provide capacity where people need larger packages of support on leaving hospital which HART presently lacks capacity to deliver in the short-term and 10 of these beds are available for people waiting for a care home placement who do not need to wait in an acute or community hospital whilst this being sourced.
27. In addition to the HART service, the Council has historically commissioned home care specifically to support hospital discharge. This service supports people home with high level needs (up to 24hr live-in care) for a maximum of six weeks. We are spending £1m for additional units of this support increasing from the current provision of supporting 50 people rising to 80 people over the summer (a time when home care is more difficult to source). Annual cost £2m, with £1m committed for 17/18 and £2m for 18/19. This capacity is fully in place.

Performance measures

28. Local systems are asked to submit up to ten local indicators which will be used to assure the delivery of the agreed reduction in delayed discharges and measure the success of the Improved Better Care Fund. Oxfordshire has chosen our nine indicators on the basis of those which represent a true picture of the challenges and successes in our system; and where information is available.

29. Seven of these measures are reported to Health & Wellbeing Board under priorities 5 to 4 of the Health & Wellbeing Strategy; the 2 additional measures are reported to the A&E Delivery Board. A summary of the measures and progress against these is shown below.

Measure	Trajectory	Comments
Hours of reablement delivered by the Home Assessment & Reablement Team (HART)	Improving	The hours delivered in quarter 2 (12,594) saw a marginal improvement from quarter 1 (12,609). Whilst we recognise that the performance of the HART service is moving in the correct direction; overall service performance remains short of contracted expectations. The measures outlined in paragraph 12 above regarding the temporary reconfiguration of the HART service are intended to result in an increased number of hours of reablement delivered.
Reduce the average length of days' delay for people discharged from hospital to HART	Improving	This figure is not available for quarter 1 but the baseline figure is 65. Quarter 2 figure is 41 showing that people are waiting less time in hospital to receive HART services. Whilst the quarter 2 figure is an improvement, the DTOC reduction measures discussed in this paper are expected to result in improved timeliness in this pathway.
Increase the number of people who need no ongoing care following a reablement episode	Deteriorating	The expectation is that 70% of people will not require support following an episode of reablement. In quarter 1 the figure was 56%, in quarter 2 the figure is 51%. Further work is underway to understand the reasons for the performance of this indicator.
Number of hours homecare purchased.	Deteriorating	This is measured by a snapshot taken in the final week of each quarter. Quarter 1 snapshot showed 22,368 hours purchased, quarter 2 snapshot showed 22,163 hours purchased. This shows that the Council's ability to purchase care is restricted by the supply of hours available; whilst market stability has improved this has not translated into market growth.
Reduce the average	Improving	The baseline figure is 762, in quarter 1 this figure

days' delay for people discharged from hospital to care homes.		was 632 and in quarter 2 this figure was 529. This measure remains on target with the DTOC trajectory in our Better Care Fund plan.
Proportion of providers measured by CQC as 'outstanding' or 'good' remains above the national average.	Improving	Increase from 87.5% in Q1 to 89.3% in Q2. We are pleased to note that quality of care in Oxfordshire remains good.
Reduction in the number of avoidable emergency admissions for acute conditions that should not usually require hospital admission for people of all ages.	Improving	The baseline figure is 524, in quarter 1 this figure was 511. Quarter 2 figures are not yet available.
Reduction in the number of people funded by Oxfordshire County Council and placed into a care home.	Improving	The baseline for this measure is 11.25. In quarter 1 the figure was 13, in quarter 2 this figure was 12.8. Whilst this indicator shows a marginal improvement, the Council's ability to source alternative home care for people to avoid care home admissions is limited by capacity in the home care market.
Discharges from hospital on Saturdays and Sundays are at least 60% of the Monday - Friday average.		

Local System Review

30. The Care Quality Commission (CQC) are carrying out a local system review in Oxfordshire. This is currently underway and involves a site visit to Oxfordshire week commencing 27th November. This review forms part of a targeted programme of 20

local authority areas being undertaken by CQC to understand how people move through the health & social care system with a focus on the interfaces between services. This will be followed by a national report by CQC for government that will bring together key findings from the 20 system reviews.

31. Partners in the Oxfordshire system are currently preparing for this review, which we expect will explore the key areas of partnership between us including (but not limited to) management of the iBCF and actions undertaken to address delayed transfers of care. This is an opportunity for the system to benefit from external review and the outcome of this will be reported to the Health & Wellbeing Board once the review is completed.

Recommendations

32. The Board is RECOMMENDED to review and endorse the iBCF plan.
33. The Board is RECOMMENDED to note and confirm the planned DTOC trajectory set out at paragraph 8 endorsed on behalf of the Board by the Leader of the Council with the agreement of OCCG and system partners on 26th September 2017.
34. The Board is RECOMMENDED to endorse the planned investment of the iBCF and to note the risk to the future funding from the Government if the schemes that have been identified do not deliver a reduction in delayed discharges in line with the agreed trajectory
35. The Board is RECOMMENDED to critically appraise and endorse the performance measures that are proposed to be used to assure the delivery of the agreed trajectory
36. The Board is RECOMMENDED to agree a reporting regime to ensure effective delivery.

Appendix 1 – Pooled Budget Contributions and breakdown of Better Care Fund Spend

1. The Section 75 Report (Item 59/17) to Cabinet on 18 July 2017 set out the council's outline agreement with Oxfordshire Clinical Commissioning Group for the pooled budget arrangements for 2017/18 to 2018/19. Cabinet agreed to delegate responsibility for approving the detail of the schedules to the Section 75 agreement for 2017/18, including the final contributions and risk share arrangements, to the Director for Adult Services in consultation with the Cabinet Member for Adult Social Care. These also needed to be formally agreed by Oxfordshire Clinical Commissioning Group.
2. Agreement has now been reached between the County Council and the Clinical Commissioning Group on the contributions and risk shares. For 2017/18, the risk share for each of the pools has been calculated based on gross expenditure weighted to take account of the relative risk of the budgets within the pool. The level of risk varies substantially as some budgets fund block contracts, which are effectively set at a fixed agreed level, while other budgets are demand driven and expenditure can vary significantly as a result. An variations of spend or income compared to the budget within the Better Care Fund Pool will be risk shared between OCC and OCCG on a 70%:30% basis.
3. The contributions for 2017/18 for the Better Care Fund Pool reflected in the formal S75 agreement are as follows:

4.

Pool 2: Better Care Fund Pool	Oxfordshire County Council	OCCG
	£'000	£'000
Contributions to Pool		
Care Homes	84,167	27,413
Prevention	15,078	14,487
Hospital Avoidance	21,531	34,293
iBCF grant funded expenditure	6,276	0
Gross Contribution	127,052	76,193
iBCF Grant Funding	-6,276	0
Less service user income	-26,653	0
Net Contribution	94,123	76,193

5. The table on the next page sets out the current expected utilisation of the £6.276m 'improved Better Care Fund' (iBCF) ring-fenced grant funding available in 2017/18.

Use of the improved Better Care Fund	2017/18

	£m
<u>Improving Flow</u> £1.2m investment in social work team capacity which will support flow in the hospital system, including front door prevention work and support to move through intermediate care and on to independence. Recruitment began in July 2017 and the majority of the new staff are expected to be in post in by the end of October 2017. Any balance will be used to fund temporary social care staff in these teams in 2017/18. In addition to this there is also additional capacity in the Health Funded Hub Team (£0.340m cost of 7.00FTES funded by OCCG)	1.2
<u>Market Resilience</u> As a result of home care and care homes fee consultations early in 2017 and reflecting the increase in the National Living Wage from 1 April 2017, an increase in home support (£0.5m), care home (0.5m) and extra care housing (£0.1m) fee levels paid to providers has been agreed and backdated to 1 April 2017 to aid market stability. A further £1.1m is funding to support increased payments to Learning Disability providers and reflects the cost of implementing a £68 per night payment for sleep – in care. £0.045m will be used to fund influenza immunisations for care staff to help maintain capacity over the winter.	2.2
<u>Market Capacity</u> An investment of £0.150m is supporting a strategic review of home care. The intention is to seek to increase capacity in the system through innovative and alternative delivery models. In 2017/18 £0.080m will be used to fund dementia specialist nurses in care homes (with a full year cost of £0.2m in 2018/19). A further £0.2m is being used to support changes to the delivery of delegated health tasks.	0.5
<u>Additional Capacity</u> An allocation of £2.4m in additional provision is providing capacity at the back door of acute hospitals, including forty short-stay care home beds (£0.9m) and additional capacity in the Discharge to Assess service (£1.5m). This additional capacity mitigated performance issues with existing Home Assessment and Re-ablement Team (HART) service until September, and is continuing to provide additional capacity to ensure effective and timely hospital discharge.	2.4
Total iBCF Grant Funding in 2017/18	6.3

6. As set out in the Better Care Fund plan, the Better Care Fund element of the pool will be utilised as follows:

Oxfordshire County Council (*)	
	£'000
Care Homes	8,704
Home Support	6,327
Prevention and Early Support	3,500
Equipment	1,650
Carers	1,350
Total Better Care Fund (Oxfordshire County Council)	21,531

Oxfordshire Clinical Commissioning Group (#)	
	£'000
Ambulatory Emergency Care Pathways	3,064
Delayed Transfers of Care	2,500
Emergency Medical Units	2,282
Rapid Assessment Care Unit	1,751
Home Assessment & Re-ablement Service	1,364
Proactive Support to Care Homes	1,000
Long Term Conditions	900
Oxfordshire Care Summary	537
Falls Pathway	389
Carer's Support (Social Care)	1,300
Other	103
Total Better Care Fund (Oxfordshire Clinical Commissioning Group)	15,190

(#) includes £0.767m funding from other Clinical Commissioning Groups.

Appendix 2 – Eight high impact changes self assessment

	What do you need to do	When will it be done by	How will you know it is successful
early discharge planning	1) Discharge planning is being reviewed for all patients as part of the DTOC pathway exercise. This will identify the inputs and capacity to support discharge planning (planned and emergency admissions) 2) Develop supported out of hospital capacity/extend from current speciality specific approaches (e.g. respiratory)	13/10/2017 31/3/2018	Evidence that x% of patients go home on initial planned date of discharge.
systems to monitor patient flow	1) Agreed demand and capacity plan for discharge pathways 2) New pathway model agreed 3) Capacity requirements mapped onto new pathway model 4) Real time remote identification of bottlenecks and pressures which can be managed by deployment of appropriate capacity	29/09/2017 13/10/2017 27/10/2017 31/3/2018	Capacity will meet demand with built in contingency for predictable variation. Effective processes and procedures to increase capacity to manage surges in demand across individual organisations in the system. System wide operational leadership to identify and avoid potential bottlenecks with clear criteria for escalation within a business continuity framework.
multi-disciplinary/multi-agency discharge teams, including the voluntary and community sector	1) Develop single assessment and discharge plan protocols as part of the revised pathway model 2) Integrate Northants teams into	13/10/2017 31/10/2017	Reduction in A code assessment delays and elimination of coding disputes

	HGH Board rounds and discharge planning 3) Design pilot initiative to identify role for 3rd sector in the acute and community hospital setting 4) in new pathway model make recommendation re single integrated bed management and discharge function across MDT 5) Create joint assessment protocol for CHC and complex patients in non-hospital bed settings	29/9/2017 13/10/2017 29/9/2017	
home first/discharge to assess	1) Deliver HART mitigation and increase capacity and capability of the service to support more people home via D2A 2) Develop a response to self-funders through the complex patient pathway in the revised pathway model 3) Improve D2A responsiveness via: development of Trusted assessor 7 day model that eliminates hand off delays; and develop role of 3rd sector to help people manage the transition home	31/10/2017 13/10/2017 13/10/2017	Reduction in E code delays Reduction in G code delays
seven-day services	1) Develop 7 day discharge framework with contracted social care providers for access to new and restarted packages at weekends as "the norm" 2) System trigger adopted: all parts of the system to be operating at 60% of capacity at weekends	43039	Increased discharge at the weekend in to care providers and community hospitals Increased flow out of community hospitals at the weekend

trusted assessors	1) Agree one assessment format between professions as part of new care pathway	13/10/2017	Delivery of 7 day services and D2A KPI
	2) Set up trusted assessor pilot with Help to Live at Home provider	1/9/2017	
	3) Set up trusted assessor pilot with Nursing Home provider	1/9/2017	
	4) Build Trusted assessment protocol into new care pathways	13/10/2017	
focus on choice	1) Review implementation of choice protocol in the light of complex patient workstream	13/10/2017	Fewer DToC numbers attributed to G code delays
	2) make recommendations on managing choice/G codes in the revised care pathway work	13/10/2017	Fewer disputes with patients and their families
	3) Explore 3rd sector role within MDT initiative	29/9/2017	
enhancing health in care homes	1) Develop a model of 24/7 urgent healthcare support to care homes with comprehensive geographical cover to reduce A&E and NEL pressures	8/9/2017	Fewer emergency admissions from care homes; rapid return to care homes in case of admission; reduced length of stay for people newly entering NH post admission
	2) Develop a care planning approach to increase capability and capacity in care homes through medical/clinical support	8/9/2017	
	3) Trusted assessor pilot as above	1/9/2017	
	4) 7 day working protocol implemented as above	31/10/2017	

Appendix 3 – iBCF project plan

Workstream/Activity	Allocation £'000	Start Date	Expected Delivery	Status
Improving Flow				
Intermediate Care Team Additional Staffing	1,200			On track
Extend locums and employ short term staff		01.05.2017	18.05.2017	Completed
Agree required new posts		01.05.2017	23.05.2017	Completed
Advertise new posts		14.06.2017	02.07.2017	Completed
Shortlist and interview applicants		03.07.2017	28.07.2017	Completed
Appoint successful applicants		31.07.2017	31.07.2017	Completed
New starters in post		01.10.2017	31.10.2017	On track
Emergency Department Additional Staffing				On track
Extend locums and employ short term staff		01.05.2017	18.05.2017	Completed
Agree required new posts		01.05.2017	23.05.2017	Completed
Advertise new posts		14.06.2017	02.07.2017	Completed
Shortlist and interview applicants		03.07.2017	28.07.2017	Completed
Appoint successful applicants		31.07.2017	31.07.2017	On track
New starters in post		01.10.2017	31.10.2017	On track
Increased Block Purchasing				Completed
Demand modelling and write specification		03.04.2017	14.05.2017	Completed
Tender process		15.05.2017	01.06.2017	Completed
New block beds become available		01.06.2017	28.07.2017	Completed
Contract Management of Reablement Service (HART)				On track
Implementation of HART improvement plan		03.07.2017	30.09.2017	Delayed
Market Resilience				
Home Care Market	2,171			On track
Home care review consultation		15.02.2017	31.03.2017	Completed

Financial Modelling - Agree price changes (back dated to 01.04.2017)		01.04.2017	30.06.2017	Completed
Confirm prices with providers		03.07.2017	07.07.2017	Completed
Financial Modelling (LD) - Agree price changes (back dated to 01.04.2017)		08.07.2017	01.09.2017	Completed
Confirm LD prices with providers		01.09.2017	01.09.2017	Completed
Care Home Market				On track
Care home review consultation		15.02.2017	31.03.2017	Completed
Financial Modelling - agree price changes		01.04.2017	31.08.2017	Completed
Confirm prices with providers		01.09.2017	01.09.2017	Completed
Flu vaccinations	45	tbc	tbc	Not started
Market Capacity				
Delegated Health Care Tasks	200			On track
Review of delivery of delegated health care tasks		01.03.2017	31.03.2017	Completed
Agreement on revisions to delivery of tasks		01.03.2017	31.03.2017	Completed
Pilot in north of County		03.04.2017	23.06.2017	Completed
Review results of pilot		26.06.2017	30.06.2017	Completed
Decision on implementation countywide		17.07.2017	17.07.2017	Delayed
Wording for variations of contract agreed		01.07.2017	28.07.2017	Delayed
Phased implementation		01.01.2018		On track
Dementia Specialist Nurses in Care Homes	80			On track
Agreement in principle to proposals		01.05.2017	26.05.2017	Completed
Agree process		03.07.2017	22.09.2017	Completed
Recruit staff		22.09.2017	31.10.2017	On track
Go-live		01.11.2017	01.11.2017	On track
Alternative Models to Home Care	150			On track
Scope potential models for pilot		03.07.2017	01.12.2017	On track
Implement pilots		01.01.2018	31.03.2018	On track
Review results of pilots		05.04.2018	30.04.2018	On track

Decision on future implementation of models		30.04.2018	30.04.2018	On track
Direct Payment Support Function	Funded from existing budgets			Not started
co-design of new function		02.10.2017	26.01.2018	
new model agreed january		26.01.2018	26.01.2018	
implementation of new function		29.01.2018	30.03.2018	
go live of new function		02.04.2018	02.04.2018	
Additional Capacity				
Reablement	1,500			On track
Purchase additional reablement capacity within existing contract		01.04.2017	28.04.2017	Completed
Tender process for additional short term home care capacity		02.10.2017	01.12.2017	On track
New service go-live		04.12.2017	04.12.2017	On track
Care Home	900			On track
Tender process for interim beds (Phase 1)		10.02.2017	10.03.2017	Completed
Tender process for interim beds (Phase 2)		15.05.2017	01.06.2017	Completed
New interim beds available		01.04.2017	28.07.2017	Completed

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NHS England
Skipton House
80 London Road
London
SE1 6LH

30 October 2017

To: *(by email)*

Cllr Ian Hudspeth

Peter Clark

Dr Joe McManners

David Smith

Leader of Oxfordshire County Council and Chair, Oxfordshire
Health and Wellbeing Board

Chief Executive, Oxfordshire County Council

Clinical Chair, NHS Oxfordshire CCG

Chief Executive, NHS Oxfordshire CCG

Dear Colleagues

BETTER CARE FUND 2017-19

Thank you for submitting your Better Care Fund (BCF) plan for regional assurance. We know that the BCF has again presented challenges in preparing plans at pace and we are grateful for your commitment in providing your agreed plan. The Better Care Fund is the only mandatory policy to facilitate integration of health and social care and the continuation of the BCF itself. It brings together health and social care funding, with a major injection of social care money announced at Spring Budget 2017. For the first time, this policy framework for the Fund covers two financial years to align with NHS planning timetables and to give areas the opportunity to plan more strategically.

Your plan has been assessed in accordance with the process set out in the *Better Care Fund 2017-19: Guide to Assurance of Plans*.

In determining and exercising further powers in connection with your application, NHS England has had regard to the extent to which there is a need for the provision of health services; health-related services (within the meaning given in section 14Z1 of the NHS Act 2006); and social care services.

I am delighted to let you know that, following the regional assurance process, your plan has been classified as '**Approved**'. In summary, the assurance team recognises your plan has been agreed by all parties (Reading Borough Council and your Health and Wellbeing Board), and the plan submitted meets all requirements and the focus should now be on delivery.

Your BCF funding can therefore now be released subject to the funding being used in accordance with your final approved plan, and the funding being transferred into pooled funds under a section 75 agreement.

High quality care for all, now and for future generations

These conditions have been imposed through NHS England's powers under sections 223G and 223GA of the NHS Act 2006 (as amended by the Care Act 2014). These sections allow NHS England to make payment of the BCF funding subject to conditions. If the conditions are not complied with, NHS England is able to withhold or recover funding, or direct the CCG(s) in your Health and Wellbeing Board area as to the use of the funding.

Amounts payable to the CCG in respect of the BCF are subject to the following conditions under section 223GA of the NHS Act 2006:

1. That the CCG will meet the performance objectives specified in its BCF plan; and
2. That the CCG will meet any additional performance objectives specified by NHS England from time to time.

If the CCG fails to meet those objectives, NHS England may withhold the funds (in so far as they have not already been paid to the CCG) or recover payments already made; and may direct the CCG as to the use of the amounts payable in respect of the BCF.

In addition to the BCF funding, the Spring Budget 2017 increased funding via the Improved Better Care Fund (IBCF) for adult social care in 2017-19. This has been pooled into the local BCF. The new IBCF grant (and as previously the Disabled Facilities Grant) will be paid directly to local authorities via a Section 31 grant from the Department for Communities and Local Government. The Government has attached a set of conditions to the Section 31 grant, to ensure it is included in the BCF at local level and will be spent on adult social care.

You should now progress with your plans for implementation. Ongoing support and oversight with your BCF plan will be led by your local better care manager.

Once again, thank you for your work and best wishes with implementation and delivery.

Yours faithfully,



Simon Weldon
**Director of NHS Operations and Delivery and SRO for the Better Care Fund
NHS England**

Copy (by email) to:

Kate Terroni	Director of Adult Social Services, Oxfordshire County Council
Jo Farrar	Director General, Department for Communities & Local Government
Jonathan Marron	Director General, Department of Health
Sarah Pickup	Deputy Chief Executive, Local Government Association
NHS England South	
Anne Eden	Regional Director
David Radbourne	Director of Commissioning Operations
Jo Cogswell	Regional Lead
Kevin Johnson	Better Care Manager
Better Care Support team	
Anthony Kealy	Head of Integration Delivery
Rosie Seymour	Deputy Director

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Oxfordshire
Clinical Commissioning Group

Oxfordshire Health and Wellbeing Board

9 November 2017

Accountable Care Systems

Accountable Care Systems (ACSs) are systems in which NHS organisations (both commissioners and providers), often in partnership with local authorities, choose to take on clear collective responsibility for resources and population health. They were proposed in “Next Steps on the NHS Five Year Forward View”, NHS England (March 2017).

It is proposed that an ACS would get far more control and freedom over the total operations of the health and care system in their area and they will get a fair share of the national transformation funding to deliver key priorities, rather than having to bid competitively against other areas.

Specifically, ACSs can:

- Agree an **accountable performance contract** with NHS England and NHS Improvement that can credibly commit to make **faster improvements**.
- Together manage **funding for their defined population**, committing to shared performance goals and a financial system that will, for example, allow them to move beyond tariff payments where appropriate, deploy their shared workforce and facilities and effectively end the annual contract negotiations within their area.
- Create an effective **collective decision making and governance structure**.
- Demonstrate how their provider organisations will operate on a **horizontally integrated** basis, whether virtually or through actual mergers.
- Demonstrate how they will also operate as a **vertically integrated** care system, partnering with local GP practices formed into clinical hubs serving 30,000-50,000 populations. This will also mean a new relationship with local community and mental health providers as well as social services.
- Deploy **population health management capabilities** that improve prevention, enhance patient activation and supported self- management for

long term conditions, manage avoidable demand, and reduce unwarranted variation in line with the RightCare programme.

- Establish clear mechanisms by which residents can exercise **patient choice** over where they are treated for elective care.

This would be a complex transition which would require careful management to create opportunity while also reducing instability and managing risk. ACSs require a staged implementation. This also provides the opportunity to prove their ability to manage demand in ways that other areas can subsequently adopt.

Why do we need to change?

Fundamentally, we believe that the required improvements to services and the necessary financial efficiencies are only achievable by working together as a system. Ideally, this would be across health and social care with the agreement of all organisations – NHS and local authority.

Different organisations operate different financial regimes which do not incentivise the redesign of care pathways, particularly if this is across more than one organisation. Costs can become stranded at an organisational level and the historical approaches of Quality, Innovation, Productivity and Prevention (QIPP) programmes and Cost Improvement Programmes (CIP) do not address this. The current financial mechanisms are not enabling us to shift resources at the scale and pace we need to transform our system.

Other challenges include the different regulations and governance that exist, the limited interoperability of our IT systems, the workforce challenges of working as a system and the increasing need for all of us to take greater ownership of our health and wellbeing, particularly relating to lifestyles and management of long term conditions.

Accountable Care Organisations (ACO)

In time some ACSs may lead to the establishment of an Accountable Care Organisation (ACO). This is where the commissioners in that area have a contract with a single organisation for the great majority of health and care services and for population health in the area. A few areas in England are on the road to establishing an ACO, but this takes several years. The complexity of the procurement process needed, and the requirements for systematic evaluation and management of risk, means they will not be the focus of activity in most areas over the next few years.

Local development of an ACS

The first wave of ACSs has been announced by NHS England and two of those are our neighbours in Buckinghamshire¹ and Berkshire West. This provides Oxfordshire an opportunity to benefit from the work and learning they have already done and to share in the work they will be doing from now on.

Very early stage discussions have taken place between Oxfordshire CCG and the following organisations' Chairs and Chief Executives to scope the support for working together under an ACS model for Oxfordshire. These organisations include:

- Oxford University Hospitals NHS Foundation Trust
- Oxford Health NHS Foundation Trust
- Oxfed (Oxford Federation for General Practice and Primary Care)
- Abingdon GP Federation
- PML² Federation of GPs
- SEOX (South East Oxfordshire Federation of GPs)
- Oxfordshire County Council (two meetings were held, the first with the Chief Executive and Strategic Director of People; the second with the Leader).

An ACS would enable us to:

- Take a system-wide approach to population health.
- Accelerate implementation of integrated care across the County.
- Enable us to better align incentives to improve outcomes.
- Enable financial transparency and development of a financial system that supports sustainability of all parts of the system.
- Engage constructively with the universities and local democratic processes.
- Develop a single integrated data set focused on data for business intelligence and improved patient care rather than contract monitoring.
- Work as a system with the regulators.

What are the benefits for patients and citizens?

Patients would see one system responsible for their health and social care, thereby facilitating a more responsive and individualised service. Services would be seamless.

Our citizens would know that all the organisations who are spending their taxes are working together to deliver the best outcomes and value within the money available. It would enable resources to be moved into prevention and services closer to home. Choices about where to invest and disinvest would be more transparent and would

¹ Oxford Health NHS Foundation Trust is a partner in the Buckinghamshire ACS.

² PML is a not-for-profit healthcare provider run by local GPs for local patients delivering NHS primary healthcare contracts in Oxfordshire and Northamptonshire

enable far greater involvement of citizens and their elected representatives in determining where the money is spent.

Next steps

Discussions are continuing across organisations. Moving in this direction would be a significant shift for Oxfordshire and there needs to be agreement across all organisations that this will deliver the benefits we need before we begin to develop any detailed plans.

Dr Joe McManners
Clinical Chair

David Smith
Chief Executive

31 October 2017

Oxfordshire Health and Wellbeing Board, 9th November 2017

Proposal for a Review of Governance of the Health and Wellbeing Board.

The Health and Wellbeing Board has carried out its statutory remit since April 2013, having met in shadow form since November 2011, fulfilling its role in accordance with the Health and Social Care Act.

It is now timely to undertake a review of the governance and terms of reference of the Board for the following reasons:

1. The NHS's priority, as stated in the 'Five Year Forward View' and subsequent documents, is to move to Accountable Care Systems. A number of these have been established. Clearly Health and Wellbeing Boards have a key role to play in their development and it is proposed that we review governance arrangements and Terms of Reference so as to play an active role in this development.
2. The NHS has also moved to an emphasis on 'whole system working' as opposed to a clear-cut distinction between commissioners and providers. The architecture of the Health and Wellbeing Board was designed in the 'commissioner/provider split' era – hence a membership based on those in receipt of direct government funding. We have balanced this by having a wide membership on the Board's three sub-groups to ensure that the views of service providers and other voices were reflected. It is now timely to change this arrangement to one which reflects whole system working at the level of the Health and Wellbeing Board itself and which takes account of the major role played by Foundation Trusts and the Voluntary Sector for example.
3. The Oxfordshire Transformation Board¹ continues to work on practical issues of service transformation in the County and, although there is a strong synergy and an overlapping membership between it and the Health and Wellbeing Board, the Governance links between the two would benefit from clearer definition. This is anticipated to assist further whole system working and the development of Accountable Care Systems.
4. Over the years the Health and Wellbeing Board has received requests to expand its membership. These have come from many sectors, including patient groups and advocacy groups, the voluntary and community sector, cultural and arts organisations, the police and the military. Our initial thinking

¹ Extract from the Terms of Reference for the Transformation Board: "The Transformation Board is set up to drive forward the transformation of the health and social care system in Oxfordshire, and more specifically: 1) To bring together in one place all the partners and programmes of work that will deliver significant change in the Oxfordshire health and care system. 2) To oversee the set up and delivery of the joint Oxfordshire Healthcare Transformation programme"

was to avoid a Board which would be too large to be effective and so we decided to be guided by the statutory membership. The changing nature of the Health and Social Care system means that it is now timely to review the membership of the Board again.

Proposal

It is proposed that the Health and Wellbeing Board discuss this issue and agree to set up a working group under its Chairman and Vice-Chairman. This group is asked to make recommendations to the next Health and Wellbeing Board meeting in March 2018, proposing changes to governance arrangements and terms of reference. It is further proposed that the Transformation Board is approached to align with this process so that the governance arrangements between the two Boards can be clarified and formalised.

Recommendation

To discuss and agree the detail of the proposal stated in the paragraph above.

Jonathan McWilliam

**Strategic Director for People & Director of Public Health
Oxfordshire County Council**

Health and Wellbeing Board

9 November 2017

Development of a new Older Peoples Strategy

Purpose

1. The Health and Wellbeing Board are asked to agree the proposed approach to developing a new Older Peoples Strategy for Oxfordshire.

Background

2. The Older People's Joint Commissioning Strategy 2013-2016 has now expired. This was developed jointly by the County Council and Clinical Commissioning Group and focused on services for older people that were commissioned by either Organisation, or jointly.
3. It was intended that the replacement for this strategy would be developed following the agreement of the Oxfordshire Transformation Programme and the Buckinghamshire, Oxfordshire and West Berkshire Sustainability and Transformation Plan, to allow close alignment.
4. It is now considered that, whilst these plans are not yet finalised, proposals have taken shape sufficiently for work to commence on the new Older People's Strategy for Oxfordshire.
5. The timing will also enable any learning from the upcoming Care Quality Commission (CQC) inspection of the health and social care system in the county to be built into the new strategy, embedding agreed actions into shared plans.

Approach to the new Strategy.

6. It is likely that the new strategy will build on the vision and priorities in the previous strategy, which were:

To enable people to live independent and successful lives

Priority 1:	I can take part in a range of activities and services that help me stay well and be part of a supportive community.
Priority 2:	I get the care and support I need in the most appropriate way and at the right time.
Priority 3:	When I am in hospital or longer term care it is because I need to be there. While I am there, I receive high quality care and am discharged home when I am ready.
Priority 4:	As a carer, I am supported in my caring role.
Priority 5:	Living with dementia, I and my carers, receive good advice and support early on and I get the right help at the right time to live well.
Priority 6:	I see health and social care services working well together.

7. Being a joint commissioning strategy, the emphasis was very much on the delivery of health and social care services for older people in the county.
8. It is proposed that the new Older People's Strategy takes a broader focus, recognising the wide range of possibilities for older people's lives, that do not have to be bound up in service delivery.
9. As such, there will be greater emphasis on the role on non-statutory services, community and voluntary support, and the role of individuals and their families in helping people to live independent and successful lives.
10. The strategy will need to set out how, by working together, we will seek to tackle the major health and social care issues facing the county, particularly around workforce, population growth, increasing demand for services, and the development and use of technology in new and different ways to support people.
11. It will also be important that the strategy reflects the significant changes already underway in the county as part of the Oxfordshire Transformation Programme, including the work towards accountable care systems and better integration and close links between primary care, secondary / tertiary care and social care.
12. We therefore anticipate the Older People's Strategy will be a strategy for the county as a whole, and its development will involve a wide range of partners across the county.
13. It is proposed that the Health and Wellbeing Board has overall responsibility for agreeing and overseeing the implementation of the strategy, given its broad cross-cutting role, responsibility for Better Care Fund, and links to the Health and Wellbeing Strategy for the county.
14. A steering group will be established to oversee and drive the development of the strategy, including representatives from:
 - Oxfordshire County Council
 - Oxfordshire Clinical Commissioning Group
 - District and City Councils
 - NHS providers including Oxford Health NHS Trust and Oxford University Hospitals NHS Trust.
 - Primary care, including GPs and GP federations
 - Relevant Voluntary and Community organisations (eg Age UK)
 - Older people and carers
 - Oxfordshire Healthwatch
 - Other stakeholders as identified through the process including business, university and technology exemplars to help identify new ways to tackle major issues.
15. We want to make sure this is a strategy that can deliver for everyone. It will make demands of a wide variety of service providers – not just the county council and CCG.
16. By bringing a wide range of partners on board, we intend to increase the reach and scope of the strategy; embed the shared principles in the work of a wider range of organisations; improve the opportunities for engagement in its

development and implementation; and overall to ensure older people in Oxfordshire are better able to live independent and successful lives.

Consultation and engagement

17. Engagement will be fundamental in developing the new strategy, building on our commitment to co-production and meaningful involvement of people themselves in determining what an independent and successful life means for them, and what support (if any) they need to achieve it).

18. The first step will be an engagement exercise, to establish:

- what older people want to see in the county,
- what different agencies are currently and could be offering;
- what is currently working well, and should be built on;
- what isn't working well or people are not currently able to access, and why;
- how this connects together with other issues, such as prevention, ambulatory support, supporting frailty pathways, accessibility and transport, housing, employment / workforce, social interaction and so on.

19. We will use the results and analysis of the engagement exercise to build an initial strategy, including proposed actions and measures of success, which will then be subject to consultation prior to final agreement and sign off from the Health and Wellbeing Board.

Timeline

20. It is proposed that the new Older People's Strategy is brought to the July meeting of the Health and Wellbeing Board for agreement. This will align to the refresh of the Joint Health and Wellbeing Strategy, which will also be considered at the same meeting.

21. To achieve this, the high-level timeline will be as follows:

November 2017 – March 2018	Engagement exercise and intelligence gathering to develop evidence base for strategy, linked to ongoing development of other strategic plans, pathways mapping for winter, and CQC inspection outcomes.
March - April 2018	Co-production of draft strategy, including alignment to partners strategies and action plans, and outcomes of JSNA
April – May 2018	Consultation on draft strategy
June - July 2018	Coproduction of final strategy, including specific actions and measures of success
July 2018	Agreement of strategy by Health and Wellbeing Board
July 2018 onwards	Implementation of strategy, with oversight by Health and Wellbeing Board.

Recommendation

22. The Health and Wellbeing Board is asked to:

- Agree the proposed approach to developing the Older People's Strategy, including the broader focus and engagement of wider range of people and partner organisations.

Diane Hedges, Chief Operating Officer and Deputy Chief Executive, Oxfordshire Clinical Commissioning Group

Benedict Leigh, Deputy Director Joint Commissioning, Oxfordshire County Council

November 2017

Contact: Ben Threadgold, Policy and Performance Service Manager, Oxfordshire County Council, ben.threadgold@oxfordshire.gov.uk



Your voice on health and social care

Healthwatch Oxfordshire Update November 2017

1. Introduction

The Healthwatch Oxfordshire (HWO) Board has met twice since last HWWB meeting on 11th July and 10th October 2017. Minutes of the July meeting are on Healthwatch Oxfordshire web page:

<http://healthwatchoxfordshire.co.uk/healthwatch-oxfordshire-board-meetings-and-minutes>

1.1 Health Improvement Board

Richard Lohman, ex HWO Board member and Commissioner on the Oxfordshire Health Inequalities Commission has agreed to take up the vacant position of Healthwatch Ambassador on the HIB.

1.2 Children's Trust

Sylvia Buckingham, Director of Healthwatch Oxfordshire is to attend the Children's Trust Board as Healthwatch Oxfordshire representative.

2. Key points relevant to the Health and Wellbeing Board Agenda November 2017

2.1 Governance

One of the suggestions made by attendees at our Voluntary Sector forum in July was to explore how the sector can be represented on the Health & Wellbeing Board - with a seat reserved for it.

2.2 Special Educational Needs and Disability (SEND) reform

Healthwatch Oxfordshire was asked by the CQC Children's Services Inspector to contribute information to their recent inspection of SEN Children services & disability.

2.3 Director of Public Health Annual Report

The Director of Public Health was the key speaker at the Board's last meeting in October.

We welcome his report and are particularly supportive of the section on population and the need for all stakeholders to work together to plan for health and social care services.

2.4 Health Inequalities Commission

Healthwatch Oxfordshire continue to support the implementation of the recommendations of the Commission and play an active part in the implementation group. The development of a strategic approach to supporting social prescribing across Oxfordshire is an exciting outcome that will support self-care and properly begin to engage with the voluntary organisations in the health agenda.

3.0 Bicester Town event - summary early points to note

Bicester Town event ran from Friday 29th September to Friday 14th October. The first two events organised and delivered by HWO staff were held on the 29th September:

‘The Healthwatch Happening’ where 24 different organisations involved in health and social care were promoting their services and available to offer to members of the public advice and support. The Mayor of Bicester Cllr Les Sibley opened the event and spent over two hours meeting exhibitors and talking to the public.

Dr Helen van Oss, Chair of North Oxfordshire Locality Forum kindly offered free blood pressure readings - out of 11 readings taken she advised three people to visit their doctor to have their pressure checked and seek advice.

Bicester market HWO stall and in seven hours we spoke to over 150 people. A long day but very worthwhile.

We often heard about how difficult (impossible) it is to register with a NHS dentist in Bicester. Bicester Advertiser followed up this story and it was on the front page that week. We are now developing a project to find out whether other areas of Oxfordshire are experiencing similar difficulties in accessing NHS dental services.

Other activities included attending the opening of the new sports pavilion as part of Bicester Healthy New Town, a stall at the Bicester library, visited Humming bird group, met residents from The Willows and Kingsman estate, visited the veterans’ self-help group, and attended a toddlers group.

4.0 Locality Forum support

We welcome Veronica Barry who has started work at HWO as Community Information Officer (Localities) to provide the secretariat support to the Locality Forums and development support to patient participation groups.

5.0 Project Fund

HWO is to relaunch our project fund. The fund will be used to:

- support local voluntary and community groups to carry out qualitative studies and research within their communities

- support HWO projects including large qualitative studies

Further details will be available in November 2017.

6.0 Outreach activity

Over four busy months, the Healthwatch Oxfordshire team has attended several events, giving us an excellent opportunity to listen to a wide range of experiences from many different users of Oxfordshire's health and social care services.

We have heard the concerns of people from the many regions of rural Oxfordshire and have noticed some recurring themes and concerns.

Many of the events where we have run the Healthwatch Oxfordshire stall have been the Play and Activity Days organised by Oxfordshire Play Association where we have been given the opportunity to speak to parents and carers of children and younger people. A recurring theme that emerged from these days was the impact of the cuts on children's services including the loss of children's centre services resulting in feelings of isolation; difficulty in accessing services including health visitors; lack of breast feeding support in the community whilst the support at JR was excellent.

6.1 Mental health support for children

Common concerns regarding the length of time to access the service

6.2 Schools

Healthwatch Oxfordshire heard from young people that:

- Drug and alcohol sessions were not useful because the overriding message was just "Don't do it" rather than teaching young people about harm reduction which, they felt would be far more effective.
- Counselling services should be more anonymous and accessible - perhaps using a direct telephone line.
- On Healthy Eating, the students said that it cost £1.80 to buy a salad for lunch in the school canteen compared to 90p for a sausage roll or Cornish pasty. They said that there were posters around school promoting the "Eat Healthy, Eat Well" message but that the school canteen prices did not encourage students to do that.

6.3 Hospital Experiences

Good care and praise for nursing staff but concerns included those around hospital food, the use of 'technical language' by staff that is not properly understood, waiting times for physiotherapy that resulted delay in discharge.

6.4 Military Families

At the Carterton Play and Activity Day we had the opportunity to talk to the Community Fundraising Officer for Combat Stress, The Veteran's Mental Health Charity.

He informed us that only eight percent of referrals to the charity came from GPs. He explained the reason, as being that veterans were reluctant to talk about their feelings due to the stigma that still surrounds mental health. This creates a barrier to seeking help and support for those who are finding it difficult to adjust to life as a civilian.

He felt that the solution was at the point of referral so that it is clear on patient's referrals whether they have served in the armed forces, allowing the GP to see this and be aware of the patient's history.

6.5 GP Practices

Lots of feedback on lots of practices across the county, and common theme was the wait associated with getting a GP appointment. We spoke to a lady who pointed out the challenge of phoning the GP practice and being made to wait in a queue which eats away at phone credit. She told us that she has previously run out of credit, lost her place in the queue, and had to go to a neighbour to phone again. She felt that there should be a free phone number.

6.6 Physiotherapy

We have received many expressions of concern about the transfer of physiotherapy services from OHFT/OUHFT to Healthshare Ltd. The loss of facilities in Abingdon and Wantage, poor communication between the authorities and the public, and the difficulty of establishing continuity of appointments and treatment, have given rise to much anxiety. The proposal to concentrate stroke rehabilitation facilities in Abingdon Community Hospital raises further issues. We consider that greater clarity is required regarding the future provision of, and continuity between, in-patient and out-patient physiotherapy services for stroke patients in the Abingdon area, following the transfer of services

7.0 Voluntary Sector Forum July 2017

Focussing on Health Inequalities the Forum with presentations from Richard Lohman, Health Inequalities Commissioner and Jackie Witherspoon, Public Health Oxfordshire - on progress made since the Oxfordshire Health Inequalities Commission Report was published in November 2016. This was an opportunity for the voluntary sector to hear what is happening, contribute to the debate, and explore the role of the sector in addressing health inequalities in Oxfordshire. The report is available on HWO web site follow the link here <http://healthwatchoxfordshire.co.uk/healthwatchoxfordshirereports>.

To summarise what the sector had to say:

The voluntary sector has an important role in tackling health inequalities including:

- Signposting their communities to services
- Prevention and awareness raising
- Developing and delivering social prescribing services / activities
- Challenging the system when it does not work for their community
- They are experts in their communities, have access to the community and often fill the gaps in services where the statutory sector is unable to meet a need

Suggestions made on what needs to be done to tackle health inequalities included:

- Involving the voluntary sector organisation early on in-service design and delivery.
- Explore how the sector can be represented on the Health & Wellbeing Board - with a seat reserved for it.
- Following the Forum, Healthwatch Oxfordshire reported that in light of the issues raised by attendees, we recognise that we can play an important role in supporting community and voluntary groups, including local, self-help groups to:
- Have their voices and their members' voices heard by decision makers, commissioners and providers of health and social care services in the county.
- Stay informed
- Network with each other on key issues and areas of interest.

Healthwatch Oxfordshire is keen to develop further our mechanisms for ensuring this happens. To this end, we will be holding another Forum in December 2017 to explore with voluntary sector partners how we can strengthen this aspect of our work.

8.0 Travel Survey Outcome

Our travel survey report of patient experiences travelling to the four Oxford University Hospital NHS Trust (OUHT) sites completed in May 2017 has been accepted and included in the documents for consideration during implementation of the Oxfordshire Health Transformation Programme.

9.0 Witney

The Report on our Witney Town activity is now available.

In September Healthwatch facilitated a meeting of stakeholders including Deer Park Action Group, Witney Town, West Oxfordshire District Councillors, County Councillor and Officers from Oxfordshire Clinical Commissioning Group, and WODC, local patient participation group members, Chair of WO Locality Forum and representatives from local GP surgeries.

The purpose of the meeting was agreed in April following discussions between HWO, OCCG and Deer Park Action Group to explore how well all stakeholders work together when planning health services. Key notes / actions:

1. WODC and OCCG are working together regarding information sharing and planning particularly around housing development.
2. Key emerging themes for the West Oxfordshire Locality Plan were shared - timeline for completion to OCCG Board December 2017
3. OCCG to work with Healthwatch to make data information aka OCCG slide show more accessible for wider distribution
4. Deer Park patient group has concerns that the Locality Planning is not within the IRP report parameters.
5. OCCG slide presentation and PCLP data is the start for planning Locality Plan, now need to reach out to PPGs, patients and public to find out their ideas for future and opinions on emerging themes.
 - a. Two meetings in public with PPGs and others to be arranged by CCG with support from the Forum and Healthwatch

10.0 Links with Foundation Trust Councils of Governors

The Council of Governors of a Foundation Trust is intended to be the voice of the people whom the Trust serves. It helps to set priorities and shape services, and holds the Trust Board to account. There is a commonality of interests between such Councils and Healthwatch. We have had a cordial and productive meeting with the Governors of OHFT, and a similar meeting with the Governors of OUHFT is scheduled to take place early in the New Year. We expect that, by providing evidence-based reports to these bodies, we will be able to increase our influence upon key strategic decisions within the Trusts.



OSCB Annual Report 2016/17 - Executive Summary

Summary of the OSCB annual report.
The full OSCB report is published on the OSCB website.

The key purpose of the OSCB Annual Report is to assess the impact of the Board's work in 2016/17 on:

- service quality and effectiveness
- safeguarding outcomes for children and young people in Oxfordshire.

It evaluates our performance against the priorities that we set in our Business Plan for the year and against other statutory functions that the LSCB must undertake.

It celebrates a number of areas of success and achievement but also identifies areas that present continuing challenge in safeguarding children and young people in Oxfordshire, challenges which form the basis of priorities for improvement in the Business Plan for 2017/18.

THE LOCAL SAFEGUARDING CONTEXT AND PROFILE

The first chapter of the Annual Report examines the safeguarding profile of the child population in Oxfordshire. It presents a picture of increasing demand on services and higher rates of escalation into child protection and care which clearly create concern for the OSCB.

The child population of Oxfordshire has grown by 6% in the last ten years and is estimated to stand at 141,800 young people aged under-18. Alongside this growth there has been increased demand for services particularly towards the high end of the continuum of need.

Key data presented shows that:

- **458 early help assessments** – a considerable reduction in comparison to the number of CAFs undertaken in the previous year;
- A rise to **1549** in the number of **troubled families** worked with in 2016/17;
- A rise from 569 (2015/16) to **607** (2016/17) in the number of **children subject to child protection plans**. This is higher than both the national average and the average for similar authorities;

- **67%** of children newly subject to child protection plans become so **as a result of neglect**. This compares to 58% of cases last year and is higher than the national average of 45%;
- The number of **disabled children with a child protection plan (16)** is in line with previous years;
- The number of **children in care rose by 14%** in the year from 592 to 675. In March 2011 the county had 47% fewer looked after children than the national average - the county currently has 27% fewer
- Since **2011 the percentage of children with child protection plans and in care has progressively increased** at a higher rate than the national average;
- The number of **children placed out of county** and not in neighbouring authorities **has increased from 77 to 118**;
- The number of **unaccompanied asylum seeker children** who came into the care of the local authority **rose by 38% from 42 to 58**.
- Between 2014 and 2016 **the percentage rate of 19 year old care leavers in education, employment or training was less than both the national figure and that of our statistical neighbours** though performance improved in 2015/16
- **236 CSE screening tools completed** in 2016-17 compared with 223 in 2015/16.
- Prevalence reporting continues to evidence that CSE is an issue across Oxfordshire with varying models of grooming and patterns of offending and some 'hot spot' areas.
- The number of **children who have gone missing from home** has **fallen** in the last year **from 817 to 798**;
- The number who went missing three or more times was 148 (compared to 149 last year) - the proportion of children who repeatedly went missing from home remained at around 18.5%;
- There was a **21% increase** in the numbers of children in **elective home education** since last year, taking the total number of cases to over 450;
- **Persistent absence increased** from 6.7% in 2014/15 to 13.9% in 2015/16 which is higher than the national average;
- **Permanent exclusions** from school are on an **upward trend** compared to last year;
- The number of **young people offending** (receiving a caution or above) **rose slightly** to 280 in 2016/17 from 246 in the previous 2 years;
- The proportion of **children receiving a custodial sentence dropped** to 4.3% in 2016/17 from 7.1% in 2015/16.
- The proportion of **children remanded to custody increased** to 6.3% from 5.2% in 2015/16;
- 50 children were identified as living in a privately arranged foster placement, compared to 43 at 31 March 2016;
- 6153 children and young people were referred to Oxford CAMHS of which 5371 were accepted as appropriate referrals (87%) and 3362 young people were assessed by CAMHS during this period.
- 13% of the CAMHS referrals were either inappropriate or signposted to alternative provisions;
- The open CAMHS caseload average is 4800 young people at any given time across Oxfordshire;

- CAMHS continue to meet targets for young people who need to be seen urgently or as an emergency;
- Targeted work to reduce waiting times has secured improvement and at the time of publishing this report 71% of all routine referrals are seen within 12 weeks across the county.

What does this mean for the OSCB?

The increased demand on specialist and high cost services and rises against other key indicator measures creates concern for the OSCB in a number of ways:

- Children appear not to have been as regularly identified for early help and the opportunity to address needs early missed – the recent launch of the Locality and Community Support Service (LCSS) is intended to reverse this trend and the OSCB will be scrutinising progress regularly to ensure this happens;
- The hypothesis that effective early help can reduce escalation to child protection and care interventions needs to be rigorously pursued to ‘turn the curve’ in the long-term increases in numbers in the child protection and care systems;
- Increased demand can result in higher caseloads for staff creating pressure and risk around sustained quality and effectiveness of safeguarding work;
- We need to be confident that agencies are working collectively, efficiently and effectively to manage and reduce demand;
- We need to be confident that the workforce has the skills and competences to maximise the impact of new initiatives designed to reduce demand and the workforce development impacts positively on service quality and safeguarding outcomes for children and young people.
- As organisations and roles change, more complex cases are held in universal services and more support and training is needed for these services.
- The workforces needs to know how to work effectively with families experiencing domestic abuse , parental mental health and drug and alcohol issues – and this is why we also need to work with the Safeguarding Adults Board on these issues to improve our capacity and impact.

During 2017/18 this will translate into a number of key priorities for the OSCB:

- Work needs be to done to ensure that partners in the safeguarding system understand early help and their role in it.
- The workforce needs to be competent, confident and capable.
- The OSCB needs to be assured that resources are allocated to work at the correct threshold level and that the right level of work passes through children's services for full assessment.
- OSCB partners should support a co-ordinated and multi-agency response to neglect by ensuring that the neglect strategy is fully implemented across the county. Parental issues such as substance misuse, mental health problems and domestic abuse are addressed as part of this problem.
- OSCB partners should improve multi-agency responses to safeguard vulnerable adolescents in particular where they are (1) transitioning from children to adult

services (2) at risk of domestic abuse or peer abuse (3) at risk of criminal exploitation including drug and sexual exploitation (4) not in full time education.

GOVERNANCE AND ACCOUNTABILITY ARRANGEMENTS

The second chapter of the Annual Report focused on the Board's governance and accountability arrangements. This outlines the current frameworks under which the OSCB operates and headlines changes that will take place as a result of the Children and Social Work Act 2017.

The key purposes of the OSCB are to:

- Ensure effective safeguarding across Oxfordshire
- Co-ordinate what is done by individuals and agencies represented on the Board to ensure effective safeguarding and promote the welfare of children in Oxfordshire

The report outlines the:

- Current governance structure and the roles of the OSCB, the Executive and the subgroups
- Independent nature of the Board including the role of the Independent Chair
- Relationship of the Board with the County Council, other partners and other partnerships operating in Oxfordshire
- Links to the Safeguarding Adult Board which is a key partner in securing effective safeguarding in Oxfordshire
- Changes in representation from the voluntary and community sector
- Representation from the Soldiers, Sailors, Airmen and Families Association (SSAFA)
- Work of our lay members

The report on the budget illustrates that we have operated within budget and sustained a reserve that is largely held to resource serious case reviews that may be required in the coming year.

Most importantly the Annual Report evaluates performance against the OSCB Business Plan for 2016/17.

PROGRESS AND ACHIEVEMENTS IN 2016/17

The Annual Report evaluates performance against the 3 key aims of the OSCB as set out in the Business Plan 2016/17:

Aim 1: To provide leadership and governance

Aim 2: To drive forward practice improvement

Aim 3: To scrutinise and quality assure

Headline progress, achievements and areas for further improvement are as follows:

To provide leadership and governance

The OSCB set three priorities for leadership and governance – to ensure that:

- Local partnership arrangements are understood and that the Multi-agency Safeguarding Hub (MASH) provides a swift and robust response to all children.
- Local communities are better engaged in the work of the Board and within the partnership
- Children and young people's views are reflected within the OSCB partnership

Progress on partnership arrangements includes:

- ✓ The Multi-agency Safeguarding Hub has been a consistent area of scrutiny. The Chair has visited the hub; the board has checked risk management, timeliness and feedback.
- ✓ The OSCB and the Safeguarding Adults Board now meet twice a year and is committed to:
 - Joint work on: training, domestic abuse, transitions from children to adult services.
 - An 'impact assessment' on the effect of efficiency savings and transformation of services across on the child protection partnership.
 - A 'safeguarding self-assessment' of partners compliance against safeguarding standards for working with children and adults was undertaken
- ✓ The OSCB and Community Safety Partnerships worked on case reviews, Prevent training to address radicalisation and used funding from the Police and Crime Commissioner to build the resilience of vulnerable children and tackle child sexual exploitation. Grants given to:
 - Barnardo's: intervention work with young people in Oxford schools
 - Nomad: one to one mentoring sessions to children moving to secondary
 - Damascus: building resilience in targeted young people
 - Sunrise: work with boys aged 14 to 19
- ✓ OSCB and Children's Trust linked up on priority setting. The Trust now has three priorities: early help, educational attainment of vulnerable groups and transitions to adult services.

Progress on community engagement includes:

- ✓ Relaunch of Area Safeguarding Group meetings on a termly basis
- ✓ Mapping of community safety groups to ensure consistency of approach safeguarding
- ✓ Checking children with care and support needs are safely transported
- ✓ Improved links with Oxfordshire Community and Voluntary Association (OCVA)
- ✓ Better connection to the OCVA's 'Children and young people Forum'
- ✓ Three board members and at least five subgroup members come from the private, community and voluntary sector

Progress on children and young people's views being reflected within the OSCB partnership

- ✓ The OSCB has engaged with VOXY – the Voice of Young People in Oxfordshire – both to enable them to work in partnership with the OSCB in agreeing strategic priorities and action to secure improvement and to widen engagement with children and young people at both community of interest and service user levels
- ✓ The on-line bullying survey that continues to enable us to monitor and scrutinise prevalence in Oxfordshire
- ✓ Work to address the needs of Oxfordshire's young LGBT community which was a focus of our annual conference

OSCB view of progress made in terms of leadership and governance:

The OSCB is assured that the local partnership is focussed on the effectiveness of safeguarding arrangements. There is commitment to ensure that the MASH provides a swift and robust response. However the OSCB needs to be further assured that front-door arrangements are understood, early assessments are completed and that new processes are fully embedded. The evidence of success is not yet sufficient. Improvement should also be evidenced in terms of feedback on referrals and timeliness of action.

There is assurance that work has begun to better engage local communities in the work of the Board and within the partnership. This must continue if it is to have impact.

There is evidence that Children and young people's views are reflected within the partnership but the OSCB is clear that there is room for improvement and is keen to review what impact 'MOMO' will have for children in the safeguarding system.

To drive forward practice improvement

The OSCB priorities in this areas has been **to protect younger children from the harm of neglect and parental risk factors** and **to protect older children from harm**

Progress on protecting children from the harm of neglect and parental risk factors

Strategic leadership

- ✓ Multi-agency Task and Finish Group led by Oxford Health NHS FT and Children's Social Care to oversee the work on neglect different way to address the issue of neglect
- ✓ Implementation of a resources budget for work to address neglect

Resources

- ✓ New threshold of needs matrix - which helps everyone in the safeguarding partnership identify need in the same way and use the same language
- ✓ New early help assessment to replace the common assessment framework
- ✓ Work to collate all guidance and toolkits online

Learning and improvement

- ✓ New learning summary following the serious case review on child Q
- ✓ Workshops on neglect rolled out for social workers

Listening to those who need support

- ✓ The views of families and children were collated through audit work. They had all been involved in child protection planning where 'neglect' was the main reason. Some of the messages were:
 - **Practical help and advice matters.** Families said want more of this.
 - **Clear, honest, straightforward language is best.** Families said that jargon, language and paperwork is disempowering and bewildering.
 - **Needing and wanting to understand** is a common theme. Some children said they needed more communication and didn't understand why they had a child protection plan.
 - **Children want more say in their care as they get older.**

Progress on protecting older children from harm

Strategic leadership and co-ordination

- ✓ Self-harm networks for professionals have been expanded: they identify young people, share good practice and ensure there is good interagency join up for them
- ✓ Co-ordinated response from the County Council, NHS Trusts and Voluntary Groups in supporting families, school community after a suicide or serious self-harm incident
- ✓ OUH NHS FT emergency duty team ensure good communication with schools and colleagues as appropriate following an admission due to self-harm (tested by audit)
- ✓ Oxfordshire County Council and Barnardo's have jointly delivered Safer Futures – for parents, carers and families of young people thought to be at risk of CSE
- ✓ Oxford City Council, the County Council and Thames Valley Police led an event for local faith and community groups on addressing CSE
- ✓ District councils launched Hotel Watch to increase awareness of exploitation and intelligence sharing of all crime amongst bed and breakfast/hoteliers and partners
- ✓ District councils promoted training to all hotel staff in order to safeguard victims and potential victims of crime.
- ✓ Thames Valley Police has co-ordinated investigations which led to successful prosecutions against perpetrators of Child sexual exploitation

Resources

- ✓ Resources invested into the county's "Placement Strategy" in 2013 have created additional capacity to meet demand of increasing numbers of children with complex needs.
- ✓ Out of the 265 children referred to Residential and Edge of Care Service specifically to prevent imminent accommodation into care 203 (77%) were diverted from the care system.
- ✓ There was a 14% increase of in-house fostering – the overall proportion of children in fostering settings has climbed from 66.9% to 68.8%. Family based options avoid many of the peer association risks arising in residential settings, which these children are vulnerable to
- ✓ Oxford Sexual Abuse and Rape Crisis Centre has provided a face-to-face counselling service to young adult female survivors of sexual violence, including child sexual exploitation. Feedback has rated the service as 'excellent'.
- ✓ New CSE screening tool – shorter, easier to complete, mindful of boys as victims.
- ✓ Revised CSE professionals' handbook - clear guidance and direction

- ✓ New toolkit for practitioners working with lesbian, gay, bi-sexual and transgender young people

Learning and improvement

- ✓ Work has been done to understand the level of health practitioner 'knowledge and attitude' to consent by undertaking a survey of a wide range of health staff across all Trusts and services.
- ✓ CSE learning summary; a presentation on working with parents; guide for parents on the OSCB website
- ✓ OSCB partner learning events for over 150 practitioners on online safety
- ✓ OSCB conference for over 200 practitioners attended the on young people and their identity – thanks to pupils from the Warriner School from Project Q
- ✓ OSCB launch of the My Normal film. My Normal is a creativity based project aiming to give LGBTQ+ youth safe spaces and a bigger voice in Oxfordshire.
- ✓ Work to develop new training to reduce bullying amongst children, with a particular focus on children with Special Educational Needs and Disabilities
- ✓ The My Normal Project and Ark T Centre in Oxford City has also set up a new music project working with LGBTQ+ young people and young people with disabilities.

OSCB view of progress made in terms of practice improvement against these two priorities:

OSCB partners have had a strategic drive to focus on neglect and resources have been identifies to support practice improvement. Being clear on what children and families think is essential and commendable. However, the evidence is that neglect is the most common reason for children to be subject to child protection plans. At 67% this is higher than the national average. **This local drive must continue in order to embed new tools and for changes in practice to have an impact on neglect.** Neglect must remain a priority for the OSCB.

The concerns regarding older children are reflected in the data that we have on our safeguarding system. We know that their needs are placing a pressure on the system. It is there re-assuring to see the many examples of work by OSCB partners in terms of strategic leadership and co-ordination, resource allocation and work to improve practice. The partnership is stepping up to and not shirking from these challenges. However, these safeguarding concerns are a challenge. Recent serious case reviews and current data re-enforces this message. **The OSCB partners must keep the work to protect older children from harm as a priority.**

Improving Mental Health Services

The increased demands on mental health services have been a concern for the OSCB for some time. This annual report therefore sets out in more detail what work is taking place to meet those needs.

The Oxford Health Mental Health Foundation Trust has been awarded a new five year contract for delivering mental health services in Oxfordshire. The new service model has

been developed in response to the parliamentary review of CAMHS nationally, the Department of Health report “Future in Mind” 2015, the OCCG review of CAMHS 2014/15 and the NHS England Five Year Transformation Plan for CAMHS.

New partnerships have developed for CAMHS and the service is integrating with other local agencies and providers to deliver a service that increases resilience and self-help, reduces waiting times to ensure easy and timely access to the most appropriate interventions, safeguards children and young people from harm and offers a range of evidence based interventions targeted at those who require them. The new model introduces a pathway approach for service users with access via a county wide Single Point of Access (SPA) launching approximately September 2017.

The arrangements include the delivery of:

The Oxon Specialist Eating Disorder Service

The Horizon service which aims to support young people and their families who have been affected by sexual harm

The School In-Reach service

The Autism Diagnostic Clinic pilot

To scrutinise and quality assure

The OSCB priorities under this heading has been to **check the effectiveness of joint working through audit, to scrutinise OSCB agencies’ safeguarding practice**

Progress on checking the effectiveness of joint working through audit:

- ✓ Multi-agency audits reviewed over 20 cases from the perspectives of the different agencies involved. Partner agencies included Thames Valley Police, Oxford University Hospitals NHS FT, Oxford Health NHS FT, the County Council – services for children and adults, the National Probation Service, Educationalists and voluntary sector groups such as ‘Reducing the Risk’ and PACT (Bounceback4kids).
- ✓ Learning summaries produced on serious case reviews for Baby L, Child Q and Children A & B
- ✓ Data mapping work from young victims of crime and vulnerable groups to highlight need and improved joint action
- ✓ Checking actions have been seen through by agencies e.g. The National Probation Service’s Public Protection Unit have received the national Child Safeguarding Training mandated by the service which, along with learning from the child sexual exploitation case reviews, has widened the skills set of officers

Progress on scrutinising OSCB agencies’ safeguarding practice:

The OSCB evaluates the effectiveness of the local safeguarding system to ensure that children and young people are kept as safe as possible. Progress includes:

- ✓ OSCB partner agencies completed **Safeguarding Self-assessments**. A peer review was held to reinforce the OSCB’s culture of challenge. The returns demonstrated good compliance and regard to safeguarding practice as well as positive direction of travel.

They provided *broad* assurance that partner agencies understand the safeguarding obligations and have frameworks in place to deliver them. For example:

- Senior management commitment is strong
- Information sharing is effective
- Safer Recruitment and Vetting procedures are in place and working
- The Effectiveness of the Safeguarding Boards is deemed sufficient

The one area that partner agencies were not always able to provide evidence of was:

- Involvement of service users in service development, where the responses were not as robust as other areas
- ✓ Single agency audits enabled an in-depth look at safeguarding practice. There were some good examples of how safeguarding had improved:
- Thames Valley Police have improved the collation of information with respect to children in the home at the time when responding to domestic abuse incidents
 - The Children's Directorate within OUH NHS FT has increased feedback from children, and parents or carers by 73% ensuring that they are capturing views of those coming in to hospital in order to improve change
 - Children's Social Care case has demonstrated that 'planning and review of cases' has effectively involved fathers in 70% of cases sampled
 - National Probation Service officers have wider skills sets following learning from the child sexual exploitation case reviews, in particular to be alert to 'relationships' with children under 18.
 - The Emergency Department within OUH NHS FT consistently informs schools where there has been an admission due to self-harm

OSCB view of progress made in terms of scrutiny and quality assurance:

The extent of the agency auditing of safeguarding work is positive and there are some examples of changes made to improve working. To improve this learning and improvement work OSCB partners should seek to better demonstrate how they involve service users in the development of services; how young people's views are sought in audit work as well as how the voice of the practitioner is captured too.

LEARNING AND IMPROVEMENT

Workforce Development

The OSCB delivered over **150 free safeguarding training and learning events** plus online learning that **reached over 9000 members of the Oxfordshire workforce**.

Over 85% of delegates reported that they found the training good or excellent.

A recent phone survey showed that 96% of respondents said that they had better safeguarding practice as a result of their training.

The majority of training is delivered by a pool of professionals working in our services – and they are highly regarded by delegates.

CSE has been a major focus and these programmes have reached over 4000 staff.

In addition to training courses we have delivered a programme of **Learning Events** to **over 400 local practitioners**. Learning Events have targeted:

- Safeguarding risks online
- Relationships and identity
- Working with children with disability
- Working with neglect

The Child Death Overview Panel (CDOP)

CDOP is a sub-group of the OSCB. It carries out a systematic review of all child deaths to help understand why children have died.

In 2016-17 the CDOP reviewed 36 cases and identified the following modifiable factors:

- Co sleeping
- Domestic Abuse
- Smoking and alcohol
- Potential risk of car seat use by neonates
- Maternal obesity and diabetes
- Lack of lifesaving aids at riverside
- Housing issues

Actions and activities were undertaken to address these identified factors.

The Rapid Response Service

This service provides an immediate response to reported child deaths. The team is coordinated the Oxford University Hospitals NHS Foundation Trust. It is well established and assists in gathering as much information as possible in a timely, systematic and sensitive manner to inform understanding of why the child has died. In addition its primary role is to ensure bereavement support for the family is initiated

In 2016/17, 88 child deaths were reported to the Oxfordshire CDOP and were discussed with the Designated Doctor for child deaths. Thirty-six of the child deaths reported were of children normally resident in Oxfordshire.

Serious Case Reviews

A serious case review is undertaken when:

- (a) abuse or neglect of a child is known or suspected; and
- (b) either (i) the child has died or;
(ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

The purpose of a serious case review is to establish whether there are lessons to be learnt from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children.

The OSCB has worked on **five serious case reviews** since the last annual report. Of those five reviews: three were published, one is active and one has been completed as far as possible, whilst a parallel investigation is underway.

The published reports are Baby L (September 2016), Child Q (January 2017), Child A and Child B (February 2017).

Four new cases were brought to the attention of the OSCB for consideration in 2016/17. One was referred by Thames Valley Police and three were referred by Children's Social Care. Of these four referrals three serious case reviews have been commissioned for 2017/18 and one was deemed not to meet the criteria but has led to a partnership review.

All reviews and learning summaries can be found on the OSCB website.

Key learning points from SCRs undertaken are:

1. The role of the fathers in the family system together with communication with and involvement of fathers and male carers;
2. The need for curiosity about family history, relationships and current circumstances that moves beyond reliance on self-reported information;
3. More challenges are faced by professionals working with vulnerable families where neglect is an embedded issue;
4. The impact of the parent's mental health problems on the safety and wellbeing of children;
5. Understanding of substance misuse and interventions, the changing levels of risk, and the impact on the child;
6. Normalising and misinterpreting behaviour - linked to Special Educational Needs;
7. Identifying the increased safeguarding risks for children with learning disabilities and Special Educational Needs;
8. Identification of physical abuse and following safeguarding processes thoroughly;
9. Multi-agency work must be well co-ordinated in order to share planning and to better understand what is happening to the child. Effective risk management requires systematic planning across the multi-agency partnership;
10. The capacity of adolescents to protect themselves can be overestimated and a tendency to view teenagers as adults rather than children can mean that proactive steps to protect them are not always taken.

CHALLENGES AHEAD AND FUTURE PRIORITIES

The annual report concludes with headlines about our future priorities which include:

National drivers

- Implications of the Children and Social Work Act 2016-17 for LSCBs
- Implications of reduced resources from Government
- Planned statutory changes to elective home education

For the Board business plan

- Improving the effectiveness of the board; collaboration with Oxfordshire Safeguarding Adults Board (OSAB) and engagement with local communities including the VCS
- Tackling neglect and safeguarding adolescents at risk of exploitation
- Taking robust action following learning; to ensure continuous improvement and to assess risk and capacity across the partnership

For local multi-agency work

- Ensuring good understanding of thresholds;
- Being vigilant to emerging pressure points and concerns: safety online; self-harm; modern slavery; transgender young people and the potential radicalisation of children
- Managing and improving change (transitions) for young people
- Long-term planning for children in a multi-agency context

Future priorities

- Early Help. Increasing access to early help and securing assurance it prevents escalation to child protection and care
- Increasing school attendance and reducing exclusions – leading to improved attainment and improved safeguarding
- Tackling criminal exploitation of children in relation to drugs
- Safely reduce the number of looked after children. Work needs to be done to work effectively with families at an earlier stage to reduce the need to place children in care
- Improving the confidence and capability of the whole workforce.
- Work effectively with families experiencing domestic abuse , parental mental health and drug and alcohol issues

WHAT NEXT FOR CHILD PROTECTION IN OXFORDSHIRE –SOME KEY MESSAGES

Our local community: safeguarding is your concern too. Report a concern if you are worried.

Heads and Governors of schools:

- Check your pupil attendance and take action – know their ‘whereabouts’. We know that children are safer in school and that this remains a safeguarding issue in Oxfordshire
- Be informed. Know how to support pupils dealing with concerns like self-harm; radicalisation; sexting; sexual identity
- Undertake the on-line Prevent training and RAP training
- Use the termly e-bulletin to stay up-to-date on safeguarding

The community, faith and voluntary sector:

- Undertake your safeguarding training;
- Consider becoming an OSCB trainer yourself;
- Find out how ‘early help’ works in Oxfordshire and play your role in its implementation

Children:

- Thank you for telling us what you think
- We understand that LGBT is something that you want to talk more about; that we need to find better ways to talk about healthy relationships, consent and sex; that what we understand as ‘sexting’ is something we need to be better at dealing with.

Children’s workforce:

- Use supervision to check your thinking and decision making
- Escalate your concerns and follow up if necessary
- Make sure you understand the new early help arrangements
- Remember that “Every child needs at least one adult who is irrationally crazy about him or her”, Urie Bronfenbrenner.

Senior managers and leaders:

- Engage with our priorities and lead your organisations in support of these
- Improve the confidence and capability of the whole workforce – to work effectively with families experiencing domestic abuse, parental mental health and drug and alcohol issues

CONCLUSION- A MESSAGE FROM THE INDEPENDENT CHAIR, PAUL BURNETT

I would like to take this opportunity to thank all Board members and those who have participated in subgroups for their continued commitment in 2016/17. In addition I would like to thank staff from across our partnerships for their motivation, enthusiasm and continued contribution to keeping the children and young people of Oxfordshire safe.

Safeguarding is everyone's business. The achievements set out in this Annual Report have been achieved not just by the Safeguarding Board but by staff working in the agencies that form the partnership. The further improvements we seek to achieve in 2017/18 will require continued commitment from all and I look forward to continuing to work with you next year in ensuring that children and young people in Oxfordshire are safe.

I commend this report to all our partner agencies.

A handwritten signature in black ink, appearing to read 'P. R. Burnett', with a stylized, flowing script.

Paul Burnett, Independent Chair, Oxfordshire Safeguarding Children Board

The full version of the OSCB Annual Report is available on our website at www.oscb.org.uk

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OSCB ANNUAL REPORT 2014-2015





Annual Report Introduction:

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

The findings from audits, data, serious case reviews and reporting schedules provided to the OSCB during 2014/15 have given me a clear view of how well child protection work is being managed.

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

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

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

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

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



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



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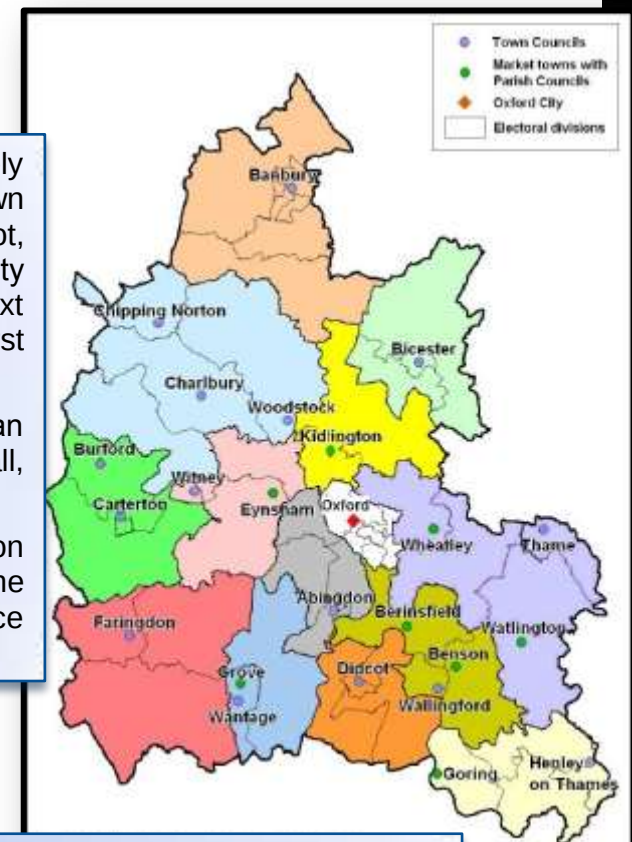
CHAPTER 1: LOCAL SAFEGUARDING CONTEXT

Oxfordshire demographics

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

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

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



Vulnerable groups

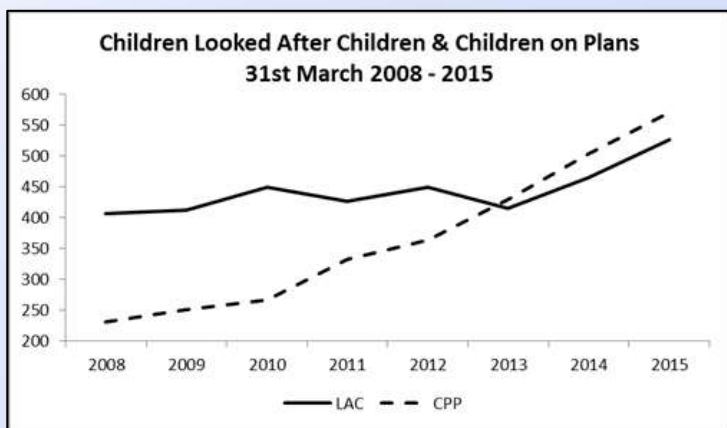
The OSCB focuses on those children who are most vulnerable or at risk of suffering harm. We know that there are many reasons why children can become vulnerable or at increased risk of harm. For example children living in households where there is domestic abuse, substance misuse or their parents are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

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



Children with a child protection plan

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



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

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

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

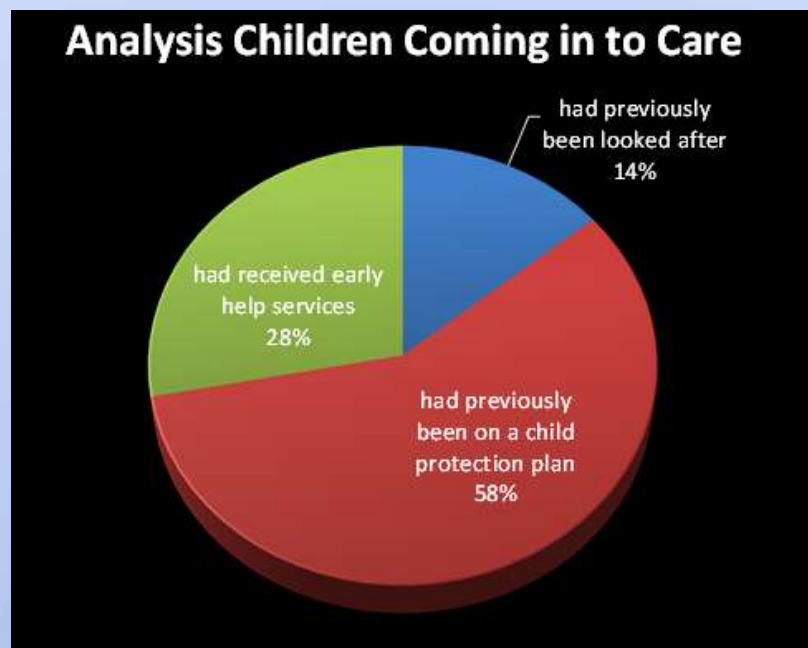
In Oxfordshire this has not led to significantly more referrals; it has led to more referrals converting into assessments and CP plans. This would indicate more in-depth appreciation of risk and responsibility. There is a better recognition of the combined accountability of professionals to identify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

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

Children in Care

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

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

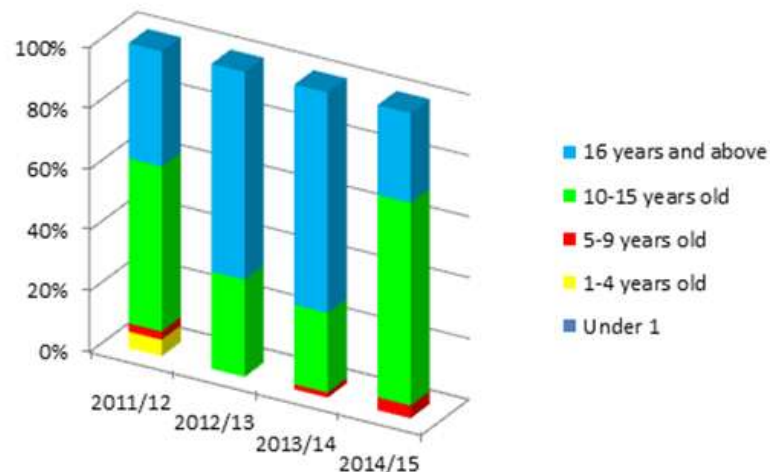


The majority of children (355) were living with foster families.

Children who are privately fostered

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

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



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

Disabled children

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



Children who offend

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

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

Children who are at risk of sexual exploitation

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

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

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

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

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



Children with mental health issues

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

Page 180 Local transformation plans are currently in development which will enable children and parents to have easier access to targeted and specialist mental health services when needed.

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



Children who self-harm

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

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

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



Children missing from home

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

Chapter 2: Governance and accountability arrangements

What is the OSCB?

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

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



To co-ordinate local work by:

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

To ensure the effectiveness of that work:

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



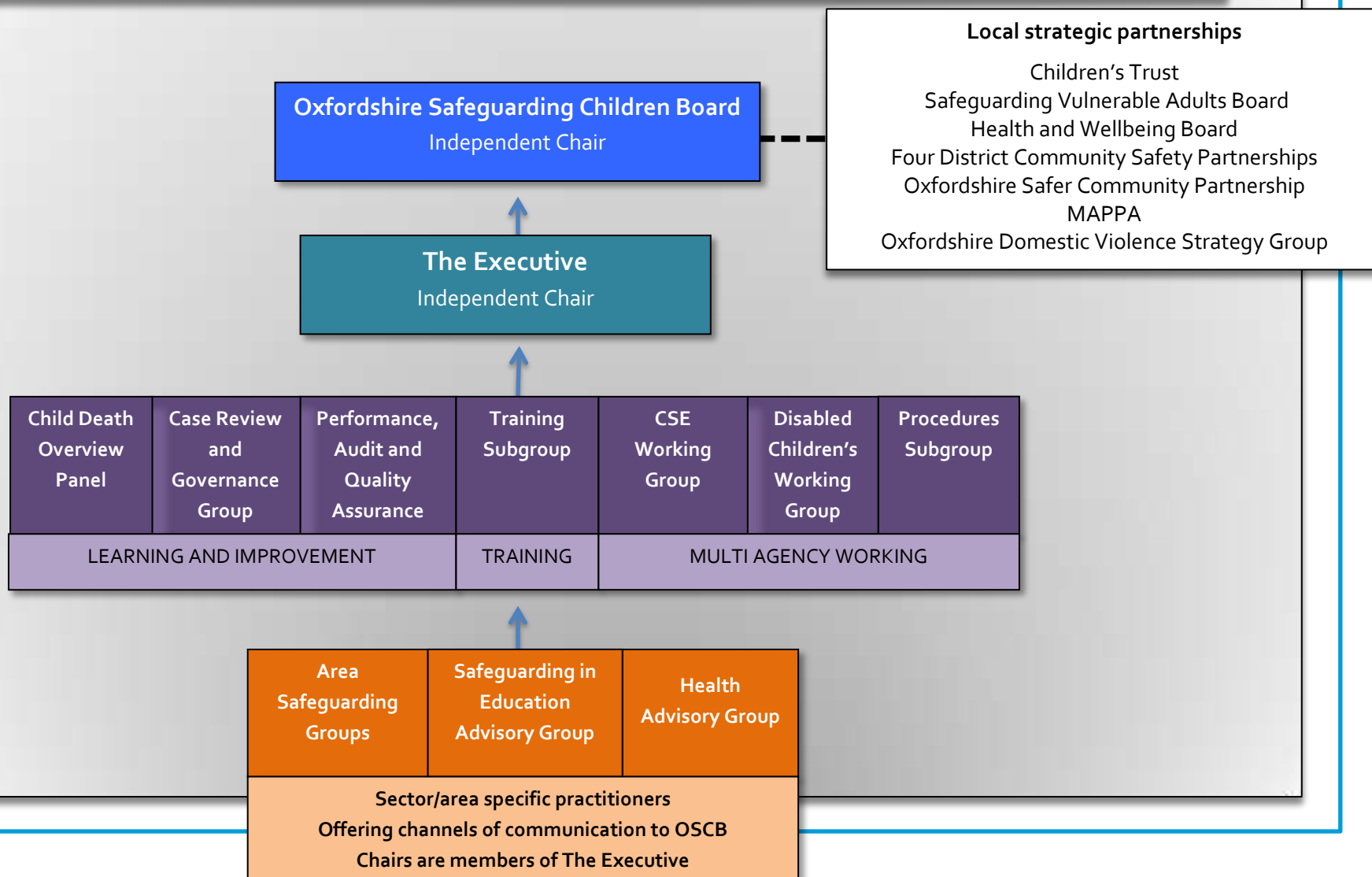
Board Membership:

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

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

OSCB Structure

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



How the Board works

Statutory body

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

Local Authority

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

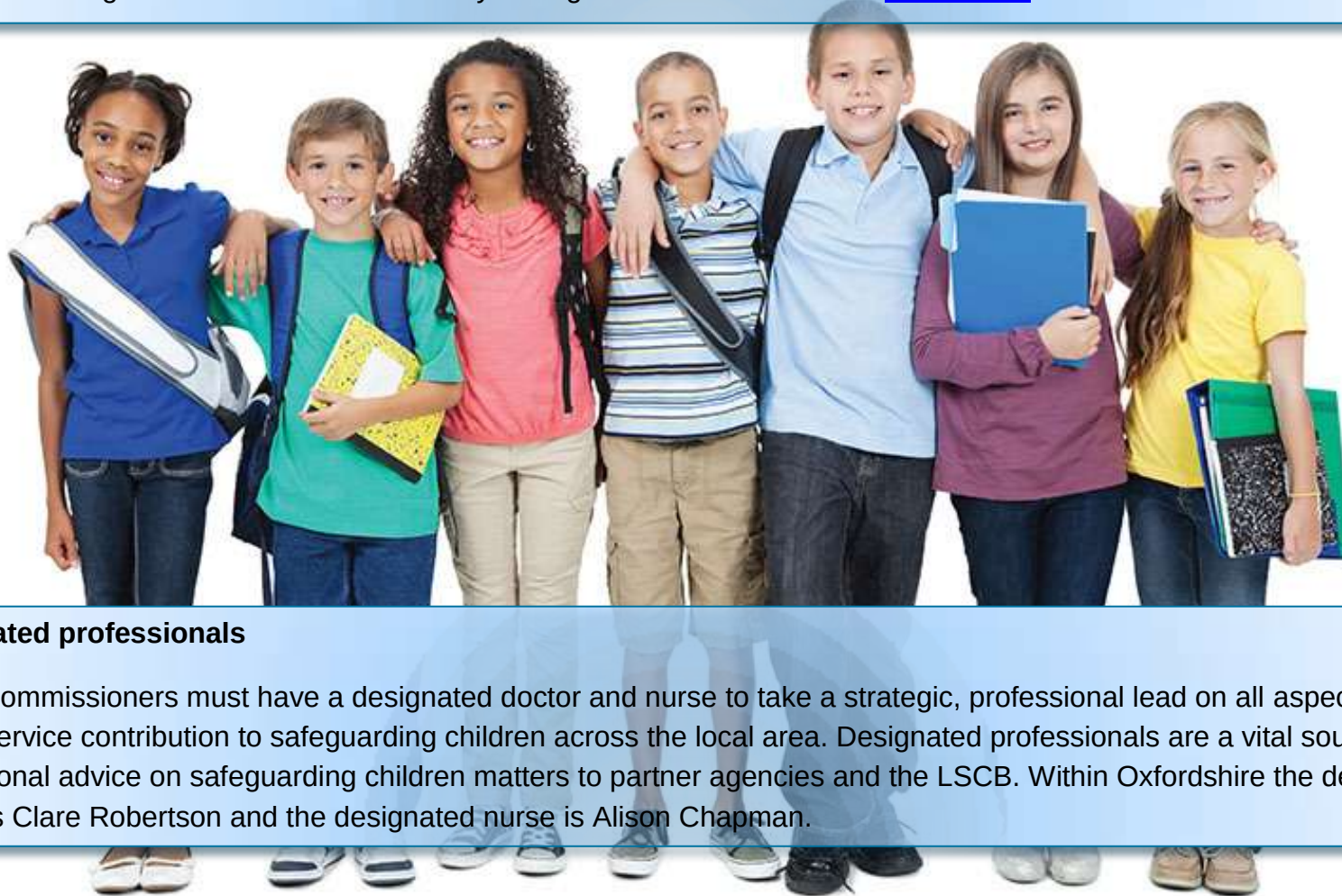
Independence

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

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

Individual partners

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



Designated professionals

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

Key Relationships

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



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

Oxfordshire Children's Trust

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

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

The Health and Wellbeing Board (HWB)

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

**Police and Crime Commissioner**

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

Health Economy

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

Oxfordshire Safer Community Partnership (OxSCP)

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

Community Safety Partnerships

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



The Safeguarding Adults Board

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

Financial arrangements

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

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

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



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

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

Key priorities:

The OSCB had 5 priorities which were to ensure:

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

...and to improve...

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



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

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

Identifying need

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



Early help

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

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

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

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

Multi-agency safeguarding hub

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

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





Multi- agency tools

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

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

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

Addressing issues of neglect:

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

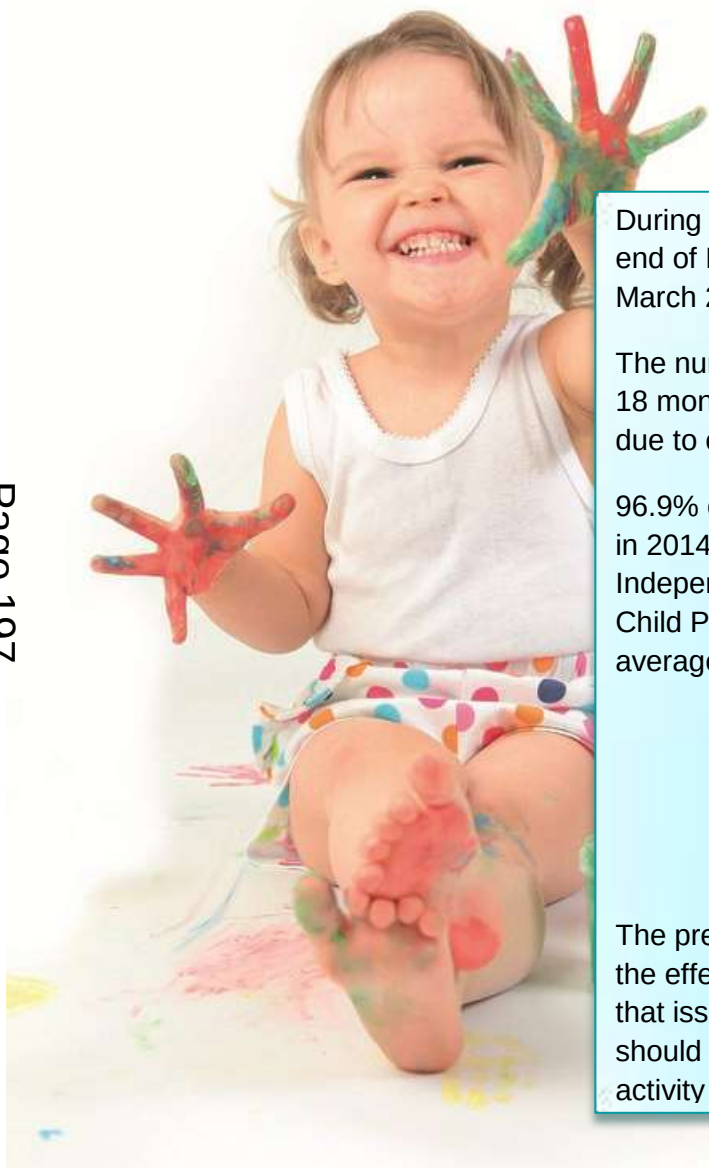
The pilot will build on the learning from the Thriving Families programme by seeking to develop whole family working, where families have a lead worker and one plan supporting them. The aims are to reduce the number of children requiring child protection plans due to neglect; to reduce the number of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

Child Protection Activity

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

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

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



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

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

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

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

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

Children in care

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

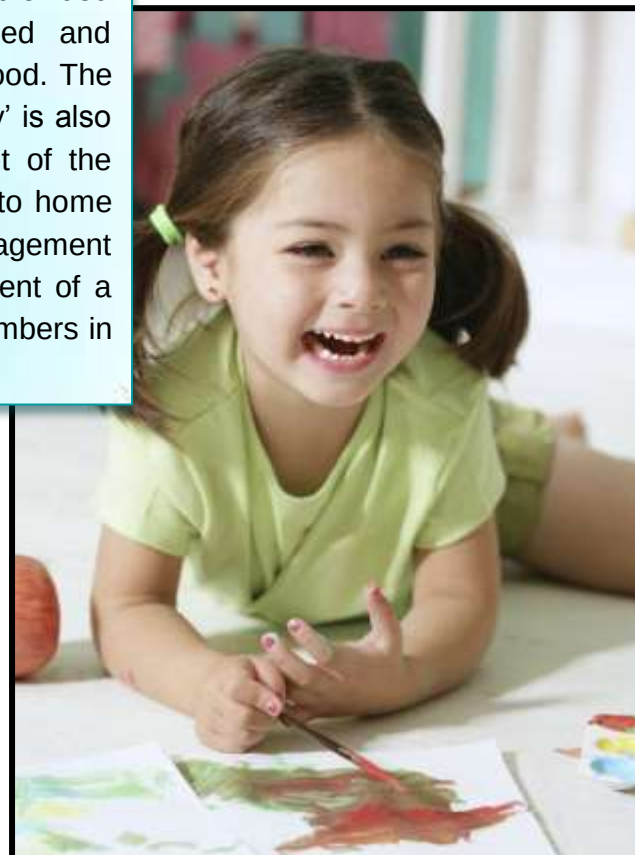
Children in care and leaving care have high level emotional and behavioural needs compared to Oxfordshire's statistical neighbours and the national average. This brings into sharp relief the importance of social care, health and education services working together to provide high quality support, therapeutic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

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

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

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

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



In summary,

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

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

Here is...

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

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

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

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

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

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

Priority 2: improving our quality assurance work

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

OCSB partners audit work

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

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

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



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

Schools and further education colleges audit work

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

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

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

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

Early years audit work

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

The section 11 safeguarding self-assessment

Page 20 OSCB received Section 11 self-audit responses from 26 agencies. This was 100% compliance of statutory returns as well as additional returns from commissioned services such as provider services British Pregnancy Advisory Service, Outdoor Learning and Lifeline. Five agencies returned completed practitioners questionnaires. A peer review was held by OSCB in April 2015, which reinforced the responsibility of all Board members to challenge. Providers, commissioners and senior leads scrutinised and compared the results of their S11 audits. Twenty agencies attended.

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

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

Local Authority Designated Officer

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

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

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

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



Independent Reviewing Officers of the County Council

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

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

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





The OSCB data set: what does it tell us?

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

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

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

Day in the life of a health visitor...

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

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

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

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

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

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

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

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

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

Priority 3: capturing the views of children and practitioners

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

What children, parents & carers said:

The serious case review conversations with parents told us a range of things for example, that they wanted:

To have their concerns listened to and be taken seriously,
To not have to chase the services for answers and information,

To receive interventions sooner, for them and their child, especially when it was so painful to have to ask for help

The conversations with children told us:

Sometimes the fear of speaking up is too great

They would give lots of small details thinking (hoping) that workers would connect the dots

They want workers to meet them at their starting point

The Youth Parliament told us they didn't know enough about the role of school health nurses and what they could talk to the nurse about

The sounding board meetings told us: their safeguarding concerns: fear of speaking up; boundaries and safe relationships; mental health and suicide; drugs

The Children in Care Council told us: they have developed a pledge with the Corporate Parenting Panel and includes issues raised about keep safe

What OSCB partners are doing:

OSCB has had input from families at four of the multi-agency learning events in 2014/2015. The moving talks from children and parents formed an integral part of the learning for frontline and senior staff, and practitioners reported them having an impact on the messages they took away with them.

One of the multi-agency learning events was dedicated to listening to parents / children

The OSCB has included parents' messages in the training on child sexual exploitation
The OSCB child sexual exploitation strategy is being developed in partnership with previous victims of this abuse

The OSCB is putting together a summary of learning points from parents and carers involved in case reviews for use by practitioners so that we fully understand what it means to be a child in the safeguarding system

This was taken on board by the service and posters were available in each school. Oxford Health NHS FT school health nurses are now an integral part of partnership working and are linked in more closely to the board, for training, sharing of learning resources, and a helpful way of raising awareness with children.

From this initial meeting a group of 12 will be established (some children in care and some not) to take forward issues from the Sounding Board and 'new issues' which arose such as "how police talk to children and children".

The OSCB supported the 'keeping safe' section of the Oxford City council 'Bungee app' for use by children in the school holidays

The OSCB endorsed the NSPCC Childline assemblies for all primary schools in Oxfordshire

OSCB partners (the county council and the police) funded Values versus Violence which encourages children to speak up and make good decisions for themselves
OSCB partner (the county council) funded Chelsea's Choice for the third year running for all secondary schools in Oxfordshire

Ensuring that the issues regarding staying safe are reported back to the OSCB as part of the annual children in care report by the county council

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

What practitioners told the OSCB:

The area safeguarding groups which meet across the county told us:

- Child protection cases are more complex now; children and families have a range of issues which take time to address – the volume of children in the child protection system at presents additional pressures
- ...as a result multi-agency work is more effective when everyone understands their own role and what is expected of them:
- The issues that are coming to the fore currently are: self-harming, sexting (and e-safety), male harmful sexual behaviour, appropriate and healthy relationships between children, accessing mental health support for children; unaccompanied asylum seekers, tackling child sexual exploitation; domestic violence amongst children

Practitioners told us through their Board members they had concerns about:

- female genital mutilation highlighted through health settings
- self-harm amongst children in particular in the north of the county highlighted through the LADO, schools and health settings
- transport for disabled children highlighted through schools and voluntary organisations
- representation of community, voluntary and faith organisations on the board's structures

What the OSCB partners are doing:

- Training on 'working as part of a core group' for children with child protection plans is being developed; the good-practice guide to multi-agency working has been promoted at the four learning events
- Ran multi-agency learning events on tackling child sexual exploitation; accessing mental health support for children which reached over 200 practitioners
- Developed training on sexual health and consent and developing more of a focus on appropriate and healthy relationships to meet the needs of practitioners
- Ran awareness raising on 'sexting' through the area safeguarding groups
- The Business plan for 2015-17 is taking on board the safeguarding issues raised by practitioners
- The OSCB 2015 annual conference is covering safeguarding risks facing vulnerable adolescents, which will pick up on issues such as domestic violence amongst children
- OSCB partners assessed the prevalence of **FGM** in the county; produced a screening tool and procedures for working on this and worked with the Department of Health to run a conference on FGM in the county. The OSCB supported the community organisation "Oxford Against Cutting" to access local schools and run an awareness raising project. OSCB trainers received training on FGM.
- OSCB partners formed a North Oxfordshire Self-Harm Network which produced a screening tool and provides a regular information-share to ensure that children were safe and had supported
- OSCB partners are including a focus on transport for vulnerable children in the 2015 section 11 safeguarding self-assessment and set up a Task and Finish Group to review transport issues across the county and districts.
- The OSCB worked with the OCVA to run two forums to recruit VCS members to the Board and subgroups; OSCB attended VCS workshops and conferences to raise awareness of safeguarding messages, opportunities to participate and training

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

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

Troubled children with a complex range of needs

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





Self-harm

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

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

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

Children missing

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

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



Vulnerable Learners

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

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

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

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



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

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

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

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

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

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

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

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

FGM – Female Genital Mutilation

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



Radicalisation

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

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

Children at risk of domestic abuse

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

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

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

Child sexual exploitation

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

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

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

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

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

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

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

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



Priority 5: improving our effectiveness as a board

Ofsted's review of the LSCB

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

Increase the influence of the Board by clarifying relationships with key strategic groups in Oxfordshire

The Board has protocols with Children's Trust and the HWB to show clear lines of accountability. The Board's business plan reflects shared objectives with these partnerships. The Independent Chair has set up a twice yearly safeguarding summit with chief officers. The Board has a renewed constitution and refreshed terms of reference for all subgroups. It has effective governance arrangements and operating structure. The Performance, Audit and Quality Assurance subgroup is now formally accountable to both the Children's Trust and the OSCB. The challenge now is to improve cross agency engagement with the City and District Councils on safeguarding.

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Ensure that this annual report has a closer focus on the child's experiences of safeguarding services

Children's views from serious case reviews, the Children in Care Council; the Youth Parliament and local sounding boards have contributed to this report. This report challenges board members to provide more focus on the child's experiences in their auditing work.

Ensure that the views of children and their families inform planning and training and that this contribution is then fed back to families

Parents and children's views have directly contributed to OSCB training events on parental substance misuse, mental health, child sexual exploitation and managing risk for vulnerable teenagers. Partner agencies have examples of views informing the 'placement strategy', the child sexual exploitation strategy, FGM promotion, school health nurse promotion and the Values versus violence programme.

Evaluate the learning and impact of training delivered across the partnership particularly its longer term impact on the quality of practice in partners agencies

A review was undertaken on the impact of training, which collated feedback from trainers and delegates. Responses confirmed the practical application of the OSCB training courses; that attendees felt more knowledgeable about local safeguarding issues; that they knew how and where to raise a concern; that they would share their learning with colleagues. Agencies are now also required to gain feedback through the section 11 feedback and through an annual report in to the training subgroup. Read more about training below.

Accelerate the implementation of a strategy in relation to female genital mutilation.

OSCB partners assessed the prevalence of FGM in the county; produced a screening tool and procedures for working on this and worked with the Department of Health to run a conference on FGM in the county. The OSCB supported the community organisation 'Oxford against Cutting' to access local schools and run an awareness raising project, which produced a booklet for children. OSCB trainers received training on FGM so that they are confident in communicating the issue to delegates.

Learning and improvement: OSCB safeguarding training

Who delivers it?

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

What is delivered?

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

How many people benefit?

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

What difference does it make?

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

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

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



Learning and improvement: OSCB procedures

OSCB online procedures were rated by Inspectors as *"comprehensive and up to date"*. All priority procedures have been reviewed and updated in light of new legislation and guidance. The layout has been improved to provide better clarity and more coherent formatting. Emerging national and local issues, such as Female Genital Mutilation, have been addressed and procedures have been put in place in a timely fashion. The group is currently reviewing the procedures on self-harm. The challenge is to increase reference to and usage of the online manual.

Learning and improvement: OSCB communication

The OSCB was highly productive in ensuring that the learning from the three audits and three newly published case reviews reached frontline practitioner and was used to develop practice. Examples of work to communicate safeguarding messages are:

- Five multi-agency learning events following case review and audit themes. They were on neglect, parental substance misuses; tackling child sexual exploitation; accessing mental health support for children and working with vulnerable adolescents. Most of these events were chaired by the OSCB Independent Chair and involved the county's interim deputy director for safeguarding, the county's designated nurse, parents and children and experts in the chosen field. which reached over 200 practitioners
- 'Eyes on' learning documents were produce on the themes from case reviews and audits. They cover neglect; parental substance misuse, another successful annual conference for over 200 delegates with 6 workshops on key subjects such as; self-harm, behaviour and attendance, child sexual exploitation, social media and the internet, drugs & alcohol and working together on high risk cases.
- e- bulletin on safeguarding issues for safeguarding leads in education
- workshops on MASH; female genital mutilation and the 'prevent' programme for OSCB trainers
- meetings with the children in care council; sounding boards; Children's Parliament to explain OSCB purpose and role in safeguarding
- meetings with voluntary, community and faith groups at conferences OSCB purpose and their role in safeguarding
- new cross-agency communications group and strategy in order to communicate messages from case reviews



CHAPTER 4: WHAT HAPPENS WHEN A CHILD DIES OR IS SERIOUSLY HARMED IN OXFORDSHIRE?

Child death review

The Child Death Overview Panel (CDOP)

CDOP is a sub-group of the OSCB. It enables the LSCBs to carry out their statutory functions relating to child deaths. It carries out a systematic review of all child deaths to help understand why children have died. Child deaths are very distressing for parents, carers, siblings and clinical staff. By focusing on the unexpected deaths in children, the panel can recommend interventions to help improve child safety and welfare to prevent future deaths. The findings are used to inform local strategic planning on how best to safeguard and promote the welfare of the children.

In 2014-15 there were 40 deaths of children who had lived in Oxfordshire, of which 15 were unexpected and 25 were expected. Over the last two years there has been no significant change in the number of child deaths in Oxfordshire.

Most unexpected deaths were considered medically explained following post-mortem. However CDOP did consider that modifiable factors were present in some cases such as: smoking in the antenatal period; alcohol consumption and smoking in pregnancy; alcohol consumption in the post-natal period; substance misuse; storage of nappy sacks; bicycle not road worthy and co-sleeping. Many of these messages are nationally known and campaigns are on-going, however specific recommendations were made by the CDOP in relation to:

- Maternity staff to ensure that mothers have information on safe sleep guidance and safe nappy sack storage.
- Health and Safety assessments required for children operating heavy machinery
- OSCB to advertise training to health professionals on the issues around children and substance misuse
- Guidance for schools dealing with suicide clusters to be produced
- The importance of taking folic acid in pregnancy needs to be highlighted to new mothers

The Rapid Response Service

When a child dies unexpectedly a process is set in motion to review the circumstances of the child's death called the 'rapid response' process. Colleagues work together to gather information in a timely, systematic yet sensitive manner to inform understanding of why the child has died.

In Oxfordshire, the rapid response service is well established. It is provided by the Chaplaincy and Bereavement Team at the John Radcliffe Hospital. In collaboration with the Designated Doctor for Child Deaths the rapid response service provides support to families, professionals and the wider community in the event of a sudden and unexpected child death.

The service has continued to work collaboratively with other organisations including the Coroner's office, Schools, Youth Projects, Social Care, South Central Ambulance Service, Thames Valley Police, Oxford University Hospitals NHS Trust, Oxford Health NHS FT, Helen and Douglas House Hospice and the child bereavement charity SEE SAW, in order to enhance the quality of care provided to all those whose work brings them into contact with bereaved families.

Home visits take place in consultation with Designated Doctor for Child Deaths and other responding agencies including the Coroner's Officer. Home visits inform the rapid response multi-agency meeting and assist in developing a programme of support based on the family's particular needs as well as providing extended support and information to other agencies involved with the family.

Update on recommendations from 2013/14

- Oxfordshire Sports Partnership added to its safeguarding training a case scenario about alcohol cultures within sports settings and about the issue of private hire of their premises. This was to raise awareness of the issues linked with under-age drinking and mental well-being.
- There have been discussions between Oxfordshire Family Liaison Officers the Safeguarding Services Manager and See Saw on the rapid response process, responding to a child death and the impact on child witnesses. This has resulted in improved understanding and clarification of roles and stronger working relationships
- There has been work within bereavement teams to identify when support is required for children who are witnesses to a child death to minimise Post Traumatic Stress Disorder. In situations when a child is a witness consideration is now given to the capacity of the child to give evidence and this capacity is discussed at the rapid response meeting to ensure appropriate support is in place.

Reviews of serious cases

A serious case is one where:

- (a) abuse or neglect of a child is known or suspected; and
- (b) either (i) the child has died;
or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

Serious case reviews (SCR)

LSCBs must always undertake a review of cases that meet the criteria for an SCR. The purpose of a SCR is to establish whether there are lessons to be learnt from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children. OSCB has also been committed to undertaking smaller scale partnership reviews for instances where the case does not meet the criteria for a serious case review but it is considered that there are lessons for multi-agency working to be learnt.

There has been an exceptionally high volume of work on serious case reviews. During 2014-15 three serious case reviews were completed and one was amended and re-published. Seven new cases were brought to the attention of the OSCB for consideration; of these two serious case reviews were commissioned, one was subject to a learning review with partners and the remainder led to no further action by the OSCB. The OSCB has another two on-going serious case reviews: one which is waiting for a criminal investigation to complete and one which has been delayed due to an Independent Police Complaints Commission investigation which is now complete. All [case reviews](#) and [learning from reviews](#) can be found on the OSCB website.

The OSCB is generating a lot of learning f about how we can work better together. It takes seriously its responsibilities to ensure that lessons learned from case reviews are disseminated and embedded into frontline practice and used to support improvements across agencies. The themes of sexual exploitation, supporting adolescents at risk, the impact of mental health problems and substance misuse on parental capacity have emerged from the three serious case reviews published in 2014/15. The outlines of the three reviews completed are provided below.

Story of Child H

This case concerned a one year old child accidentally ingesting 40-50ml of prescribed methadone that had been in a bottle in the mother's handbag, whilst temporarily alone in the room. There was a delay in emergency services being called and Child H needed resuscitation. However Child H made a full recovery.

Child H's mother had been known to Children's Social Care since the age of 15 and had a history of drug use. Child H's older sibling was removed at the age of 5 months due to concerns about mother's substance abuse and its impact on her ability to parent.

When child H was born the case was monitored via a 'child protection plan'. This was stepped down to a 'child in need plan' when he was aged seven months and closed five months later. The case remained open to other services.

At the time of the incident, child H lived with their mother and the father was not involved in child H's upbringing. Mother was known to a number of different universal and specialist services including adult drug services, police and social care.

Responding to the findings:

A learning event for practitioners and managers was held in December 2014. A learning summary was produced and is on line for all practitioners.

The Board has ensured that pharmacists in the county are reminded of the expectation that Children's Social Care or Police should be informed if they are concerned a drug dependent person might pose a risk to their own or another child.

Commissioners of GP Services and Public Health Commissioners have been asked to review their monitoring processes to ensure collaborative management of contracted services provided in General Practice in particular drug and alcohol services.

Story of Child N

The serious case review concerns the services provided for a child who tragically died, aged one. The child was found dead in the flat where they had lived with their mother. Child N had been the subject of contested proceedings for residence and contact in the family court between the mother and the father. The child is believed to have been in the mother's care during the last days of life. The initial post mortem examination was unable to ascertain the cause of death of Child N; however it noted that the child did not have the commonly observed symptoms of unexplained sudden infant death.

Responding to the findings:

The themes from this event were highlighted at a learning event for practitioners and managers were held in January 2015. A learning summary was produced and is on line for all practitioners.

A report is to be submitted to the OSCB in September from the Multi-Agency Safeguarding Hub project board on the effectiveness of arrangements in dealing with alleged incidents of domestic abuse. The purpose is to ensure that there is good multi-agency management of risks arising from domestic abuse

An audit has been undertaken to test the effectiveness of multi-agency working in domestic abuse cases through audit work. In addition a progress report is scheduled for the OSCB in September from the Oxfordshire Community Safety Partnership on the effectiveness of pathways into domestic abuse services and outlining what information is required from professionals making referrals. The purpose is to ensure that agencies that commission and provide domestic abuse services take account of the need for professionals to obtain relevant factual information about incidents of domestic abuse and its impact on children before making referrals for services.

The OSCB quality assurance subgroup has developed a new Section 11 Audit Tool to make the process more suitable for commissioners. It includes the requirement for member agencies to provide an update on their work/planned work with minority ethnic groups. The purpose is to ensure that member agencies' policy, procedures and practice in relation to children and families from minority ethnic groups reflect the needs of the changing population of Oxfordshire.

Story of Children A-F

This review was about the sexual exploitation of children in Oxfordshire. It used the experiences of six girls who were the victims in the Operation Bullfinch trial. When most of the abuse took place there was almost no knowledge of group or gang related Child Sexual Exploitation anywhere in the country. Looking back it is easy to say “it was obvious” but at the time it was something organisations did not understand. The Review says many errors were made between 2005 and 2010, and shows what lay behind them. The key findings have been identified as:

- Organisations had a weak understanding of government guidance related to the exploitation of children
- This lack of understanding meant that police and social workers did not look hard enough at what was happening to the girls. The girls were not able to make their own decisions because of the grooming, but staff tended to see them as difficult girls making ‘bad choices’
- The language used by professionals described the girls’ behaviour as caused by them, not their situation. As a result, the girls received much less sympathy. They were often in care for their own protection, but their frequent episodes of going missing were seen to be because they were ‘difficult children’
- There was not enough investigation into what was happening and professionals relied too much on the girls statements and reporting what was happening to them
- The law around consent was not properly implemented and was misinterpreted. For example, there was confusion around the fact that young teenagers could consent to using contraception when they were having sex that might be illegal
- Young teenagers were seen too much as young adults rather than as children. Some professionals seemed to get used to knowing the girls were having sex with men, rather than having a clear view that it was wrong, full stop.
- There was a failure to recognise that the situation was so bad it should be reported to top managers, so they could start a county-wide response. Instead, the cases were seen more in isolation, with the focus mainly on protecting and containing the girls, rather than tackling the perpetrators.
- There was no evidence that the race and ethnic background of the exploiters stopped the professionals from identifying the Child Sexual Exploitation earlier.
- The Oxfordshire Safeguarding Children Board, and the committee there before it, did not show sufficient grip or curiosity when some early signs were presented, and child sexual exploitation drifted off the agenda.

The Review shows that from 2005-10 there was enough known about the girls, drugs, sexual exploitation, and association with adult men to start a more serious response. However this did not happen and most of the information did not reach high levels. Details can be found with the other case reviews published by the OSCB. The Review identifies around 60 learning points that will help agencies understand why and what needs to happen to be sure Child Sexual Exploitation continues to be tackled well. The OSCB was charged with taking action on, amongst other things, ensuring that supervisions arrangements are robust and evidenced; escalation procedures are clear and used; consent guidance is understood and applied, multi-agency meetings fit into the strategic partnerships and are properly recorded and issues are escalated.

The response to child sexual exploitation has been robust across Oxfordshire agencies and is most recently outlined in the report: [CHILD SEXUAL EXPLOITATION 'MAKING A DIFFERENCE' - The impact of the multi-agency approach to tackling CSE in Oxfordshire](#). This report pulls together collective work by Oxfordshire agencies to tackle the perpetrators of child sexual exploitation (CSE) and protect children. It headlines the progress that has been made since 2011 when Operation Bullfinch commenced, in the identification and analysis of CSE and in the provision of clear pathways for children at risk through the Kingfisher team and the work of the CSE sub-group of the Oxfordshire Safeguarding Children Board (OSCB). The report concludes that services and interventions across all agencies in Oxfordshire are making a difference to children because of changes made since 2011. The overall conclusion is that there has been good progress in setting up specialist interventions for children at risk of CSE and robust measures used to identify perpetrators and bring them to justice.

Chapter 5: Challenges ahead and future priorities

National Drivers

- Addressing child sexual exploitation
- Implementation of new safeguarding guidance
- Focus on safeguarding across the inspection regime to drive local compliance with audits



For the Board

- Strengthening partnership arrangements
- Working and engaging with local community, voluntary and faith groups
- Ensuring compliance against safeguarding standards
- Testing if learning from case reviews is embedded across partner agencies

For local multi-agency work

- Improving practice to address neglect
- Progressing work to better safeguard vulnerable adolescents
- Remaining vigilant to where the next pressure points lie and escalating safeguarding concerns
- Ensuring there is sufficient provision of 'early help' and services are integrated

**Key priority areas**

Reviewing the challenges ahead the Board is committed to delivering on its priorities with due attention to

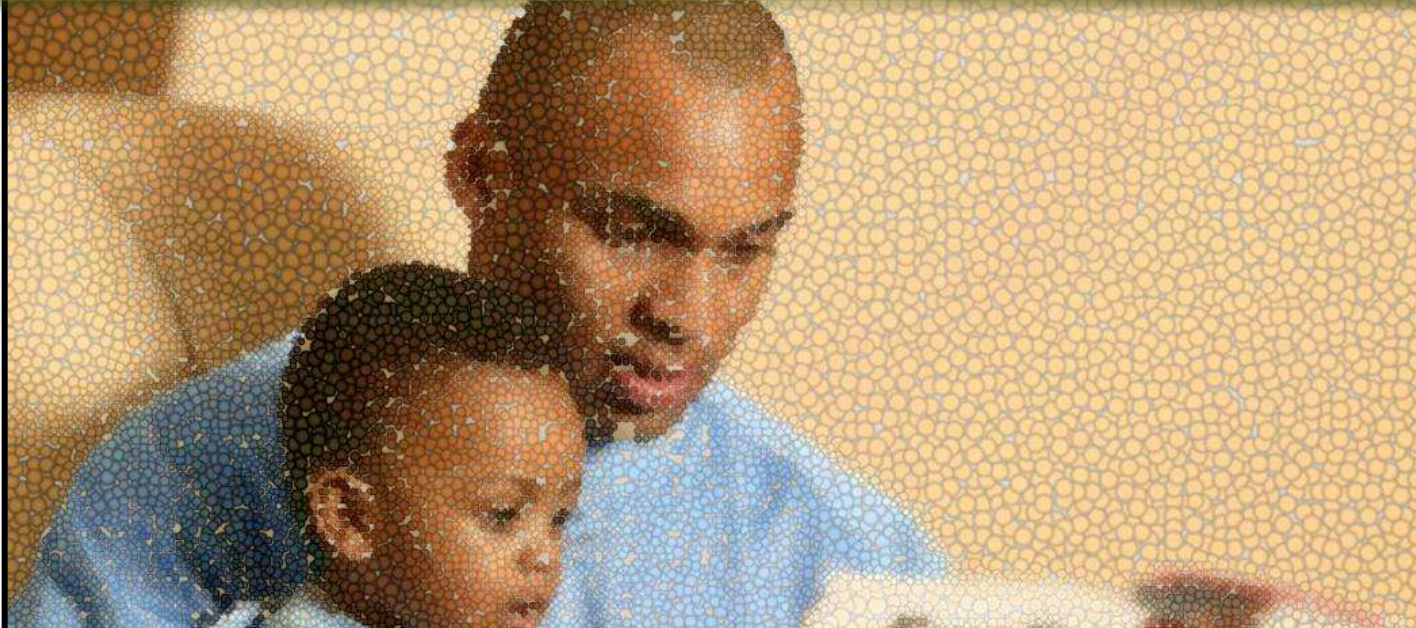
- The increasing pressures on the safeguarding system as the number of children with child protection plans and in care rises
- Safeguarding in transport: regulation of taxis and commissioning of transport for vulnerable children
- Commissioning of services to provide help and therapy for children into adulthood

CHAPTER 6: WHAT NEXT FOR CHILD PROTECTION IN OXFORDSHIRE

Key messages to:

Children

Your voices are most important. Tell us what you think when we ask and help us to improve the way that agencies help you and your family



Children's workforce

- Ensure that you have attended all safeguarding courses and learning that is relevant to your role
- Get the basics right: be informed; use the multi-agency tools and procedures on the OSCB website
- Use your representative on the safeguarding board to escalate concerns
- Be connected to your local safeguarding group as appropriate

The community

- You are in the best place to look out for children and to raise the alarm if something goes wrong
- We all share responsibility for protecting children. Report a concern if you are worried.

The community, faith and voluntary sector

- Ensure that you have attended all safeguarding courses and learning that is relevant to your role
- Use online resources available through the NSPCC
- Find out about and use the multi-agency tools where they are relevant to your role

**Head and Governors of schools**

- Complete the OSCB endorsed safeguarding audit for your setting
- Ensure your workforce is trained and get involved in the delivery of OSCB safeguarding training
- Be aware of the latest statutory guidance on safeguarding and ensure your safeguarding lead is signed up to the OSCB e-bulletin
- Understand and know how to deal with safeguarding concerns like self-harm; sexting; online safety and radicalisation of children
- Access and promote road safety information for pupils and their families
- Take responsibility for ensuring that all pupils' whereabouts are known; children out of school are at increased risk of harm
- Make the most of local safeguarding initiatives e.g. NSPCC Childline assemblies and Chelsea's Choice

Clinical commissioning groups

- You have a key role in the health sector to scrutinise the governance and planning across a range of organisations. Consider the needs to vulnerable families within the course of this work
- You are required to discharge your safeguarding duties effectively and ensure that services are commissioned for the most vulnerable children

**Chief executives and directors**

- Your agency's contribution to the work of the OSCB should be of the highest priority; you have made good progress in working collectively to tackle issues such as child sexual exploitation, female genital mutilation and self-harm but there is *continuing* need of strategic co-ordination of activity across your organisations
- Take responsibility to ensure that all serious safeguarding matters are escalated to the Board for challenge by the partnership
- Ensure that senior managers meet with frontline practitioners and are assured that safeguarding practice is well understood
- Strong and persistent leadership will change culture and attitudes towards vulnerable children; be vigilant to where the next pressure points lie

Police and crime commissioner

- Ensure that victims voices are taken notice of within the criminal justice system
- Monitor and support the work of the Oxfordshire Safer Community Partnerships and the local community safety partnerships

**Local politicians**

- You have a crucial role in your local community to convey concerns. You can raise issues and concerns for vulnerable families. Councillor Melinda Tilley is the lead member for children and families.
- Keep the protection of children at the forefront when you scrutinise plans and consider proposals for change

Local media

- We all share responsibility for protecting children; you are in a crucial position to convey this to your readers
- Find out about the Safeguarding Board and current concerns; this will be of interest to your readers

Reporting Concerns

Multi-Agency Safeguarding Hub (MASH)

For any new concerns or enquiries please contact the MASH:

0845 050 7666

Oxford City

(including Cowley, Botley, Headington, the Leys and Kidlington)

01865 328563

North Oxfordshire

(including Banbury, Witney, Bicester, Carterton and Woodstock)

01865 323039

South Oxfordshire

(including Faringdon, Wantage, Thame, Didcot and Henley)

01865 323041

The Emergency Duty Team

Please contact this number if your call is outside of normal office hours

0800 833 408

John Radcliffe Hospital Assessment Team

for antenatal safeguarding concerns and issues concerning children in the hospital

01865 221236

Child Sexual Exploitation (the Kingfisher Team)

If a child or young person has made a disclosure regarding sexual exploitation or if you think a child may be at risk of being sexually exploited, please contact the Kingfisher Team on:

01865 335276

Out of hours calls to this number will be diverted to the Thames Valley Police Referral Centre

Oxfordshire Safeguarding Adults Board 2016-17 Annual Report



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Executive Summary

The Oxfordshire Safeguarding Adults Board has made great strides in the last year in bringing together partners to better protect adults in Oxfordshire.



How well are we safeguarding people?

Within Oxfordshire we have seen a reduction in the numbers of adults going missing and an increase in the number of care providers rated as Good by the Care Quality Commission.

Our Fire & Rescue Service have conducted over 3,000 wellbeing checks on some of the most vulnerable in our society.

While there has been an increase in activity within safeguarding, we have also seen an increase in those who have had their risk reduced or removed by the interventions of the professionals.

Making safeguarding personal: how we measure it

As part of empowering those who are involved in safeguarding, 90% of people are now defining what they want to happen and a majority report they are satisfied with the outcome of the safeguarding work.

Safeguarding Board effectiveness

The peer review challenge session showed the Safeguarding Board had made “significant improvements across all areas of activity in a relatively short time”. The Board will work to maintain these high standards and has built the recommendations from the challenge session into the strategic plan for 2017/18.

Board Strategy 2017-18

The Board will work on increasing professionals’ understanding of safeguarding across the partnership and improve the levels of concerns that go on to become investigations. We will also work on how we engage those who have experienced safeguarding so the Board hears the voice of these experts by experience to improve our response to safeguarding issues and work to prevent them occurring in the first place.

Introduction by Pamela Marsden, Independent Chair

"I am delighted to present my first report as the Independent Chair of the Oxfordshire Safeguarding Adults Board (OSAB). Following the departure of the previous chair, Sula Wiltshire, Director of Quality/Lead Nurse Oxfordshire Clinical Commissioning Group and Deputy Chair of the OSAB, kindly agreed to become interim chair until my appointment. I would like to take this opportunity to thank her for her contribution and for the help she offered to me on my arrival in November 2016. I am also very grateful to other partners for their welcome to me in this role and their on-going support."



"This has been yet again a very busy year for all of the members of the OSAB. A number of procedures have been reviewed and a significant number of new policies have been agreed. We now have clear guidance around, for example, hoarding and self-neglect. During the year we also saw the adult social work service reconfigure their safeguarding service into a centralised team in order to meet increasing demand and create a more consistent response. Feedback has been positive and the learning from an evaluation in the autumn will help further refine their response."

"The Board was subject to a Peer Review in 2015 and a number of key areas of development were identified. The Peer Review team returned in January 2017 and were impressed with the progress that had been made and the leadership in place to drive the changes identified. The resulting action plan has been incorporated into the overall business plan detailed later in the report."

"Cooperation and commitment to the work of the partnership has been maintained despite the pressures within each individual agency. However, we always need to consider if we can do things differently to make better use of scarce resources and members time whilst ensuring we make a positive impact for those requiring our services. We now have much closer ties with the Oxfordshire Safeguarding Children Board (OSCB) and have agreed a number of joint meetings and priorities for the year ahead to include training, as this will help develop a common approach to safeguarding and support the 'Think Family' policy. The other joint priorities are domestic abuse and transitional arrangements for children who move to adult services, as these are seen as clear areas of risk that straddle the work of both Boards."

“Underpinning the Oxfordshire Safeguarding Adults Board (OSAB) is the work of the subgroups and I would like to thank all of those who take part in progressing the work of the Board. I would also like to thank Steven Turner our Board Business Manager and Diane Dillon, Board Support Officer for all of their hard work this past year. Finally, I would like to thank Members for their interest and enthusiasm and in particular Councillor Judith Heathcoat for her commitment to the safeguarding agenda.”

“In 2016 the Government commissioned the Wood Review to consider the work of Local Safeguarding Children Boards. The review has reported its findings and if implemented will lead to fundamental changes. This would not explicitly impact on Safeguarding Adults Boards but there would be learning and unexpected opportunities as a result, so we will need to monitor developments and be mindful of any implications during the forthcoming year. The Law Commission has also reported on its findings and made recommendations on the Deprivation of Liberty Safeguards which again if accepted by Government will mean practice changes and will lead in the Commission's view to a less onerous system whilst still offering human rights protections.”

“The report is important because it shows what the Board both as a partnership and through the individual agency activity aimed to achieve this past year on behalf of Oxfordshire residents and what it plans to do over the forthcoming year. What is clear is that the next year will be another challenging one. There is still a great deal more we need to do to reduce the risk of abuse and neglect in Oxfordshire. Our priorities for the forthcoming year are detailed later in the report but a significant development will be greater involvement of service users in the work of the Board and ensuring that the approach to those requiring our services is always person-centred and empowering. We also need to ensure we continue to refine and develop a data set which helps us evaluate our effectiveness.”

“I look forward to continuing to chair the OSAB and I hope it will be a rewarding year where our aim of safeguarding the most vulnerable in our communities continues to be realised.”

Who are we protecting?

The Care Act 2014 places duties on statutory agencies (e.g. social care and health) to protect adults with care and support needs.

Oxfordshire is the most rural county in the South East. It has a population of around 672,500 people, one third of which lives in towns or villages of less than 10,000 people. The population has grown by 10% in the last 15 years and there is a predicted increase of 13% over the next 10 years.

Population growth in Oxfordshire

Over the next 5 years we are expecting a growth in the elderly population in Oxfordshire and a further increase by 2030¹, detailed below.

Age Group	Next 5 years	2030
18-64	4%	9%
65-74	2%	20%
75-84	21%	43%
85+	17%	57%

In addition - with the growth in the elderly population - national estimates suggest the proportion of adults with a learning disability with eligible care and support needs will rise by around 2% per year. Many of these will have some or all of their needs met by their family and friends.

¹ Further information can be found in the Joint Strategic Needs Assessment 2017
https://mycouncil.oxfordshire.gov.uk/documents/s36717/HWB_MAR2317R05-%20JSNA.pdf

Making Safeguarding Personal

Making Safeguarding Personal means our approach to working with adults with care and support needs should be person-led and outcome-focused. It should engage the person in a conversation about how best to respond to their safeguarding situation in a way that enhances their involvement, choice and control as well as improving quality of life, wellbeing and safety.

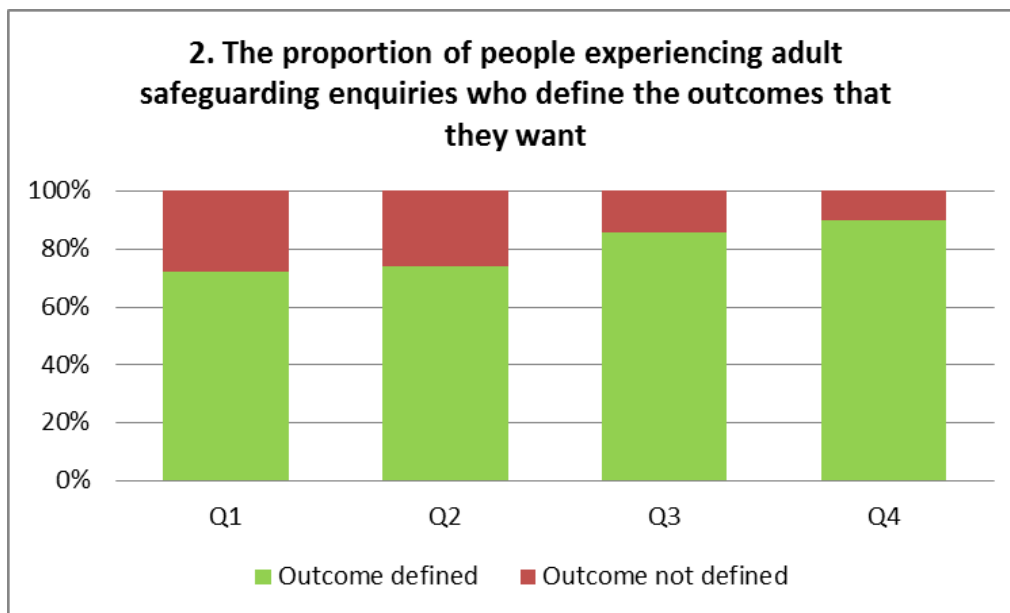
Six key principles underpin all adult safeguarding work:

- **Empowerment** – People being supported and encouraged to make their own decisions and informed consent.
- **Prevention** – It is better to take action before harm occurs.
- **Proportionality** – The least intrusive response appropriate to the risk presented.
- **Protection** – Support and representation for those in greatest need.
- **Partnership** – Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- **Accountability** – Accountability and transparency in delivering safeguarding.

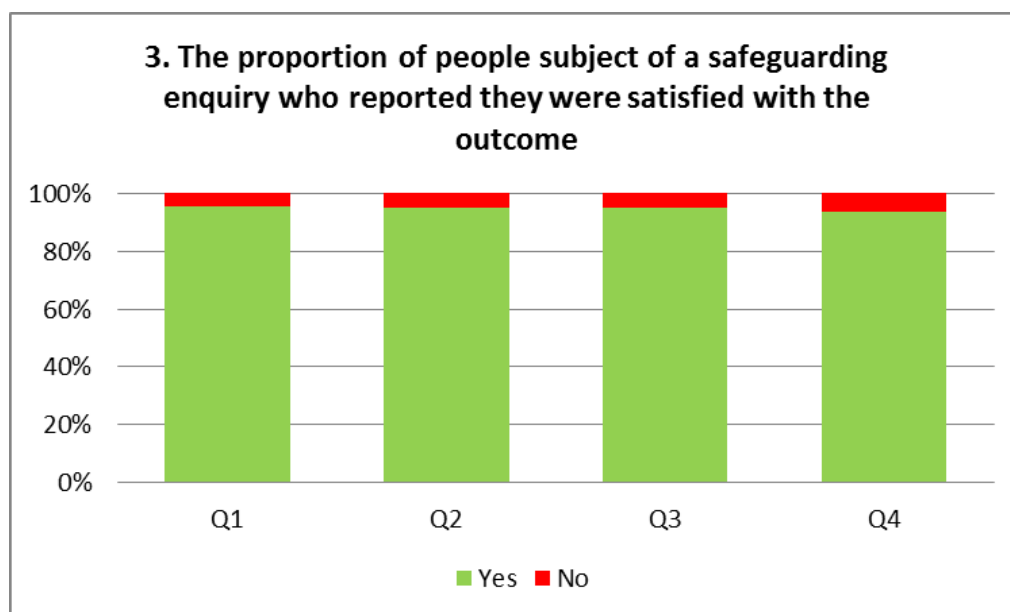
In addition to these principles, it is also important that all agencies take a broad community approach to establishing safeguarding arrangements. We all have different preferences, histories, circumstances and life-styles, so it is unhelpful to prescribe a process that must be followed whenever a concern is raised.

By the end of 2016-17, of those adults subject to the 1,778 safeguarding enquiries, 90% of people had defined the outcomes that they wanted in comparison with the start of the year figure of 72%.

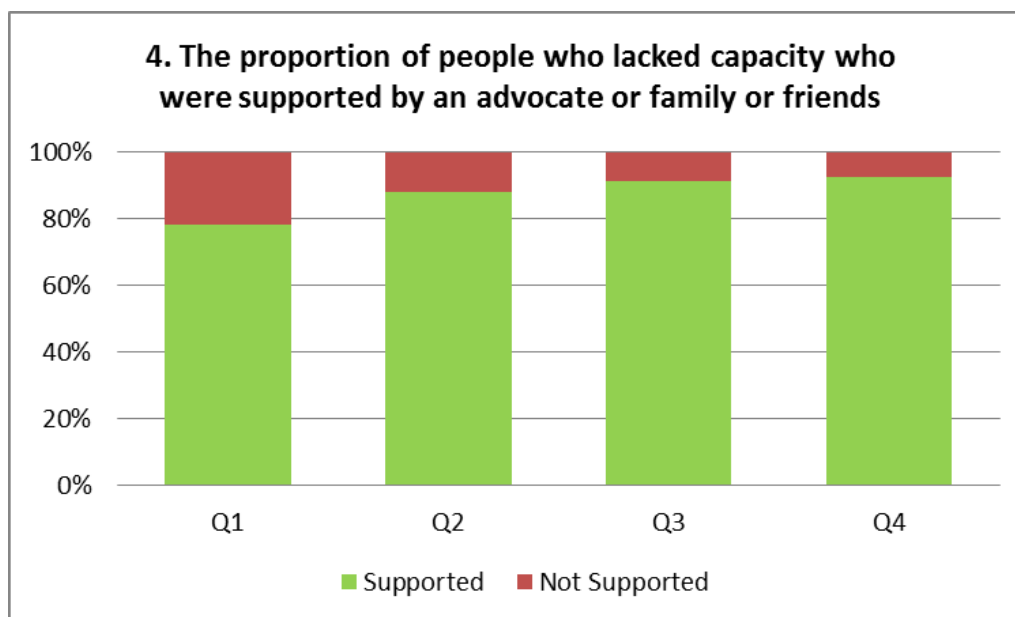
This increase is believed to be due to empowerment becoming more embedded in practice across the partnership, with professionals placing the adult firmly at the centre of all their actions to help protect them.



Most people who responded indicated that they were satisfied with the outcome of their enquiry. In all cases where people were not satisfied the Safeguarding Team followed up to see if there was learning for professionals on how we could better safeguard the person in future.

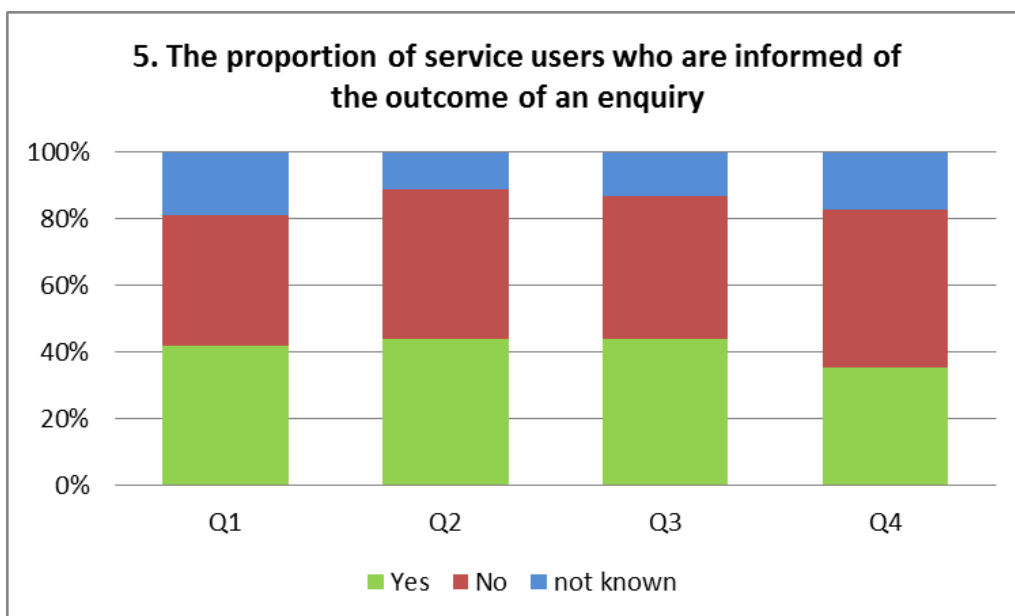


By March 2017, 97% of people who were recorded as lacking capacity, were supported through the enquiry process by an advocate, family or friend. Performance has improved throughout the year as Making Safeguarding Personal becomes more embedded. The focus on this will continue in 2017-18.

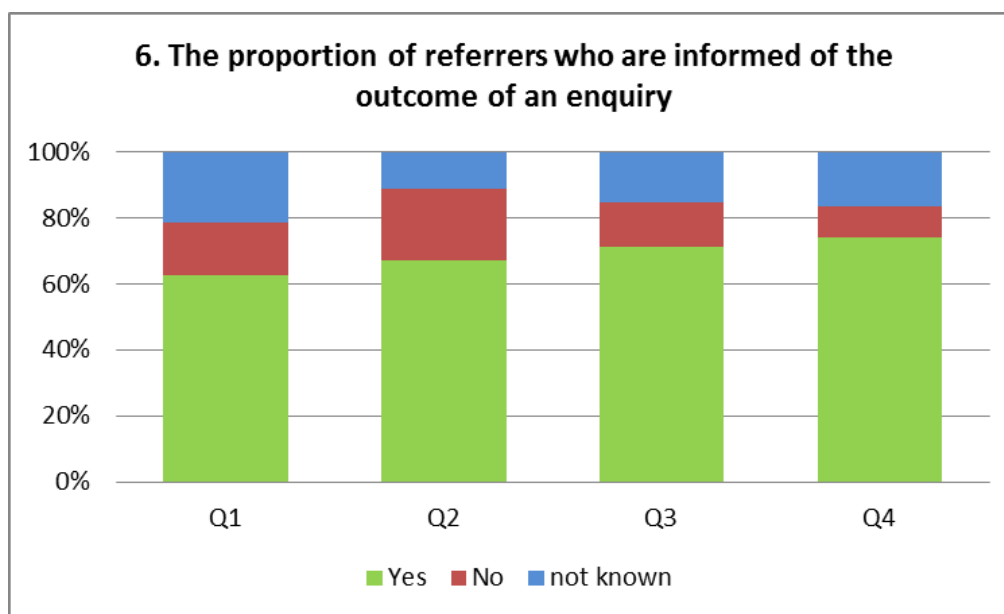


42% of service users and 68% of referrers had been informed of the outcome of their enquiry.

The reported figures only count the number of service users who are directly informed. Where an advocate is involved as the person has substantial difficulties participating in the safeguarding process, the advocate will be informed for them to relay to the person with care and support needs.

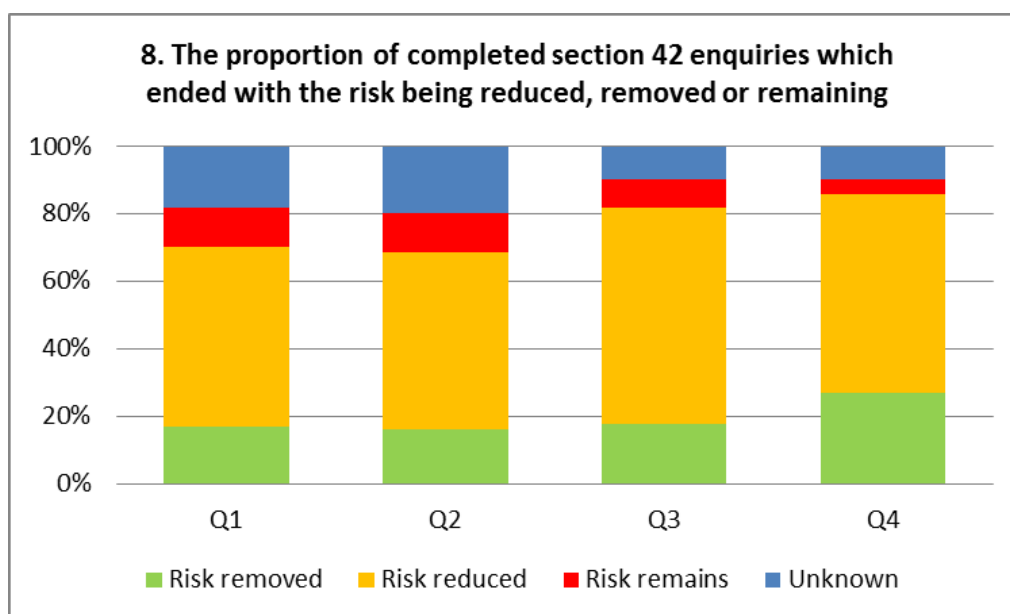


The number of referrers being informed of the outcome is steadily increasing and our focus is to constantly improve this.



For completed enquiries the risk was removed or reduced for 75% of enquiries. As the diagram shows, performance has improved quarter by quarter.

Following the principles of Making Safeguarding Personal which focus upon the outcome with the service user, the number of cases where the risk is reduced improved in each quarter. In the small number of situations where risk remained, this has been due to the individual making the choice not to follow the protection plan. In these cases, mechanisms were put in place to monitor so the risks are not increased.



Making Safeguarding Personal: a local case study

The Safeguarding Team received a concern from a professional about this service user's potential vulnerability with regards to a relationship with a male who was known to their service. They were concerned that the relationship was potentially exploitative due to the fact that the service user was very dependent on the male.

The Safeguarding Team therefore arranged to meet with both the service user and carer initially to discuss how they were coping with the current situation and find out whether they needed any additional support. They met with them separately, the purpose of this being to establish whether the service user was happy with the relationship and whether she felt safe.

A mental capacity assessment was completed and it was agreed that based on the information received she had capacity to consent to this relationship. The Safeguarding Team provided her with guidance around ways that she could receive support if she did not wish to continue with the relationship.

By doing this, the service user was able to make an informed decision about her life and relationships and both were informed of the support available to them.

How did the Social Worker help you?

"I saw [the social worker] once with [alleged abuser] and once alone. She made me feel comfortable – good at listening – caring – I did get a little annoyed by all the questions but that it is her job and she was just making sure I was safe"

How well did the Social Worker communicate with you?

"Very good and aware of my circumstances and conditions"

Is there anything the Social Worker could have done better?

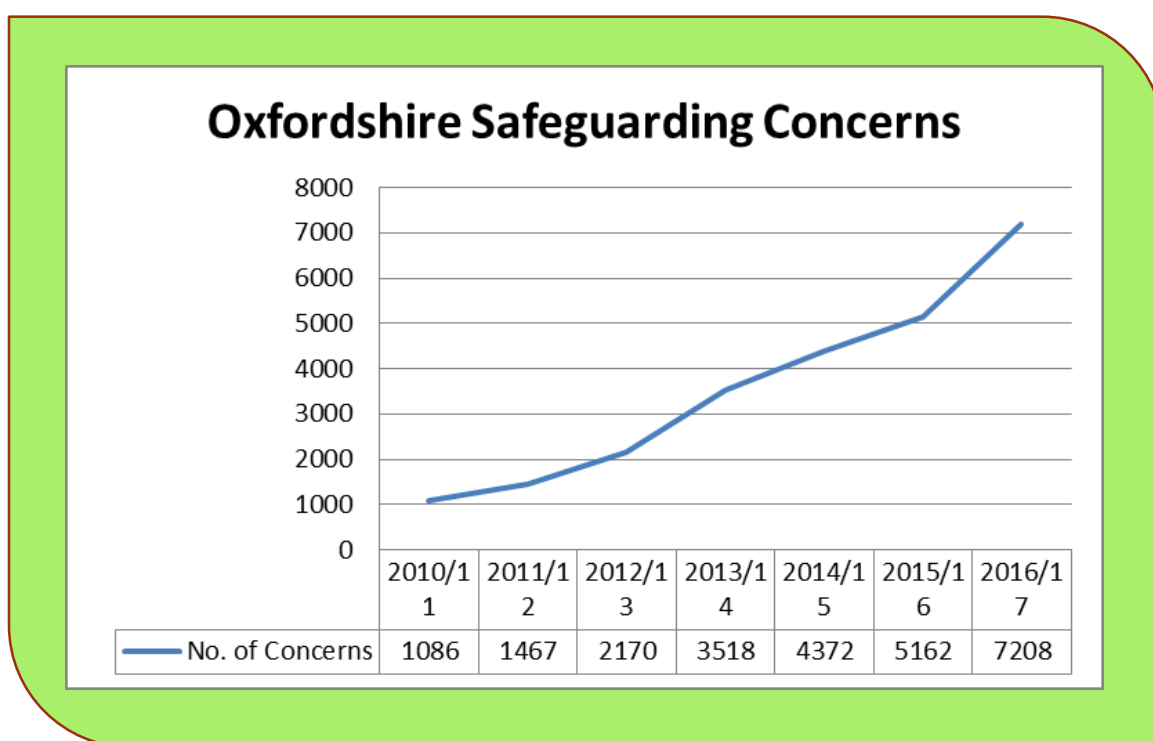
"No, she did everything to make sure I felt safe and comfortable – and to see if I could understand my money – she was concerned about [alleged abuser] – so took him outside to have a private chat with him to understand if he was an abusive person or not. She then came to see me on my own so that I could talk and say what I liked without [alleged abuser]'s presence."

Safeguarding Activity Data

Safeguarding Concerns

Oxfordshire received 7208 concerns, formerly known as “alerts”, in 2016-17. This was an increase on 2015-16.

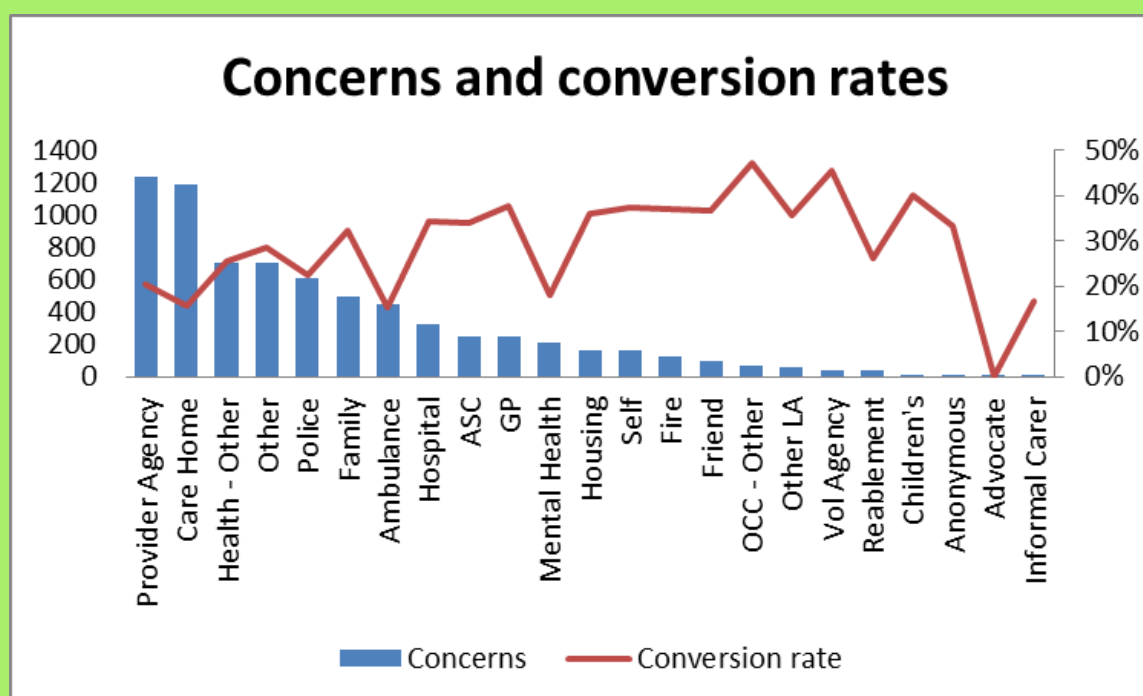
The number of concerns has increased consistently over the period since 2010/11 and is now over 6.5 times the figure in 2010/11. This is thought to be because of a greater public awareness and simpler ways to raise a concern (80% of all concerns raised this year have been electronic) rather than an increase in instances of abuse and neglect.



Concerns and Conversion

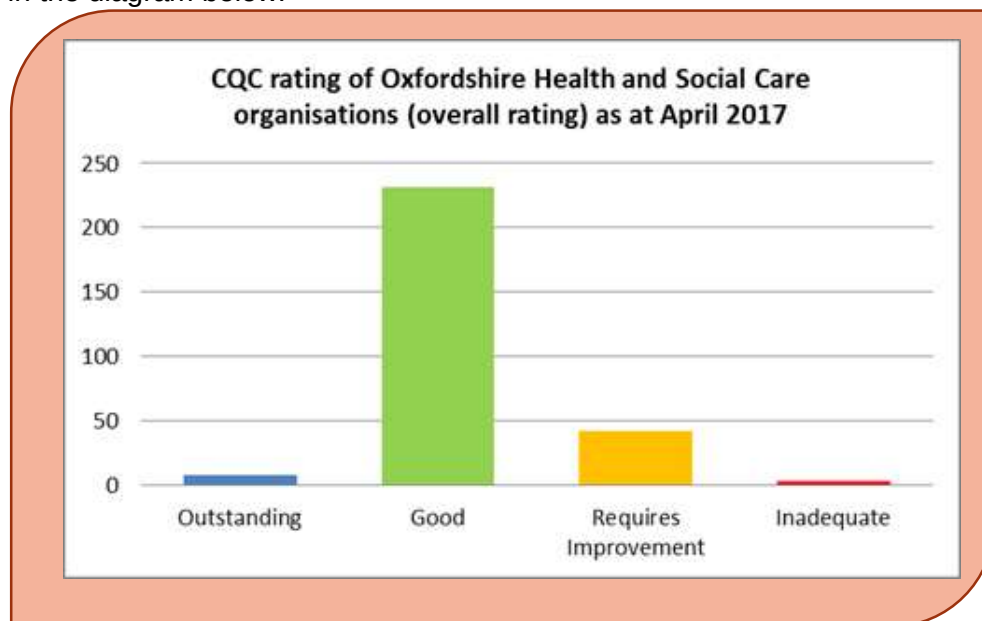
Oxfordshire care homes and provider agencies account for 34% of all concerns raised. Health Services account for a further 27%. 10% of concerns were raised by family, friends or the person themselves. The source of concern is not indicative of the alleged abuse. It is apparent that the conversion rate varies across agencies with higher conversion rates from concerns to enquiries raised by some agencies when compared to others. More information can be seen in the table below.

While there has been an increase in the number of concerns overall the percentage of concerns that require further investigation has fallen. Potentially it may be that as there is now a single countywide safeguarding service the initial investigation is more standardised and consistent, meaning cases are not going through to an investigation unnecessarily and thus the individual is made safe through alternative solutions.



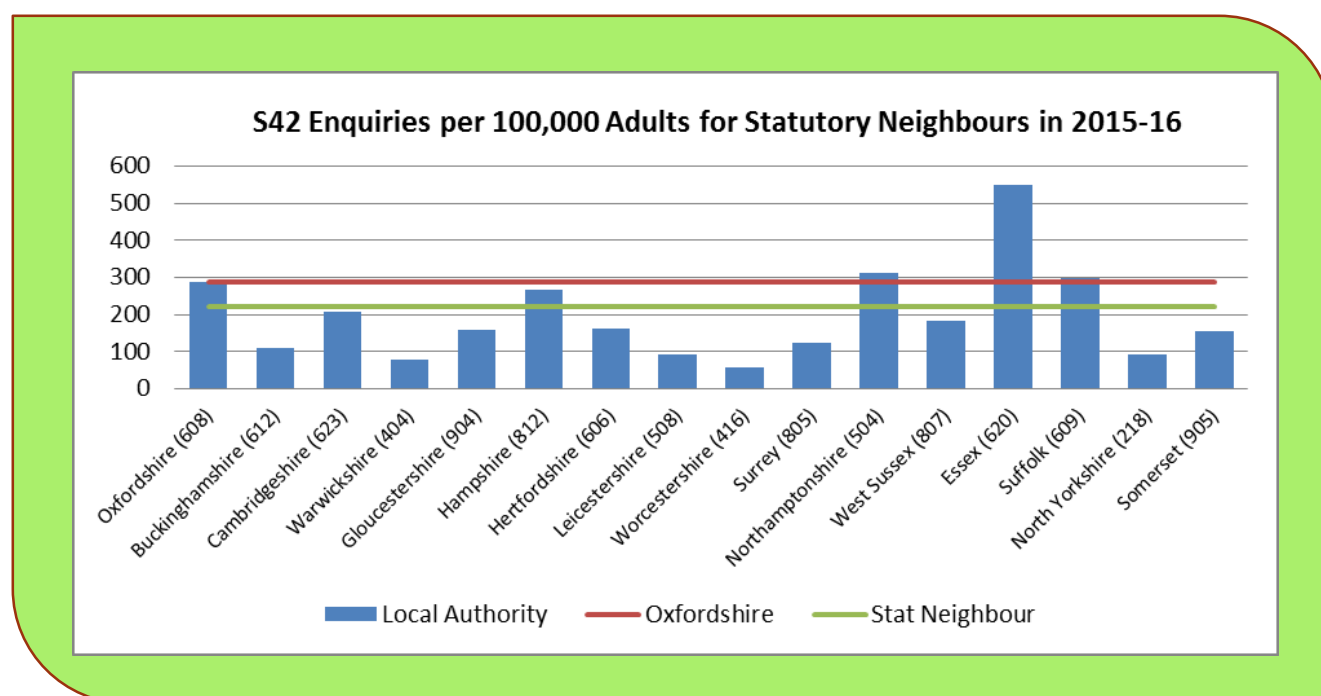
The Safeguarding Board has undertaken audits of the concerns raised by those agencies that have high referral rates but a low rate of conversion to understand why the rates are low. The Board will then commence targeted work with these agencies to improve rates.

It should be noted that Care Quality Commission (CQC) have rated over 90% of the Health and Social Care organisations in Oxfordshire as either good or outstanding, as can be seen in the diagram below.



Safeguarding Enquiries

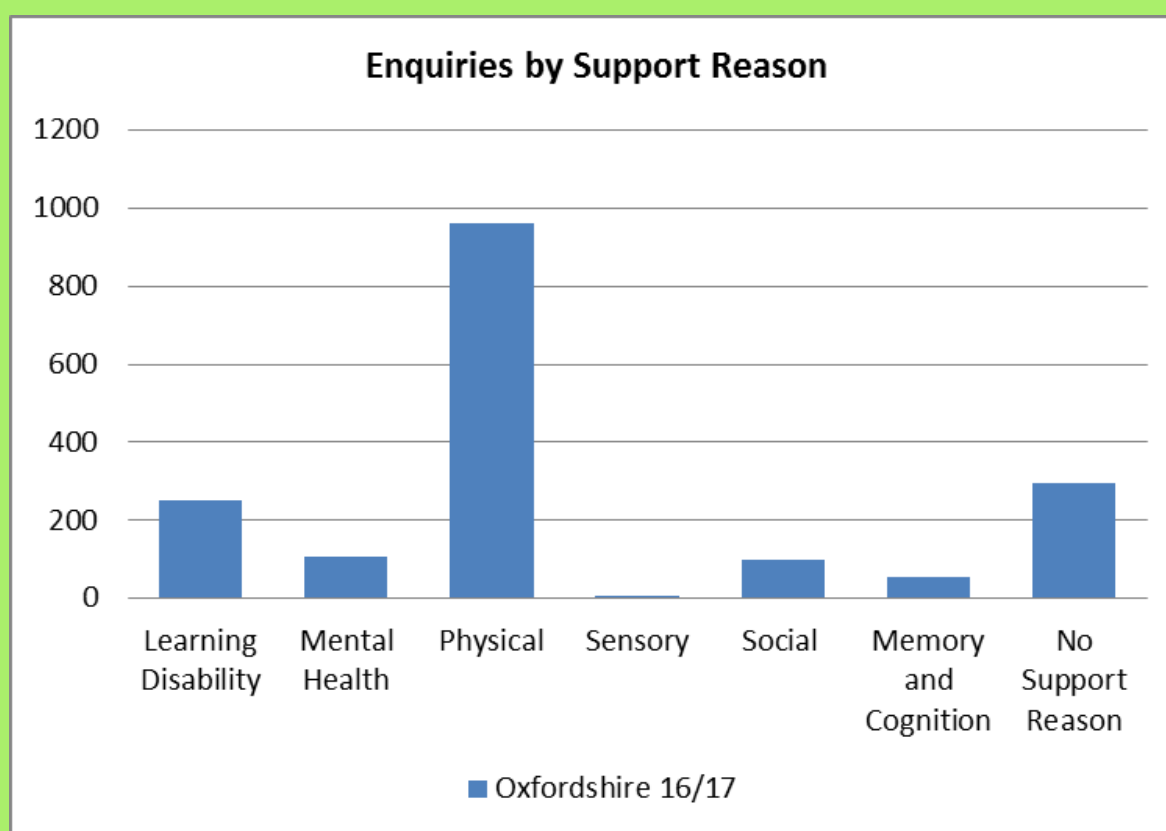
In 2015-16 there were 1542 enquiries (concerns requiring further investigation) which equates to 288 per 100,000 population compared with our statutory neighbours' figure of 222 and an England average of 239. In 2016-17, the numbers of enquiries in Oxfordshire rose to 1778.



In 2015-16, the conversion rate of concerns to enquiries was around 30%, in line with the national figure, but above our statistical neighbours. In 2016-17, only 25% of the concerns converted to a Section 42 enquiry. This is a 5% decrease compared to last year. We do know if that is in line with our statistical neighbours as we do not have as yet any comparative data for 2016-17.

Enquiries by Support Reason

Most people who are the subject of a safeguarding enquiry have care and support needs because of their physical disability. This is similar to the pattern recorded in 2015-16.



Enquiries by Category of Abuse

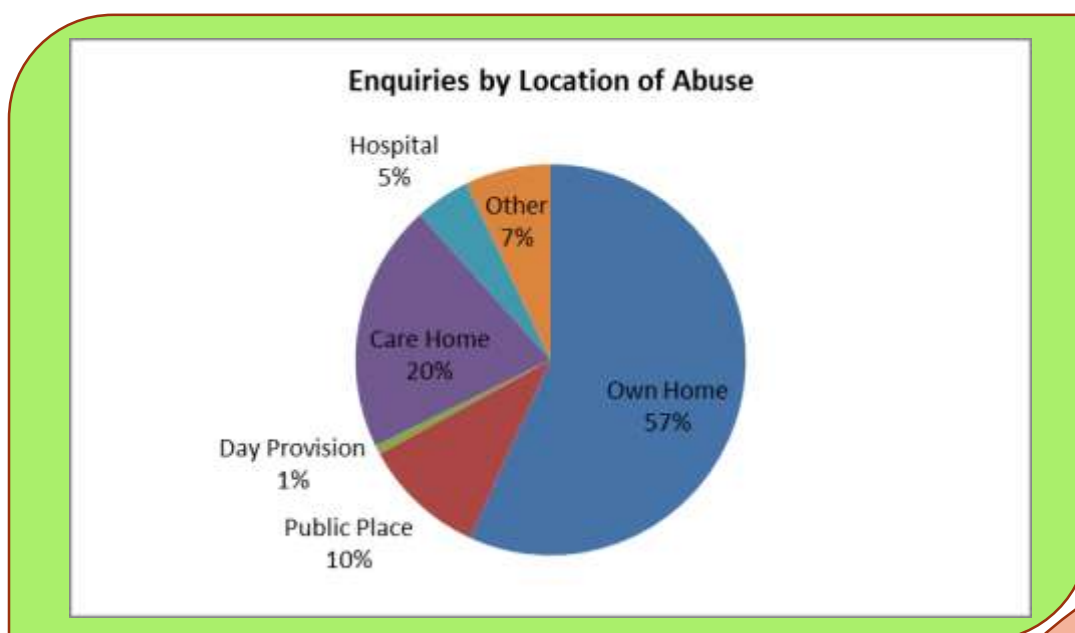
Enquiries by key categories of abuse are shown in the table below. This shows that there has been a rise in Oxfordshire in the numbers of enquiries due to psychological abuse, emotional abuse and also financial and material abuse. 1 in 3 cases are due to neglect and omission, which is in line with national figures for 2015-16.

Abuse Category	Oxon 15-16	Oxon 16-17
Physical	24%	21%
Psychological Emotional	13%	19%
Financial and Material	13%	18%
Neglect and Omission	46%	34%
Other (including discriminatory, institutional and sexual)	5%	8%

The Care Act 2014 introduced new categories of abuse including modern slavery, domestic abuse and self-neglect, but it is not yet possible to report accurately on these categories. Work is underway to ensure that we are able to report on these categories in future years.

Enquiries by Location of Abuse

57% of enquiries are about abuse which takes place in the home of the person. 20% were reported from Residential and Nursing homes.



People subject of Enquiries by Ethnicity

The numbers of people who are the subject of a safeguarding enquiry by ethnicity is shown below. There has been a reduction in the numbers of white people who are the subject of an enquiry but an increase in the numbers for whom ethnicity is not known or not declared. We are investigating the reasons for this and will address it in the coming year. There was only a slight increase in the numbers coming from a minority ethnic group.

Ethnicity	15/16	%	16/17	%
White	1331	86%	1140	77%
Mixed	5	0%	13	1%
Asian/Asian British	28	2%	26	2%
Black/African/Caribbean/Black British	17	1%	20	1%
Other Ethnic Group	6	0%	7	0%
Total Recorded	1387	90%	1206	82%
Not known or not declared	155	10%	270	18%
Total	1542	100%	1476	100%

People subject of Enquiries by Age

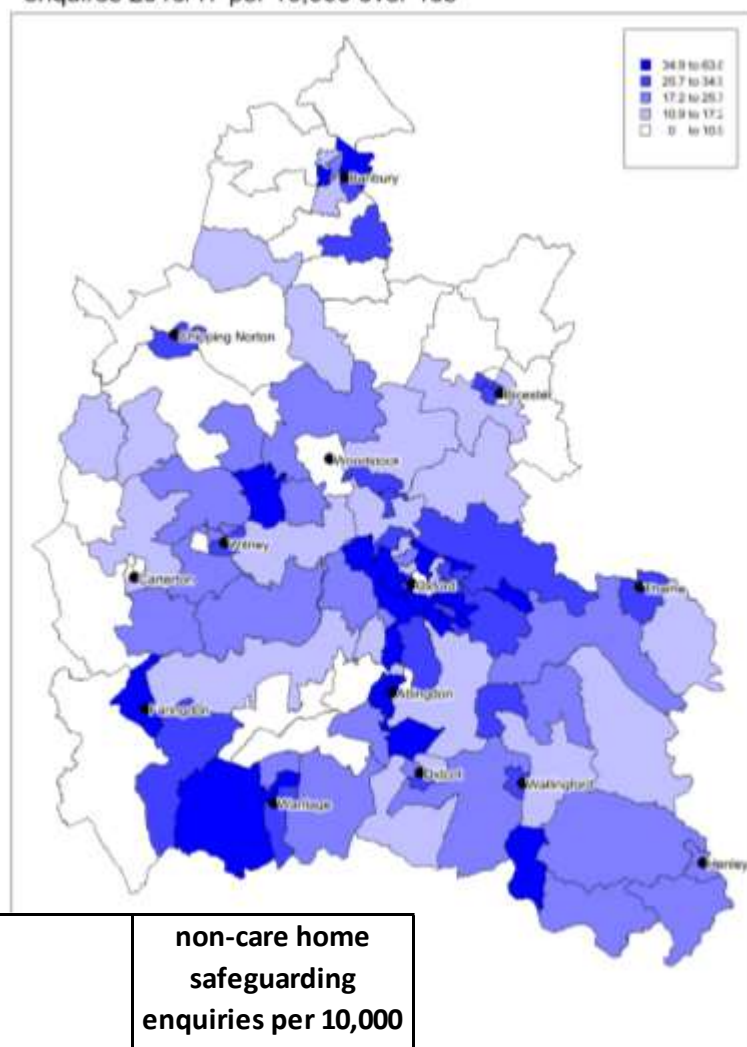
The number of the people who are subject of a safeguarding enquiry by age group is shown below.

Age Group	15/16	%	16/17	%
18-64	480	31%	516	35%
65-74	220	14%	204	14%
75-84	322	21%	324	22%
85-94	441	29%	352	24%
95+	79	5%	69	5%
Total Recorded	1542	100%	1465	99%
Not known	0	0%	11	1%
Total	1542	100%	1476	100%

The relative numbers of enquiries per 10,000 of the population over 18 are depicted by ward (based on the postcode of the person abused) in the following map.

This is the first year we have reported this data and we will monitor the number of concerns by area to see if there is an increase or decrease in 2017-18. This information will help us set up local multi-agency safeguarding groups to help professionals respond appropriately to emerging concerns and spot patterns and trends.

Location of abuse for non-Care home safeguarding enquires 2016/17 per 10,000 over 18s

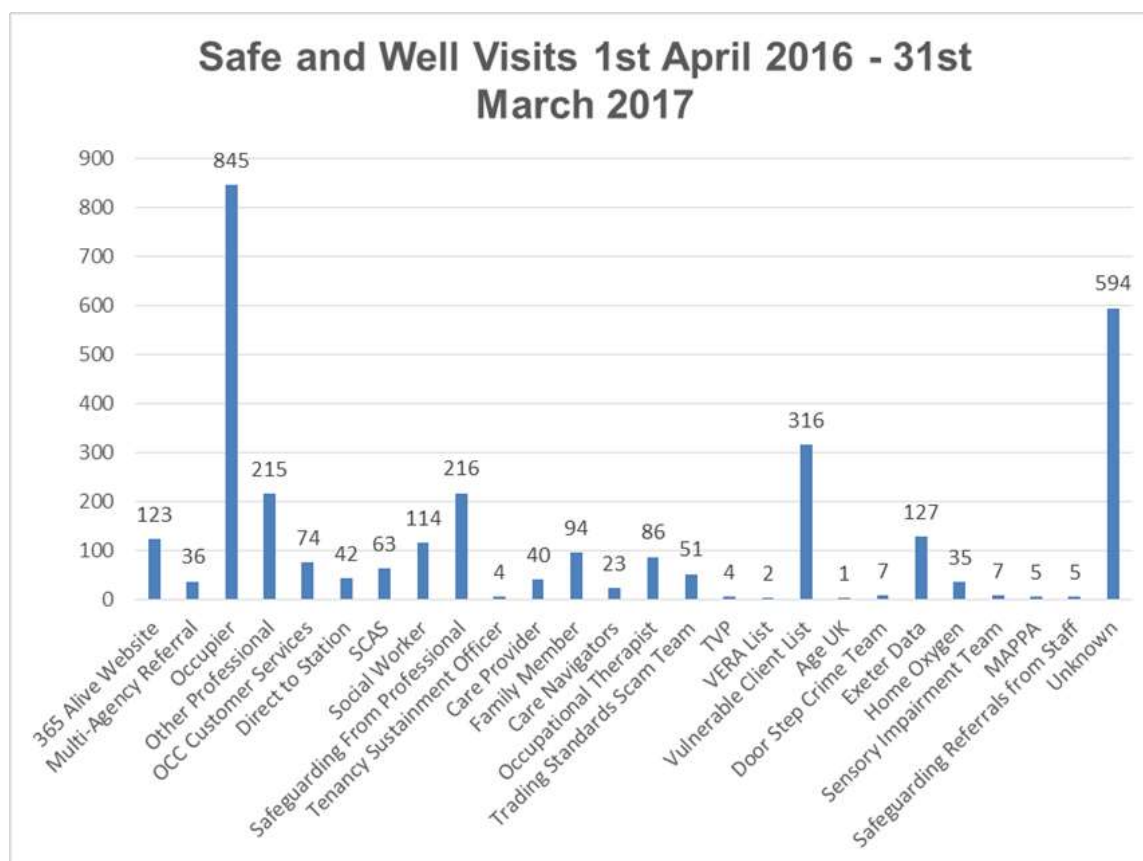


Ward Name	non-care home safeguarding enquiries per 10,000 population over 18s
Blackbird Leys Ward	64
Littlemore Ward	57
Abingdon Caldecott Ward	54
North Leigh Ward	51
Abingdon Abbey Northcourt Ward	50
Barton and Sandhills Ward	46
Rose Hill and Iffley Ward	46
Banbury Grimsbury and Castle Ward	45
Banbury Ruscote Ward	45
Jericho and Osney Ward	45
Iffley Fields Ward	43
Hinksey Park Ward	43

Preventative Work by the Fire and Rescue Service

In 2016-17, 3129 safe and wellbeing checks were undertaken by the Oxfordshire County Council Fire and Rescue Services.

The diagram below shows a breakdown of where the referrals to carry out the safe and wellbeing check originated. It should be noted that support services such as AgeUK work with the occupier to help them make their own referral so would be classed as occupier as the source of the referral.



Deprivation of Liberties Safeguards (DoLS)

There has been a continued increase in referrals following Cheshire West Supreme Court judgment in March 2014. In response to this, Oxfordshire has taken a positive approach to ensuring staff are qualified to complete this increase in applications.

We have an increased number of qualified Best Interests Assessors (60 staff to date).

A key response has been to combine the teams responsible for all Deprivation of Liberty requests, both the statutory DoLS and community Deprivation of Liberty authorisations, to create a high level of expertise.

We have established an Oxfordshire Mental Capacity Act forum continuing to create good working relationships with providers and advocacy services.

Oxfordshire continues to work to meet the necessary demand of the Deprivation of Liberty safeguard (DoLS) applications and has extended its training to target healthcare professionals to share this responsibility with those trained in the local authority.

DOLS Activity 2015-2017	2015-6	2016-7
No. requests received	1433	1739
No. Granted	159	159
No. withdrawn	335	630
No. Not Granted	15	17
Not signed off at year's end	924	933
No. assessments in year	509	806

In March 2017 the Law Commission published its long awaited report on proposals to amend the current Mental Capacity Act and DoLS framework. Significantly, the report proposes to change the name of the scheme to 'Liberty Protection Safeguards' (LPS). At this stage these are proposals only, and the Government's response is awaited.

What is the Safeguarding Adults Board?

The Oxfordshire Safeguarding Adults Board (OSAB) is a group of statutory, private, voluntary, and independent organisations across Oxfordshire who work together to empower and protect some of the most vulnerable members of our community. Our purpose is to raise awareness and promote the welfare of vulnerable adults by the development of an effective co-operative. This group is committed to ensuring that the work done effectively brings about good outcomes for adults so that people live safe and secure lives.

There has been an OSAB in place in Oxfordshire since 2009. However, the Care Act 2014 gave the OSAB a statutory footing for the first time as of 1st April 2015.

The legislation set out three main duties under the Care Act 2014:

- It must publish a strategic plan for each financial year.
- It must publish an annual report detailing what the OSAB has done during the year.
- It must conduct any safeguarding adults review in accordance with Section 44 of the Act.

However, the OSAB undertakes many other roles with its partners to ensure individuals in their care are safe and protected.

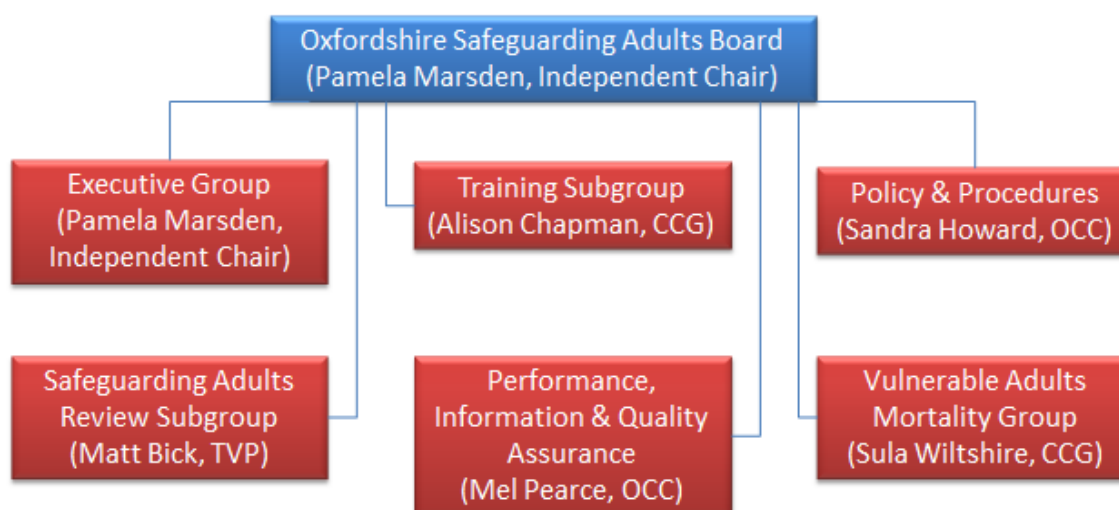
Governance and Accountability

Board Structure

The Board is supported through the Full Board and six supporting subgroups who drive the work. The subgroups are: the Executive Group; the Training Subgroup (joint with the Oxfordshire Safeguarding Children Board); Policy and Procedures Subgroup; Performance, Information & Quality Assurance (PIQA) Subgroup; Vulnerable Adults Mortality (VAM) Subgroup and the Safeguarding Adults Review (SAR) Subgroup.

The diagram below shows the structure and contains the names of the subgroup Chairs

Oxfordshire Safeguarding Adults Board Structure and Chair Information



What have we done

During 2016-17 the Oxfordshire Safeguarding Adults Board undertook significant work to ensure that it fulfilled its statutory responsibilities and has established a firm platform for continuing to do so. This work has been centred around the findings of the 2015 Local Government Association Peer Review.

Safeguarding Board Effectiveness – Peer Review Challenge Session

A peer review was held in 2015 and set a number of recommendations reported in last year's Annual Report (2015-16). In January 2017 the Peer Review team returned to Oxfordshire to see our progress against the actions agreed. The review took place against a background of change for the Oxfordshire Safeguarding Adults Board.

Progress against findings

Progress has been made against all the key findings. Of note were:

- the development and agreement of new Oxfordshire Safeguarding Adults Board (OSAB) joint policies,
- the on-line referral process,
- the greater links between commissioning and contracting, and
- more involvement by all partners sharing leadership roles.

The Peer Review Report Conclusions

“The OSAB should be congratulated for the significant improvements that have been made across all areas of activity in a relatively short time... The Team felt this demonstrated that Oxfordshire has the key building blocks of clear leadership, commitment and energy to make improvements for the benefit of its population.”

The actions from the Peer Review Challenge Session have been incorporated into the Strategic Plan for 2017-18, which can be found at the end of this report.

Safeguarding Board Subgroups

Performance, Information and Quality Assurance (PIQA) Subgroup

The Performance, Information and Quality Assurance (PIQA) subgroup has convened quarterly in June, September, December 2016 and March 2017. A new chair was appointed from October 2016.

Performance

- The subgroup has developed an agreed multi-agency draft dataset for agencies of the Board to report on to establish their performance in meeting the needs of vulnerable people, which includes both quantitative and qualitative information.

Action Plans

- It is the role of the subgroup to monitor and track the implementation of action plans from individual safeguarding adult reviews (SAR) and evaluate progress. The subgroup is overseeing two current actions plans following SARs. Further information about the SARs can be found on **page 26**. A draft protocol has been developed, 'Delivering Social Care across Boundaries' following a previous SAR (2016/17) and this will be implemented and reviewed by the PIQA group (2017/18).

Multi-agency Audits

- The subgroup has identified priorities for multi-agency audits, and will then commission the audits and will oversee the implementation of any resulting recommendations and action plans from the audits. There is now a standard template for all audits which has ensured consistency.

Single agency audits

- Following the learning from a Safeguarding Adult Review, Oxford University Hospital Trust and Oxford Health simultaneously shared their annual pressure ulcer reports and action plans to assure the Board of good communication and practice in this area. There is a further audit planned for September 2017.
- There is a further schedule of audits planned throughout 2017/18.

The Vulnerable Adult Mortality (VAM) Subgroup

In 2015, the Mazars Report into deaths within Southern Health Foundation Trust, identified a lack of robust investigation into the deaths of vulnerable adults. Subsequently, in December 2016, Care Quality Commission (CQC) have published a report “Learning, Candour and Accountability”, which supported the findings of Mazars, and identified a need to develop more consistent and thorough processes in reviewing deaths.

Since the Mazars Report, Oxfordshire Safeguarding Adults Board has been developing local multi-agency processes for reviewing the deaths of vulnerable adults across its services. In September 2016, it established the Vulnerable Adult Mortality (VAM) subgroup, to provide a forum for reviewing all vulnerable adult deaths in Oxfordshire.

The VAM subgroup review the deaths of all individuals identified with a learning disability, and the death of any vulnerable adult, where concern or suspicion related to the circumstances has been identified. This could include known vulnerabilities affecting access to services, sudden death that was unexpected, and a death which is perceived to be preventable. The purpose of this review is to review the quality of services and learn any lessons, which may inform future care provision. Where any service deficits are identified, these are escalated to the Safeguarding Board for further action.

The outcome of the process is to:

- classify cause of death
- identify modifiable factors
- decide on preventability of death
- consider whether to make recommendations and to whom they should be addressed.

Further information about the process can be found on the Oxfordshire Safeguarding Adults Board website.

The Vulnerable Adult Mortality subgroup is made up of senior staff from strategic partner agencies. Service user representation and small provider representatives are also included where appropriate.

Vulnerable Adult Death Review Process Update

To date 8 cases have been reviewed within the VAM subgroup and all have been considered. At this time there are too few to draw any themes or conclusions about the learning from these reviews, however the discussions have led to improved understanding of service provision within the subgroup.

Joint Training Subgroup (TSG)

The Training subgroup (TSG) continues to provide a strategic overview of interagency training, to promote effective practice to safeguard adults and children, promoting their welfare.

It takes responsibility on behalf of the Oxfordshire Safeguarding Children Board (OSCB) and the Oxfordshire Safeguarding Adults Board (OSAB) to ensure good quality, multidisciplinary training is provided and to support agencies in delivering in-house training, ensuring appropriate use of Safeguarding Board materials. This training will use a mixed learning methodology.

For 2017-18 the partner agencies have agreed an increased contribution to improve upon what we have been able to accomplish to date.

Achievements in 2016-17

- The OSAB Training Strategy for 2016-2018 was agreed.
- Joint training discussions are included in every meeting with OSCB TSG members.
- Training materials for 2 levels (basic awareness and frontline professional) of safeguarding adults training courses finalised. As of 31st March 2017, 5 courses have been run, with a further 16 scheduled over 2017-18.
- The basic awareness course is available online and the frontline professionals course is taught face-to-face.
- Related training areas, such as domestic abuse, radicalisation and Female Genital Mutilation, have all be the focus of joint discussions that have informed both adult and children training courses.
- Work plan priorities from strategy confirmed for 2017-18, including learning events and the annual conference.

Future Plans

- Develop a safeguarding competency framework with training recommendations to meet the requirements of the Oxfordshire workforce.
- Support the development and delivery of multi-agency training related to the expectations and requirements identified in the Mental Capacity Act.
- Develop a pool of experienced practitioners to facilitate multi-agency training on behalf of the Board.
- Promote a learning culture, to support increased joint working through shared learning events.
- Develop a process for quality assuring the training programme.

Policy and Procedures Subgroup

This subgroup is responsible for the development and implementation of local multi-agency policies and procedures for the protection of vulnerable adults from abuse in Oxfordshire that ensure:

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

Achievements in 2016-17

Over 2016-17 the Policy and Procedures subgroup has agreed the following policies and procedures which are all available on the Oxfordshire Safeguarding Adults Board website.

- Modern slavery & human trafficking
- Hoarding protocol
- Self-neglect policy
- Complex and organised abuse procedure
- Practice guidance on common safeguarding issues:
 - Trips & falls
 - Incidents between residents in residential settings

Work for 2017-18

1. **Agreement of a multi-agency Allegations Management Policy.** The Care Act 2014 guidance states that a Safeguarding Adults Board should have procedures that include *“a statement of the procedures for dealing with allegations of abuse, including those for dealing with emergencies by ensuring immediate safety, the processes for initially assessing abuse and neglect and deciding when*

intervention is appropriate, and the arrangements for reporting to the police, urgently when necessary". As of 31st March 2017 the work is nearly completed and is on the agenda for the Summer 2017 Full Board meeting for sign off.

2. **Practice Guidance on Financial Abuse.** This has been an area noted of increasing concern for professionals.
3. **Practice Guidance on Delayed & Missed Visits.** This is an area where a number of concerns are raised that are not safeguarding and so the Board is producing clear guidance for professionals on when to refer.
4. **Review of current procedures.** The subgroups duty is to review the current procedures ensuring that there is a multi-agency approach to improved outcomes for the public.

Safeguarding Adults Review (SAR) Subgroup

The Oxfordshire Safeguarding Adults Board (OSAB) has a statutory duty to conduct a Safeguarding Adults Review (SAR) when a person with a care and support need has died or been seriously harmed as a result of abuse or neglect and there are concerns about how agencies worked together to protect the individual.

Over 2016-17, 12 cases were referred to the Safeguarding Adults Review (SAR) Subgroup for consideration for a Safeguarding Adult Review, 9 involved a death and 3 involved serious harm. In 3 of these cases the adult referred did not have a care and support need as defined in the Care Act 2014. In the cases where the concern centred on the practice of a single agency, the subgroup received the relevant management reports, including action plans to address the findings where appropriate.

Two Safeguarding Adult Reviews (SARs) were completed in 2016-17.

The first SAR was Mrs K, who was admitted to hospital after she had attempted suicide. Before a mental health bed and transport could be arranged Mrs K left the Emergency Assessment Unit and made her way to the railway where she died by suicide.

How did we review the case?

This case used the Appreciative Inquiry² model of case reviewing. Feedback from practitioners involved was that they felt engaged and listened to and that the learning from the case had a significant impact.

What did we learn?

- There were governance issues around information sharing, risk assessment and ownership of the patient.
- There was poor communication between professionals, including assumptions of the roles of other professionals working with the person.

² Information about the AI model can be found here: www.ripfa.org.uk/blog/blog-appreciative-inquiry-decisions-action-plans-for-change/

- The demand for mental health inpatient beds outstripped the capacity within local provision and finding placements outside of the county was time-consuming.
- A&E staff did not all have a shared understanding of the risks associated with mental health.

What have we done?

- The information sharing protocol has been reviewed.
- Access to electronic records across agencies has been improved in line with Caldecott requirements.
- Issues around responsibilities have been resolved.
- The demand and capacity issues in mental health have been escalated.
- Mental Health training is being rolled out across A&E staff.

The second SAR concerns Mr B, who was a man in his 50s with moderate learning disability. The cause of death was recorded as 'unascertained' due to the extent of decomposition, but was thought to most likely be due to complications from diabetes, alcohol intake or both.

How did we review the case?

This case used the traditional model of Case Reviews with agencies providing formal written reports which were analysed and an overview report produced.

What did we learn?

- The multiple hospital admissions were not thought of as a whole and the pattern was not noted.
- There was no specialist service within the hospital for adults with learning disability.
- There was limited understanding of the Care Programme Approach³ and use of Hospital Passports⁴ across the whole system.
- Mental Capacity was not fully understood.

What have we done?

- The hospital has implemented a system for reviewing cases of multiple admissions.
- The hospital has recruited a specialist nurse for learning disability.
- The Board has requested agencies confirm their levels of staff training on Mental Capacity Act as part of the annual Safeguarding Self-assessment

³ Information about the Care Programme Approach can be found here:

<http://www.nhs.uk/Conditions/social-care-and-support-guide/Pages/care-programme-approach.aspx>

⁴ Information about Hospital Passports can be found here:

<http://www.nhs.uk/Livewell/Childrenwithalearningdisability/Pages/Going-into-hospital-with-learning-disability.aspx>

How partner agencies are safeguarding people

In the next chapter Oxfordshire Safeguarding Adults Board (OSAB) partners set out how they have contributed to the work of the OSAB and to the ongoing improvement of local safeguarding adults arrangements.

Each key partner was asked to frame their contribution in response to the following key questions:

What did you achieve in 2016-17

What planned activity and challenges do you foresee for 2017-18

Also as part of the Safeguarding Self-Assessment, agencies challenged themselves and partner agencies on what they did to ensure adults with care and support needs were protected.

Oxfordshire County Council – Adult Social Services

What we did

Introduction of a dedicated Safeguarding Service

From October 2016 the Council implemented an organisational change, creating a specialist countywide Safeguarding Service, delivering its adult safeguarding duties within the 'Responsible Locality Model'. Their work includes the initial investigations of all incoming safeguarding concerns to ensure those at risk are protected from harm.

This new model has enabled a one team approach, aiming to ensure continuity and a consistent approach to safeguarding new concerns work across the Council. All team members have completed an induction and appropriate training and are linked to areas within the County to develop links with locality teams and local partners and providers.

Consultation Service

The safeguarding team now offers a preventative consultation service for professionals and providers to discuss concerns and seek advice in line with the Care Act 2014. This has been reported as a positive addition to the service and the number of contacts are growing. There is evidence from Providers that this service has helped them make appropriate referrals.

Safeguarding Governance

The Council continues to use its Care Governance Framework. This Framework sets out how the Council monitors services and the organisations that provide these. It outlines what will happen when concerns are identified or raised and how they will be managed and providers are supported to address any areas of change/improvement.

The main aims of introducing a Care Governance framework are to:

- Ensure that standards of quality and safety are maintained.
- Identify any concerns early on and intervene as soon as possible.
- Develop a supportive process aimed at addressing problems.
- Ensure we work in partnership with providers.
- Share information with a view to being open and transparent.
- Make continual improvements to the services being delivered.

Through the use of this framework there has been substantial work over the last year with individual providers in the local market to improve quality and address serious concerns and standards of care.

What we need to do

- Review the progress of the new countywide service.
- Work with our providers to continue to look at developing the provider market and support quality standards.
- Continue to closely monitor the level of concerns and enquiries via the Council's daily reporting mechanism.

Oxfordshire County Council - Community Safety Services

Oxfordshire County Council's Community Safety Services consist of the Fire and Rescue Service, Trading Standards Service, Emergency Planning and Gypsy and Traveller Service. Our priorities include:

- Providing a safety net to reduce risks to the community and particularly the vulnerable.
- Working with partners to provide services that support health, wellbeing and independence.
- Reducing demand on health, social care and criminal justice agencies through our prevention work.

We are actively engaged with the Oxfordshire Safeguarding Adults Board, including through supporting the Training and Policy and Procedures subgroups.

We continue to support partners to safeguard individuals through the sharing of information in our day to day activities, such as Safe and Well visits and following fire related incidents or financial abuse investigations (doorstep crime and scams). Community Safety personnel are actively encouraged to report any concerns they should have regarding the wellbeing and safety of adults.

What we did

Hoarding

We continue to support and facilitate significant joint working to help individuals identified to be at risk due to hoarding and neglect. We supported the development of the new OSAB Multi-Agency Hoarding Guidance and participate in local hoarding partnership meetings to identify and manage individual cases. On an increasing frequency this work requires multiple joint visits to the person concerned (e.g. including Social Workers, Environmental Health, Housing Services, Fire and Rescue, etc.).

Safe and Well

Our Safe and Well visits are designed to reduce the risks to people in their homes and reach over 4000 people each year through more than 3200 visits. The content of Safe and Well visits continues to be enhanced and now includes elements relating to fire risks, slips, trips and falls, alcohol and drug use, financial abuse and health lifestyles. Fire and Rescue personnel undertake joint Safe and Well visits with Trading Standards personnel covering smoke alarms, escape plans, electrical safety, scam mail and cold calling.

Scams and Fraud

We continue to work with the National Trading Standards Scams Project to identify and support victims of financial abuse in the County (telephone scams, fake lotteries and prize draws, etc.). Through our Doorstep Crime Team £238,000 was saved for victims of cold-calling fraud.

Training

Safeguarding training is delivered to all Community Safety staff on a 3-yearly basis and refresher training was delivered in 2016 covering all safeguarding elements relevant to our work. This training has been expanded to include a much broader range of safeguarding concerns, including Child Sexual Exploitation, Female Genital Mutilation, radicalisation, reducing reoffending, modern slavery and hoarding.

Partnerships

To understand the risks to our most vulnerable residents, we have built strong relationships with partners such as Age UK to use their knowledge, experience and local connections to inform our work. We are also developing stronger relationships with health and social care colleagues through supporting the area-based Health & Social Care Locality Group. Team members also attend case management meetings (e.g. MAPPA (Multi Agency Public Protection Assessment) and MARAC (Multi-Agency Risk Assessment Conference) to support safeguarding arrangements in relation to priority offenders or victims of domestic abuse.

Fire Risk Reduction

Last year we developed and implemented a new Fatal Fire Prevention Policy which includes a structured learning process from any fatal fires to reduce chances of similar fire deaths in the future. Fatal Fire Prevention reports are provided to the Coroner for relevant inquests alongside the Fire Investigation report to inform decisions on fire risk reduction.

Prevent

The Director for Community Safety and Chief Fire Officer is the Director responsible for ensuring compliance with the statutory Prevent duty across Oxfordshire County Council. All front line staff from Fire and Rescue, Trading Standards, Emergency Planning and the Gypsy & Traveller Unit have received initial training on Prevent. Further in-depth training

is being rolled out across the County. In addition, the Director of Community Safety and Chief Fire Officer is the Chair of the Channel Panel with the administrative support for this panel being provided by the Fire and Rescue Prevention Manager and Safeguarding Leads.

Key Planned Activity for in 2017-18

- **Chief Fire Officers Association (CFOA) Safe and Well Evaluation** - Oxfordshire County Council Fire and Rescue Service have been selected to take part in the national Chief Fire Officers Association Safe and Well Evaluation. This evaluation will inform future developments of these visits and help us understand their effectiveness and potential.
- **Increasing Demand for Risk Reduction Visits** - through our engagement with new partners we are starting to see an increase in the numbers of requests for visits to individuals at greater risk. These visits can be more complex than a standard Safe and Well visit and lead to repeat visits and requirements for cross-agency input.
- **Home Office Prevent Peer Review** - Oxfordshire recently took part in a Home Office Peer Review on the partnership work on Prevent. A key challenge for the Service will be to respond to the outcomes of the review in association with our partners.
- **Safeguarding Self-Assessment Analysis** – through the Prevent Implementation Group, the Service will analyse the results of the safeguarding self-assessment returns with regard to the question around Prevent. The assessment has asked agencies to show how they are compliant with the Prevent duty particularly in relation to policies and procedures regarding staff training, use of public resources and referring to the Channel Panel.

Oxford University Hospitals (OUH) NHS Foundation Trust

The team is comprised of a Band 7 Lead Nurse, a Band 6 Specialist Nurse, a Learning Disability Liaison Nurse and a full time Administrator who is also a registered mental health nurse. The team is led by the Head of Adult Safeguarding who is an Occupational Therapist.

The team has provided safeguarding advice for 882 situations over the year involving vulnerable adults. This advice and support includes clinical advice, training and education and partnership work with Oxford Health NHS Foundation Trust, General Practitioners (GPs), Thames Valley Police, Families and Southern Health NHS Foundation Trust.

The team attends the key partnership groups of Multi-Agency Risk Assessment Committees (MARAC), Multi-Agency Public Protection Arrangements (MAPPA), Community Safety Partnerships and Channel Panels. These multi-agency groups include the Police, Oxford Health NHS Foundation Trust, Oxfordshire County Council, the

Oxfordshire Clinical Commissioning Group (OCCG), Care Home providers, and Southern Health NHS Foundation Trust. These groups have been established to enable teams across the county to work together with the specific aim of keeping people safe.

The team is a member of the Oxfordshire Safeguarding Adults Board (OSAB) Safeguarding Adult Review (SAR) subgroup, the OUH Serious Incident (SI) forum and the County's multi-agency Problems in Practice. These groups have been established to learn from incidents and to ensure that people are safe.

There have been 56 safeguarding concerns raised about the care patients have received from the Trust. Of these, 25 were unsubstantiated, 28 were substantiated and three investigations are not yet complete.

There have been 153 Deprivation of Liberty Safeguards (DoLS) applications and of these 11 or 9% were unnecessary. There continue to be significant issues relating to DoLS applications because of the large number of applications across the county following the Cheshire West judgment in 2014.

The training compliance for safeguarding adults within the Trust is 87.2%. This is increased considerably over the last year although remains lower than the 90% agreed with the OCCG. The team has delivered the multi-agency Oxfordshire Safeguarding Adults Board training and the Trust's safeguarding leaders training. This three day programme included working with the police, Female Genital Mutilation, Wrap 3, Domestic Abuse, Modern Slavery and Human Trafficking, Mental Capacity Act and DoLS. Oxford Health took several places on this course. Considerable training has been delivered to junior doctors and clinical teams in relation to the Mental Capacity Act and DoLS following the Care Quality Commission (CQC) inspection in October 2016.

Key achievements

- The team has given 882 safeguarding consultations during the year.
- The '**Prevent**' awareness training has been attended by 4059 staff and 105 people have attended the Home Office Workshop to Raise Awareness about PREVENT (WRAP) 3 training.
- The Trust has contributed to the countywide review of the care received by people with learning disabilities if they died between 2010 and 2016. Now everyone with a learning disability who sadly dies in our care is reviewed and presented by the person's clinical team at the Trust's Mortality Group. This is so we can learn to improve our care.
- The Trust has been awarded £200,000 to recruit learning disability liaison nurses to work across all four hospitals.
- The Safeguarding Adults and Children Teams and Human Resources Teams presented the first joint self-assessment to a peer review panel in April 2017. The Trust received some excellent feedback on the safeguarding services in place.

- The Safeguarding Adults and Children Teams have adopted the '**Think Family**' approach. Three questions have been developed to assist clinicians in recognising abuse in families.
 - *In your normal life – at school/college, at home, with friends, do you feel safe?*
 - *Has anyone forced you to do anything you did not want to do, that frightened you?*
 - *In your relationship do you feel safe?*
- The Team reviews all the safeguarding referrals from the Emergency Department every day. These referrals include Domestic Abuse, concerns about people not coping at home, homelessness and mental health problems.
- The Team is collecting data about the types of domestic abuse issues to help us better understand the training we need to help clinicians feel more confident in domestic abuse situations.
- The team makes sure the learning from safeguarding investigations is included in the Trust's key quality improvement groups. These are for Falls, Discharge and pressure ulcers.
- The Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) practice was audited and more training offered to clinicians.

Future plans for 2017-18

- Recruit the learning disability liaison nurses.
- Complete the project identifying the health needs of people with learning disabilities in the Oxfordshire.
- Develop and pilot a new 'Friends and Family Test', an annual survey and 'lived experience' events to capture the experience of people with learning disabilities and their families receiving health care.
- Recruit and support '**Think Family**' safeguarding champions across children and adult services.
- Implement the Protection of Liberty Safeguards once Mental Capacity Act (2005) has been amended and the national guidance has been published.

Oxford Health NHS Foundation (OHFT) Trust

Oxford Health Foundation Trust (OHFT) in line with other statutory organisations has been working within the context of rising demand for services and resource constraints. To keep patients safe, OHFT is working within a sound framework of safer recruitment and staff development and monitoring. Effective safeguarding of adults requires a sound partnership approach with other agencies.

Partnership Working

On 23rd February 2016, we hosted an event with the Oxfordshire Clinical Commissioning Group (OCCG) and other organisations (Connection Floating Support, Elmore Community Services, Oxfordshire Mind, Response and Restore, Thames Valley Police and South Central Ambulance Service) to showcase how these partnerships are helping individuals to focus on their personal journey towards recovery by identifying the goals that are important to them.

During 2016/17 the Oxfordshire Safeguarding Adults Board developed and introduced a multi-agency training course for staff working with vulnerable adults in Oxfordshire. The course enables people working in Oxfordshire to develop a common understanding and approach when there are concerns for people's safety. OHFT is providing a trainer to support this training.

For a retrospective understanding of what has happened to people, there is now a system in place to review all deaths that occur within Oxfordshire across all agencies. OHFT is engaged with this work.

Staff Working

From the point of becoming junior managers, OHFT has a training programme in place to ensure all managers are able to implement the safer recruitment process. There is a robust structure in place to ensure the appropriate checks are completed on staff and repeated 3 yearly during their employment.

During 2016 the Care Quality Commission (CQC) published their report following their comprehensive inspection of the Trust. The Trust was rated as 'good' overall and 'good' for 14/15 of its core services. It was identified within this report that staff would feel confident to raise issues if they felt concerned. To support people to do this, the Trust has a Freedom to Speak up Guardian, who offers independent and confidential support to staff who wish to raise concerns that could affect patient safety. The role was created following recommendations made by the Freedom to Speak Up Review conducted by Sir Robert Francis and the aim is to promote a culture where staff feel safe to raise any concerns.

Working with Adults at Risk

Throughout 2016/17, the Trust has demonstrated a robust response to allegations that may have implications for the safety of patients. Where necessary, people are facilitated to contact the police and make their own reports into the system. This helps promote the person's autonomy and empower them to ensure their goals are achieved.

The Trust has designated places of safety for people who may be very vulnerable but have not been subject to any formal mental health assessment. These areas are subject to CCTV monitoring. The CCTV has been effective in monitoring what happens in the interests of both patients and staff.

For day to day issues, all of the ward areas across OHFT have a system to display publicly the issues raised by patients and visitors and the action they have taken to respond to these issues (you said ... we did). This process helps ensure that issues are explicitly responded to.

Radicalisation and Exploitation

Radicalisation continues to be a high profile concern nationally. To raise awareness about possible radicalisation amongst those who are vulnerable, the national training programme (WRAP 3) has been implemented in the Trust. The techniques used to influence people susceptible to radicalisation can be similar to those used to exploit people. During 2016/17, Oxford Health supported police lead operations to disrupt gangs who were exploiting people.

Key challenges in relation to safeguarding for 2017-18

In Oxford Health, the key areas of development related to the safeguarding of adults during 2017/18 will be:

1. **Pressure Ulcer management:** Pressure ulcers can be an important indicator of quality of care. Preventing the occurrence of pressure ulcers requires engagement of the patient, carers and any agency working with the person. This can be high challenging for the teams working in the community.
2. **Transition of learning disability services from Southern Health NHS Foundation Trust to OHFT:** It is expected that in 2017/18 OHFT will take over the provision of community and forensic learning disability services in Oxfordshire. With any significant change, there can be disruption of care for service users. There is robust project management in place to reduce this risk. The transition of services will be evaluated.
3. **The Think Family Agenda** is identifying that there can be gaps in people identifying the children of parents who are admitted for mental health treatment. This can delay the effective support of the children. During 2016/17 there will be on-going work with the safeguarding children team to help develop robust systems.

Cherwell District Council (CDC)

Introduction of a dedicated Safeguarding Officer

An independent review of the Cherwell District Council's (CDC) Safeguarding Policy and Procedures in 2015 recommended the appointment of a dedicated Safeguarding Officer. This post was recruited in October 2016 and started in February 2017.

Employee Training

The Designated Safeguarding Officer (DSO) has delivered safeguarding training at the Managers Forum and Staff Briefings during the year to raise awareness amongst staff of their responsibilities in relation to safeguarding. The importance of a good safeguarding culture has also been advocated by the Chief Executive at quarterly all staff briefings and the Designated Safeguarding Officer (DSO) has also conducted training for elected Councillors.

Management are aware of the safeguarding training requirements for them and their teams and resources of the Oxfordshire Safeguarding Children Board/Oxfordshire Safeguarding Adults Board are utilised to fulfil this. At this time, the recording of training is not centrally recorded but a project has been initiated to develop a training register to ensure more accurate recording of training requirements and completions. This will be a key responsibility of the Safeguarding Officer upon commencement of employment.

Safeguarding Governance

Safeguarding Leads have been appointed across CDC who are responsible for the adherence of their service areas (those of greatest exposure to vulnerable groups) to the CDC's Safeguarding Policy and Procedures. These Leads meet on a bi-monthly basis to review safeguarding intelligence (including information to feed into the Section 11 return), discuss best practice (including the use of toolkits), consider legislative change and the impact it may have on CDC, agree strategy, identify areas of concern/weakness and develop/track action plans where necessary.

The corporate service planning process now also requires Heads of Service to provide more detail around how they safeguard children, young people and vulnerable adults during the course of service delivery.

A recent external audit of corporate performance reporting for CDC considered Safeguarding and recommended that the internal escalation process be captured in the process notes that accompany the Safeguarding policy. This will be actioned within the first 2 quarters of 2017/18.

Safeguarding in the Community

Following the decision by Oxfordshire County Council to close/reduce services at a number of Children's Centres across the district, CDC, through its Young People, Play and Wellbeing Partnership, is supporting children's centres in bidding for funding to enable them to continue to provide universal services. The partnership is also working with local voluntary groups to pick up areas that will be lost as a result of the closures. Without such easily accessible resources, vulnerable parents may not be able to get the vital support they need.

Taxi Licensing

The CDC Licensing team has played a key role, as part of the Joint Operating Framework, in implementing mandatory safeguarding training and assessment as a condition for obtaining a taxi licence in Cherwell.

The licensing team have been instrumental in instigating a 'Hotel Watch' initiative in the district which raises awareness of Child Sexual Exploitation (CSE) amongst all businesses offering accommodation and other services during the night time. This includes the conducting of test purchase operations at hotels (i.e. where an older male with a clearly younger female tries to book a room) to verify their application of appropriate safeguarding procedures. 50% of businesses failed the test purchase and were revisited and re-educated.

The licensing team are also working alongside Thames Valley Police (TVP) in implementing and promoting a joint 'Night Time Economy' plan. This involves safety checks of licensed vehicles, test purchases to ensure licensed drivers are aware of the law, visits to licensed premises to ensure compliance with conditions and in December manning a 'Departure Zone' in Banbury to give out advice to customers and help ensure they made it home safely.

Planned activity for 2017-18

- **Development and implementation of a robust training framework during 2017.** This will formalise the training requirements depending on the exposure that each role faces to children, young people and vulnerable adults and the level of responsibilities that each has for their protection. The training relies on the resources of the Oxfordshire Safeguarding Children Board/Oxfordshire Safeguarding Adults Board (online and face to face courses) and we are sourcing the services of external trainers to provide more specialists training where required, i.e. mental capacity act, safer recruitment etc. Regular awareness sessions will be developed and delivered to look at different subject areas, refresh knowledge of internal procedures and will be open to all staff. Our training will also extend to the development and delivery of member engagement sessions to raise awareness of safeguarding amongst our counsellor population. A centralised safeguarding training register will be developed which will accurately document the training requirements of all employees and record completions. It will act as a monitoring tool to track expiration and refresher.
- **Development of a formalised Communication Plan.** To schedule regular awareness raising communications via the all staff newsletter, poster campaigns and introduce an annual safeguarding week to be held early 2018.
- **Formalise the role of the Quarterly Safeguarding Leads Meeting.** Introduce a terms of reference for the group to outline the role and responsibilities of the leads in ensuring adherence of CDC with the Safeguarding Policy and associated procedures.

- **Review the Safeguarding Policy and associated procedures.** This will include the conducting of audits of higher risk service areas (e.g. Housing, Customer Services, Leisure, Revenue and Benefits) to ensure procedures in place are adequate and operating as intended to meet the requirements of the policy. These audits may also extend to our contracting partners (e.g. housing providers and to gain confidence that they are operating in line with expected standards in terms of safeguarding).
- **Develop the in house concern reporting system 'See it; Report it' to provide better reporting and encourage staff to use it.** The current system provides a mechanism for reporting any types of concerns (specifically relating to the safeguarding and protection of vulnerable groups in our communities) that our employees may encounter during their day to day activities. We have a repository for recording these concerns; however, the reporting capabilities are currently limited. Improvements will be made to the reporting form and recording system to ensure greater detail is captured and an improved reporting capability. Intelligence and data can then better inform multi-agency discussions and provide overarching statistics.

Oxford City Council

For Oxford City Council safeguarding and the wellbeing of children and vulnerable adults is a corporate priority and the Council is actively striving towards best practice in this area of work.

Working in Partnership

The Council's external partnership working has continued to strengthen through regular attendance at strategic and operational Boards and Working Groups. These include Oxfordshire Safeguarding Children Board and Oxfordshire Safeguarding Adults Board Working Groups which drive forward the Boards key areas of work on Performance Management, Policy Development and Training.

The Council's Policy and Partnership Manager has also actively participated in a number of operational steering groups on behalf of the districts.

Integration of a safeguarding clause into lease renewals for community centres to ensure that they are aware of their key safeguarding responsibilities and that these are acted upon.

Safeguarding Training Programme

Oxford City Council has a comprehensive safeguarding awareness package. This has been fully reviewed and updated by a working group this year. We have 8 internal trainers to deliver these sessions throughout the year. This training subgroup has met quarterly to support the delivery.

A safeguarding training package has been developed and delivered for elected members through the year. All current members have attended one of these sessions.

The total number of staff that have received safeguarding training between 01/04/16-31/03/17 is 624.

Further to the results of the safeguarding questionnaire from 142 staff, we identified the need to deliver training to our staff on the Mental Capacity Act. We have sourced and commissioned an external trainer to deliver this training. To date over 100 members and staff have completed this training within the last 4 months.

Safeguarding awareness training is tracked and monitored through Itrent (the Council's Human Resources Electronic Record System).

Licensing Standards

Oxford City Council has led the development of the Joint Operating Framework for Taxi Licensing. The aim is to have standard requirements for safeguarding measures for all taxi services across the Oxfordshire local authorities. It includes an agreed level of checks, standard training packages and improved information sharing across agencies. This is now well developed and monitored by Oxfordshire Safeguarding Children Board.

Language Schools

The Community Safety Team have played a key part in the Language School Forum this year, driving forward a set of actions to further develop partnerships with language schools and encourage a consistent safeguarding framework in language schools across the city.

Hotel Watch

Oxford City Hotel Watch was established to build closer relationships with Thames Valley Police, Oxford City Council and the hotel industry. It is aimed at helping to identify offences that take place in hotels and other forms of accommodation and to protect vulnerable people from exploitation.

Safeguarding Coordinator Role

Permanent appointment of a Safeguarding Coordinator. This role has actively supported internal and external partnerships and has taken a lead in the support and progression of the Council's Safeguarding Action Plan 2017/18. This is now complete.

Priorities to focus on 2017/18

Oxford City Council have developed a Safeguarding Action Plan 2017/18.

The key areas of focus include:

- Central recording system - centrally collate concerns raised within teams as well as external referrals/requests for assessment/welfare checks. This would give the Council the ability to recognise pockets across the city that perhaps have high numbers of safeguarding concerns and be able to feed this knowledge into local plans when developing service provision.
- Ensure that our Safeguarding Training Programme continues to meet the needs of staff, is kept up to date and evaluated.
- Ensure that departmental safeguarding policy and procedures align with the corporate policy and procedures and introduction of a central reporting system.
- Developing a Safeguarding Communication Strategy that delivers key safeguarding messages throughout the year (to staff and local residents) and to ensure that relevant information is provided in a child friendly format.
- Ensure that there is effective and integrated working with the Oxford Community Safety Partnership Strategies and Plans.
- Agreeing and prioritising which safeguarding assessment tools are to be used (for example Child Sexual Exploitation and Neglect) and to enable staff to use them effectively.
- Ensuring volunteers are provided with opportunities to have the safeguarding training they require.

Thames Valley Police

Safeguarding remains at the heart of the response by all officers and staff in Thames Valley Police (TVP). We are dedicated to work in partnership to keep people safe and hold perpetrators to account. The police inspectorate, Her Majesty's Inspectorate of Constabulary (HMIC) in the 2016 Effectiveness Inspection judged the force to be good. *"It is good at protecting vulnerable people and provides the right support to them in conjunction with partner organisations. Officers and staff are trained to recognise when a person is vulnerable and there are good systems in place to assess and address risks to vulnerable people. Frontline officers display a good knowledge about how to identify a vulnerable person. An enhanced training course, known as safeguarding, vulnerability and exploitation (SaVE), has ensured that their knowledge of vulnerability has increased. SaVE training also encourages front line staff to place a vulnerable person's needs at the centre of all police work."*

Building on this TVP have introduced the SaVE 2 training to further explore our identification of and response to vulnerability and safeguarding for the front line uniformed staff. There has also been SaVE specialist training for the detectives and SaVE training for our senior leaders.

Domestic abuse remains a core area of business for TVP and our priorities include increasing prosecutions and reducing the repeat victimisation of people in our communities. We have specific teams to deal with high risk cases, and there is significant multi-agency work that is completed to help protect the victims of Domestic Abuse, but less so to tackle the perpetrators. TVP have been active in forming the joint strategy for domestic abuse across the partnership in Oxfordshire. This will be an exciting challenge for us over the next year and we believe the new strategy will significantly contribute to safeguarding more victims and their children who are at risk of harm from domestic abuse. TVP are putting more focus on the perpetrators and hope to have a perpetrator programme available to divert people towards. The TVP offender managers will also be available to focus on these types of perpetrators to reduce the harm they pose.

Honour Based Abuse continues to be an area of concern for Thames Valley Police and during the last 12 months we have trained specialist officers investigating honor-based abuse to ensure we maintain and improve our effectiveness in this area as we work to protect people from harm.

The Domestic Abuse Unit have been actively engaging with the Care Quality Commission (CQC) as part of our responsibilities to jointly investigate care home deaths and share expertise to better safeguard vulnerable adults in receipt of care. In order to more effectively implement this, we have taken part in joint training and liaison and have worked jointly to investigate a number of incidents and continue to develop a closer and more efficient working relationship where we can both learn and develop each other to better provide a quality service.

As a service we continue to work with new legislation dealing with coercive control and stalking offences in a Domestic Abuse setting and this presents a challenge for investigators and support agencies. In Oxfordshire we have had recent success in gaining charges for Coercive Control and stalking and continue to work with the Crown Prosecution Service to bring those perpetrators to justice and protect the victims using this new legislation.

Exploitation of vulnerable adults is an emerging issue for Thames Valley Police. Vulnerable adults are also being targeted where drug dealing takes place in their homes, and they are being exploited in numerous ways by county line drug dealers. The police are responding to bring perpetrators to justice and disrupt their activities and safeguarding pathways need to be defined.

During 2016/17 we have developed a monthly partnership meeting (Vulnerable Adults Meeting) where we are able to identify those adults we believe are at risk of exploitation/are being exploited. We have then been able to work with partners such as Turning Point, Salvation Army, Adult Social Care and Housing to get these individuals reengaged with the support that is available. We have also been able to use this as an opportunity to share information and gather intelligence to support our enforcement work and disrupt those offenders who are preying on vulnerable people. We have worked with Housing officers to safeguard vulnerable adults through the use of Closure Orders. We

have persuaded Registered Social Landlords to work with us and not seek eviction when we seek a closure order. (An order is mandatory grounds for possession). The orders help those vulnerable adults who are not able to police their own front door by providing powers of arrest for anyone found in breach of an order. Officers will regularly check addresses subject to an order and in many cases the vulnerable adults have provided statements saying they support the order as it prevents them being exploited by drug lines looking to use their premises. We have used 15 closure orders in this way across the local police area since January 2017. In March 2017 we had Operation Reacher in Banbury. This was an operation which saw 7 warrants executed at addresses of vulnerable adults in order to disrupt county drug lines. Seven arrests were made in connection with the supply of controlled drugs a quantity of class A drugs seized and seven closure orders granted on these addresses in one day. One vulnerable adult was referred to the National Referral Mechanism due to a disclosure in relation to modern slavery. We have continued to work with our partners to safeguard vulnerable adults in this way and it has proved to be an effective tactic.

Changes to the Bail Act came into force in April 2017 and this has presented challenges when safeguarding victims from both a police and partner perspective where bail with conditions was not achievable. This necessitated a review of the measures available to protect victims and involved many joint agency conversations and an increased use of Domestic Violence Protection Orders to successfully protect victims.

Key challenges for the coming year include the need to develop a perpetrator programme to address the behaviour of serial perpetrators with a proven programme to educate and prevent on-going abuse. There is also a need to train more officers in the use of preventative powers or protection orders to protect victims and improve their confidence in obtaining these orders.

Oxfordshire Clinical Commissioning Group (OCCG)

An Assurance Audit of GP Safeguarding Practice in Oxfordshire

The Oxfordshire Clinical Commissioning Group (OCCG) safeguarding team undertook an audit in July 2016 of GP's safeguarding practice for adults and children. The audit, based on section 11 of the Children Act and the Care Act 2014 requirements, was designed by a team of Named GPs in the Thames Valley Safeguarding Network, supported by NHS England. It was circulated to safeguarding leads and practice managers in Oxfordshire primary care practices. The practices were asked to assess themselves and rate their practice under the standards statements as red, amber or green (RAG rating). They were asked to identify evidence demonstrating compliance and areas for development with a time scheme for achieving this. A thematic analysis identified areas in which practices needed continued support and improved resources.

Results

Responses were received from 61/75 practices (81% return). Overall all practices were able to present evidence of compliance with good practice. Within the sub sections there were areas for improved and further development, discussed below.

Themes from the analysis

Training needs

In general, practice self-assessment of training levels was good in core safeguarding knowledge. Areas for development were focused on requiring further training in specific areas of safeguarding knowledge (Prevent Strategy, child sexual exploitation, female genital mutilation, Mental Capacity Act, and Deprivation of Liberty Safeguards). These are emerging areas of knowledge development required because of local and national drivers.

Policy development

Safeguarding leads highlighted the need for more rigorous practice policies in some areas, particularly adult safeguarding, and GP's contribution to case conferences. Several practices identified documenting feedback from children and young people, as not generally embedded in GP practice culture and requested help with this. Some practices felt they required more understanding of escalation policies.

Record keeping

Other areas raised related to the complexity of record keeping in safeguarding situations, for example how to minute all safeguarding discussions and case reviews, and a need for clearer guidance around record keeping and information sharing in split families.

Discussion

This self-assessment exercise identified a wide variation in safeguarding need across practices in the county. Developing local networks in 2016 has enabled the sharing of good practice and supporting the improvement of safeguarding across the county.

Actions

Improvements to the safeguarding website such as increasing the easy access via links to key safeguarding documents.

- Draft policy templates sent to practices for local adaptation.
- Focused adult safeguarding training sessions provided to address identified knowledge deficits such as Prevent, Mental Capacity Act and Deprivation of Liberties Safeguards and learning from partnership reviews.
- Opportunities for primary care to join multi-agency training and learning events included in the General Practitioner (GP) newsletter and at regular safeguarding leads meetings.

- Support to practices for training by providing information and resources.
- The audit tool used was subsequently adapted for use across small contracts within joint commissioning and public health. It will be added to the annual audit cycle

Provider Contract 2017-19 update

Safeguarding reporting requirements for providers have been standardised. The Oxfordshire Clinical Commissioning Group (OCCG) Quality Team has established regular safeguarding support and monitoring meetings with providers, providing opportunities to share good safeguarding practice across the health teams and services. A new dataset to identify safeguarding activity will provide assurance and identify concerns as they arise with performance. The dataset is included in the updated contract for 2017-19. The smaller independent providers will submit a safeguarding audit annually and will continue to be assessed against national standards.

Annual Safeguarding Self-Assessment

The Oxfordshire Clinical Commissioning Group's safeguarding self-assessment to the Oxfordshire Safeguarding Boards provided evidence of compliance for all the standards.

The return included an assessment of staff knowledge from within organisations. Questionnaires were returned from 25% of staff across the directorates. Within the OCCG staff knowledge was found to be of a good standard, commensurate with their roles, with everyone aware of how to access procedures and advice when required. 76% of staff felt they would be confident to ask providers about safeguarding issues. Those identifying a lack of confidence would not normally contact providers directly. 96% of staff were clear about how to manage allegations about a staff member and 100% were able to name the organisational safeguarding leads.

Oxfordshire's Focus on Mortality Review Processes

Following the publication of the Mazars review, OCCG has undertaken a retrospective review of all deaths of Oxfordshire people with learning disabilities in the period of the review (1/4/2011 – 31/3/2015). 106 patients were reviewed. Wherever possible the next of kin has been identified, contacted and asked how they would like to be involved. Of the 106, 60 were closed with the decision being made that we had sufficient evidence to conclude that there were no significant deficits in their care and that we had sufficient information to close. For 6 there were existing investigations. For the remaining 40 we took the decision that we needed to seek out further information.

For these 40 cases, the agencies involved in their care were requested to undertake a case audit. There was a focus on the areas identified by Mazars as requiring further scrutiny (delays in referral treatment, dysphagia assessments and nutrition). We then held two multi-agency events where multidisciplinary groups were asked to review the cases. The results of these events are currently being prepared.

On 13th December 2016 the Care Quality Commission (CQC) published '*Learning, Candour and Accountability*'. The report was the result of a year-long investigation of how deaths are reported and investigated and how families are engaged with. The report recommendations have all been considered as part of the wider development of a multi-agency review process.

Health care providers commissioned by the Oxfordshire Clinical Commissioning Group (OCCG) have all reviewed and updated their process for reviewing deaths within their services. All undertake mortality reviews. OCCG has also led on the establishment of a subgroup of the Oxfordshire Adult Safeguarding Board to review the deaths of people with learning disabilities and other vulnerable adults. The Vulnerable Adults Mortality subgroup will be informed by the mortality reviews being undertaken in provider services and provides a structure for sharing issue and learning across the partnership. The group has agreed a process similar to the well-established Child Death Overview Process.

West Oxfordshire District Council

Achievements 2016/2017

- During the year West Oxfordshire District Council undertook a comprehensive review of policies and procedures. These were revised so that they now cover children, young people and vulnerable adults in the same document thus giving a single reference point for staff.
- The Safeguarding Leads have undertaken additional training in respect of vulnerable adults.
- West Oxfordshire District Council has been fully involved in the Prevent initiative and the Channel Panel and ensure that key staff are familiar with the requirements of the Counter Terrorism & Security Act (February, 2015). Training is also in place for staff.
- The Safeguarding Leads met with the Chair of Oxfordshire Safeguarding Adults Board (OSAB) to discuss issues and future relationship with the board.

Planned Activity/Challenges 2017/2018

- To review the training requirements of staff. As a District Council we tend to have as much interaction with vulnerable adults as other groups. Therefore, it has been identified that frontline staff need to be properly trained. Specific areas such as housing, revenues and benefits and parking have been identified as key target areas for training and awareness.

- The Lead Safeguarding Officers also plan to engage more with elected members on issues associated with vulnerable adults. The Cabinet portfolio holder is already 'on board' and it is planned to have awareness sessions/briefings with councillors.
- On a corporate basis the continuing budget issues will be a challenge for the council.
- The council is moving to a new management model later in the year and it is a target to ensure that safeguarding is fully considered and covered in any new structures to ensure that all requirements are met.
- The council aims to strengthen its relationship with OSAB and ensure that we are fully participating.

Safeguarding Self-Assessment 2016-17

In 2016, the Oxfordshire Safeguarding Children Board and the Oxfordshire Safeguarding Adults Board worked together to produce a joint safeguarding self-assessment for agencies to complete.

In summary the returns demonstrated good compliance and regard to safeguarding practice as well as positive direction of travel.

Five agencies state that they meet all points and can 'evidence best practice' for the majority of the standards (six or more).

Strengths were:

- Senior management commitment is strong (1A)
- Information sharing is effective (2C)
- Safer Recruitment and Vetting procedures are in place and working (3B)
- The Effectiveness of the Safeguarding Boards is deemed sufficient (1C)

The main area for improvement across all agencies was:

- Involvement of Service Users in Service Development (2A) where the responses were not as robust as other areas

Based on the main area of improvement, the following action has been added to the OSAB Business Plan for 2017-18:

***Empowerment** - Gaining feedback from users of safeguarding services and involving them in the strategic development of safeguarding and at OSAB meetings.*

This will be achieved through audits of User-defined Outcomes information recorded by Social Care. Healthwatch will also be approached to facilitate safeguarding service user engagement to better understand the journey of someone experiencing a safeguarding issue.

Oxfordshire Safeguarding Adults Board in 2017-18

OSAB Strategic Plan – 2017-2018

This document outlines the vision, strategy and business plan for Safeguarding Adults in Oxfordshire. The Oxfordshire Safeguarding Adults Board is a partnership committed to working together to ensure local safeguarding services are effective. Its remit is to lead the strategic development of adult safeguarding and to hold agencies to account for their safeguarding work.

Our Vision for Oxfordshire

“Oxfordshire is a place where safeguarding is everyone’s responsibility, where the OSAB partners work together to recognise and prevent abuse so that adults at risk from harm feel safe and empowered to make their own life decisions.”

Principles and Values

The Principles and Values of the OSAB are as follows:

Prevention: *All organisations will have the necessary culture and structures in place to work to prevent abuse from occurring; which takes all concerns seriously, working transparently and enabling swift proportionate interventions at an early stage. There is active engagement with all sections of the local community so that everyone is well informed about safeguarding and related issues.*

Proportionality: *All staff and volunteers in whatever the setting have a key role in working towards preventing abuse or neglect from occurring and in taking prompt, proportionate action when concerns arise. All staff and volunteers will have the appropriate level of skills, knowledge and training to safeguard adults from abuse.*

Empowerment: *Any intervention and support provided is person centred and focused on the outcomes identified by the individual. People must be supported with dignity and respect and be in control of decision making as much as possible; enabling individuals to safeguard themselves from harm and to be able to report any concerns that they have.*

Governance: *There is a robust outcome focused process and performance framework so that everyone undergoing safeguarding procedures will receive a consistently high quality service which is underpinned by multi-agency cooperation and continuous learning. The Board and its partners are accountable for what agencies do and learn from local experience and national policy.*

Our Priorities for 2017-18

Following the principles and values above, the Board has agreed the following priorities for 2017-18.

Prevention - It is better to take action before harm occurs.

- Developing a prevention and early intervention strategy

Proportionality - Proportionate and least intrusive response.

- Championing the multi-agency approach to safeguarding

Empowerment - Presumption of person led decisions and informed consent.

- Running Stakeholder events (public, service users, grass roots organisations and staff)
- Gaining feedback from users of safeguarding services and involving them in the strategic development of safeguarding and at OSAB meetings.

Governance - Ensuring the Board is fit for purpose and working effectively

- Ensuring Making Safeguarding Personal is fully implemented across the partnership. (R2.1)
- Ensuring the data collected by the Full Board provides a full picture of safeguarding activities and issues. (R2.2)
- Ensuring that all partners are encouraged and enabled to take on a leadership role (R2.3.1)
- Reducing the paperwork associated with the Board (R2.4)
- Reviewing the operational changes within Oxfordshire County Council's (OCC) safeguarding service. (R2.5)

Joint Working – working together with the Oxfordshire Safeguarding Children Board to ensure people are protected from birth until end of life.

- Ensuring the work done with children transitioning to adult life is exemplary and offers them the best possible life chances, optimising opportunities.
- Ensuring domestic abuse services within Oxfordshire are fit for purpose and support victims and their dependents while ensuring high levels of prosecution of perpetrators
- Ensuring the workforce within Oxfordshire undertake high quality safeguarding training that meets the needs of staff and volunteers, giving them the skills to work with safeguarding issues.

OSAB Business Plan 2017-18

The OSAB Business Plan is designed to address the priorities agreed in the strategic plan, detailed above.

No.	Theme	Action Required	Subgroup	How	Success Measure
1	Prevention It is better to take action before harm occurs.	Developing a prevention and early intervention strategy	Executive Group	Task & finish group to develop guidance	People at risk are identified at an early stage and offered appropriate advice and support before a crisis develops
2	Proportionality Proportionate and least intrusive response appropriate to the risk presented.	Championing the multi-agency approach to safeguarding	All Board Members	Clear statement in all agency safeguarding policies regarding multi-agency working	Staff across all agencies are clear on their safeguarding responsibilities and those of other partners and involve partners appropriately in safeguarding work
3	Empowerment Presumption of person led decisions and informed consent.	Ensuring Stakeholder events (public, service users, grass roots organisations and staff).	Executive Group	Healthwatch to be approached to facilitate a service user engagement subgroup/panel	Increased numbers of service users involved in safeguarding adults work. People at risk have a voice and are able to influence change
4		Gaining feedback from users of safeguarding services and involving them in the strategic development of safeguarding and at OSAB meetings. (R2.3.2)	PIQA	Audits of Outcomes information recorded by Social Care. Healthwatch to be approached to facilitate a service user engagement subgroup/panel	Increased numbers of service users involved in safeguarding adults work. People at risk have a voice and are able to influence change
5	Governance <i>[picks up peer review and</i>	Ensuring Making Safeguarding Personal is fully implemented across the partnership	Executive Group	Conduct temperature check, reporting	All agencies are compliant with the requirements of Making Safeguarding

No.	Theme	Action Required	Subgroup	How	Success Measure
	<i>annual report action plans]</i>	through use of the MSP Temperature Check Tool for Local Authorities.		to Autumn Full Board	Personal and can demonstrate this.
6		Ensuring the data collected by the Full Board provides a full picture of safeguarding activities and issues, to enable the OSAB to identify priorities and help evaluate the effectiveness of its collective endeavours.	PIQA	Dataset to come to Full Board for challenge and scrutiny	All Members are satisfied the dataset from the Board gives an accurate and informative picture of safeguarding and is used to focus the work of the Board on those areas of need.
7		Ensuring that all partners are encouraged and enabled to take on a leadership role, such as chairing subgroups.	Executive Group	Review current Chairs and make recommendations for Summer 2017 Full Board	All Members are in agreement that leadership roles within the Board are appropriately shared across the partnership.
8		Reducing the paperwork associated with the Board to ensure Members have clarity in regards to the Board, its role and purpose.	Executive Group	Streamlined documentation to be created and brought to Summer Full Board for sign off	Documentation is reduced to a minimum, that it uses plain English and that it has a clear summary if over 10 pages (excl Report Cover Sheet and appendices).
9		Reviewing the operational changes within OCC's safeguarding service to understand impact these arrangements have had on partners, how capacity and demand	Full Board	Report to be provided for the Autumn Full Board	All members are assured that OCC , who have responsibility for safeguarding, are sufficiently resourced and working effectively and that partners are fulfilling their role in supporting

No.	Theme	Action Required	Subgroup	How	Success Measure
		is managed, whether there has been an increase in handovers, and how skills within the locality hubs is maintained.			safeguarding investigative work.
10	Joint working <i>[Joint working initiatives the OSAB and OSCB have agreed]</i>	The Safeguarding Boards to work together to agree three top priorities and work jointly on these over the year. For 2017-18 these have been agreed as: • Transitions • Domestic Abuse • Training	Full Board	Twice yearly report to both Boards on progress against this (March & Sept).	Professionals across Oxfordshire are assured that these areas of joint working are approached with a truly “think family” approach, considering the needs of all individuals concerned.

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**DIRECTOR OF
PUBLIC HEALTH
FOR OXFORDSHIRE**

ANNUAL REPORT

X

Reporting on 2016/17
Produced: August 2017

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Foreword

Every Director of Public Health must produce an Annual Report on the population's health.

This is my 10th Annual Report for Oxfordshire.

It uses science and fact to describe the health of Oxfordshire and to make recommendations for the future.

It is for all people and all organisations.

I hope you find it interesting, but more than that I hope it is found to be useful in shaping the County's services for the future.

I am responsible for its content, but it draws on the work of many too numerous to name. I thank you all for your help, support and encouragement.

With best wishes,

Dr Jonathan McWilliam
Director of Public Health for Oxfordshire.
August 2017

Chapter 1: The Demographic Challenge

Let's keep this simple.

There are two major challenges facing Oxfordshire:

- How do we cope with the increasing stresses and strains a growing population brings?
- How do we keep children and adults of all ages healthy so that disease is minimised as the population grows?

Of course there are many other problems and issues, but these two are the overwhelming ones, and this report looks at these two issues from many different angles.

This chapter focusses on the first of these two – the demographic challenge.

The demographic challenge is a challenge because of 5 interlocking factors:

1. The population is growing
2. The population is ageing
3. The proportion of older people is increasing
4. Public expectations are high
5. Money is tight

A further problem is rapidly approaching which will further complicate matters – being overweight is the new norm in adults and increasingly prevalent in younger people, and this will inevitably lead to higher levels of disease – but that's for chapter 4.

Disadvantage also acts as a brake to stop people achieving their full potential and this is another confounding factor – you will find that topic in chapter 3.

Population growth means we have to plan our communities better and poor air quality - generated by more people and more activity – is an important issue - covered in chapter 2.

All of these changes put stresses and strains on the mental wellbeing of young people – see chapter 5.

..... and of course, let's never forget the shadow cast by infectious disease – sleeping, but not defeated - chapter 6.

So let's look first at population growth and population ageing.

Population Growth

Between 2000 and 2015, the total population of Oxfordshire increased by 70,700 people (+12%) compared with 11% across England.

Plans for a significant expansion in new housing, following the Oxfordshire Strategic Housing Market Assessment, imply a growth in the population of Oxfordshire over the next 15 years of more than double that of the previous 15-year period.

Oxfordshire County Council population forecasts, based on expected housing growth, predict an increase in the number of Oxfordshire residents of 183,900 people (+27%) between 2015 and 2030.

This is a massive increase by any standards and will put a huge strain on our already stretched infrastructure such as roads and schools- a factor I will pick up in chapter 2.

Will Government funding of statutory services keep pace? No one knows the answer, but we do know that health and social services are already stretched to breaking point.

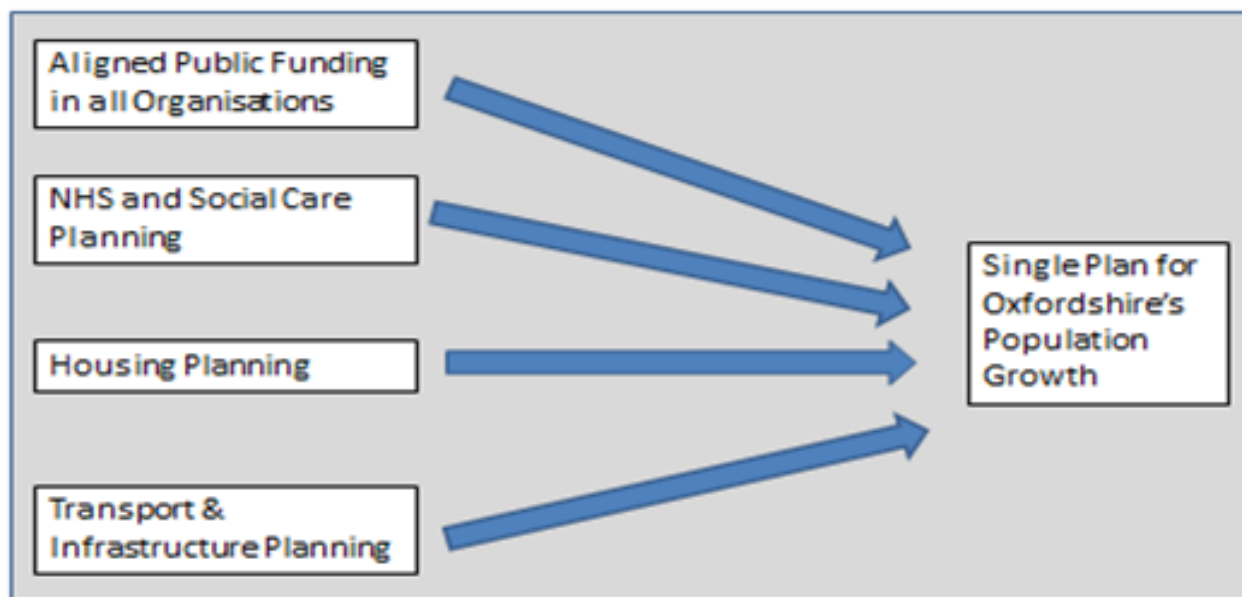
What we also know is that the old ways of doing things aren't likely to cope with such an increase as they stand. Our planning systems need to work far more slickly and intelligently if we are to have the transport systems people will demand. The daily commute will become increasingly tortuous and movement more difficult. Perhaps home working and IT solutions point the way forward.

Of course, people tend not to like change – it's hard-wired into us. During the last year local NHS organisations put forward proposals about radically changing the way hospitals and community services might be changed to cope with this pressure. The response was - to put it mildly - mixed. It's like one of those problems in which you push the problem down in one place but that makes it pop up in another – for example, the NHS proposed increasing the care carried out by people coming to hospitals for the day (ambulatory care), but it is outside the NHS's remit to plan for the increase in journeys and traffic and parking that implies, and so another problem is created.

All of this means that the problem of population growth is too big for any one organisation to cope with alone – we need to harness plans for housing, transport, the NHS and social care to the same yoke so that we can plough a single furrow.

We haven't solved this yet but the problem is staring senior executives and senior Councillors in the face. Necessity will, as always, drive the solution, and the solution we need is to craft a unified planning system.

In simple terms it will need to look something like this:



There are signs that we are closer to this than ever before, and these have occurred during the last 18 months. These are:

- Council Leaders and the NHS, Local Enterprise Partnership and the Universities debating new forms of local Government and Devolution
- The NHS trying to join up the currently fractured system through a single plan
- The Hospital Trusts and Universities reaching out to Local Authority planners to seek a 'joined up' approach.

This is good. These are green shoots. They cause much controversy, but they are clear signs that all the big organisations are saying 'we can't go on as we are' and that is always the first step. No one knows where it will lead, but we seem to have begun the journey, and this is to be welcomed, for the problem of population growth is very real and the solution is likely to be radical.

Expected growth in housing

The plans for housing growth recommended for Oxfordshire shed a factual side-light on the scale of future population growth. In April 2014 the Oxfordshire Local Authorities, published the Strategic Housing Market Assessment (SHMA) for Oxfordshire.

The Assessment suggested that the demographic trends and growth of the County economy and the level of affordable housing required would necessitate **100,060** additional new homes in Oxfordshire between 2011 and 2031. More houses mean more people. There are currently over 600,000 people living in Oxfordshire. 100,060 more houses will swell this number considerably.

Up to the end of March 2016, just under 11,700 homes had been built in Oxfordshire and, since 2011, the year with the highest rate of housing completions was 2015/16 with 3,350 homes built. This leaves a remaining requirement of 88,400 new homes to be built by 2031, or just under

6,000 homes per year for each of the next 15 years. This is a contentious topic and is much debated. Where will the houses go? When exactly will they be built? Will they be grouped to make best use of the 'developer contributions' which can fund the sensible road and transport links we need? The risk is that a piecemeal planning system which doesn't take a view of the whole is less likely to help. This is another reason why organisations need to pull together if we are to cope.

The Strategic Housing Market Assessment represents a view of how Oxfordshire 'should' grow in the national context. Of course it's not just about houses. Houses mean people and people mean more roads, more schools and more workplaces....and more diseases. More people also implies a much higher volume of attendances at GP surgeries and hospitals and more need for social care. All of this requires careful planning and, as highlighted in previous annual reports, there is a widely shared view that our current planning processes are fragmented and won't cope well as they stand. Hence the need to move towards a single planning process.

During the year, a useful start has been made on this and the infrastructure requirements of all organisations across the County have been drawn together in one place in a document called Oxfordshire Infrastructure Strategy. This is a start and is to be applauded. The question is, can this be used to make the disparate cogs of the planning process turn as one smooth machine to serve local people? Only time will tell.

Where will the nurses, home care workers and ancillary staff come from?

The very real and tangible effects of population growth, the relative prosperity of Oxfordshire, low unemployment and sluggish housing growth of affordable housing all combine to create a very big problem for services.

It is becoming increasingly difficult to recruit the staff we need to fill nursing, caring and ancillary posts. In the last few weeks, I attended meetings where the hospital and social care services were spelling this out very clearly. Some hospital wards are for example reported to be running with 25% vacancies. This is unlikely to be sustainable. Looking at local house prices sheds light on this and underlines the problems of high house prices in Oxfordshire. The statistics are as follows:

Housing affordability

- In 2016, house prices in Britain were 10 times the annual salary of residents.
- **Oxford was the least affordable city, with house prices being 16.7 times higher than annual earnings** - on a par with London.
- Burnley was the most affordable city, with house prices being 4.1 times the average annual earnings – 4 times more affordable than Oxfordshire.
- All the top 10 least affordable cities were located in the South of England. The majority of the most affordable locations were in the North West and Yorkshire regions.

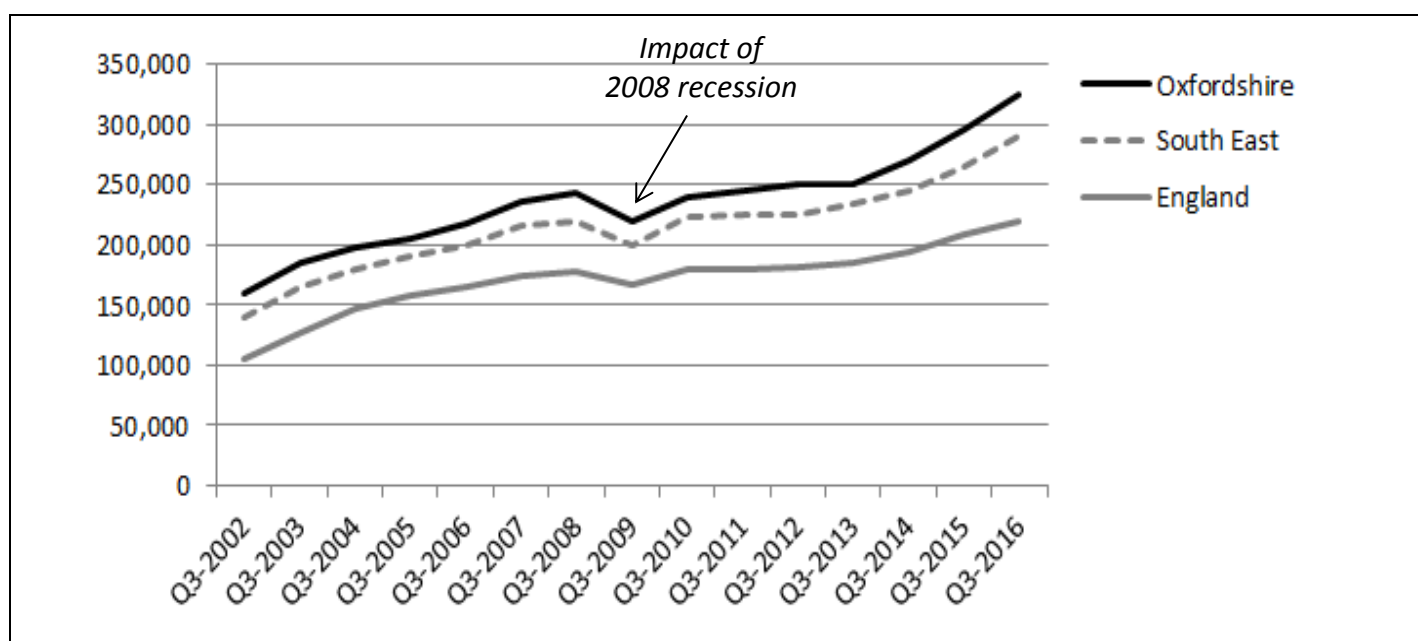
Here is the relevant table.

Rank	City	Affordability ratio	Average house price, 2016 (£)	Yearly wages, 2016 (£)
10 cities with the highest affordability ratio				
1	Oxford	16.7	491,900	29,400
2	London	16.7	561,400	33,700
3	Cambridge	15.8	475,800	30,100
4	Brighton	13.7	367,900	26,800
5	Bournemouth	12.5	309,300	24,700
6	Aldershot	11.6	360,400	31,200
7	Reading	11.3	375,200	33,300
8	Worthing	10.7	279,100	26,100
9	Exeter	10.5	253,500	24,100
10	Bristol	10.4	275,900	26,600

Trends in house prices

Over the past 10 years the increase in the median (mid-point) house price in Oxfordshire has been above the South East region and England. Between 2006 and 2016, the median price of housing in Oxfordshire increased from £218,000 to £325,000, an increase of 49% compared with 46% in the South East and 33% in England. The districts seeing the highest increase were Cherwell (60%) and Oxford (60%). In other words, the local affordability gap is getting worse compared with England.

Median house price 2002 to 2016



Source: ONS released March 2017; These data are part of the House Price Statistics for Small Areas (HPSSAs) release, produced by ONS. These statistics report the count and median price of all dwellings sold and registered in a given year. They are calculated using open data from the Land Registry, a source of comprehensive record level administrative data on property transactions.

Median house price 2006 to 2016

	Q3-2006	Q3-2016	Q3-2006 to Q3 2016	
Cherwell	£183,000	£292,250	<i>£109,250</i>	<i>+60%</i>
Oxford	£235,000	£375,000	<i>£140,000</i>	<i>+60%</i>
South Oxfordshire	£241,100	£355,000	<i>£113,900</i>	<i>+47%</i>
Vale of White Horse	£225,000	£325,000	<i>£100,000</i>	<i>+44%</i>
West Oxfordshire	£212,000	£300,000	<i>£88,000</i>	<i>+42%</i>
Oxfordshire	£218,000	£325,000	<i>£107,000</i>	<i>+49%</i>
South East	£198,950	£290,000	<i>£91,050</i>	<i>+46%</i>
England	£165,000	£220,000	<i>£55,000</i>	<i>+33%</i>

Source: ONS, released March 2017

All services are trying to find new ways to address this problem, and we are likely to need to look beyond the county boundary to developments around, say, High Wycombe to find the solution. Other options such as building hostels for workers are also being considered.

I have dwelt on housing prices because they illustrate with crystal clarity why the demographic challenge is real, it is here now, and it our most pressing challenge.

The ageing population

It is a blessing and a great achievement that people are living longer, often into a productive and active old age..... But it brings with it a new raft of issues for society to deal with.....

Growth of the population aged 65+

Between 2015 and 2030, Oxfordshire County Council predicts that the growth of people in the age group 65+ to be, 62,700 or **an increase of 53%**. This takes into account the plans available for new housing.

Growth of the population aged 85+

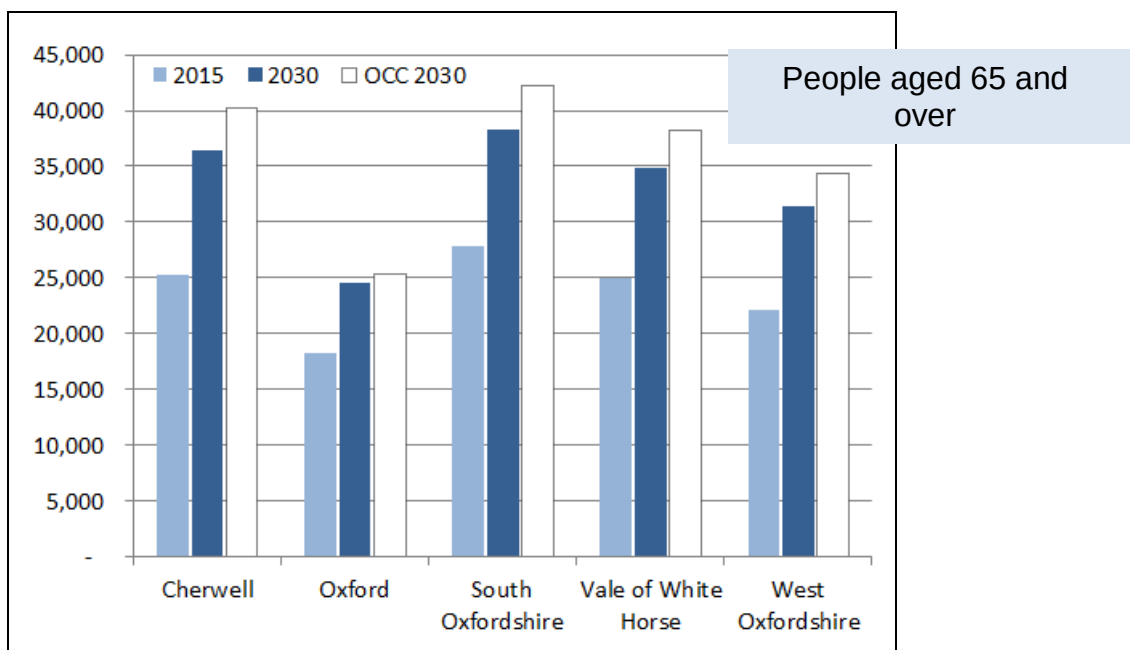
Between 2015 and 2030, Oxfordshire County Council predicts that the increase in people aged 85 and over in Oxfordshire to increase by +15,600 or **an increase of 96%** - a huge percentage increase.

Why does this matter? It is to be welcomed that life expectancy is increasing and in terms of opportunities it has been said that “70 is the new 50”. But in planning terms it presents a serious dilemma. It matters because as well as being simply more people, it means more people in the age group who experience most long term disease and disability, and, with advances in treatment and care that means more expense per head than in previous decades..... and not only that.....

.....It matters also because at the same time the proportion of older to younger adults is increasing and this puts a pressure on the tax-base. Every penny going into the exchequer has to be made to go further while the demand on every pound increases.

Looking at this in more detail, different parts of the county are affected differently. The chart below tells the story. It shows the 65 plus population in 2015 and then shows two growth scenarios for 2030. The middle bar in each group shows the growth without house building and the bar on the right of each group takes account of what we know of planned housing growth.

Forecast growth in the number of people aged 65 and over between 2015 and 2030– ONS vs Oxfordshire County Council projections



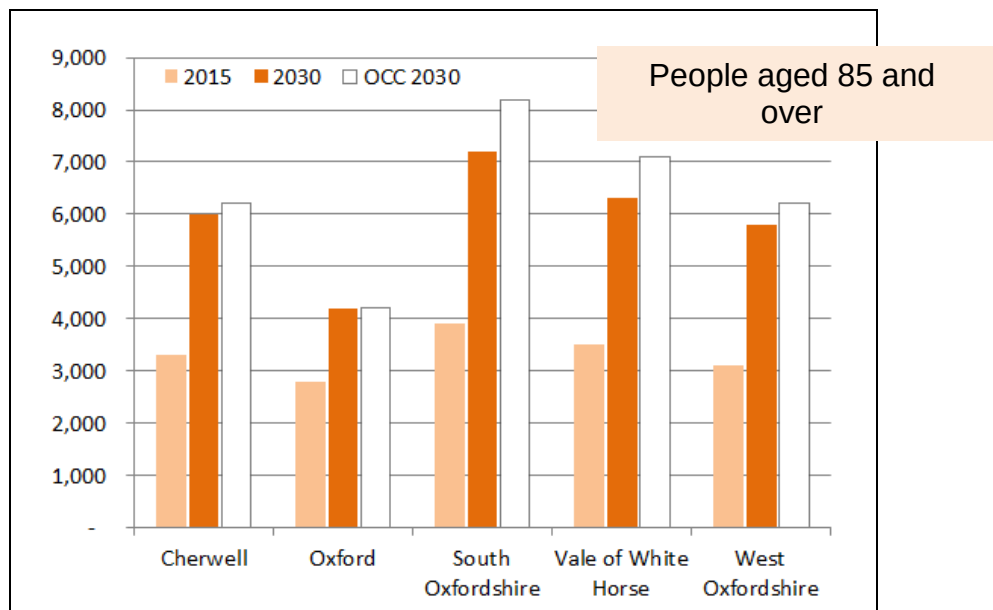
Source: ONS 2014-based sub-national population projections and Oxfordshire County Council released December 2016 including assumptions on expected housing growth

It shows that:

- The rate of growth is pretty evenly spread across all Districts
- Housing increase swells the numbers considerably, apart from in Oxford where housing growth is constrained

Looking at the same data for over 85's using the same format gives the picture below:

Forecast growth in the number of people aged 85 and over between 2015 and 2030 ONS and Oxfordshire County Council projections



Source: ONS 2014-based sub-national population projections and Oxfordshire County Council released December 2016 including assumptions on expected housing growth

It shows that:

- There is uneven growth. The city is the outlier as it has a 'younger' population.
- Housing growth adds to the predicted rise more in South Oxfordshire and Vale of the White Horse than elsewhere.

OK, one might ask, so ***the population is ageing, but is it getting healthier?***

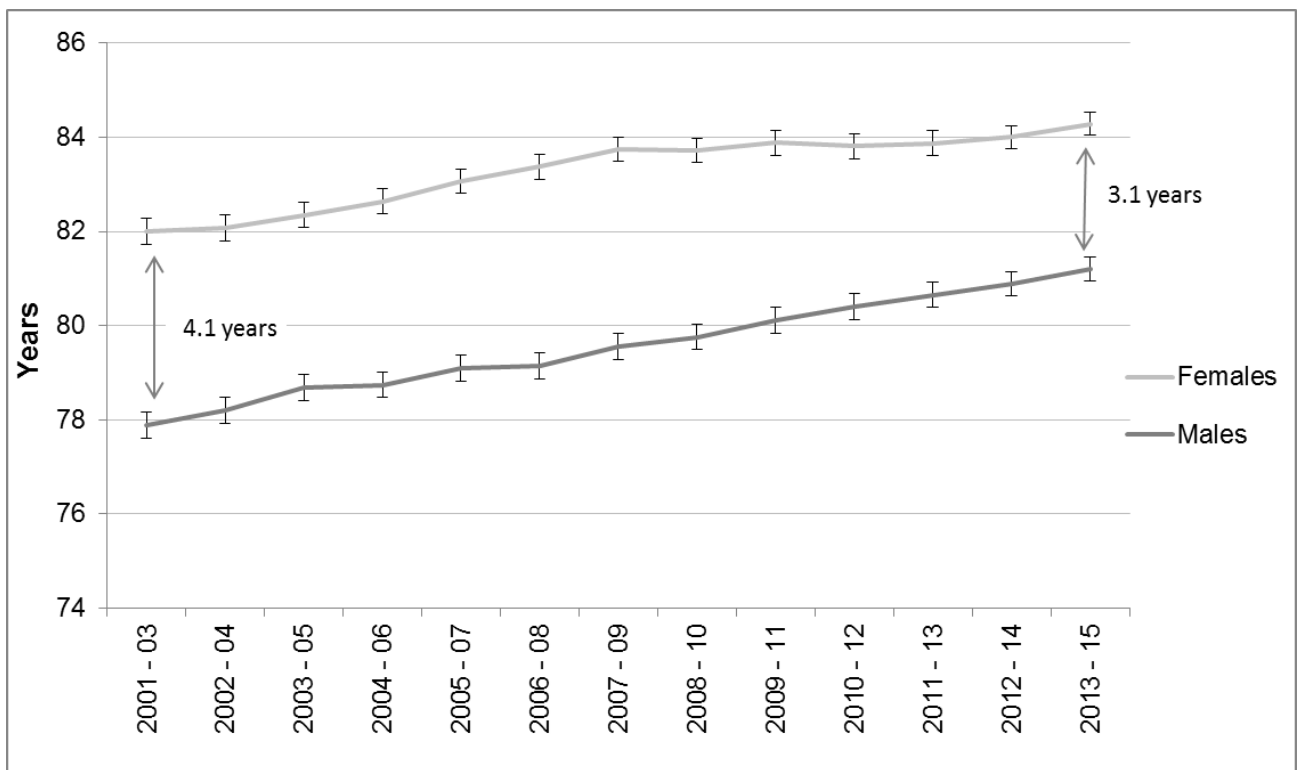
.....An interesting question with no easy overall answer.

We can shed light on it by comparing two statistics.

The first is called 'life expectancy at birth' which estimates the average number of years a person born in an area could expect to live if they were to experience that area's mortality rates in the future. It's a best estimate, as no one really knows the exact answer.

It predicts that both males and females will continue to live longer. The gap between male and female life expectancy in Oxfordshire is narrowing. The gap in 2013-15 is the same as it was in 2012-14. A similar narrowing can be seen for England and in the South East region, so this is a national trend.

**Male and female life expectancy at birth in Oxfordshire,
3-year rolling data for 2001-03 to 2013-15**



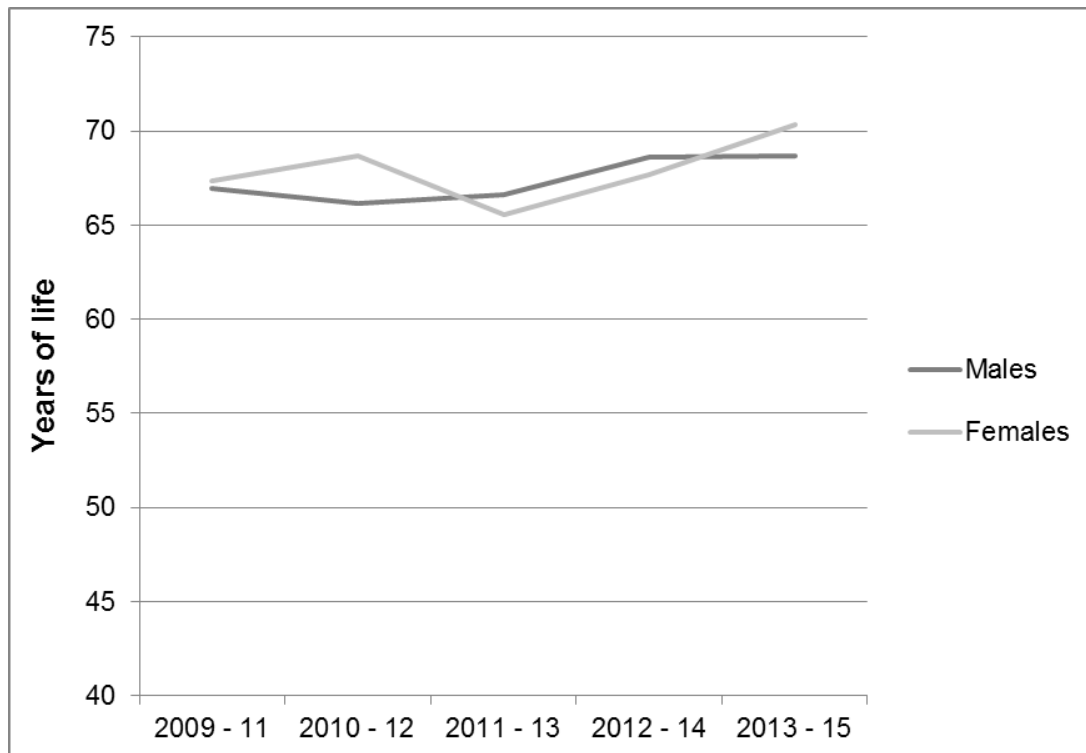
Source: Office for National Statistics (ONS). Vertical axis starts at 74 years, not zero

So far so good – longer life is the engine which drives the demographic challenge with regard to ageing, but the big question is ***are we ageing well or will more older people add to the demand for health and social care?***

A second statistic called ‘Healthy Life Expectancy’ points towards an answer. This statistic estimates how long we can expect to live in a reasonable state of health.

The picture is shown over the page:

Healthy Life expectancy at birth in Oxfordshire (2009-11 to 2013-15)



It shows that, on average, healthy life expectancy lasts into one's late sixties and the trend is moving slowly upwards – which is a good thing, BUT it isn't increasing as fast as average overall life expectancy.....

So we can conclude that ***an ageing population will indeed create a further increase in demand for services because 'good health' isn't increasing as fast as 'long life'***. This in turn means that services really do need to adapt quickly to demographic change, or, other things being equal, they will simply not cope.

What should we do about it?

Keeping it very simple again, and assuming the exchequer doesn't find a crock of gold any time soon, the answer would seem to contain the following elements:

1. Stay in good health for longer through preventing ill health
2. Coordinate all health and social care services so that they pull together, using new technologies to find new solutions
3. Create a single planning system for Oxfordshire encompassing health, social care, housing, and infrastructure planning
4. Be open to new ways of doing things because.....

The demographic challenge means the change is inevitable.

What did we say last year and what progress has been made?

Last year's recommendations have essentially been met. They talked about the need to have a full debate about the NHS's consultation and to scrutinise it thoroughly. The recommendations also proposed that health and social care should be better integrated and more should be done to prevent disease before it starts. So what has been achieved? Looking at the big picture:

- The NHS has put forward significant proposals for change to meet these challenges in a lengthy consultation. Its reception was mixed to say the least. Overall, I think the need for change was broadly accepted, but the specific changes put forward proved controversial. A decision has now been made and is currently being challenged – we await the results.
- Local Government leaders have debated publicly the need to pull together via the many different proposals for reshaping Local Government and through devolution proposals. This has also proved to be very contentious.
- Integration of health and social care has moved forward through the Government's new 'Improved Better Care Fund' and we have a new Director of Adult Social Services in post who is reviewing current arrangements thoroughly so that we can move forward.
- The basics of prevention are in good order (immunisation, screening, maternal health etc.), but organisations have not been able to release funding to make a further step change as tight budgets are swallowed by the immediate service needs of today.

What should we do next?

Again, keeping it very simple, essentially we need to resolve these issues and move on – which is what we are all trying to do. It sounds easy but in practice it is difficult because the precise solutions are not obvious and so debate continues. However, being locked in debate and achieving little is unlikely to suffice for long. Perhaps we need to find a 'good enough' solution that everyone can agree to live with so that we can move on. I understand that this is a re-statement of the obvious, but I am hoping it might help to do just that. The key is that these are interlocking issues that need to be solved as a single whole.

Recommendations

1. The NHS, County Council, District Councils, Universities and the Local Enterprise Partnership should pull together to resolve the current debates about 4 topics:
 - What is the best shape for NHS services for Oxfordshire?
 - What is the best way of achieving a sensible integration of health and social care - including local democracy in health care planning?
 - How can all organisations pull together a 'masterplan' to tackle issues such as the future use of NHS sites in Headington and Banbury, including travel and transport issues, so that services are improved and the 'knowledge economy' boosted?
 - How should housing growth be best coordinated so that developments and their supporting infrastructure are planned as one?

2. Local Government organisations should work together to create a single planning framework including 'health and social care planning', housing planning and infrastructure planning as a single whole.
3. All organisations should agree how to fund a step change in preventative services.

Chapter 2: Building Healthy Communities

For the last two years I have concentrated on public health aspects of the built environment. This year I want to combine that topic with a focus on air quality because two are closely connected in terms of solutions. I will look at air quality first.

Air quality

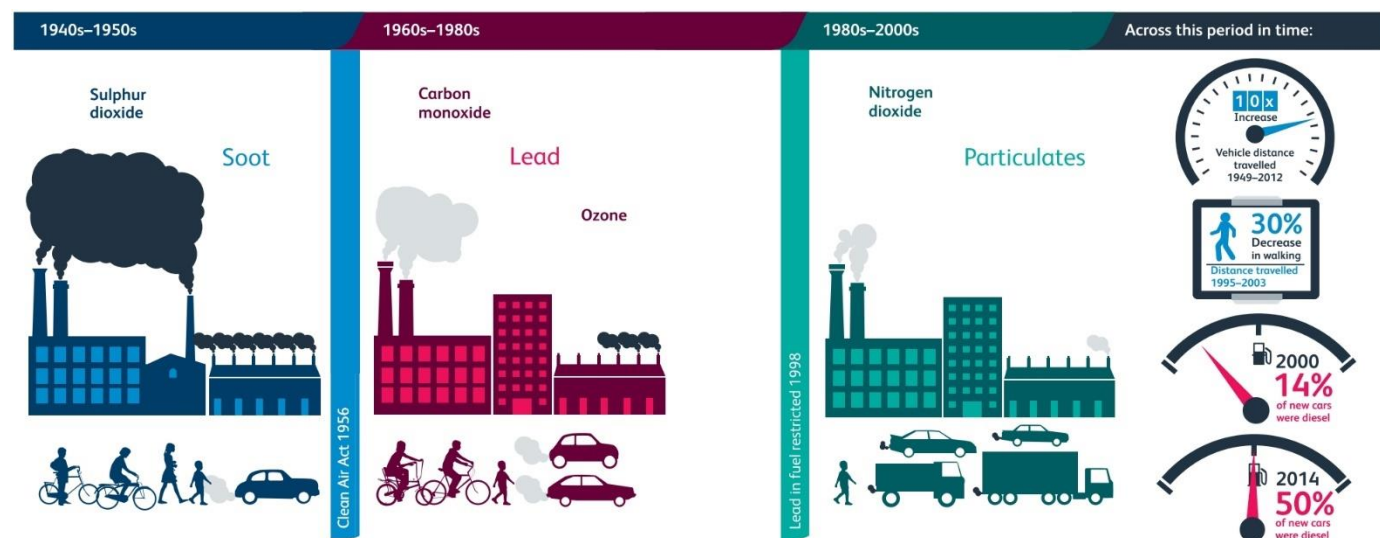
Air quality is a complex topic and I want to approach it from a Public Health point of view. The history of the long term improvement of the air we breathe is a jewel in Public Health's crown.

It's also an interesting topic because it underlines a historical truth of all public health activity – you solve one problem and another rises up to take its place.

Just as beating off many infectious diseases leads to the challenges of long life, and just as improving prosperity and diet leads to the challenges of obesity, so it is with air quality.

In this case it's an issue of scientific advances revealing underlying problems we didn't know were there before – in this case the problems of 'particulates' in the air and their health consequences.

The history of Public health and air quality is summarised in the following schematic:



This shows that in the 19th and 20th centuries the big problem was soot from coal fires and industry – which we solved. In the mid to late 20th century the big problem was lead, mainly from petrol – which we solved.

The new problem is oxides of nitrogen - nitrogen dioxide and its family of gasses – shorthand as NOx. This has grabbed the headlines recently and is now being grappled with by Government because it is the only atmospheric pollutant where the UK fails to meet EU standards and the Government have been obliged to tackle this by the High Court.

Road transport makes up 38% of all NOx pollution, and it is highly concentrated in towns & cities where people live. Road traffic continues to grow: between 2000 – 2015 the number of licensed

cars increased from 24.4m to 30.3m. Diesel cars, the worst offenders when it comes to nitrogen oxide, have increased their share of the car market from 12.9% to 37.8%. The widely reported controversy over the accuracy of testing vehicles for particulate emissions has helped to push this issue to the top of the agenda.

Historically the problems of air pollution have generally been solved through national and European standards and legislation. There is a huge debate raging as I write about the Government's proposals to tackle NOx. This includes extending initiatives such as clean air zones and whether responsibility should sit at national or local level. Whatever the outcome of that debate, money remains tight and we need to seek out low cost options we can start to do today.

In this report I want to concentrate on what we can do NOW in Oxfordshire and under our own steam as individuals and within current organisational budgets irrespective of Government's deliberations

Let's look in more detail at particulates in the air

In the 1990s it was felt that air pollution was no longer a major health issue in the United Kingdom. Legislation had made the great smogs of the 1950s a thing of the past. But evidence started to emerge that small particles emitted to the air from various sources, such as road transport, industry, agriculture and domestic fires, were still having an effect on health. This type of air pollution is so small that it can't be seen by the naked eye, but can get into our respiratory systems. For example, nitrogen dioxide and sulphur dioxide are produced by burning fuel, whilst ozone is formed by chemical reactions in the air.

The scientific understanding of the health effects of everyday air pollution has changed dramatically in recent years. Population effects of air pollution that were largely unknown in the 1990s and uncertain until recently are now quantifiable.

Studies have shown that long-term exposure (**over several years**) reduces average life-expectancy, mainly due to triggering death from cardiovascular and respiratory causes and from lung cancer. Air pollution is now associated with much greater public health risk than was understood even a decade ago.

In the UK, the Committee on the Medical Effects of Air Pollutants (COMEAP) estimated the burden of particulate air pollution in the UK in 2008 to be equivalent to nearly 29,000 deaths and an associated loss of population life of 340,000 life years lost.

It is important to understand that long-term exposure to air pollution is not thought to be the sole cause of deaths. Rather, it is considered to be a contributory factor – this is an important point.

Impact on deaths

An Air Quality Toolkit for Directors of Public Health was published by Defra in March 2017 and looks at the health impact of air pollution and particulates in particular. According to the toolkit:

'Short-term exposure to particulates over a period of a few hours to weeks can cause respiratory effects such as wheezing, coughing and exacerbations of asthma and chronic

bronchitis. It can trigger CVD-related mortality and non-fatal events including myocardial ischemia and myocardial infarctions (MI), acute decompensated MI, arrhythmias and strokes.'

In plain English, this means that if you are exposed to particulates for a period of time, it may cause breathing problems and in some cases it can trigger underlying heart problems and strokes. These may in turn contribute to one's death. This is, it seems, the mechanism through which particulates impact on health.

Because of the indirect nature of the effect, it is difficult to measure, estimate or be certain about.

The toolkit sets out a method for calculating the rate of mortality 'attributable' to Particulate Matter. We always need to be careful with 'attributable' statistics. It means that a group of experts have looked at the science and have made a best estimate. In Oxfordshire this rate is 12.6 deaths per 100,000 population per year. What does this actually mean? Well, there is a sort of 'league table' of 'attributable' causes of death (all are best estimates) which looks like this for under 75s:

<u>Measure</u>	<u>Mortality rate, per 100,000</u>	
	Oxfordshire	England
Overall preventable mortality	142.6	184.5
Preventable cancer	64.5	81.1
Preventable heart disease and stroke	34.7	48.1
Mortality attributable to Particulate Matter	12.6	39.0
Preventable Liver disease	11.3	15.9
Communicable diseases	9.4	10.5

It is very clear that the number of deaths relating to air quality, preventable cancer, heart disease stroke, preventable liver disease and communicable diseases in Oxfordshire are well below the national averages and this is a good result. However, this does not mean that we should be complacent. We need to act to consolidate this position and strengthen it further.

The figures mean that preventable deaths associated with particulates are estimated to be associated around 1/5th of the number of preventable deaths due to cancer and around 1/3 of the number of preventable deaths associated with preventable heart disease and stroke.

It is important to grasp when particulates contribute to a death they generally act as a trigger. This isn't like smoking or alcohol related deaths where the main cause is the tobacco or the alcohol directly.

Clearly this isn't an exact science. It is easy to build castles on sand using these statistics, but it does give us a guide – enough to say that the experts think that particulates are a real health issue and should be tackled.

The Government's recent consultation on the topic summed it up as follows,

Poor air quality is the largest **environmental** risk to public health in the UK. It is known to have more severe effects on vulnerable groups, for example the elderly, children and people already suffering from **pre-existing** health conditions such as respiratory and cardiovascular conditions. Studies have suggested that the most deprived areas of Britain bear a disproportionate share of poor air quality.

I would stress that this isn't the biggest threat to the public's health, but it is judged the most pressing environmental risk.

Much of the action has to come nationally from Government, but there is evidence that people are voting with their feet and sales of diesel cars are reported to have fallen recently.

Where does air pollution come from?

The following schematic paints the picture and shows that the sources of pollution are many and varied from the fire in your hearth, to traffic, to pollen, to aircraft, to industry, to agriculture. There's no escape, but this diversity of sources *does* mean that we can all do something about it. for example, 39% of these tiny particles of dust that lodge in the lungs are caused by coal and wood burning.



Exposure to air pollution in everyday life can come from ordinary activities like being near traffic, sitting in traffic jams, traditional home fires and bonfires.

The effects are localised, so, although they are more concentrated in towns, they also occur at hot spots in rural areas like busy crossroads.

Also, air pollution levels tend to be higher in less well-off areas, this is yet another cause of disadvantage which being less well-off brings. These are analysed in chapter 3.

What can we do about it?

While we wait for Government to decide what to do, there are actions we can take – and the good news is that many of these are already in hand. For example, we can:

- Make it easier for people to cycle and walk more through better planning
- Plan cycle routes through quiet areas
- Build pedestrian areas and green spaces into the design of communities and regeneration schemes
- Shift transport fleets to electric or electric hybrid vehicles
- Choose new cars with more care.
- Encourage fewer car journeys through 'park and ride' and similar schemes
- If you suffer from diseases that high levels of pollution might trigger, you can keep an eye on DEFRA's pollution warnings and adapt your lifestyle to avoid areas with high levels of emissions.
- Consider 'no-idling zones' outside schools and similar areas
- Consider where possible installing gas central heating, or modern wood stoves rather than open fires, smokeless coal rather than house coal or burning dry high quality wood rather than green wood.

Whatever the outcomes of the debate on air pollution, the local actions will all boil down to better local planning, which builds health into community design, and residents making choices which are healthy ones.

All of which leads us nicely into an update on the main featured item from last year's report, namely getting health into local planning and the 2 healthy new towns we have as pilot sites in Oxfordshire in Bicester and in Barton.

What did we say last year and what has been done?

Last year we talked about the benefits of building green spaces, community areas, cycle paths and the like into the design of communities. I want to report on progress in two ways – a report of a workshop we held and an update on the Healthy New Towns.

'Planning For Health' Workshop

In November 2016, the County Council hosted a County-wide Health and Planning learning event for Officers working in areas such as planning, transport planning, health commissioning and health improvement. Officers from County, District and City Councils and the local NHS attended. The idea of the event was to enable us to learn together about best practice for creating healthy environments. We were grateful for the support from our regional colleagues at Public Health England (South East) who helped with guiding the learning themes and sourcing the key note speakers.

We aimed for participants to be able to:

- understand the link between health and the built environment
- understand how the planning system works and how it can contribute to health improvement
- keep abreast of national, regional and local work to improve health through the built environment

- learn about current good practice through case studies
- meet other health and planning colleagues from across Oxfordshire to network and learn more about each other's roles.

A wide range of speakers gave the national, regional and local perspective. Some of our speakers included Public Health England, the Town and Country Planning Association, other Local Authorities and both Healthy New Towns in Oxfordshire.

The event was really 'buzzing' and enthusiastic. The main lessons learned included:

- **Early involvement in the Planning Process** - including the need for early health involvement in planning and for a Health Impact Assessment (HIA) to be completed early on for new developments.
- Working in constructive partnerships is essential.
- Understanding the **roles of stakeholders/organisations** and how they could contribute to health through planning.
- Understanding the specialist 'tools' that help to make sound plans.
- Learning from **examples of good practice** elsewhere.
- **Evidence and statistics** being useful to be able to demonstrate the impact of planning innovation on health
- **Understanding the health issues** within communities, and that loneliness and isolation are big issues that need to be addressed. There was recognition of the impact of disadvantage on health and the potential of small initiatives to make a big difference.
- **Understanding the economic benefits** of greener and healthier forms of transport and how these can be encouraged - including the long term benefits of investment in walking. Considering and encouraging active travel (i.e. going by bike or walking) at the earliest possible stage in planning new communities.

The event was a real boost to this area of work, and we need to keep this momentum going. We all have a part to play in this. We need to remember though, it's not just about infrastructure. It's about creating a place where people can actually meet and get together, and where it is easy to stroll, cycle and play in safety.

Healthy New Towns – what has happened in the year since my last report?

Last year I highlighted the NHS Healthy New Town Programme and the opportunities that this could bring to Oxfordshire. With two Healthy New Towns, Barton and Bicester, both within our County there is a real chance to make a difference to the health of not only those living in (or who will be living in) those areas to benefit, but momentum to share this benefit and learning wider – and this is perhaps the real added value.

We can see that the builders are on site now, but what else is happening in the actual community, and what does it mean for the people who live in those areas now or who might live there in the future?

I can report that it's been a productive year. Both areas have been:

- Fine-tuning priorities and keeping the dialogue between organisations flowing.
- Engaging the community to pave the way for new residents coming to the area. Various engagement workshops/meetings have taken place. Everyone tells me that getting residents involved early on is the key.

Bicester is taking a whole town approach and similarly Barton a whole area approach as 'One Barton'

We can look at some of the key achievements and successes of each of the Healthy New Towns in more detail.

Barton

- Funding was secured through WREN (a not-for-profit business that awards grants for to communities) for physical improvements to Fettiplace Road linking the 'linear park' to Barton Park via what is now called 'Barton's Park'. This will mean that people can access green space, play areas and socialise and it will join the new community to the existing community.
- Carrying out a 'Health Impact Assessment' (a device for systematically recording the impact on residents' health when new initiatives are planned) was commissioned which suggested improvements.
- Supporting Bury Knowle's social prescribing pilot (a jargon term for 'prescribing' healthy activities to people instead of pills and powders). This might include joining a group or a club to reduce loneliness and isolation or attending a local exercise class or health walk to become more active.
- Commissioning research to gain a deeper understanding of existing and potential residents' health needs. This can be used by health and other service providers including the voluntary and community sector providers, GPs, leisure and physical activity services, green spaces etc, to help inform the planning of services for the area.
- Providing training for people working in Barton to:
 - understand the link between food, poverty, poor diet and health, and how all that links to the price and availability of fresh fruit and veg and how to avoid the really fatty and salty foods.
 - give people brief advice about stopping smoking, cut down on drinking and tips for staying mentally healthy.

- Supporting the Oxford Brookes University's Healthy Urban Mobility study to look into how access to cycling in Barton can be improved for older people.
- Eight community-led health and wellbeing pilot projects receiving grant-funding to generate learning from practice. The grant scheme was open for applications up to £5,000. Projects included a full independent review of Food Banks to shape the future management of the food bank within the Barton Neighbourhood Centre, ensuring that people needing to access the food bank are best supported. This work then led to the creation of a Barton Community Cupboard - a market-style provision which includes a fridge, recipe cards and a cook book inspired by recipes from local residents' attending a cooking session for all ages. The project has aimed to reduce the stigma attached with using a food bank.
- Another real success story has been the work in Barton to increase the uptake of Healthy Start Vouchers. Healthy Start is a national service through which free vouchers are given to selected families every week to spend on milk, fresh and frozen fruit and vegetables, and infant formula milk. You can also get free vitamins. You qualify for Healthy Start if you're at least 10 weeks pregnant or have a child under four years old and you or your family receive:
 - Income Support, or
 - Income-based Jobseeker's Allowance, or
 - Income-related Employment and Support Allowance, or
 - Child Tax Credit (*with a family income of £16,190 or less per year*)
 - Universal Credit (*with a family take home pay of £408 or less per month*)
 - You also qualify if you are under 18 and pregnant, even if you don't get any of the above benefits.

This was done by an outfit called Good Food Oxford. They did it by producing:

- A paper and electronic map of retailers which accept Healthy Start Vouchers
- Promotion by local retailers their participation in the scheme
- Use of posters and community newspaper
- A guidance leaflet for frontline service providers to help individuals to complete the form

Bicester Healthy New Town

Initiatives during the year included:

- Launch of the community activation programme with small grants available up to £1000. Some of the activities funded have included:
 - A Scout Group purchasing equipment to provide adventurous outdoor activities for children aged 6+.
 - A pilot street-play activity delivered by Oxfordshire Play Association.

- Setting up a Bicester meeting for local learning disabled adults through the voluntary organisation My Life My Choice. The programme has encouraged the group to be active and take responsibility for their health as well as offering the usual support of the organisation which promotes volunteering and social activity.
 - Bicester and Kidlington Ramblers were funded for the printing of a book of local walks of 5 miles and under. The book aims to encourage people to get out and enjoy their local area more and to become more active.
- Looking at how to improve the care of people with diabetes between primary, secondary and community care. Some of this will involve collaborative working with other Healthy New Town sites to work out the impact of population growth on demand for GP services.
 - A Healthy Weight Strategy produced to address childhood obesity in Bicester. The plan outlines life stages, services, key messages and initiatives. The plan aims to provide a co-ordinated approach, with consistent messages which will link to national and local initiatives.
 - Engaging all Bicester schools to participate in Walk to School week for May 2017. A springboard to promote a year round walking to school programme.

What else have we done in the past year?

There are many signs that the penny has dropped and that 'getting health into planning' is now a necessity. The Public Health team's work with planners at County and District level has increased remarkably and there is a demand for more – which is a really positive development.

BUT

It doesn't just happen by accident and it needs a sustained and coordinated approach which we are now moving towards – on a shoe-string....

The key is to

- know your topic so you have something positive and easy to offer
- Know the people and get involved in the networks
- concentrate on the economic benefits and the need to cut diseases such as diabetes, heart disease and some cancers off at the source – as well as slowing the progress of dementia..... and avoid preaching and nannying!
- keep selling the message:

'planning is health and health is planning'

Recommendations

1. All Local Authorities should improve air quality at local level under our own steam through keeping up the work to integrate 'public health and planning'.

2. All Local Authorities should continue to monitor and actively engage with the Healthy New Towns programme and use the lessons learnt to improve all local planning across the County

Chapter 3: Breaking the Cycle of Disadvantage

This year I want to achieve 4 things:

1. To keep the issue of disadvantage high on organisations' agendas
2. To describe overall disadvantage in Oxfordshire in a straightforward way
3. To report in detail on the basket of indicators agreed last year to monitor progress
4. To report on the work of the excellent Health Inequalities Commission

Why is this topic important?

Because disadvantage is one of the factors strongly associated with poor health and poor life chances. Reducing disadvantage will directly improve health and will help people to live lives which are productive and less burdened by disease.

Overall disadvantage in Oxfordshire in two pictures

If I were asked to give a 'helicopter view' of disadvantage in Oxfordshire, I would do it through two pictures, one highlighting rural disadvantage and one urban disadvantage.

Rural Disadvantage

A major cause of disadvantage in the County stems from its rural nature. This means that some areas have more difficulty in accessing services as well as having a high proportion of older people. This is shown in the map below in a measure called 'geographical barriers'. It takes into account the many challenges posed by rurality in terms of accessing services. It was updated in 2015. This index is based on road distances to post offices, primary schools, GP surgeries, and general stores or supermarkets.

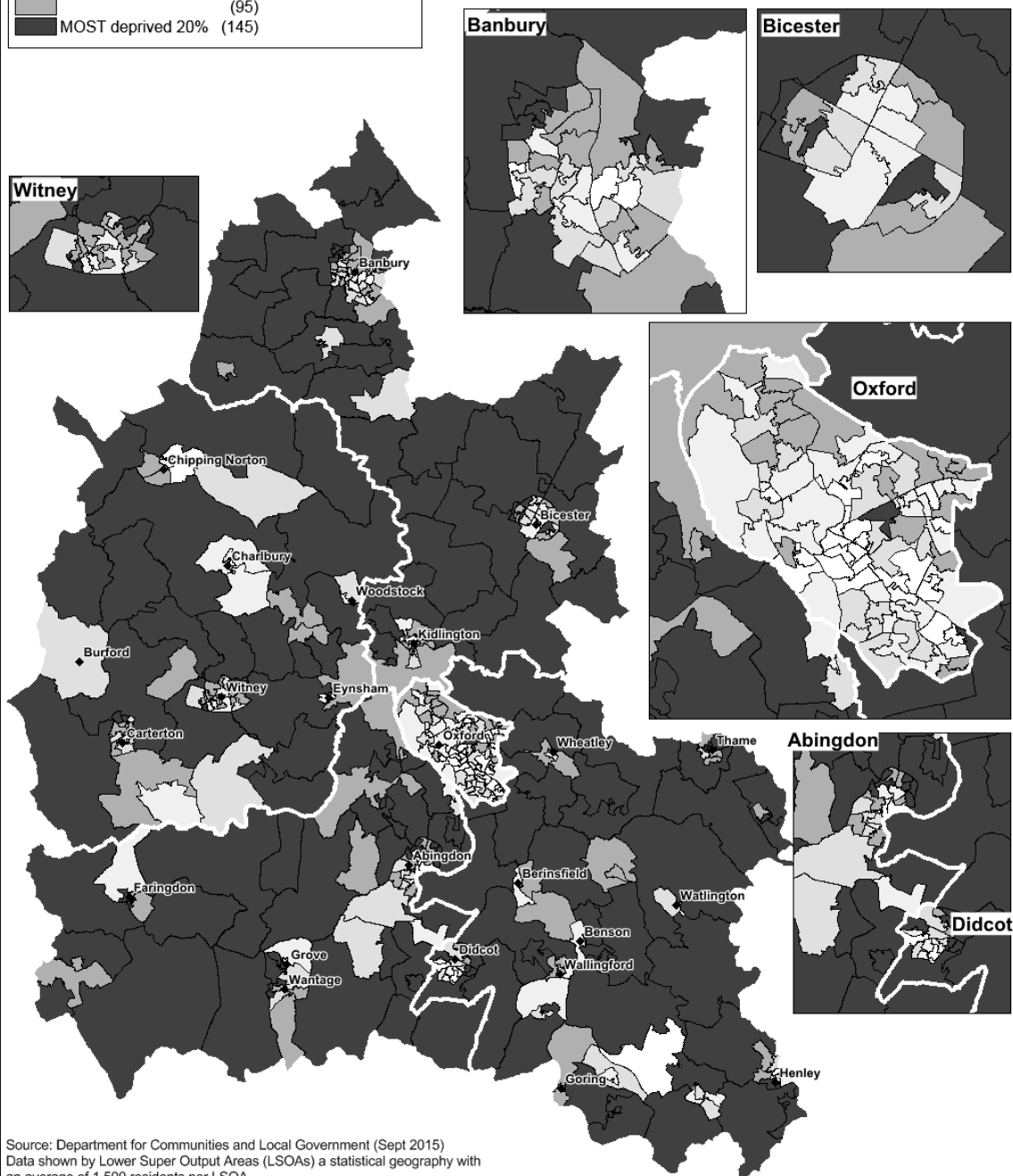
Indices of Deprivation 2015, Geographical Barriers to Services

by Lower Layer Super Output Areas showing District boundaries

IMD 2015 Geographical Barriers to Services

England deciles

	LEAST deprived 20% (33)
	(65)
	(69)
	(95)
	MOST deprived 20% (145)



Source: Department for Communities and Local Government (Sept 2015)
Data shown by Lower Super Output Areas (LSOAs) a statistical geography with an average of 1,500 residents per LSOA

The IMD 2015 Geographical Barriers sub-domain includes:

- Road distance to a post office: A measure of the mean distance to the closest post office for people living in the Lower-layer Super Output Area
- Road distance to a primary school: A measure of the mean distance to the closest primary school for people living in the Lower-layer Super Output Area
- Road distance to a general store or supermarket: A measure of the mean distance to the closest supermarket or general store for people living in the Lower-layer Super Output Area
- Road distance to a GP surgery: A measure of the mean distance to the closest GP surgery for people living in the Lower-layer Super Output Area

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The map shows that the majority of Oxfordshire's 407 small areas are more deprived according to this measure than the national average. 85 are among the 10% most deprived nationally and are concentrated outside the main urban centres. A further 60 small areas are in the 10-20% most deprived nationally.

The implications of this mostly fall on older people and we see the results particularly in terms of isolation and loneliness and in terms of difficulty in getting about. This is where the demographic challenge will be felt the most and services will need to be designed to meet the needs of these communities.

This is difficult because:

- modern hi-tech services tend to need centralised kit and centralised specialists
- it gets harder for anyone to do home visits because of the increasing busyness of the roads

The way to square the circle seems to be to use hi-tech aids (like the alarm systems some people wear on their wrists or round their necks) and on-line communication, and to plan the routes of home carers really carefully. The other solution was discussed in the previous chapter – i.e. planning new communities around communal spaces and local facilities. Nonetheless, there are inevitable challenges to come as GP surgeries coalesce, becoming more specialist and less local.

In conclusion, this picture of rural disadvantage presents one side of the coin of disadvantage in Oxfordshire.

Urban Disadvantage – the 'Index of Multiple Deprivation' (IMD)

This is the flip side of the coin and tends to pick out disadvantage in areas of greater population density - which I am loosely calling 'urban'.

This measure uses 37 indicators spanning seven broad types of disadvantage. These indicators are used to calculate an overall Index of Multiple Deprivation (IMD). The indicator looks at 407 small areas within Oxfordshire and compares them with national figures.

Overall, Oxfordshire has relatively low levels of disadvantage. It is the 11th least deprived of 152 upper tier local authorities in England (up from 12th least deprived in 2010). However, as we know, there is significant variation across different parts of the county. The map below tells the story – the areas in Oxfordshire which fall within the 20% most disadvantaged in England are shaded the darkest and the areas which fall within the least disadvantaged 20% of areas are not shaded at all.

The map shows that:

- Most of Oxfordshire's 407 small areas are less disadvantaged than the national average.
- 110 are among the least deprived 10% nationally.
- Overall, nearly half (46%) of the county's population lives in areas that are among the least disadvantaged 20% in England.
- More than four in five residents (82%) live in areas that are less disadvantaged than the national average.
- Of course this does not mean that there is no disadvantage in those areas –Berinsfield is a good example of an area where disadvantage is 'masked' by being included in larger more affluent areas, and many rural communities can tell the same story.
- 13 areas are among the 10-20% most disadvantaged (down from 17 in 2010).
- Two areas are among the 10% most disadvantaged in England. These are in Oxford City, in parts of Rose Hill and Iffley ward and Northfield Brook ward. In 2010 only Northfield Brook was among the 10% most disadvantaged areas in the country

The most disadvantaged areas are concentrated in parts of Oxford City and Banbury with one in Abingdon.

In general, the areas of Oxfordshire that were identified as the most deprived in 2010 remain the most deprived. However, in Oxford City, one area in Holywell ward, and another in Littlemore, have moved out of the 10-20% most deprived. However, one in Rose Hill has moved into the 10-20% category.

In Banbury, one area in Ruscote ward has moved out of the 10-20% most deprived.

In summary, these two 'faces of Oxfordshire' usefully sum up the overall picture when it comes to disadvantage.

Conclusion: Breaking the cycle of disadvantage in Oxfordshire is all about targeting services to level the experience of all up to the best. Disadvantage in small areas of the County remains the biggest challenge, and services need to be designed to focus on them.

Report on the Basket of Indicators

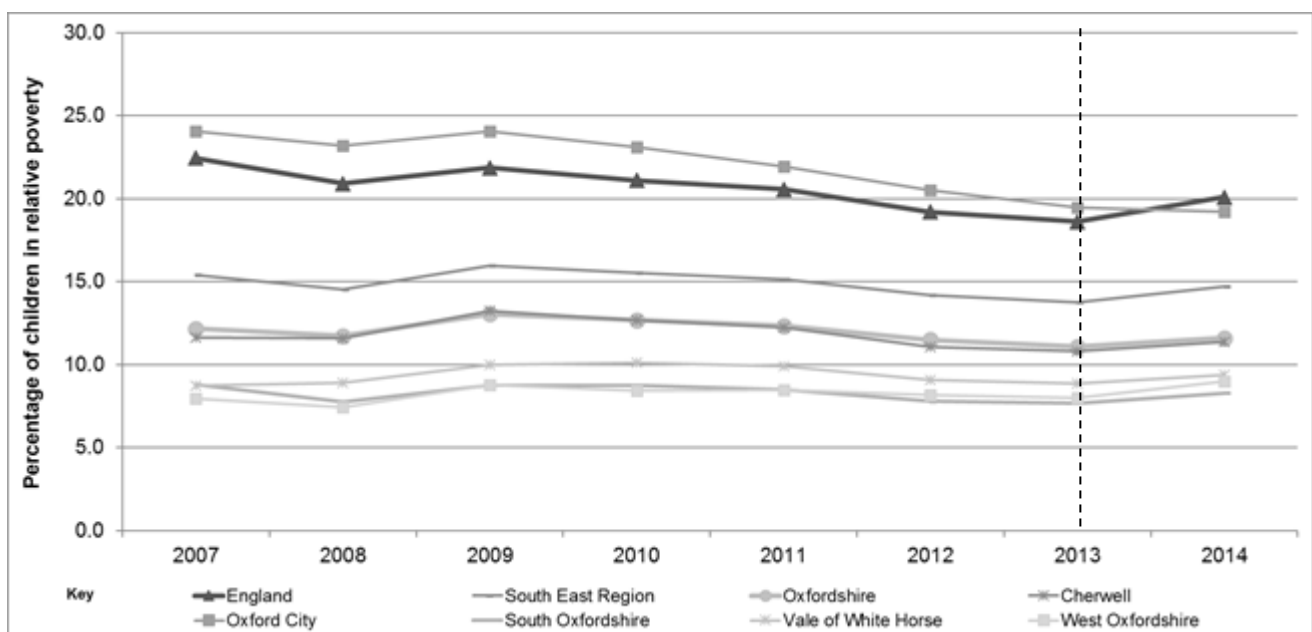
In last year's report I identified a basket of high quality indicators which would help us to measure progress in the fight against disadvantage. I set a baseline figure for comparison and will report on progress against these one by one.

Indicator 1. Child poverty

Percentage of children (under 16 years) in Low-Income Families (2007 to 2014 calendar years)

The proportion of families classed as having 'children in poverty' had fallen for the last few years but has increased slightly across the board according to the latest data from 2014. This is a national trend. The reasons for this are unclear, and a single year's figures need to be treated with caution but it is important that we closely monitor this figure going forward. The correct name for this indicator is 'relative poverty'. An individual is considered to be living in relative poverty if their household income is less than 60% of median national income. Nationally two-thirds of children in poverty are living in households where at least one adult is in work.

Percentage of children (under 16 years) in Low-Income Families Local Measure (2007 to 2014 calendar years)



Source: Child Poverty Statistics (extracted from Public Health England: Public Health Outcomes Framework)

The chart shows that:

- The proportion of children in poverty has increased slightly since we set the baseline (2013 data) across all geographic areas.
- Oxfordshire has a significantly lower percentage of children in low-income families than England. This is good news.
- Oxford City has higher levels than the rest of the County and is closer to the national average.

Note: this is a national statistic and takes time to collate and so we are still seeing historic data from 2014.

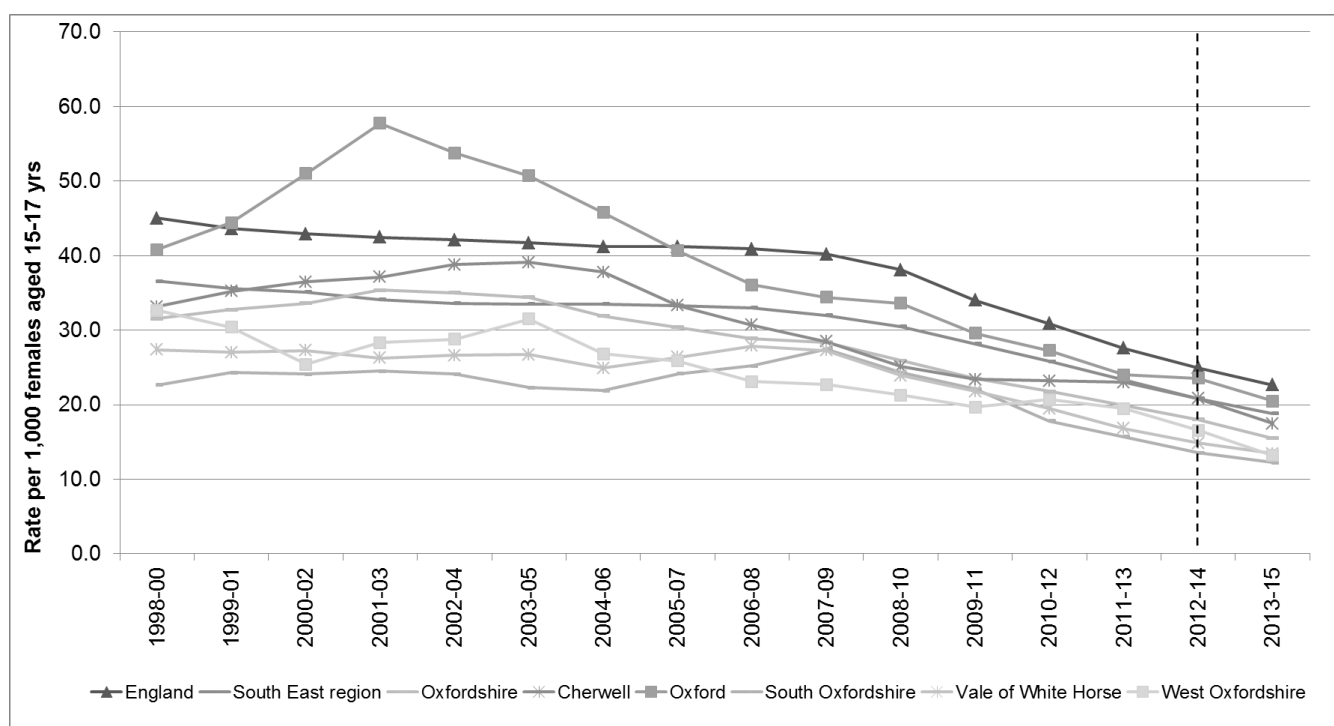
The profound influence and impact of poverty on health needs to be widely recognized and systematically addressed.

Also, as ever, if we drill down into the figures the gaps widen. Whilst Oxfordshire is overall a very 'healthy and wealthy' county, there are significant differences in poverty. For example: children living in Rose Hill & Iffley, Blackbird Leys, Banbury Ruscote, Littlemore, Churchill and Northfield Brook are in the top 10% of children in England aged 0 to 15 living in less wealthy families.

Indicator 2. Teenage pregnancy

This indicator measures all conceptions in females under 18 years of age, no matter whether the pregnancy ends in birth or in a termination.

Under 18 conception rate per 1,000 female population aged 15-17 years 1998-2000 to 2013-15 (3-years combined)



Source: Office for National Statistics (ONS) - combining information from birth registrations and abortion notifications

The chart shows that:

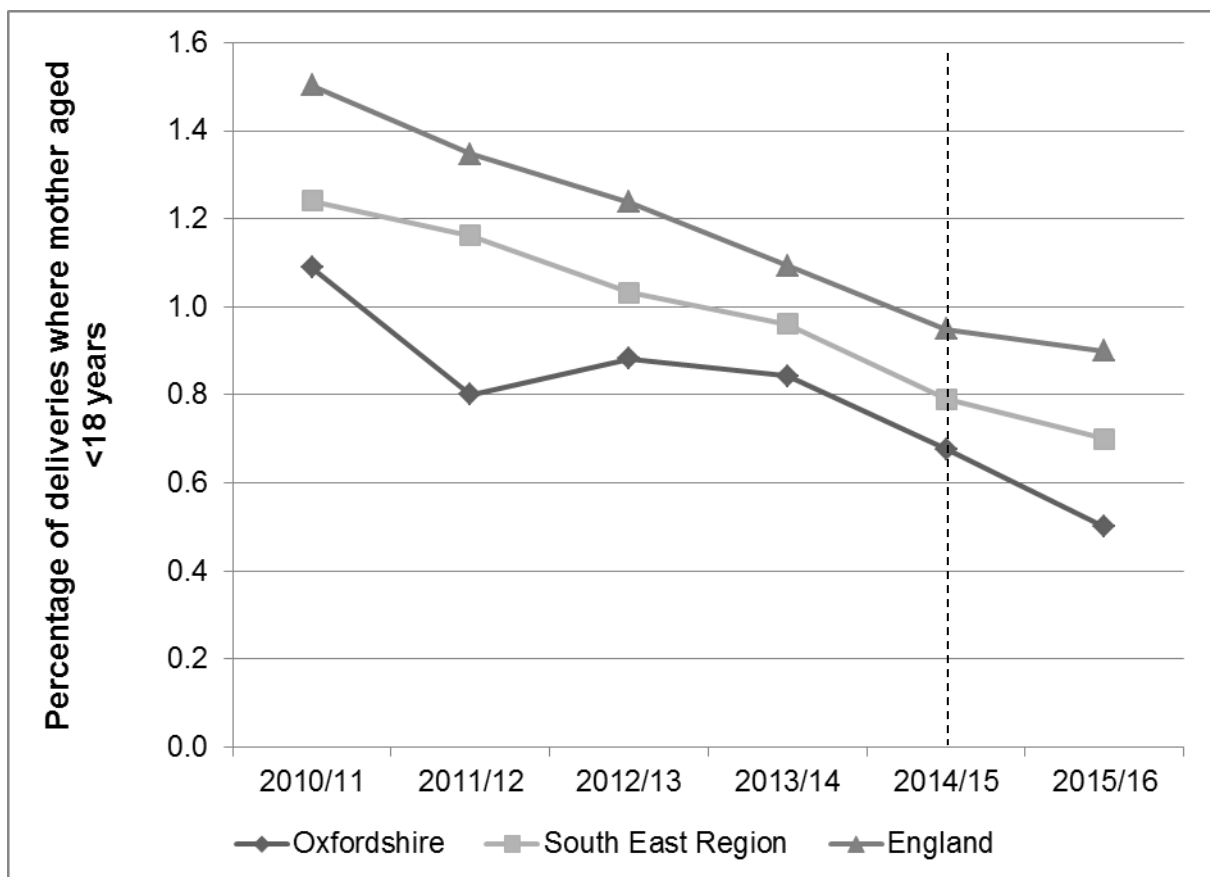
- The teenage conception rate in Oxfordshire is lower than the national average and is decreasing broadly in line with national and regional trends.
- There has been a welcome sharp decline in Oxford City since 2001-03
- Most recent data (2013-15) continues on a downward trend across all geographies.
- This is a good result.

Indicator 3. Percentage of Teenage Mothers

This indicator measures the percentage of babies delivered where the mother was under 18 years of age.

Almost half of teenage conceptions result in termination. This indicator measures the percentage of births to mothers aged under 18.

Under 18 conception rate per 1,000 female population aged 15-17 years 1998-2000 to 2013-15 (3-years combined)



Source: Public Health England: Child Health Profiles: Pregnancy & Birth

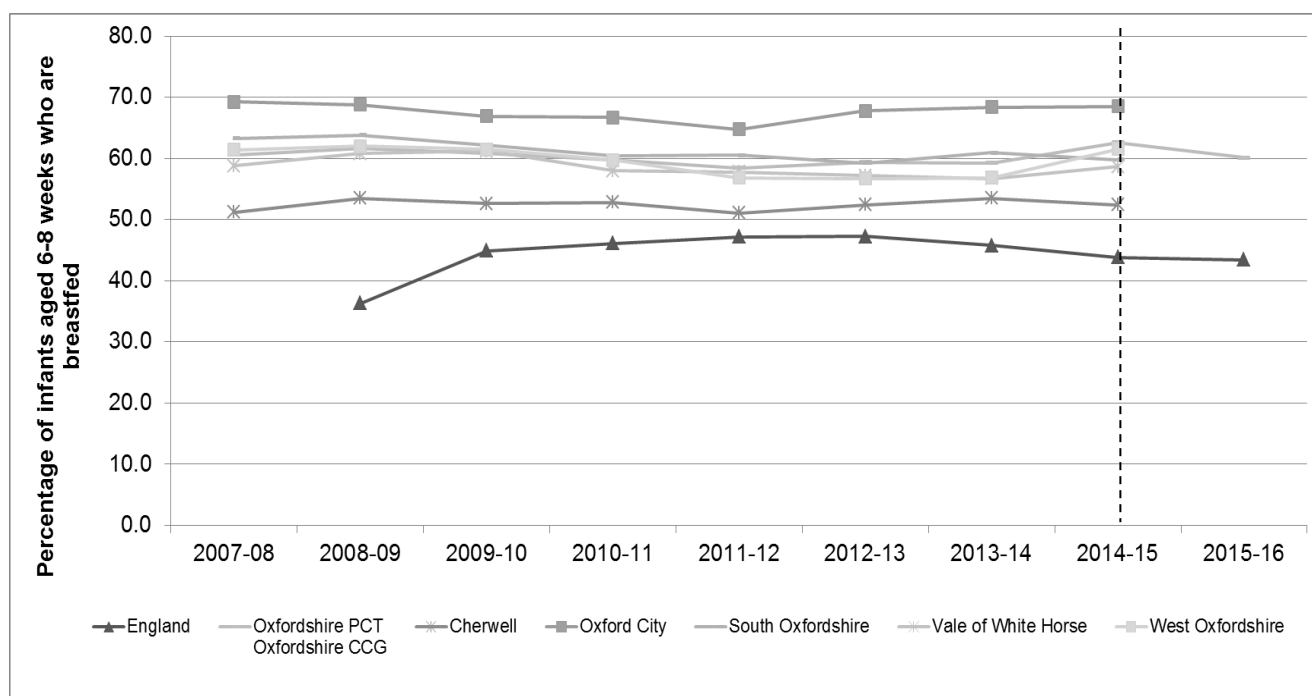
The chart shows that:

- The proportion of births to mothers under 18 years has reduced.
- This is a national trend.
- The proportion in Oxfordshire continues to be lower than the national or regional figures.
- This is another good result, and particularly good in Oxfordshire.

Indicator 4. Breastfeeding at 6-8 weeks

Breastfeeding is important and underpins a healthy life. Its positive effects on health are long-lasting. The breastfeeding rate remains high in Oxfordshire compared to England. The challenge is to get the rates higher in the lowest areas which are historically: Banbury, Bicester, Kidlington, Didcot, Wantage and South East Oxford.

Percentage of infants aged 6-8 weeks who are being breastfed (partially or wholly) – 2007/08 to 2015/16



Source: NHS England

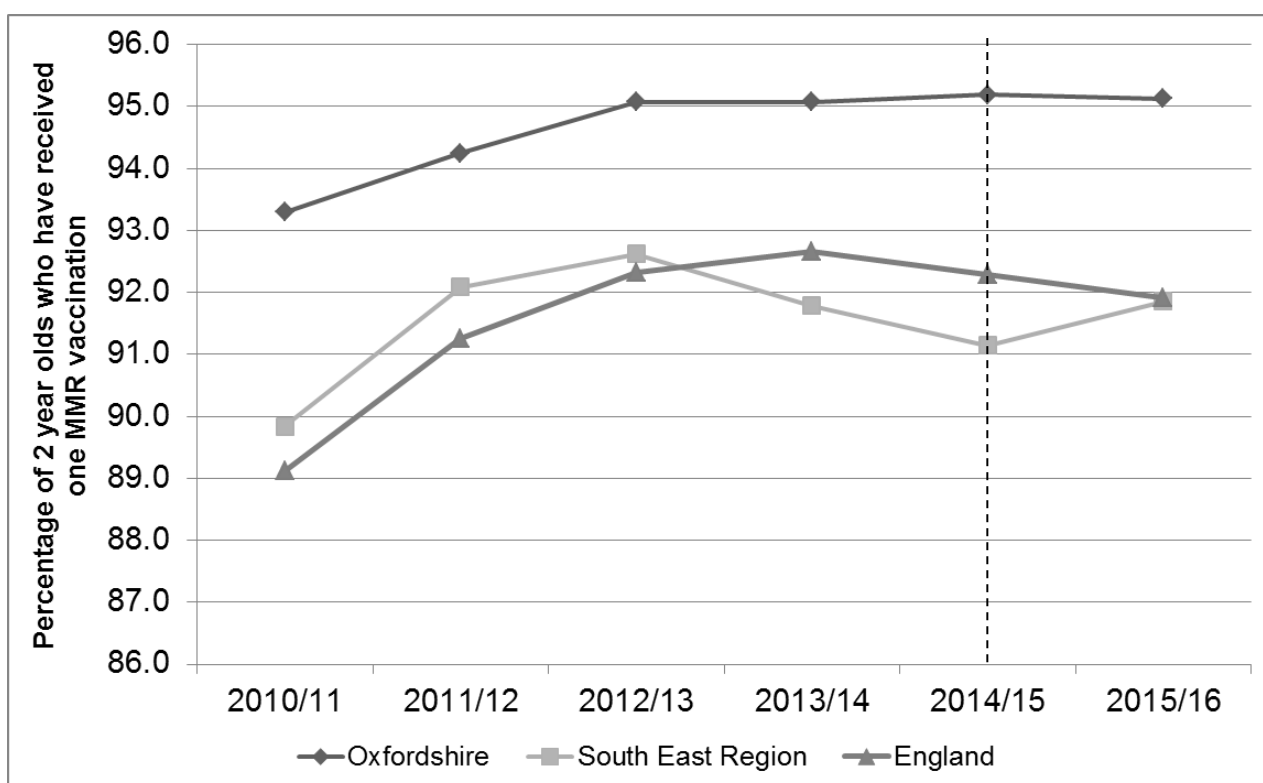
The chart shows that:

- Nationally the prevalence of breastfeeding at 6-8 weeks increased over this time period and now appears to be levelling off at around 43%
- Oxfordshire has a significantly higher rate of breastfeeding at 6-8 weeks than England average at just over 60% This is a good result.
- Locally breast feeding rates remain fairly stable for the county as a whole.
- Data at district level are currently not available for 2015/16

Indicator 5. Childhood Immunisation

Children should receive two Measles, Mumps and Rubella (MMR) vaccinations, one by the time they are 2 years old and the second by 5 years old. We use this as an indicator for the uptake of all immunisations as this is one of many immunisations for children. We monitor all the rates thoroughly through the Public Health Protection Board and through the Health Improvement Board. Oxfordshire's results are very good and NHS England and Public Health England are to be congratulated. An initiative has begun to push the rates higher by tracking down the families who slip through the net individually and offering their children the vaccine.

Percentage of 2 year olds who have received one MMR vaccination



Source: Cover of Vaccination Evaluated Rapidly (COVER) data collected by Public Health England

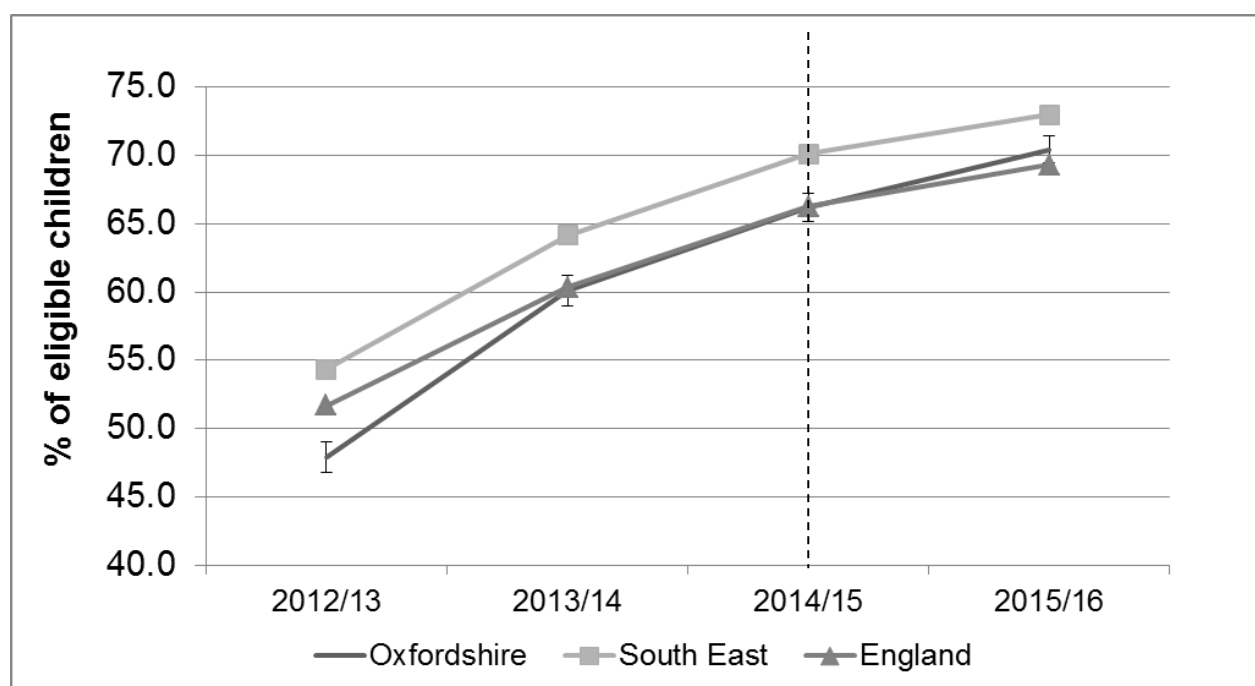
The chart shows that:

- Oxfordshire remains significantly higher than national and regional average. This is an excellent result – our vigilance is paying off.
- Nationally this vaccination coverage is falling and we are bucking this trend.

Indicator 6. School readiness

This indicator measures children defined as having reached a good level of development at the end of the Early Years Foundation Stage (EYFS) as a percentage of all eligible children. Children are defined as having reached a good level of development if they achieve at least the expected level in their 'early learning goals' in the following areas: personal, social and emotional development; physical development and, communication and languages, as well as early tests of mathematics and literacy. This is a useful measure of health in its broadest sense of 'life potential' and a useful marker for disadvantage between different groups of children.

Percentage of children achieving a good level of development at the end of reception year



The data shows that:

- Oxfordshire has a slightly higher percentage of children with a 'good development' compared with the England average but remains below the regional average.
- The proportion of children achieving a good level of development at the end of reception year has increased across all three geographies.
- There is a clear gap between males (63%) and females (78%) in Oxfordshire, similar to national and regional figures.
- The percentages in children with free school meal status is much lower at 51% (43% in males and 59% in females).
- This is reasonable progress but shows the need to focus on disadvantaged groups if performance is to improve.

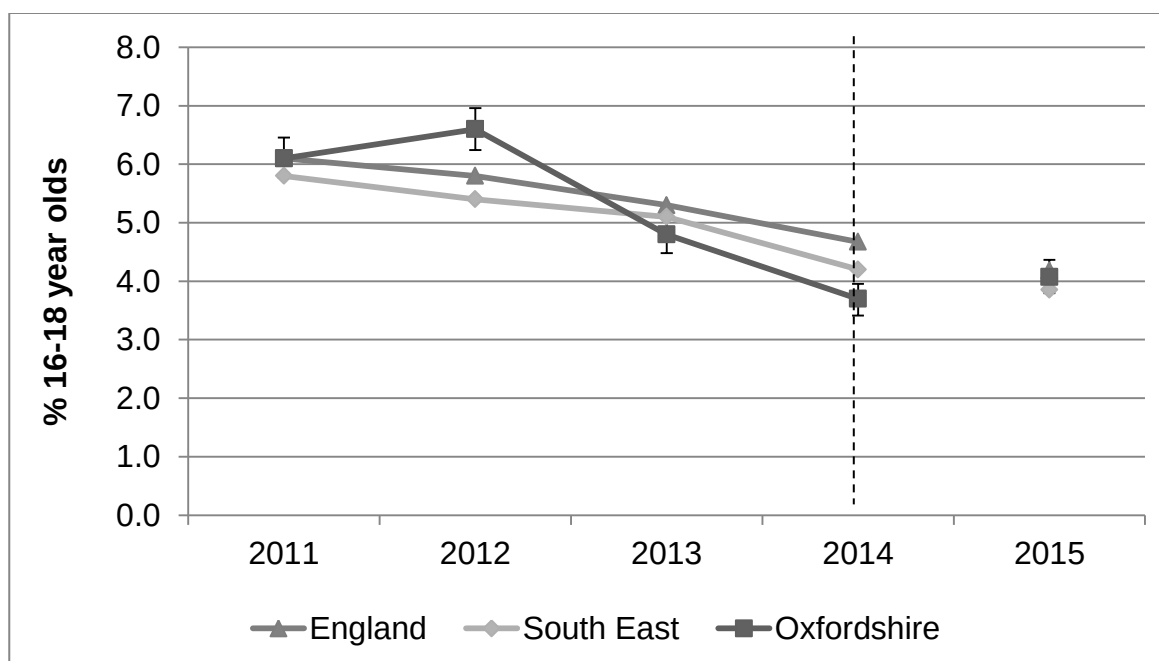
Indicator 7. GCSE results

Unfortunately, the previous indicator which allowed us to measure GCSE performance between different areas and different groups of children in the County has been discontinued by Government. It is unclear whether the new 'performance 8' statistic will be as useful – and there is as yet little data for comparison. Rather than report on this figure prematurely this year, I will need to see how well it is received before I use it to draw conclusions.

Indicator 8. 16-18 year olds not in education, employment or training

This is a useful general indicator of future life chances and prosperity for young people. The way the data has been counted has also changed since last year to try to make it more accurate, so we can't compare it accurately with previous years. The problem comes because for some young people it is not known what their status is. To try to account for this, the new method takes figures for where it is not known if young people are not in education, employment or training and assumes a proportion of them are not and adds this to the old figure. For that reason, there is a break in the line in the chart below and then new figures are shown as a new 'blob' for 2015.

Percentage of 16-18 year olds not in education, employment or training



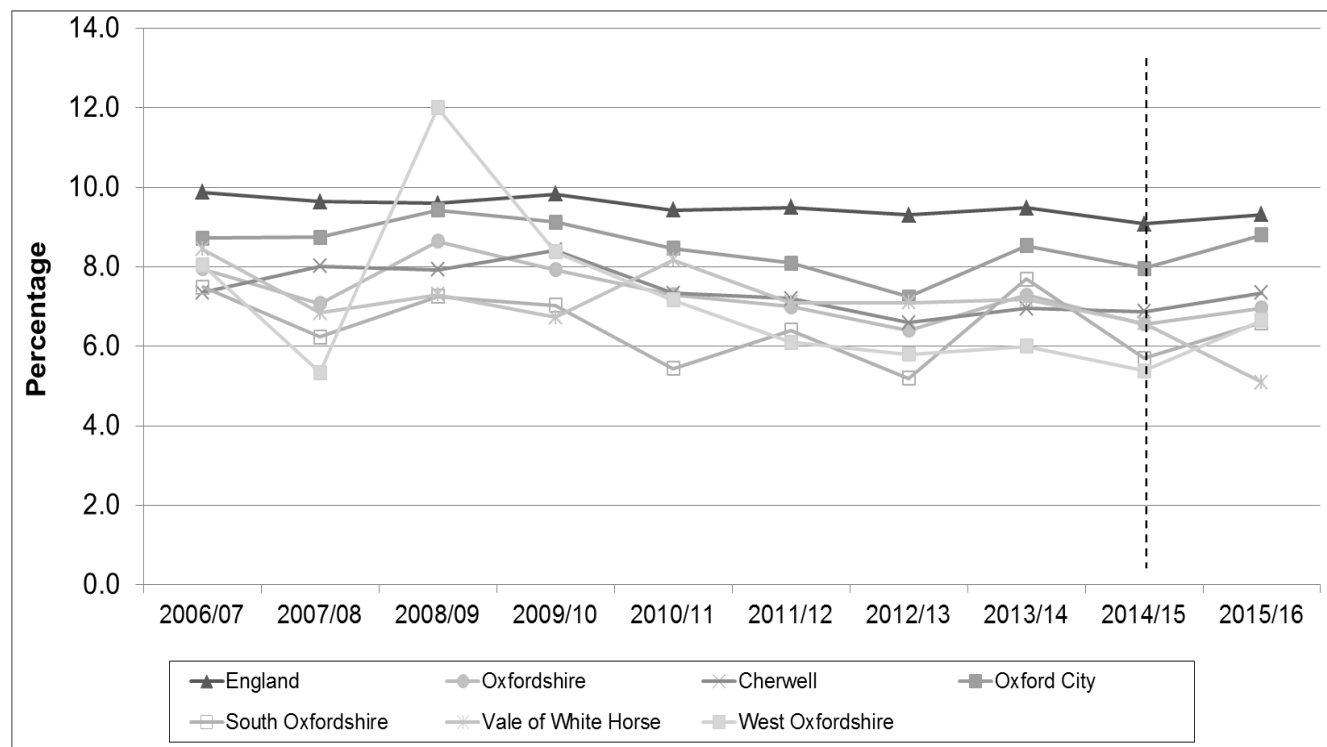
Source: Public Health Outcomes Framework

The data shows that:

- The Oxfordshire figure is comparable to regional and national levels.
- We will monitor this new data in future reports.

Indicator 9. Obesity in children in reception year

**Percentage of children in Reception Year (4/5 year olds) who are obese
2006/07 to 2015/16 (Academic years)**

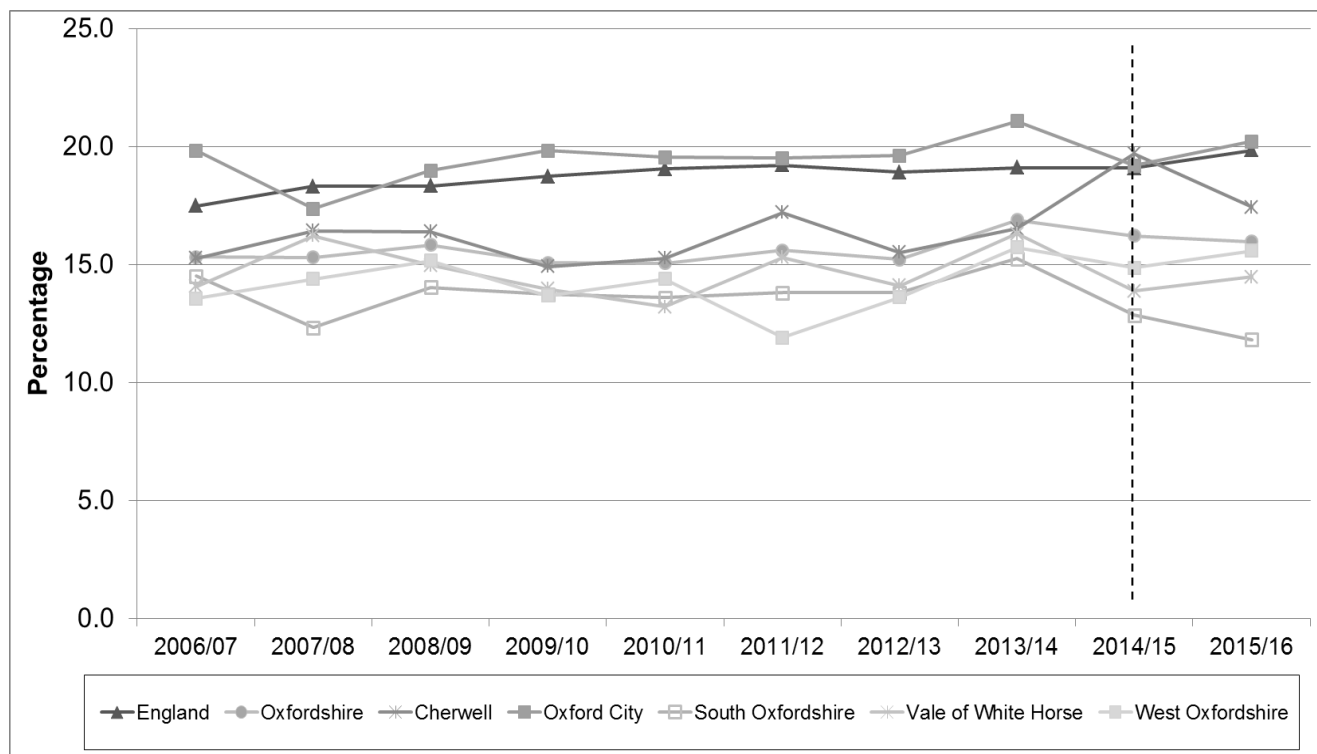


Source: National Child Measurement Programme

- Prevalence of childhood obesity among this age group has remained fairly level at around 7% with some fluctuation at a district level.
- We continue to buck the national trend which is just over 9% and this is a good result.
- Levels of obesity in this age group remain higher in Oxford City, probably reflecting the association between social disadvantage and higher levels of obesity.

Indicator 10. Obesity in Year 6 (10/11 years)

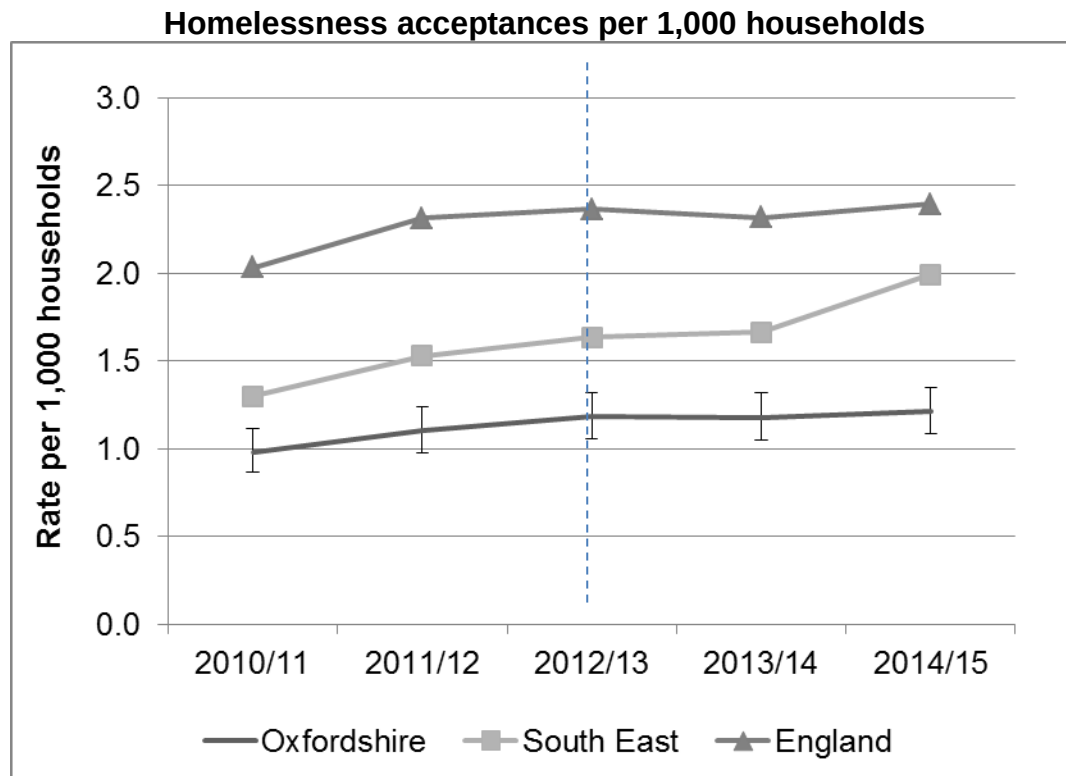
**Percentage of year 6 children (10-11 years old) who are obese
2006/07 to 2015/16 (Academic years)**



- The county figure has continued to fall and is around 16% - better than the England average by almost 4 percentage points (19.8%). This is a significant achievement.
- Oxford City has a higher rate at 20%, again, probably reflecting higher average rates of social disadvantage.
- After an increase in 2014/15 the rate in Cherwell has decreased to 17% for 2015/16 which is good news.

Indicator 11. Homeless Households

Homelessness is a direct reflection of disadvantage to families and is therefore a useful overall indicator.

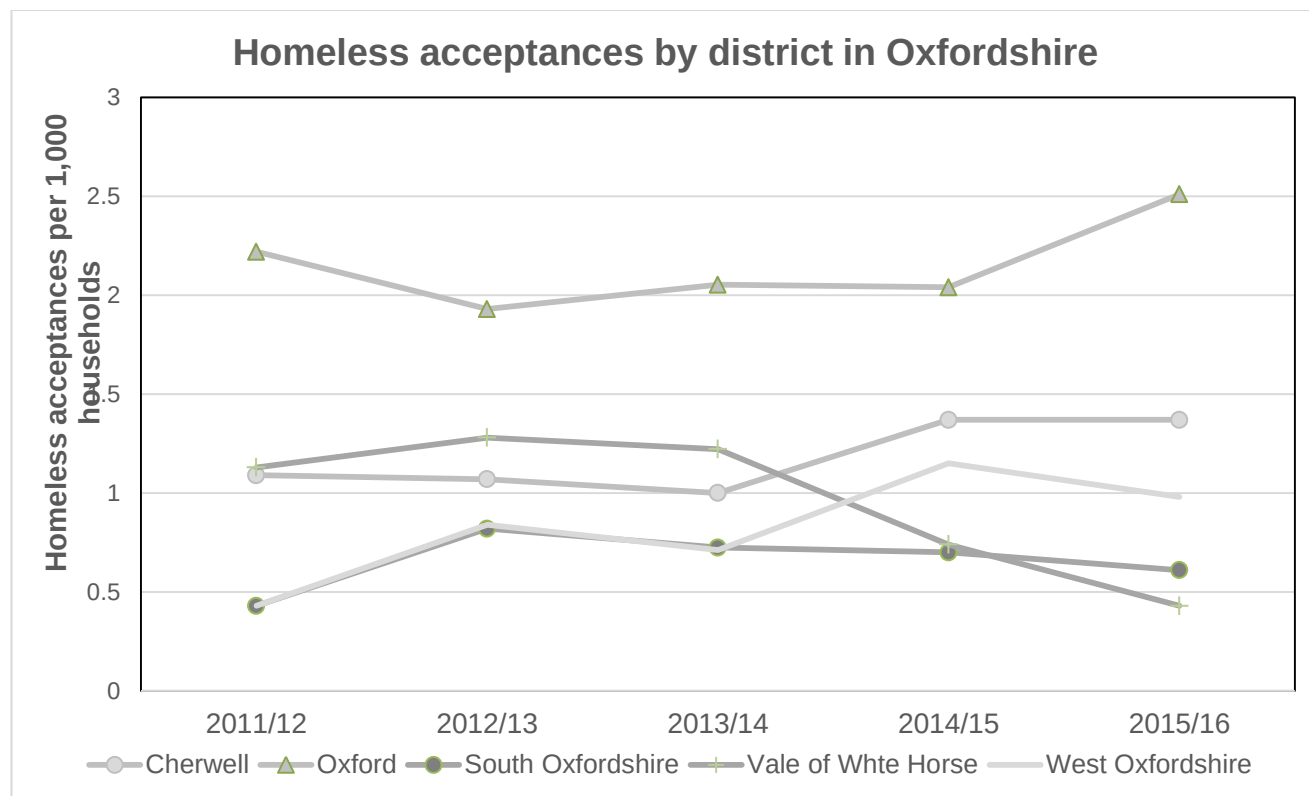


The chart shows that:

- Oxfordshire's results are well below the national average and have remained fairly stable.
- National figures are slightly up and regional figures show a sharp upward trend.
- It is a good result that Oxfordshire's figure is both lower and more stable than our regional neighbours.

Homelessness acceptances per 1000 households by districts in Oxfordshire

We know that homelessness varies widely across the different Districts. As this is an important indicator, it is worth drilling down more into the data to look at the trends at District level.



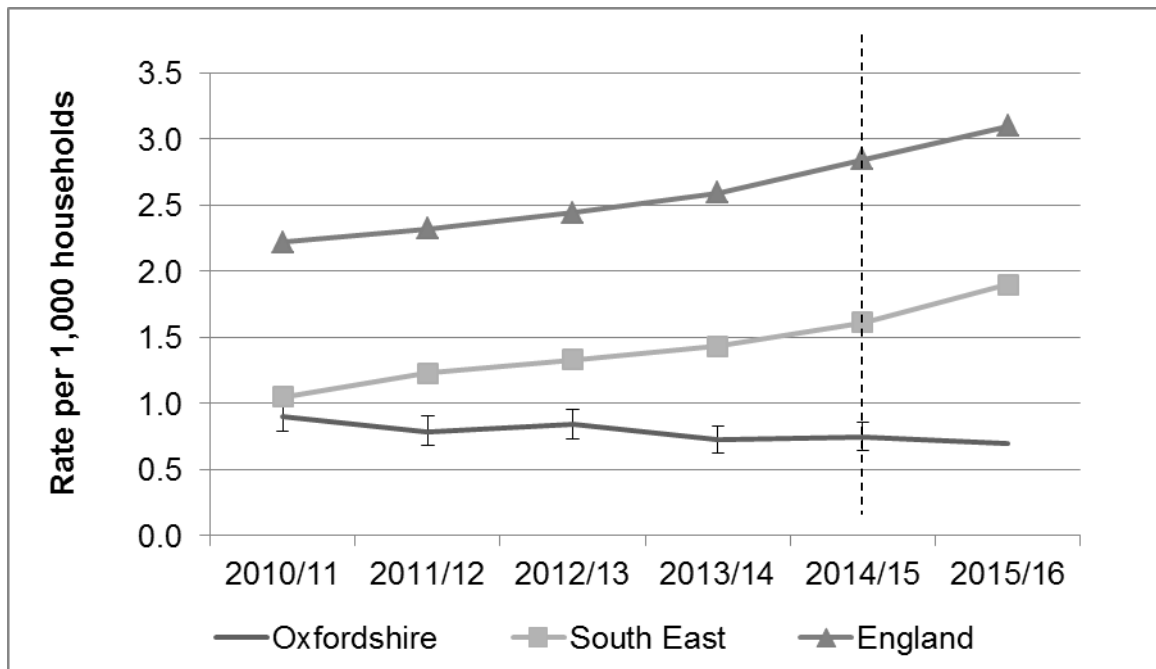
The chart shows that:

- Oxford City has increased to 2.5 homeless acceptances per 1,000 households (higher than the rate for England), putting the level higher than it has been in recent years. This is concerning and the trend needs to be monitored closely. It is possible for quite wide random fluctuations to occur in this data as the numbers involved are quite small and so a watching brief is appropriate, but the figure is a cause for concern.
- The rates in the other districts have also fluctuated – up slightly in Cherwell and down in South Oxfordshire and West Oxfordshire. Vale of the White Horse continues to show a marked downward trend.

Indicator 12. Households in temporary accommodation

Homelessness is prevented in part by placing families in temporary accommodation. This is not a good option in terms of life-chances, but it is better than facing homelessness.

Households in temporary accommodation per 1,000 households



The chart shows that:

- The rate in Oxfordshire shows a gradual continued reduction while rates nationally and regionally have increased.
- This is a good result and indicates overall success in tackling disadvantage.

Summary from the basket of indicators.

Statistics around teenage pregnancy, teenage mothers, obesity, young people in employment and training, households in temporary accommodation, homelessness overall and breastfeeding show good or reasonable results indicating that progress is being made.

Statistics around child poverty, school readiness and homeless acceptances in the city require a close watching brief.

What we said last year and what we have done about it

Last year's recommendations are set out below with a commentary on progress made:

1. The report of the Commission for Health Inequalities should be studied carefully when it is published and all organisations should use it to challenge current practice and make appropriate changes to services.

Progress report: Good progress has been made and this is set out immediately below.

2. Trends in disadvantage should continue to be monitored closely in Director of Public Health Annual Reports

Progress: This has been done through the Joint Strategic Needs Assessment and through this report.

3. The Children's Trust is requested to consider the basket of children's indicators proposed in this report and to drill down into indicators to uncover further inequalities at more local level using data from services.

Progress: This is scheduled to happen shortly.

4. The NHS's Sustainability and Transformation Plan should target disadvantaged groups and seek to level up inequalities. The NHS 'offer' should not be 'one size fits all'.

Progress: In the event, the consultation was divided into two parts. Disadvantage featured in the local phase 1 consultation document published by the CCG earlier in the year.

However, it is the mooted phase 2 consultation on community services which will probably reflect whether variations between localities have been adequately taken into account to ameliorate health inequalities, so it is too early to form a judgement.

The Work of Oxfordshire's Health Inequalities Commission

I want to report here on the most significant event in tackling health inequalities and disadvantage which happened during the year – a report on the work of Oxfordshire's Health Inequalities Commission.

What is the Health Inequalities Commission?

The independent Health Inequalities Commission for Oxfordshire was commissioned by the Health and Wellbeing Board and carried out its work throughout 2016. It was the brainchild of the Chair of Oxfordshire's Clinical Commissioning Group and took two years of persistent effort to bring about. The Clinical Commissioning Group, the County Council's Public Health team, along with many other partners, including Oxfordshire Healthwatch played a midwife role. The report of the Commission was presented by the independent Chair, Professor Sian Griffiths, to the Health and Wellbeing Board in November 2016 and at a launch event on 1st December, chaired by the Leader of the County Council, attended by the media and a wide range of partners.

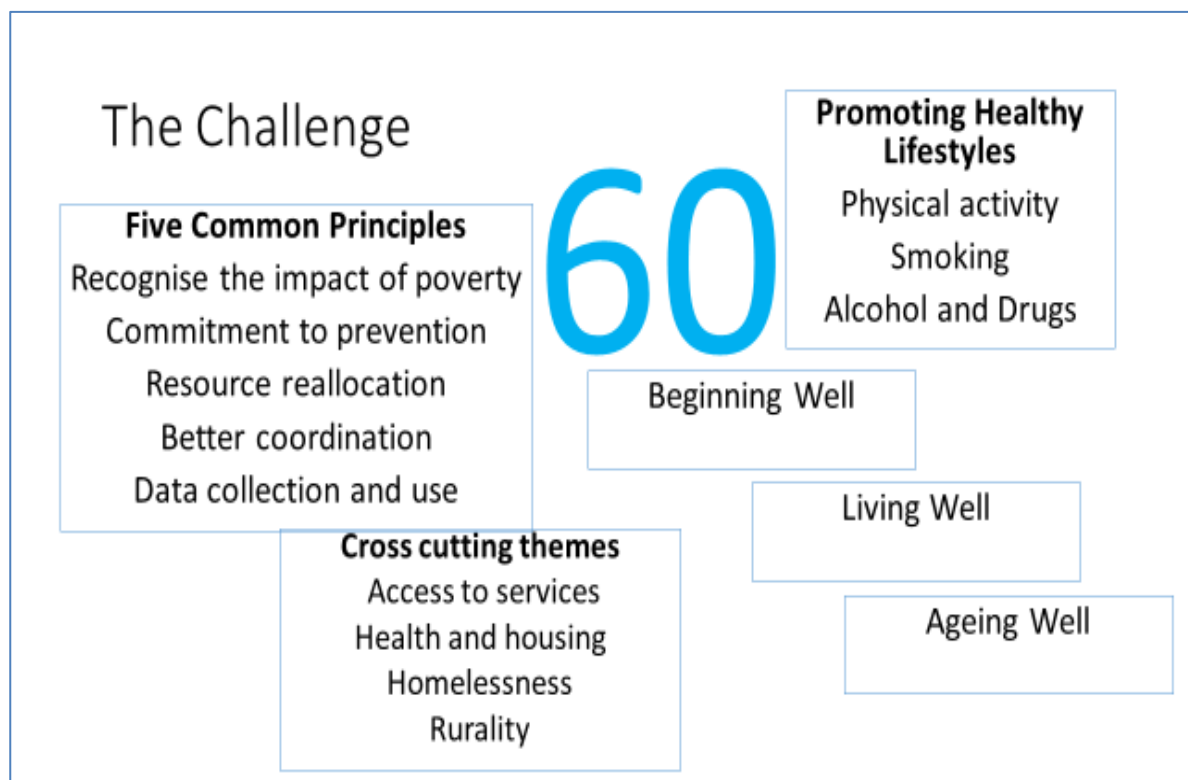
The Health Inequalities Commissioners were independent members selected from statutory and voluntary sector organisations and academia. They received written submissions and verbal presentations from a wide range of people and organisations at four public meetings held around Oxfordshire in the winter and spring of 2016. Local data and information on health inequalities were also presented to the Commissioners supported by access to a wide range of local and national documents, including the Director of Public Health Annual Reports, the Joint Strategic Needs Assessment and data from Public Health England.

What did it say and who signed up to its recommendations?

The Introduction to the report of the commission summarised their remit as follows:

Health inequalities are preventable and unjust differences in health status. People in lower socio-economic groups are more likely to experience chronic ill health and die earlier than those who are more advantaged. But as Sir Michael Marmot has highlighted, health inequalities are not just poor health for poorer people but affect us all – “it is not about them, the poor, and us the non-poor: it is about all of us below the very top who have worse health than we could have. The gradient involves everyone”.

There are 60 recommendations in the report which are arranged in a set of themes as follows:



How are we taking it forward and who is involved?

The Health and Wellbeing Board agreed to oversee the implementation of the recommendations and receive regular updates.

The report was discussed by a wide range of organisations who signed up to deliver the recommendations, including:

- Oxfordshire Health and Wellbeing Board and its subgroups - The Children's Trust, The Health Improvement Board and the Joint Management Group for Older People.
- Oxfordshire Clinical Commissioning Group Executive, Board and Localities.
- Oxford University Hospitals Foundation Trust Management Executive and Public Health Steering Group

- Oxford Health Foundation Trust Board
- The Stronger Communities partnership in Oxford and the linked Local health partnerships in Wood Farm and Rose Hill
- Cherwell Local Strategic Partnership and 'Brighter Futures' in Banbury
- Oxford City Council Scrutiny Committee, in their oversight capacity.

In addition, an Implementation Workshop was held in May 2017 attended by a wide range of public and voluntary sector organisations. They began the process of identifying current work and discussing how this can be developed.

It may be impossible to keep a complete overview of the activity that develops as a result of the report, as many groups and organisations have renewed their efforts and energy in addressing health inequalities – that was one of the goals of the Commission, to mainstream the debate about health inequalities. This is good news. In addition, a multi-agency Implementation Steering Group has now been set up and will work together in taking forward the recommendations in a more formal way. Their first tasks include:

- Making sure there is a comprehensive overview of all the recommendations and what is being done in response
- Setting up a workshop to explore social prescribing (prescribing healthy activities) as a means of improving health inequalities and beefing up existing prevention initiatives
- Setting up a (modest) Innovation Fund and determining the criteria by which money pledged by all local authorities and the Clinical Commissioning Group can be used effectively.

How do we keep this initiative going?

It is important to maintain the interest and focus on tackling inequalities and disadvantage that have been stoked by the Health Inequalities Commission. This can be done in several ways:

- Demonstrating the impact of current work and new developments on tackling inequalities will keep the momentum going. Keeping watch over a range of indicators that show the variation in health outcomes will be important and a basket of indicators is being drawn up to help with that.
- Changing systems so that they address inequalities. For example, commissioning new services should consider the needs of people in the population who have worse outcomes or poor access to services. The Joint Strategic Needs Assessment and other sources of information will help with this needs assessment.
- Adopting the "Health in All Policies" approach to developing public policies which looks at the health implications of decisions, tries to join things up and prevents harmful health impacts.

- Making sure major plans, such as the Sustainability and Transformation Plan and Joint Health and Well Being Strategy, include action to address inequalities and deliver results.
- Using the Innovation Fund well and attracting more funding to sustain and develop good practice and make a difference.

This annual report is part of that process, and also aims to help carry the torch lit by this work.

What concrete things have happened as a result?

Individual organisations will of course be taking their own actions, not all of which we will know about, and this is to be welcomed. The report aims to galvanise us all – not just the big organisations. The process of bringing about change in the statutory services will be a long haul and we are still putting the foundations in place - but there are already some encouraging signs that things are happening:

The response to the call to improve prevention initiatives includes:

- Oxfordshire Sport and Physical Activity have begun to prepare plans for improving levels of physical activity in disadvantaged groups. Although an initial bid to Sport England to take the work forward was unsuccessful, other opportunities are being worked through.
- A database of food banks and other free or affordable food suppliers has been drawn up by Good Food Oxford. They are also providing 'food poverty awareness' training for front line services and have developed guidelines on "healthy cooking" for those who are training people in cooking skills.

Challenges to improve inequalities faced by vulnerable groups are being responded to, for example:

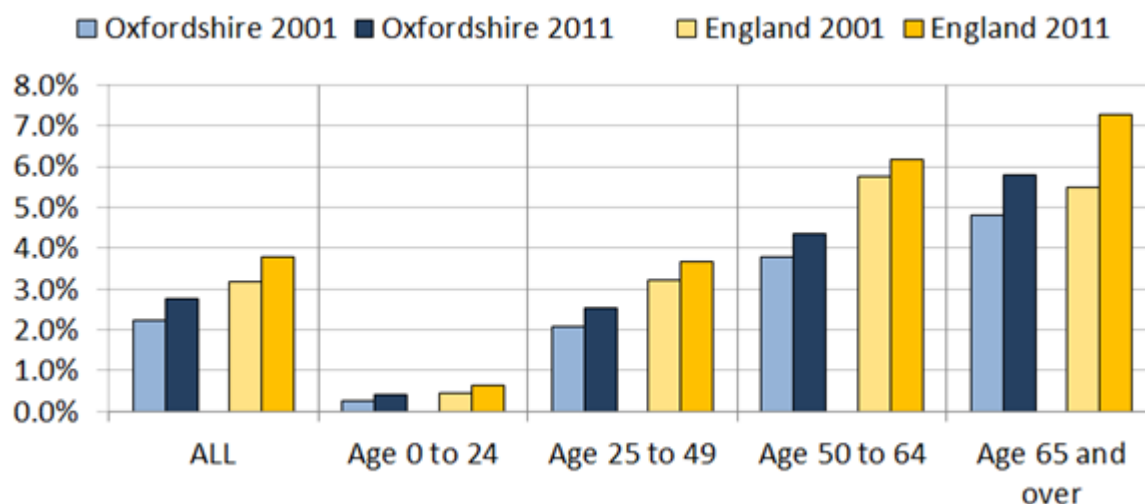
- Planning to make Barton a dementia friendly community as part of the Barton Healthy New Town initiative.
- A Trailblazer grant to reduce homelessness on discharge from hospital or prison. This involves a wide range of partners, led by the City Council.
- Programmes that promote personal resilience and positive lifestyle choices are being run for specific vulnerable groups. This includes a programme for people recovering from drugs or alcohol misuse which is called "Get Connected", run by Aspire and Turning Point. A similar programme, "Active Body, Healthy Mind", is run for mental health service users along with access to regular physical health checks.
- A pilot project has been set up to provide counselling to children who are asylum seekers or refugees. This is already in place in Oxford Spires Academy and needs more funding to be expanded. This is led by Refugee Resource.

Caring for others as a cause of disadvantage

Previous reports have highlighted caring for others as a factor which can cause disadvantage. Before I close this chapter I am keen to report on the current situation.

Looking at the last two censuses shows the following picture for Oxfordshire compared with national data:

% of people providing 20 or more hours of unpaid care per week by age 2001 to 2011, Oxfordshire and England



The chart shows:

- An increase in the proportion of people providing unpaid care (of 20 or more hours per week) across all age group in Oxfordshire.
- The proportion of carers in each of the broad age groups in Oxfordshire remains below the England average.
- Between 2001 and 2011, the increase in the proportion of carers in the age group 50 to 64 in Oxfordshire was above the increase in that age group nationally.

As highlighted in previous reports, carers do a marvellous job, and organisations should continue to make sure they are well supported and taken into account when planning new services.

Recommendations

1. The Health and Wellbeing Board should ensure that the work of the Health Inequalities Commission continues to be taken forward.
2. The Basket of indicators of inequalities in childhood should be reported in the DPH annual report next year. The Health Improvement board should monitor homeless acceptances closely during the year.
3. The next phase of the Oxfordshire Sustainability and Transformation Plan should target disadvantaged groups and seek to level up inequalities. The service 'offer' should not be 'one size fits all' and the needs of different parts of the county should be recognised.

Chapter 4: Lifestyles and Preventing Disease Before It Starts

We are what we eat, breathe, drink and do: whichever way we look at it, how we live our lives has a huge impact on our health. True, our genetics at birth deal us a basic hand of cards to play, but how well we feel, and how long we live has a lot to do with how we play our hand. What's your game-plan?

This chapter looks at some of the things people in Oxfordshire do that affect their health and looks at some of the actions we are taking to inform them of their choices and give them a helping hand.

This isn't about nannying, it's about giving the people the inside info to help them make the best choices they can.

The Health Survey for England gives us a good place to start – and the picture here will apply pretty well to Oxfordshire. In 2015 a total of 8,034 adults (aged 16 and over) and 5,714 children (aged 0 to 15) were interviewed. 5,378 adults and 1,297 children had a nurse visit as part of the survey.

The headlines (which we will unpack in this chapter) were:

- Smoking in adults fell from 28% in 1998 to 18% in 2015 – this is excellent. However, we know that around 25-30% of manual workers still smoke – this is a serious health inequality
- Alcohol consumption in adults is falling slowly (bringing with it a decline in alcohol related disease) – good news
- Obesity and overweight increased – it is now the new 'norm', with around half of adults overweight or obese – this is bad news for our future health.
- Children reporting smoking and drinking both fell steeply – more good news –though of course new threats like 'new psychoactive substances' (formerly called "legal highs") may be filling some of this gap.
- I would also add that teenage pregnancy continues to fall both locally and nationally – which is also good news.

So, what does this quick overview tell us?

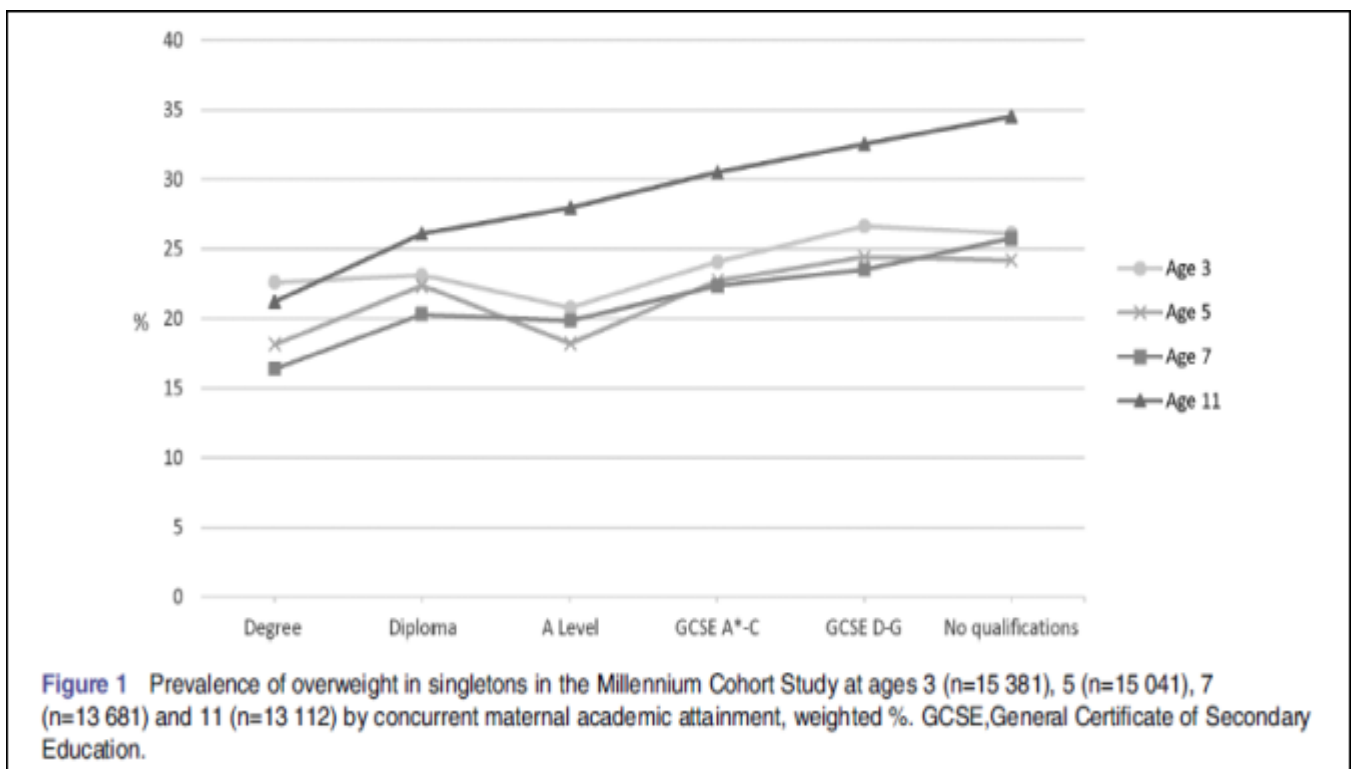
It tells us that the lifestyle challenge that is still on the rise is all about obesity. Let's look at that first.

Obesity, Diet and Exercise

I'm not for a moment minimising other challenges and issues, but the unavoidable fact is that as a society the problem we are storing up for ourselves is all about our weight. Why? Because it leads to heart disease, cancer, mobility and disability problems and costs the economy an estimated £27bn, the NHS £6bn and social care £350m each year.

We also know that it is an inequalities issue and affects women more than men, unskilled workers more than skilled and Black and Asian ethnic groups more than white.

The UK Millennium Cohort Study, published an update in 2017 which illustrates this point beautifully. The following chart from the report shows very clearly that prevalence of children overweight increased by age and by lower maternal academic attainment. Mothers without qualifications (and so with less income and fewer choices) had on average children who were around 75% more likely to be overweight than mothers with degrees. The chart also underlines the steady increase in overweight children with age.



We saw again in the previous chapter that obesity begins early – doubling between reception year and year 10, and continues to increase into adulthood.

A recent report from Public Health England sets out the situation with regard to physical inactivity well;

“Put simply, we are not burning off enough of the calories that we consume. People in the UK are around 20% less active now than in the 1960s. If current trends continue, we will be 35% less active by 2030. We are the first generation to need to make a conscious decision to build physical activity into our daily lives. Fewer of us have manual jobs. Technology dominates at home and at work, the 2 places where we spend most of our time. Societal changes have designed physical activity out of our lives.”

This won't be news to anyone who has read these reports before as it has featured as an issue in ten out of ten reports. Why? Because it is still a problem and, as a collective, we still haven't cracked it..... although there may be some 'green shoots' of hope emerging.

If it matters so much, and we all know about it, why is it so hard?

I suspect this is for a number of reasons which I have teased out below. This isn't about victim blaming – absolutely not – this is really hard stuff – if it wasn't, it wouldn't be such a problem. In brief, the issues seem to be:

1. What we want regarding our lifestyles short-term works against us long-term when it comes to weight gain. We want comfortable lives, we want to travel by car or public transport, we want to watch TV, we want fast and easy food - and all these things lead to weight gain over time.
2. Our genetic programming may work against us. The evolutionists tell us we are programmed to gobble goodies when we see them to hedge against times of famine from our hunter-gatherer days (e.g. a glut of ripe fruit on a tree) by building up a fat store. That makes sense, but we are fortunate that the famine doesn't come any more, and so the fat builds up.
3. Because weight gain is insidious and we are hard-wired for short term responses. We seem to be programmed to respond to immediate dangers and tend to be blind to longer term issues.
4. Because the problem becomes invisible when the majority have it – I suspect that if you could bring a coach full of time-travellers from the 1950's they would be truly surprised to see us now.
5. Because the answer is multi-faceted. The answer isn't simple and implies change by individuals, families, organisations employers and government. We need a 'team UK' effort – and this is always difficult.
6. Because it isn't fair –Our metabolic rates and our genetic make-up are like hands of cards dealt to us at birth. It means that we put on the pounds in different patterns to one another. Where one loses another gains – it isn't fair. It also means that the answer isn't a one shot deal. The answer will vary from individual to individual and this makes setting a consistent policy harder.
7. Because it changes with age. I think many of us know that if we were to eat now what we ate as twenty-somethings we would put on weight very quickly. We are probably on average also less active than in our younger days. This implies that our eating and exercise patterns need to change with age. It is another challenge of an ageing society – how do we adapt to each decade, because the answers at 25 do not apply to 55.
8. Because it's so easy to put on weight and so hard to get it off. It's a bit like a lobster pot: easy to get into and hard to get out again. Many of us have tried slimming, and I think we all know how difficult it is to keep the pounds off once they have been lost. It does take a lifestyle change- and that can be hard graft.
9. Because we don't like preaching – especially if it makes us feel a bit uncomfortable. The messages are I think clear to us all. But they can get a bit 'preachy' and that tends to make us close our ears.

So what do we do?

The answer has to come through teamwork between the individual, family, government, employers, planners and organisations. It's about 1000 adjustments to 1000 tillers to turn the flotilla we all sail in..... and there are green shoots - for example, in the last year or two:

- The health messages continue to seep home into the public's mind – the '5 a day' message is well embedded and shoppers are demanding healthier prepared foods – and the supermarkets are responding.
- At national level, Government has taken steps to improve food labelling and to reduce the sugar content of drinks.
- The climate in schools is changing – take for example the adoption of the 'daily mile' in schools across the country.
- Health and exercise options are being main-streamed by planners into new developments.
- The inequalities issues are clearer - and our Health Inequalities Commission report helps.
- Front-line health professionals are more willing to consider giving lifestyle advice during routine consultations.

And more locally.....

- We have made very good progress in building exercise options into planning through the Healthy New Towns.
- The Health Improvement Board has made useful efforts to begin bringing recreation and leisure services together with the Sports Partnership to update its healthy weight strategy.
- The NHS has taken the topic of 'making every contact count' more seriously so as to get health advice into more face to face consultations.
- More schools are looking at options such as the 'daily mile'.

What Did We Say Last Year and What Have We Done About It?

We said that this topic should become a priority for the NHS's Sustainability and Transformation Plan – this has happened on paper, but there is no spare cash to fund the scale of change needed.

We said that the Health Improvement Board should play its part in partnership activity and this has been more than achieved.

What should we do next?

To keep it brief, this is a long haul, so essentially it is more of the same – more awareness, more coordination and more money are required.

Recommendations regarding obesity, diet and physical activity.

1. The NHS should continue to seek a serious investment fund to take this work forwards.
2. The Health Improvement Board should continue to coordinate the activities of all Local Authorities and the NHS
3. Planners should continue to plan communities that support active lifestyles until this is the norm.

Alcohol

There seems to have been a helpful shift in drinking patterns that will reap benefits in the decades to come.

Previous reports have set out the real health risks of alcohol as a causative factor for a wide range of diseases and its corrosive effects on society when consumed to excess.

I am not saying the problems have gone away altogether because:

- There were over 1 million alcohol related hospital admissions in England in 2015 and over 23,000 deaths related to alcohol.
- Alcohol is a causal factor in many medical conditions including mouth, throat, colon, liver and breast cancers; strokes and heart failure; liver disease and pancreatitis as well as road traffic accidents and injuries due to falls.
- Alcohol affects us all – for example, the highest earners (those earning £40,000 and above annually) are more likely to be frequent drinkers and “binge” on their heaviest drinking day when compared with the lowest earners.

But on the other hand:

- Overall alcohol consumption in the UK has decreased between 2000 and 2014, reducing from over 10 litres of pure alcohol per person aged 15+ to around 9.5 litres per head
- The proportion of the adult population of Great Britain (aged 16 and over) who drink alcohol has fallen from 64% in 2005 to only 60% in 2016).
- Young people aged 16 to 24 years in Great Britain are less likely to drink than any other age group.
- Alcohol consumption in young people in general is falling

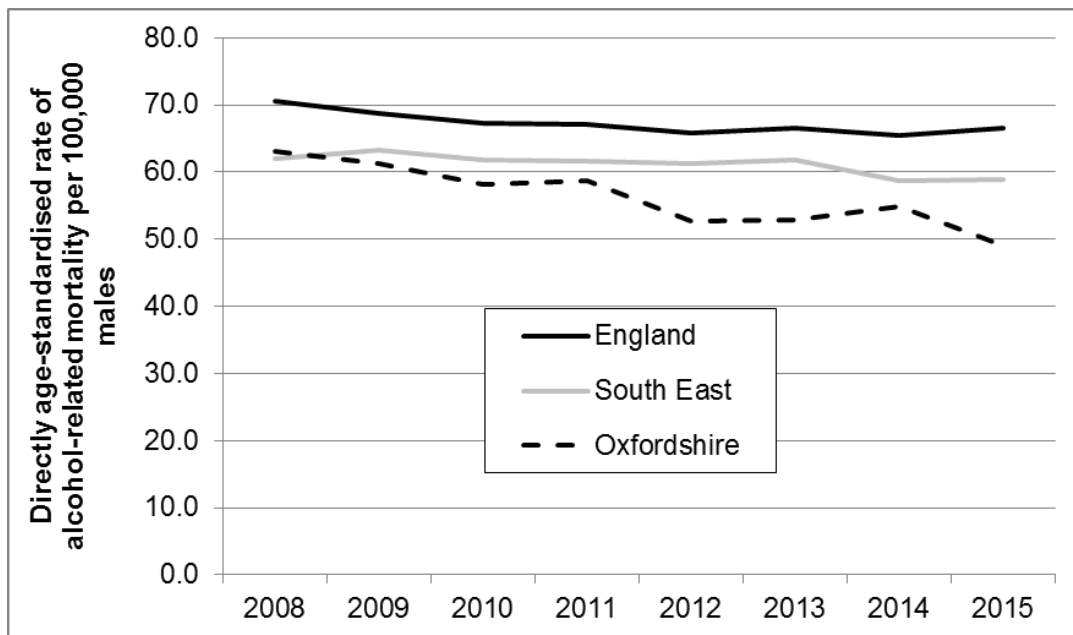
Why should this be?

I'm not sure anyone really knows. It may be that the health messages have hit home, or it may just be one of those complex societal 'fashions'. My money would be on the latter. Looked at over centuries, the average trend in alcohol consumption per capita has always fluctuated. We may have entered a down-turn and, whatever the reason, that is very good long term news.

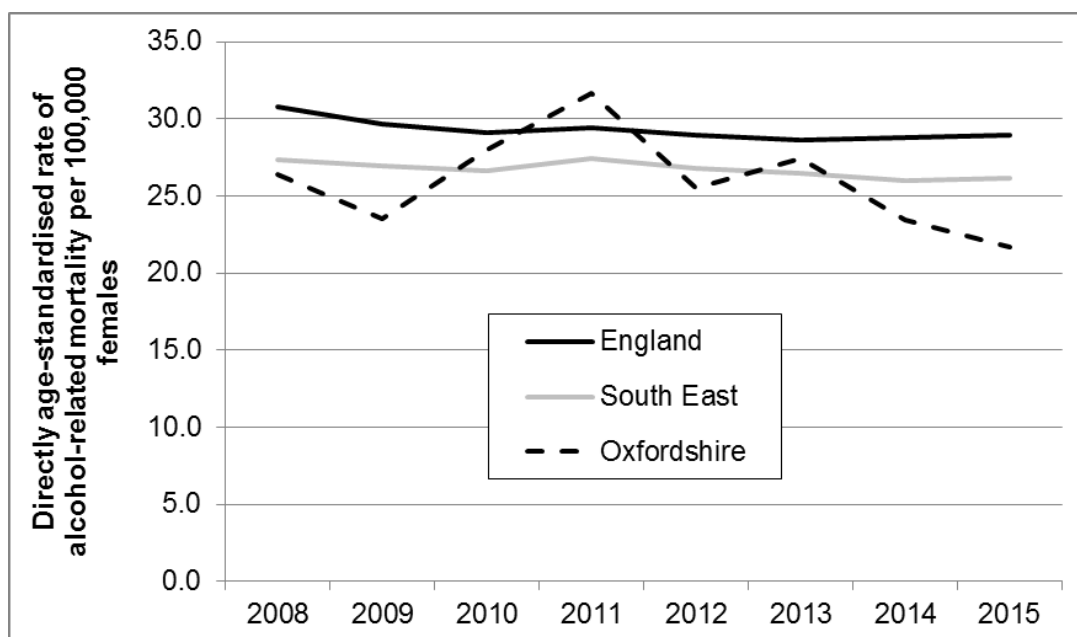
The statistics paint the picture well:

- Alcohol related deaths in males and females have been declining over the last 6 of 7 years and the figures are better for Oxfordshire than nationally. Also, deaths in females are around half of those in men

Alcohol-related mortality – males



Alcohol-related mortality – females

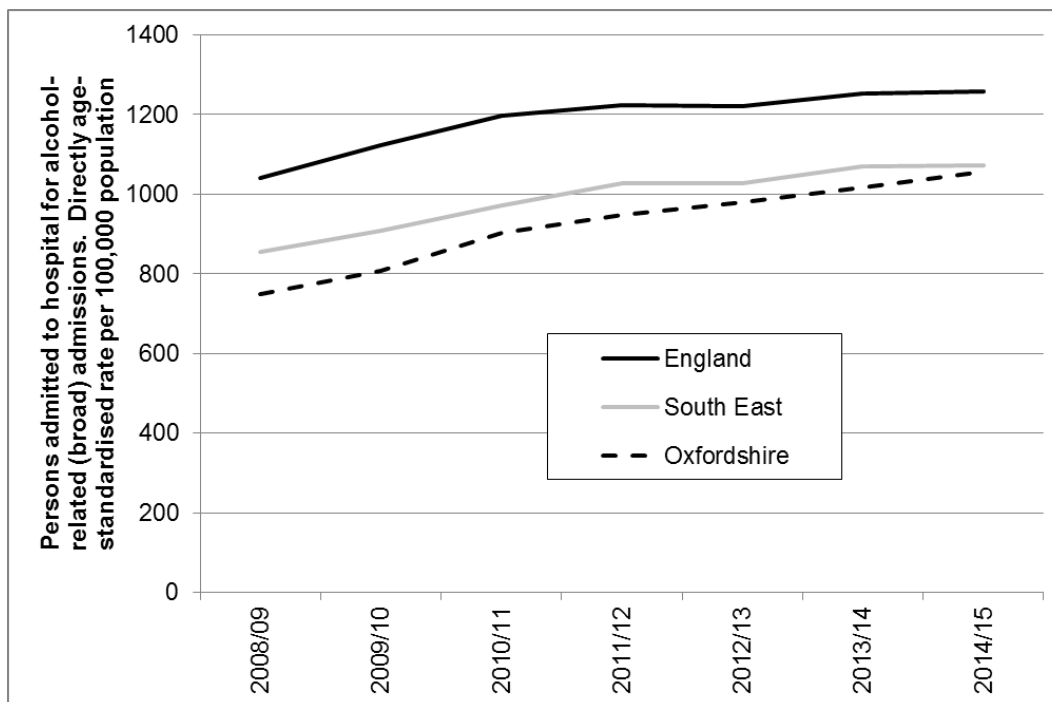


However, we aren't out of the woods yet as the figures for alcohol-related hospital admissions continue to show an upward trend. You can see this in the charts below which show people

admitted to hospital each year per 100,000 population. Because alcohol-related disease is long term, this might be the long term legacy of the drinking habits of previous decades – time will tell.

Whatever the reason, it is good news that the levels in Oxfordshire are well below national levels.

Persons admitted to hospital for alcohol-related conditions) - all ages



What Did We Say Last Year and What Have We Done About It? Achievements in 2016-17

The Alcohol and Drugs Partnership reports the following progress in partnership work:

1. Identification and Brief Advice (IBA)

The goal is to equip professionals with the confidence to give brief advice to people who are drinking too much. The partnership's role is to train the professional. This year the training was expanded to include smoking cessation and all sessions have been well attended by a range of professionals including those working in adult social care, early Intervention services, mental health organisations, charities, housing providers, primary care, pharmacies and Oxford University Hospitals Trust.

2. Targeted alcohol campaigns

This year the Dry January campaign was again supported by the Fire and Rescue Service, and included 'mocktail' sessions run by Alcohol Concern. Advertising for the campaign included social media, the County Council's Yammer pages as well as an article in the Oxford Mail.

3. Improvement in Pathways to treatment.

Oxfordshire treatment services have been working hard to improve pathways between local hospitals and their services. Referral routes from both A&E and ward admissions back into the community have been reviewed as well as barriers to communication and continuation of prescribing. Staff from Turning Point (a drug and alcohol treatment organisation) continue to develop joint-working with the NHS, and a community alcohol detoxification nurse attends the John Radcliffe Hospital weekly to discuss patients and provide on-going community support for patients leaving hospital.

4. Street Pastors

Street Pastor schemes continue to flourish in the City and several market towns across Oxfordshire. Street Pastor schemes work in partnership with organisations such as the Police, Local Authorities, local door staff and licenced premises. They patrol the streets with a remit to 'care, listen and help'. Between April and September 2016 over 577 people were assisted by the street pastors.

What we said last year and progress made

Recommendations for 2016-17 were set out as follows:

1. The NHS should use the Sustainability and Transformation Plan to embed brief advice for people with problem drinking into all consultations. This is a real opportunity to nip alcohol related diseases in the bud.
2. This should be backed up by staff training and support.

Progress report: This work is ongoing and, due to delays in publishing the Transformation Plan for Oxfordshire, it is not yet clear that last year's recommendations have been fully implemented.

Recommendations for 2017-18

1. The NHS should continue use the Sustainability and Transformation Plan to embed brief advice for people with problem drinking into all consultations. This should be backed up by staff training and support.
2. Campaigns should focus on the impact of alcohol on health so that there is increased awareness of the harmful effects of alcohol on cancer and cardiovascular disease in particular.

NHS Health Checks

The NHS Health Check is a national cardiovascular risk assessment and prevention programme which is commissioned by the County Council. It is delivered by local GPs and has been commissioned by the County Council's Public Health team since 2013

NHS Health Checks specifically target the top seven causes of preventable death: high blood pressure, smoking, high cholesterol, obesity, poor diet, physical inactivity and alcohol consumption.

Eligible individuals aged 40-74 years are invited for a Check every five years (191,000 people), which means that 20% of this age group are invited per year and every eligible person is invited at least once every five years. The 40-74 age range is set nationally because it has been determined that this is the group in which detection and prevention of cardiovascular disease is most cost effective.

In Oxfordshire, the Health Improvement Board has set a target of 55% of those invited for a NHS Health Check take up the offer and receive the Check.

In 2016/17 in Oxfordshire 34,667 people were offered NHS Health Checks (18.2% of eligible population) and 17,847 checks were completed (9.3% of the total eligible population and 51.5% of those offered a check). This is an improvement on 2015/16 in terms of uptake (51.2% in 2015/16), but a decrease in percentage offered (20% in 2015/16) and percentage completed.

During 2016/17 of the 17,847 people who had a Health Check:

- **896 people were found at high risk of CVD, with 417 people now taking a statin**
- **275 people diagnosed as having high blood pressure, with 252 now on an antihypertensive drug**
- **63 people were diagnosed with diabetes**
- **1537 people were given brief advice regarding smoking, with 148 people referred/signposted to the local stop smoking service**
- **6310 people were given brief advice regarding physical activity, with 1706 people referred/signposted to the local physical activity services**
- **5821 people were given brief advice regarding weight management, with 283 people referred/signposted to the local weight management services**
- **1574 people completed a screening tool for their alcohol consumption. In addition 1658 people were given brief advice regarding alcohol, with 8 people referred to the local alcohol services.**

This is a good result.

What Did We Say Last Year and What Have We Done About It?

Last year we said we would continue to bring the NHS Health Check programme to the public's attention in new and innovative ways to further raise awareness in the local community. This peaked with a month long campaign in January using local radio and advertising on transport links- which is thought to have contributed to the increased uptake in quarter 4.

We also said we would continue to work with GPs to improve the uptake of the offer, including the invitation process. Commissioners are working with GPs to investigate a combined approach of electronic communications from GPs and simultaneous targeted marketing online to improve uptake of the offer.

The commissioning team continue to closely support practices and have visited every practice as part of quality auditing the programme. They provide feedback to GP practices on how to improve on the quality of the programme. The approach to quality auditing taken by the public health team is still considered a national exemplar.

Recommendations for NHS Health Checks

The NHS Health Check programme continues to perform well, is now well embedded in the health system and is well received by the public. However, the concerted efforts to raise the profile of this programme with the public and improve on it must be maintained. In order to achieve this we need to:

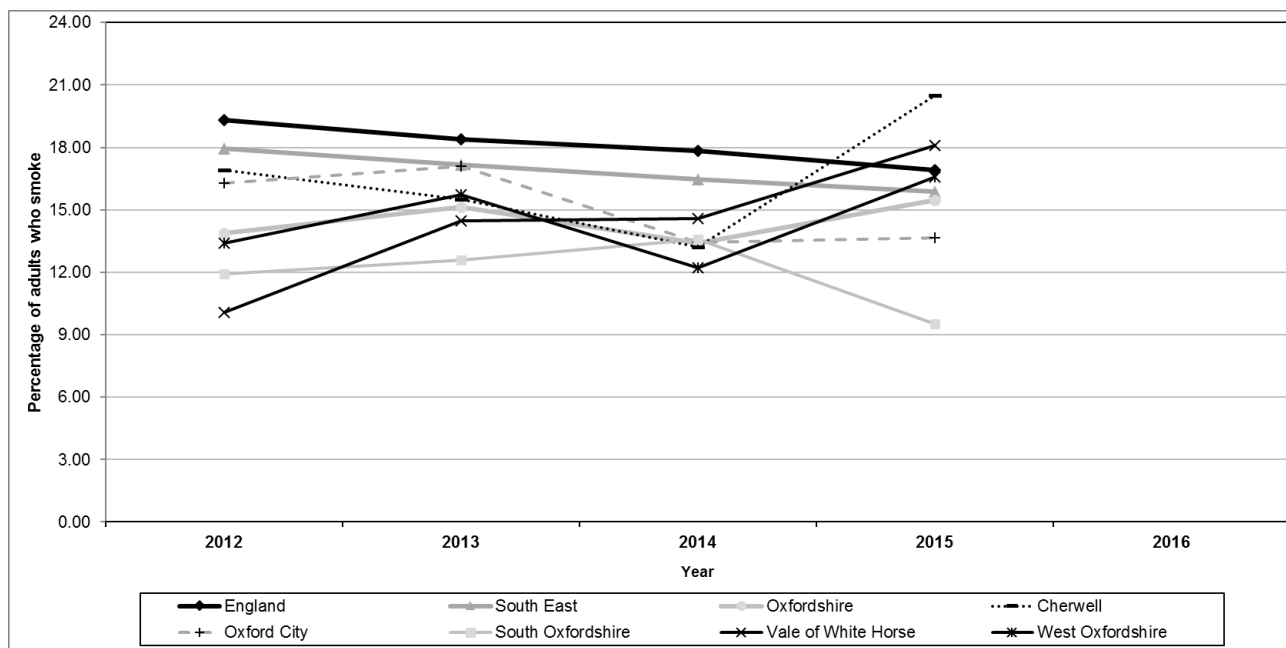
1. Continue to market the NHS Health Check programme in new and innovative ways which take advantage of emerging technologies to raise awareness and understanding of the benefits of the programme with the public.
2. Continue to work with GPs to improve on the uptake of the offer of a free NHS Health checks and investigate new ways to best collaborate on improving the invite process.
3. Better identify and engage with high risk groups to take up the offer of a free NHS Health Check.

Smoking Tobacco

Smoking Tobacco continues to be the single most harmful thing you can do to damage your health. Smoking causes conditions ranging from cancers, vascular diseases and events such as heart attacks and strokes, and dementia. In Oxfordshire the prevalence of adult smokers has seen a very welcome continued decline in the past few years. This decline is shown in the figure below. The prevalence of adults who smoke in Oxfordshire is currently estimated to be 15.5% (an estimate of 91,892 people) which is better than the national prevalence (16.9%). This is a good result.

The chart below shows the results. Because this is based on a survey of a limited number of people, the national line will be accurate, the County line fairly accurate and the District lines far less accurate and subject to wide fluctuations.

Smoking prevalence in individuals aged 18+ by District in Oxfordshire



(Source PHE)

However, we still cannot be complacent about smoking rates in the County. There is still an inequality in who smokes, with much higher levels of smoking found in more disadvantaged communities. Indeed, in routine and manual workers the level of smoking is as high as 29% - double the County average. To meet this challenge, we need to target services at the groups who need help the most.

Smoking is highly addictive and the best thing for health is not to start. Although the trend for smoking in young people is falling the prevalence of young people aged 15 years who report in the survey that they are current smokers is 10.4%. This is significantly worse than the national average of 8.2%. While this is of concern some caution has to be exercised as the data is estimated based on responses provided to surveys of young people and can be subject to statistical errors (i.e. in plain speak it may be a 'blip'). We should monitor this trend to see if this is a consistent finding.

Stop Smoking Services

The decline in people accessing traditional stop smoking services seen in recent years was halted in Oxfordshire with 1923 quits recorded for 2015/16 – three less than in the previous year total of 1926. This was against the national decrease of 10% in the recorded number of quits recorded nationally. This is to be applauded but preventing a further decline in recorded quits is becoming increasingly difficult. Why? Because there are fewer smokers 'out there' and there has been a sea-change in the way people choose to quit tobacco – increasingly opting for self-help solutions rather than statutory services.

The impact of the dramatic increase in the use of e-cigarettes in the UK is the most significant contributor to the reduction in people accessing stop smoking services. Latest data estimates:

- An estimated 2.9 million adults in Great Britain currently use e-cigarettes up from 700,000 in 2012

- For the first time there are more ex-smokers (1.5 million) who use e-cigarettes than current smokers (1.3 million).
- Over half (52%) of e-cigarette users are now ex-smokers and 45% continue to smoke as well.
- The main reason given by ex-smokers who are currently vaping is to help them stop while for current smokers the main reason is to reduce the amount they smoke.
- The use of e-cigarettes as a quit aid and their increasing usage has opened a debate in the public health community on a national and international scale. Currently in 2017, public perceptions of harm from e-cigarettes still remains inaccurate with only 13% accurately understanding that e-cigarettes are a lot less harmful than smoking. Among those who smoke, perceptions of e-cigarettes are also getting more negative, with only 20% accurately believing in that e-cigarettes are a lot less harmful than smoking compared with 31% in 2015.

With the increasing amount of conflicting information for and against e-cigarettes becoming available in the public arena there has naturally been confusion for the public and health professionals alike.

Public Health England have helped to clarify the position and published an evidence update which concluded that e-cigarettes are significantly less harmful to health than tobacco and have the potential to help smokers quit smoking.

The report also concluded there is no evidence so far that e-cigarettes are acting as a route into smoking for children or non-smokers. This is further supported by a report from the Royal College of Physicians published in April 2016 which states that e-cigarettes are an effective method for people wanting to quit tobacco and the hazard to health arising from long-term vapour inhalation from the e-cigarettes available today is unlikely to exceed 5% of the harm from smoking tobacco.

How should we move forward?

Our current services are now outdated. We need to move to a service which helps the general public but which also actively seeks out smokers in the most at-risk groups.

The public health team, in line with The National Institute for Health and Care Excellence (NICE) recommendations, are considering the following main areas for future services:

- Mass media and other education campaigns
- General education campaigns aimed at everyone;
- Media campaigns aimed at under 18s.
- Planning evidence based stop smoking services;
- Preventing children and young people from taking up smoking;
- Illegal sales
- Coordinated approach in schools
- Developing services which encourage better uptake in disadvantaged and minority communities who have higher rates of smoking.

Recommendations regarding smoking

1. The Health Improvement Board should continue to monitor activities of local smoking services and wider agencies to help people quit smoking and also not start in the first place.
2. Commissioners should re-commission services to deliver a blend of services to meet the changing attitudes and use of stop smoking services.

Oral Health

The marked improvement in oral health and the number of adults keeping their teeth as a result of better brushing with fluoride toothpaste and more awareness of oral health is welcome. However nationally in England the biggest cause of child hospital admission for general anaesthetic procedure is to provide dental extractions due to severe tooth decay. Tooth decay is one of the most easily preventable diseases and the high level of extractions under general anaesthetic is avoidable.

The picture in children

Local data is based on national surveys whose sample size is really too small to draw firm conclusions at lower than County level. However, looking at the national data, we can see that tooth decay is linked with other measures of general social disadvantage and so is a further source of inequality in the County. Latest available data from the 2015 oral health survey of five-year-old children shows that 77% of 5-year-old children are now free from any dental decay which is higher than the national average of 75% and improved locally from 67% since the 2012 survey. Whilst this is a good result there is room for improvement, the number of children who are decay free is significantly lower in Oxford than the other districts at 67%, probably reflecting social disadvantage.

During the 2016/17 dental teams have been conducting the latest national five-year-old children's survey and we expect to refresh the local data in the next twelve months.

The major sources of sugar which causes decay in children are found in soft drinks and cereals. Locally we will continue the work to educate children and parents about the impact of dietary choices on teeth and also wider health.

The picture in adults

Tooth decay has fallen in adults in England from 46% having active decay in their teeth in 1998 to 28% in 2009. The main sources of sugar in adults' diets come from cereals, soft drinks, jams and sweets.

Older adults are now keeping their own teeth into old age as the norm. The proportion of 65 to 75 year olds with their own teeth increased from just 26% in 1979 to 84% in 2009- a significant change. As the population ages it will be important that the NHS keeps pace with this changing need - particularly as the number of people needing more complex dental work rises steadily with age.

What are we doing and what should we do next?

Since the NHS reorganisation, the responsibility for oral health has been split three ways. The NHS has a responsibility for dentists and more specialised oral surgery, Public Health England provides dental public health advice while Local Government has an emphasis on prevention and commissioning oral surveys in line with the national programme.

The oral health promotion and dental epidemiology service commissioned by the County Council has been in operation since 1st April 2015. This service aims to work in collaboration with wider dental services to prevent oral health problems in children and adults. The range of activities provided by the service include:

- Accreditation scheme for pre-school settings
- Piloting tooth brushing programme in primary schools. Four primary schools took part in the pilot programme in which children brushed their teeth under supervision of staff. The programme developed better understanding of oral health and improved brushing skills in children, making tooth brushing a routine part of the day which improved attitudes to brushing in the young children involved.
- Training of school health nurses in oral health promotion to promote a 'whole school' approach to oral health in education such as through making plain drinking water freely available, providing a choice of food, drinks and snacks that are sugar-free or low in sugar and form part of a healthier diet (including those offered in vending machines), and displaying and promoting evidence-based, age-appropriate, oral health information for parents, carers and children, including details on how to access local dental services.
- Piloting an accreditation scheme for care homes for elderly residents. The pilot successfully accredited three care homes as oral health promoting environments. The service trained staff to better understand the oral health needs of residents, the causes of oral disease, good oral hygiene for their residents and how to access dental services. The participating care homes also developed policies to better promote oral health for residents.
- Delivering oral health promotion sessions and events throughout the county
- Training health visitors in oral health to better understand the causes of tooth decay, oral development in young children, looking after teeth in young children and accessing dental services.
- Training staff who work in the community with children and adults to promote oral health with their client and user groups including causes of tooth decay, oral hygiene and access to dental services.
- Delivery of oral health promotion in local workplaces including Siemens and Thames Valley Police.
- Promotional events during National Smile Month and Mouth Cancer Awareness Month
- Provision of a lending service of health promotion resources for local stakeholders.

In the next year the oral health promotion service will

- Continue the supervised tooth brushing scheme in primary schools. Two of the schools in the pilot are planning to continue the programme and the service is looking to recruit new schools for the 2017/18 academic year.
- Find ways to reach a wider number of care homes.
- Continue to train staff in healthcare and community settings to become oral health promoters within their workplace with their service users and make every contact count.
- Continue support of oral health promotion development within both school health nurse and health visitor services.
- Continue to participate in oral health promotion events and sessions in the community to directly work with the public on raising the awareness of the importance of good oral health and accessing dental services.

Recommendations for Oral Health

1. The NHS should ensure that improvements in access to NHS dentistry are maintained including complex care and domiciliary care for older people and work continue to work to reduce child admissions for dental extractions under general anaesthetic.
2. Providers of care home facilities should be aware of maintaining good oral health in their clients which can significantly affect their quality of life. Commissioners of the oral health promotion should work with colleagues to develop this programme to increase the number of care homes who sign up to this programme.
3. Continue to work with school health nurse and health visitor services to embed oral health prevention and promotion into children's health from 0-19, allowing for a healthier oral health start to life.
4. Continue to develop the supervised brushing scheme in primary schools, developing on the encouraging work of the pilot programme.

Chapter 5: Mental Health

Mental Health - Children and Young People

I reported last year on mental health in children and young people and I want to keep that focus this year.

Last year I reported on two topics – trends in mental wellbeing in this age group in general and self-harm.

Looking at each of these in turn, we noted that:

- mental wellbeing and mental distress are difficult to define and measure in this age group and that what is classed as a mental health problem changes over time
- however, the indications are that living in the modern world and a digital age puts new stresses and strains on young people
- young people are coming forward to seek help – and we can see this in the work of our school health nurses and through rising referrals to NHS services
- this increase is no bad thing as it also shows young people's awareness of the issues they face and also young people's general self-help attitude.

To recap, the picture of emotional resilience and mental wellbeing can be summed up as being built up in the following ways:

- Positive relationships with caring adults
- Effective caregiving and parenting
- Intelligence and problem-solving skills
- Self-regulation skills
- Perceived efficacy and control
- Achievement / motivation
- Positive friends or romantic partners
- Faith, hope, spirituality
- Beliefs that life has meaning
- Effective teachers and schools

In contrast, when these factors are deficient, the individual's resilience is likely to be lowered and there is a greater vulnerability to stresses and strains.

Regarding more severe mental health problems in Children and Young People, the main facts are:

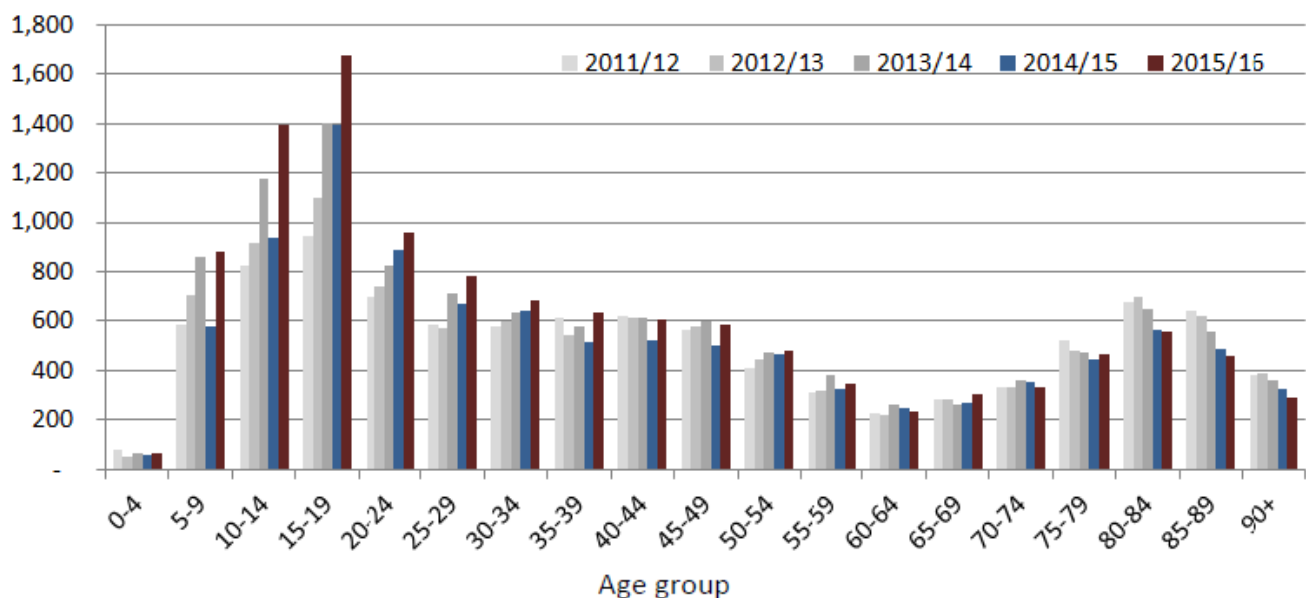
- 1 in 10 children and young people aged 5-16 suffer from a diagnosable mental health disorder; that is around three in every class at school or 8,000 children across Oxfordshire. According to national prevalence rates about half of these (5.8%) have a 'conduct disorder', whilst others have an emotional disorder (anxiety, depression) and Attention

Deficit Hyperactivity Disorder (ADHD). The prevalence increases with age and rises to 20% for the 16-24 age groups.

- The most disadvantaged communities and the most disadvantaged groups have the poorest mental and physical health and wellbeing. **Children from the poorest 20% of households have a three-fold greater risk of mental health problems than children from the wealthiest 20%.** Parental unemployment is also associated with a two-to three-fold greater risk of emotional or conduct disorder in childhood. This doesn't mean that one causes the other, it simply points out that the two factors are found together in the same families.
- Children and young people with poor mental health are more likely to have poor educational attainment and employment prospects, social relationship difficulties, physical ill health, substance misuse problems and to become involved in offending.
- These issues are therefore significant and important.

In very general terms I suspect that what we are seeing overall is a generation who are subject to more moderate stresses (cyber-bullying for example), and that they have an increasing awareness of this, and, most importantly that they are seeking help. The chart below shows this through the rise in referrals of young people to mental health services.

Number of Oxfordshire residents referred to Oxford Health mental health services (2011-12 to 2015-16)



Source: Oxford Health NHS Foundation Trust

- The 15-19 age group continues to make up the largest proportion and number of patients referred to Oxford Health mental health services in 2015-16 and has seen the biggest increase since 2011-12.
- Between 2011-12 and 2015-16, the number of patient referrals aged 15-19 increased by 77%

I reported last year that children and young peoples' mental health service had just been overhauled. This is timely. The results of this were that a new contract for a new service model was awarded. The new service focusses on early prevention and intervention in partnership with voluntary agencies, public health services, education and children's social care to ensure children, young people and their families can get information, advice and support (including self-care) when there are emerging mental health problems. This is aimed at preventing more chronic and complex mental health problems, which can affect long term outcomes into adulthood.

We should also note the very valuable contribution our School Health Nurses make to the treatment of mental distress day in day out in our secondary schools.

The new service features:

- A single point of access for all referrals including self-referrals and clear publicised pathways for the most common conditions
- Active support for families and individuals to help them access other community services where this is more appropriate
- Partnership with voluntary organisations to support families better and improve movement between services for the young people with the most complex problems
- Reducing waiting times to improve access to support and treatment using evidence-based interventions to improve long term outcomes into adulthood
- Consultation, information and advice to families, young people and the wider children's workforce and the promotion of self-care and use of technology.
- Prevention and early intervention by working in schools and colleges to provide consultation, training and treatment in partnership with school health nurses and children's social care services

The service will include newly established specialist services such as:

- A dedicated Eating Disorder Service
- A new therapeutic team specifically working with young victims of child abuse and child sexual exploitation
- A new team to work with children who are 'Looked After' and those young people who are on 'the edge of care'
- An Autism Diagnostic Service with support for families after a diagnosis has been made
- A forensic psychiatry post working in the young people's housing pathway providing mental health expertise to some of our most complex young people and building capacity in the housing provider market

The focus for the first year is to deliver the 'single point of access' which will improve access to consultation, information and advice and treatment and, in addition, to start transforming the service into providing prevention and early intervention through working with primary and secondary schools across Oxfordshire. This includes School Health Nurses and improving integration and joint working with Children's Social Care. Voluntary organisations will play a key role as partners in delivering Child & Adolescent Mental Health Services (CAMHS).

This is clearly a substantial change and seems to respond well to the needs of young people. Implementation will take time – working with every Oxfordshire school is a huge task and a long process.

I think these are useful steps in the right direction.

Careful monitoring of this service and of new trends in the overall wellbeing of this age group will be essential.

Self Harm

I also reported last year on self-harm and reviewed the recent upward trend.

The last year has seen a mixed picture.

Measuring self-harm using hospital admissions shows that:

- rates in 10-14 year olds are down slightly
- rates in 15-19 year olds are up slightly
- rates in 20-24 year olds are down slightly

All of these figures are similar to the national picture. The trends we are seeing in Oxfordshire around self-harm are part of a national picture rather than a local one.

The new service mentioned above is intended to help to relieve the stresses that result in self-harm. It will be important to monitor the situation to see if there is a lasting impact.

In addition, last year I reported on an initiative that the Public Health team had undertaken locally. To recap, we commissioned a local Oxfordshire theatre company, Pegasus, to perform a play on self-harm in secondary schools across the county. The play was called 'Under My Skin'. Its aims were to:

- Give young people vital information about coping with feelings around self-harm, stress and the relevant services that can support them.
- Reduce the stigma of discussing self-harm and accessing support.
- Highlight the School Health Nursing service as a first port of call in schools for young people and professionals who have concerns over self-harm.
- Give professionals information and subsequent confidence about how to support a young person, and who to refer to.

The evaluation of the play showed that:

- It went to 28 secondary schools and was very well received.
- Approximately 5000 young people in years 8/9 (ages 12-14) watched the play.
- 50% reported the play increased their knowledge of self-harm a lot.
- 71% of young people knew how to access support after seeing the play.

As a result, we have re-commissioned the play again for the academic year 2016/2017.

It is important that professional help to young people is made part of the mainstream of many services rather than as a stand-alone service.

Examples of this in action are shown by the following 'snapshots' of work in hand in mainstream services across Oxfordshire:

- School Health Nurses have been trained in child & young person mental health through a programme called PPEPcare. The training includes:
 - Supporting young people with low mood
 - Supporting young people with anxiety
 - Supporting young people who self-harm
- In addition, our nurses have run awareness campaigns to ensure that young people are aware of techniques they can use to improve their well-being and where they can access support should they need it.
- School Nurses also support young people with exam stress – and example comes from the Matthew Arnold School where the School Nurse ran sessions with sixth formers approaching exams. This will lead to 'Chill Out Tuesday' and 'Wind Down Wednesday' next year for all young people approaching exams.
- By the end of March 2017, the Oxfordshire Young Carers Service had identified and supported a total of 2,684 children and young adults (aged 0 -25 years) who provide unpaid care to a family member. Caring is also well known as an additional cause of stress for young people. This included 456 new young carers identified in the year 2016-17.
- The Health Visiting service also has a role to play - the County Council have commissioned Oxford Health NHS Foundation Trust to create a specialist post which will set up new postnatal mental health groups and train those who run them. This recognises that addressing mental health needs of mothers is paramount in promoting mental wellbeing and preventing mental health problems in their children.

In summary, self-harm is an important issue. There is evidence that services are responding well, but this situation needs to be actively monitored.

Recommendation

Children and Young Peoples' mental health and wellbeing and its related services should be monitored in future Director of Public Health annual reports.

Chapter 6 – Fighting Killer diseases

Main messages for this chapter:

Part 1. Epidemics and Antimicrobial Stewardship

The improvement in the quality of our living conditions and the advances in modern medicine have meant that the threat of major illness and large numbers of deaths due to communicable disease are seen as a problem of times past.

The continuing vigilance of Public Health services and sound planning of local and national organisations to respond to the spread of communicable diseases means that most of us can go about our daily lives without being aware of the efforts to protect the wider community from disease. The Ebola and Zika outbreaks of recent times are stark reminders of the continuing threat that can arise at any time and present a very real risk to us all, irrespective of borders. The Ebola cases in the Democratic Republic of Congo and elsewhere act as a stark reminder of the need for continual vigilance across the world.

We need to continue to prioritise the work that is done in the background every day of the year to prepare for the worst and the unimaginable. Directors of Public Health work closely with Public Health England and the NHS across Thames Valley to ensure that the response to any threat will be matched by a coordinated response to any outbreak, wherever it may arise. It is important that this partnership and cooperation is continued.

The right response still remains systemic and calm planning and organising ourselves NOW so we can respond when the need arises without fear or panic. The need to remain vigilant still holds true.

A continuing cause for concern is the threat of **antibiotic resistance** and the rise of “superbugs”. Antibiotics are important drugs for animals and humans in fighting bacterial infections which were once life-threatening. Bacteria are highly adaptable and the widespread misuse of antibiotics and inappropriate prescribing of antibiotics continues to lead to bacteria which have developed resistance to the antibiotics which were once effective.

The risk of bacteria which cannot be treated by any existing antibiotics is a real threat here in the UK and throughout the world. We continue to see outbreaks of resistant strains of bacteria, if we do not act we will see the number of resistant strains increase.

Failure for us all to act responsibly now could see antibiotics becoming ineffective and the return of people dying of once curable infections, returning us to the situation before the discovery of penicillin.

How do we keep this work going?

Success depends on several key elements:

- Maintaining a well-qualified and well trained cadre of Public Health specialists in Local Government.
- Continuing to build and maintain long standing relationships with colleagues in Public Health England and the NHS.
- Mainstreaming our plans by working with the Police, Military and many of the other organisations under the auspices of the Thames Valley Local Resilience Forum (LRF).
- Educating and advising professionals and the public of their role as individuals in limiting antibiotic resistance.

It is vital to keep the specialist workforce we have now to continue with this important work.

Part 2. Infectious and Communicable Diseases

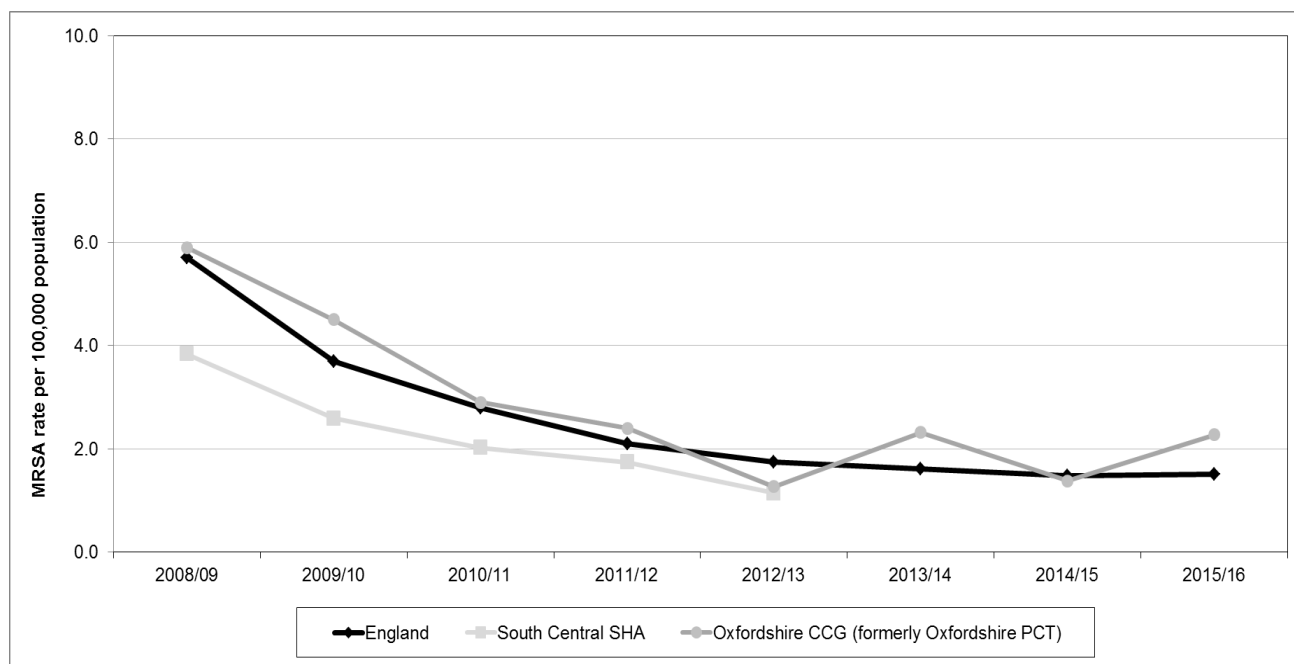
Health Care Associated Infections (HCAIs)

Infections caused by superbugs like Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium difficile (C. diff.) continue to be an important cause of avoidable sickness and death, both in hospitals and in the community. These infections do not grab headlines as they have in the past but they still need everyone to remain vigilant to limit an increase in the incidence of infection.

Methicillin Resistant Staphylococcus Aureus (MRSA)

MRSA is a bacterium found commonly on the skin. If it gains entry into the blood stream (e.g. through an invasive procedure or a chronic wound) it can cause blood poisoning (bacteraemia). It can be difficult to treat people who are already very unwell so it is important to continue to look for causes of the infection and identify measures to further reduce our numbers of new cases of infection. MRSA has fallen gradually in Oxfordshire in response to the direct measures taken by hospital and community services to combat it. The local situation is shown below.

Methicillin Resistant Staphylococcus aureus (MRSA) - crude rate per 100,000 population (2008/09 - 2015/16)



Public Health England (PHE), Health Protection Agency (HPA)

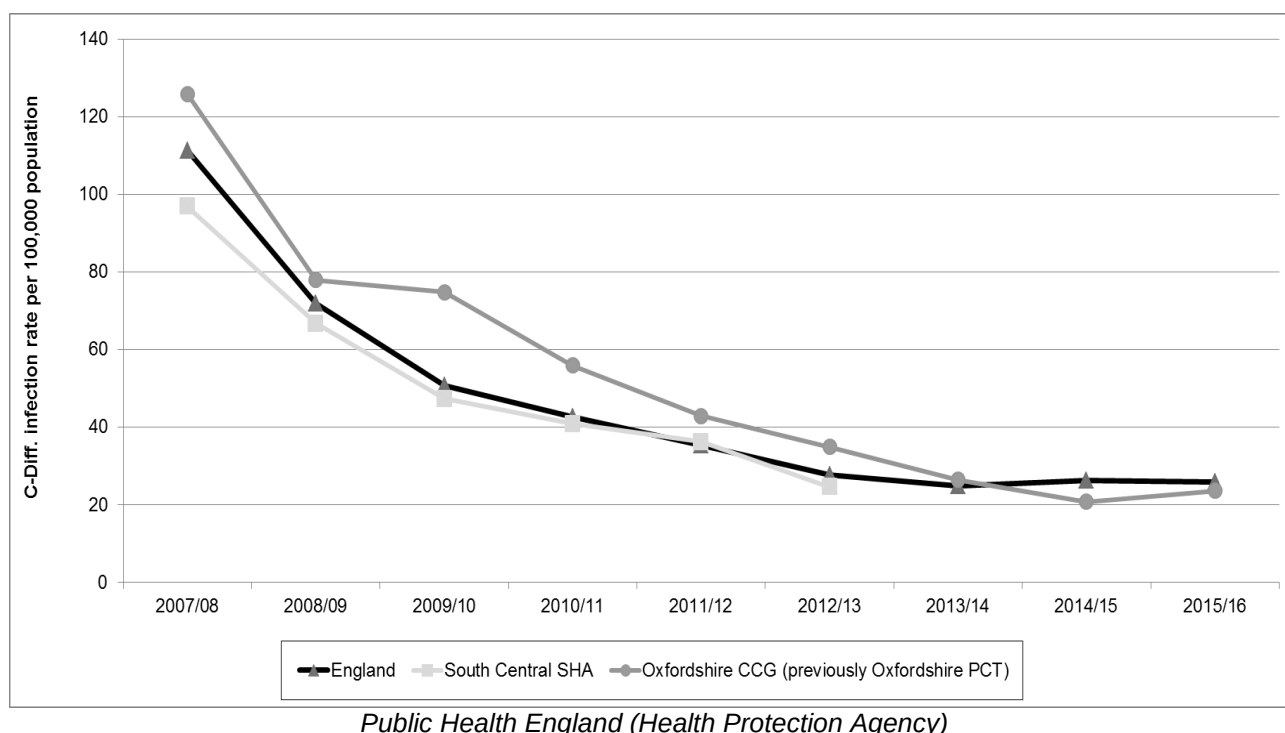
This shows that infections can be tackled, often by traditional hygiene methods. Nationally there is a zero tolerance policy and the rate of MRSA is still higher than we would like. There have been improvements in Oxfordshire over the past few years. However, the levels in Oxfordshire have increased slightly again in 2015/16 to be higher than the national average. This slight increase, which may be a statistical 'blip' due to the small number of cases each year reaffirms why continued vigilance is required by all hospital and community services to combat MRSA infections.

Clostridium difficile (C.diff)

Clostridium difficile is a bacterium that causes mild to severe diarrhoea which is potentially life-threatening especially in the old and infirm. This bacterium commonly lives harmlessly in some people's intestines but commonly used broad spectrum antibiotics can disturb the balance of bacteria in the gut which results in the C.diff bacteria producing illness.

A focussed approach on the prevention of this infection has resulted in a steady reduction in cases in Oxfordshire since 2007/08 as shown in the chart below which is in line with the National trend. The reduction in C.diff involves the coordinated efforts of healthcare organisations to identify and treat individuals infected and also careful use of the prescribing of certain antibiotics in the wider community. There are still on-going concerted efforts locally to continue to improve on the rate of C.diff infections.

**Clostridium Difficile Infection (CDI) - crude rate per 100,000 population
(2007/08 to 2015/16)**

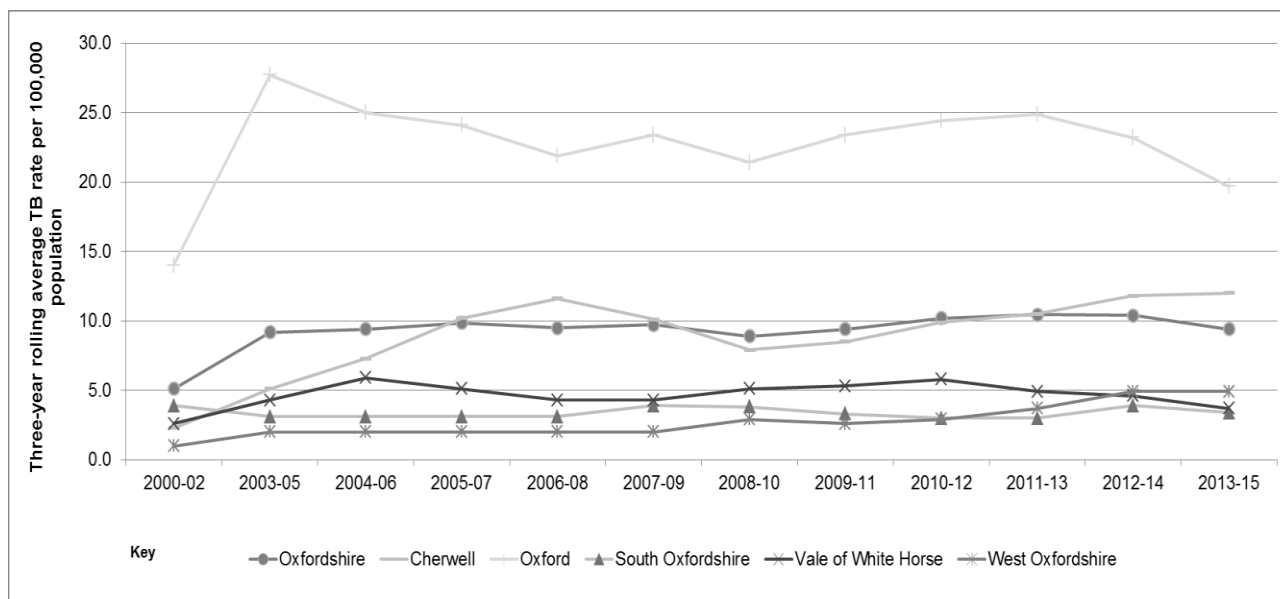


Tuberculosis (TB) in Oxfordshire

TB is a bacterial infection caused by Mycobacterium Tuberculosis which mainly affects the lungs but which can spread to many other parts of the body including the bones and nervous system. If TB is not treated, active TB can be fatal.

In Oxfordshire, the numbers of cases of TB at local authority level per year are very low. The local figures are shown below.

Tuberculosis (TB) – Incidence rate per 100,000 population (2000-2 to 2013-15)



Public Health England, Health Protection Agency (HPA) Enhanced Tuberculosis Surveillance

The levels of TB in the UK are beginning to show a reduction due to coordinated efforts by TB control boards across England to improve TB prevention, treatment and control.

The rate of TB in Oxfordshire is lower than the National average and similar to average levels in Thames Valley. In the UK the majority of cases occur in urban areas amongst young adults, those moving into the area from countries with high TB levels and those with a social risk of TB (e.g. homeless people). This is reflected in the higher rate of TB in Oxford compared to other Districts in the County.

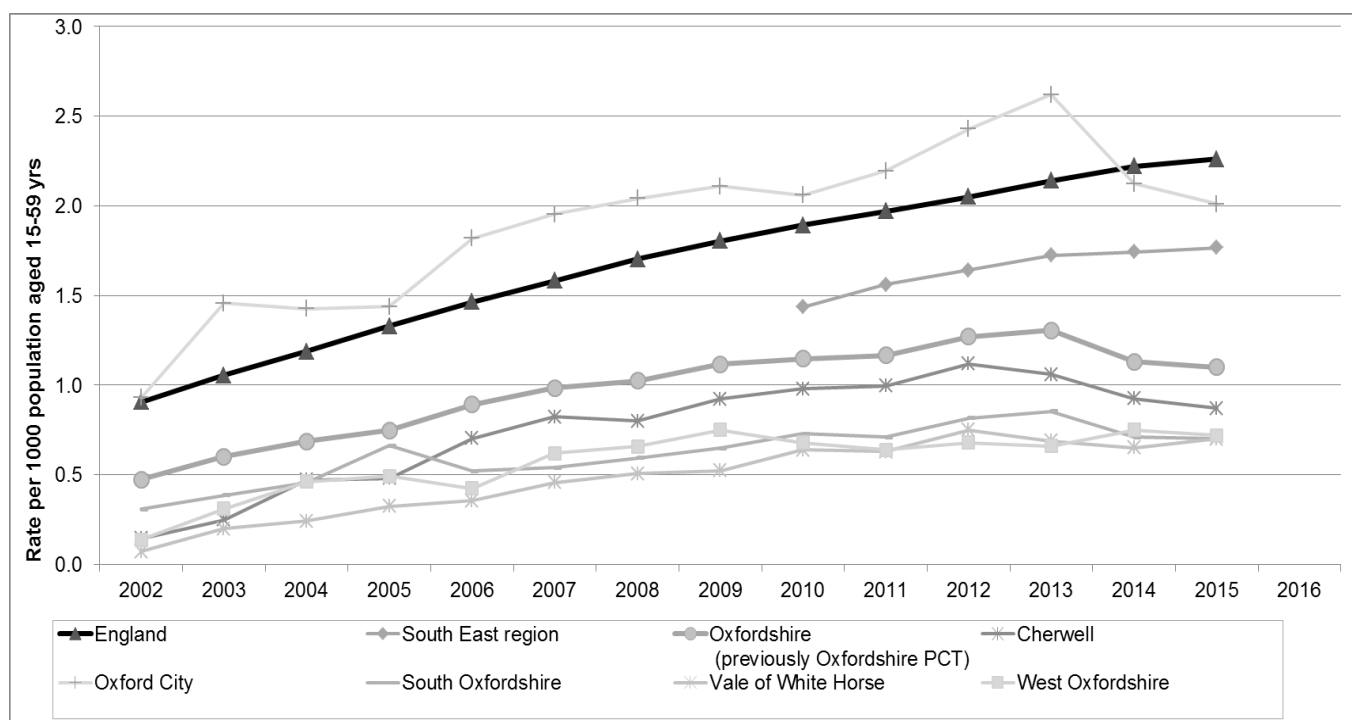
Public Health England has developed a TB strategy to address TB nationally. The TB control boards look at regional levels of TB and services to provide treatment. The Oxfordshire Clinical Commissioning Group is developing a model for a latent TB screening programme as part of a national initiative to identify and treat new entrants from high TB prevalence countries.

Sexually transmitted infections

HIV & AIDS

HIV does not raise public alarm like it did in the 1980s, but it still remains a significant disease both nationally and locally. Due to the advances in treatment, HIV is now considered a long term condition and those who have HIV infection can now expect to have a longer lifespan than previously expected by HIV carriers. As such we expect to have more people living with HIV long term. 2015 data shows that there were 448 people diagnosed with HIV living in Oxfordshire, 221 out of these 448 live in Oxford City. This trend is shown in the chart below and shows another decrease this year across the County.

Rate of diagnosed HIV per 1000 population (i.e. people living with a diagnosis of HIV) aged 15-59 years. England, South East region, Oxfordshire and districts



Public Health England Sexual and Reproductive Health Profiles

Finding people with HIV infection is important because HIV often has few symptoms and a person can be infected for years, passing on the virus before they are aware of the illness. Also the sooner an infected individual begins their treatment the more effective treatment is with a better prognosis for the individual concerned. Trying to identify people with undiagnosed HIV is vital. We do this in three ways:

- Providing accessible testing for the local population. Since it started providing services in 2014, the sexual health service has provided 48,885 HIV tests across the service.
- Through community testing - we have 'HIV rapid testing' in a pharmacy in East Oxford. This test gives people an indication as to whether they require a full test: the rapid test takes 20 minutes and gives a fast result, although fast tracking to the sexual health service for a full test is required to confirm diagnosis.
- Prevention and awareness. Educating the local population about safe sexual practices and the benefit of regular testing in high risk groups. In addition, the eligibility for accessing the condom scheme has been extended to men who have sex with men (MSM) and commercial sex workers, both groups being at higher risk of contracting HIV.

Once diagnosed, the prognosis for HIV sufferers is now good, with effective treatments available. HIV still cannot be fully cured but the progression of the disease can be slowed down considerably, symptoms suppressed and the chances of passing the disease on greatly can be decreased. Beyond Oxfordshire there are interesting developments nationally in preventing the spread of HIV in high risk groups using drugs to halt transmission (PrEP). NHS England will be trialling PrEP over the next three years.

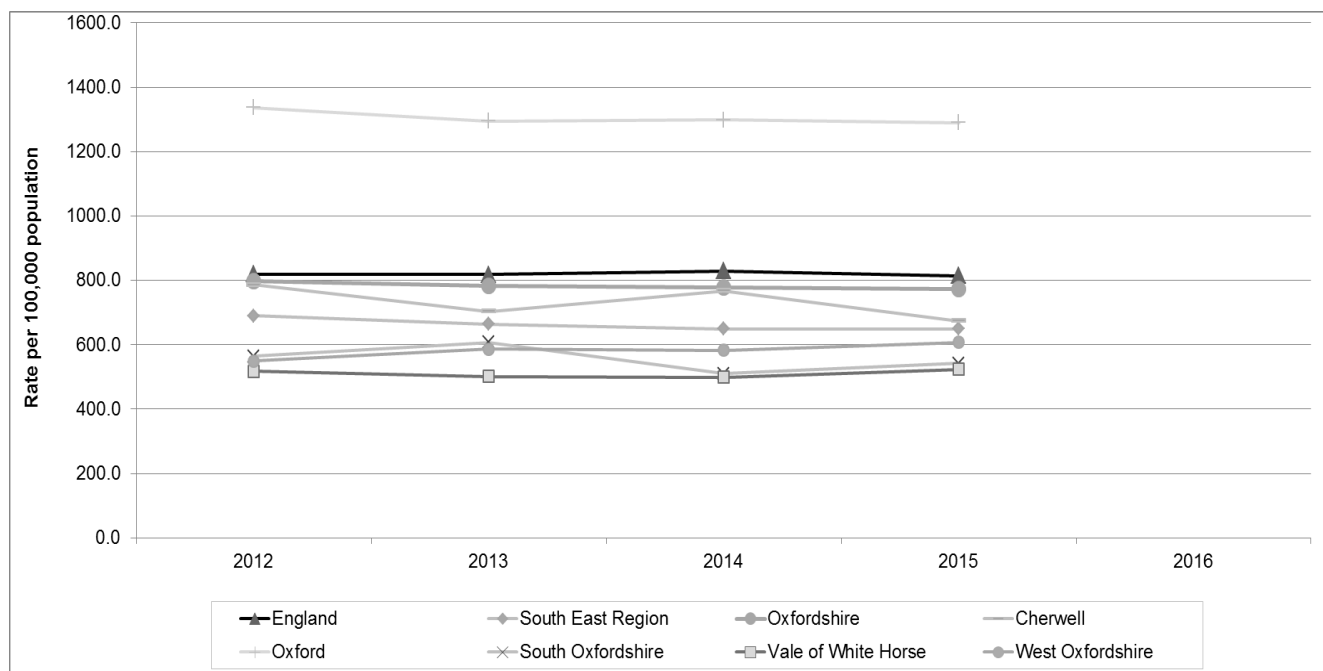
Sexual Health

Sexually Transmitted Infections (STIs) are still high in England with the greatest number of cases in young heterosexual adults, and men who have sex with men (MSM). STIs are preventable through practicing 'safe sex'. Total rates of STIs in Oxfordshire are still below the national average except in the City which has remained at a similar rate since 2013. The local picture is shown in the chart below.

Looking at each disease in turn gives the following picture which is generally good:

- Gonorrhoea- is below national average for Oxfordshire as a whole and all districts except in Oxford City. This is likely to be due to its younger age profile. There is a new system of testing to reduce the number of false positive diagnoses and it is expected that a reduction in diagnoses should be seen when the latest data are released.
- Syphilis- still continues to fall and is below average in all areas of the County.
- Chlamydia- levels are lower than the national average in all Districts. Following evaluation and consultation the local service has been reshaped to be more focussed on accessing testing through online services. It is hoped that this will be more acceptable and accessible for young people to have a Chlamydia test.
- Genital Warts – rates are still below national average and have seen a decline in line with the National trend. Oxford City still has significantly higher number of cases (reflecting the significantly younger age group) but the trend is stable. With Human Papilloma Virus vaccination programmes in place nationally we anticipate a decline in rates over the coming years.
- Genital Herpes – rates are lower than national average except in the City which has higher levels. However the total number of cases in the year is small. Again this reflects the predominantly younger population of the City.

All new sexually transmitted infections (STIs) rate per 100,000 population aged 15-64 years - 2012 to 2015



Public Health England / Health Protection Agency - Sexual and Reproductive Health Profiles

The local sexual health service, which began in 2014, has seen good levels of activity and this is to be welcomed. The service has improved access to contraceptive and sexual health services conveniently in the same location which has improved the service for local users.

Since the service began in the first three years of operation, the service has delivered

- **91,763 STI treatment and testing consultations**
- **Provided 171,213 tests for STIs and 48,885 HIV tests**
- **Positively identified 32,629 STIs, HIV infections and other sexual health diagnoses**
- **Provided 51,156 consultations for family planning**
- **Fitted 5995 contraceptive devices (Long Acting Reversible Contraception)**
- **Prescribed 27,402 other forms of contraception**
- **Prescribed 3004 Emergency Hormone Contraception Treatments**

The service has continued to deliver on its established reputation in the community as a provider across a range of locations across the county where the local population can access all their sexual health services in one location.

In addition to this in the same period GP providers have delivered 15,760 coils and contraceptive implants and pharmacies have provided 4,103 doses of emergency hormonal contraception.

In line with best practice a partnership of local stakeholders continues to work together to identify and address priorities locally to further meet the sexual health needs of Oxfordshire and further improve on the decline of STI's in Oxfordshire.

Recommendation

The Director of Public Health should report on progress on killer diseases in the next annual report and should comment on any developments.

CABINET – 17 OCTOBER 2017

Director of Public Health's Annual Report 2016/17

Comments from the Oxfordshire Joint Health Overview & Scrutiny Committee

Members of the Oxfordshire Joint Health Overview and Scrutiny Committee reviewed the Director of Public Health's Annual Report 2016/17 at their September meeting and wished share their comments on the report with Cabinet and the Oxfordshire Health & Wellbeing Board.

The following is an extract from the draft minutes of the Committee meeting on 14 September:

“Dr Jonathan McWilliam, Director of Public Health, presented his tenth annual report to the Committee and members considered the strategic and local issues highlighted in the report that could be taken forward in the year ahead.

The Committee felt the report was comprehensive and easy to read, although there was some surprise at the absence of information about levels of dementia and frailty in Oxfordshire from the report.

In particular the Committee discussed the following points:

- The pressures posed by an ageing population and difficulties obtaining accurate county population figures;
- The importance of ensuring health impact assessments are completed as part of any service redesign;
- How useful it is for all organisations to have a focus on primary prevention, particularly in relation to breaking the cycle of deprivation and supporting hard to reach groups;
- The impact of loneliness and isolation on Oxfordshire communities;
- How social housing is incorporated into healthy communities and the extent to which District/City housing authorities are meeting their affordable housing targets, including meeting the housing and employment needs of people with learning disabilities;
- The importance of ensuring that health is considered in the development of Local Plans, including the extent to which the County Council Highways team is able to comment on plans in relation to air quality and how the development of new technologies, such as electric vehicles, is being taken into account;
- The links between increasing educational outcomes and breaking the cycle of deprivation;
- The effect of day centre closures on carers and health inequalities, as well as the funding of child mental health services and the effect this has on children's carers;

After considering the Director of Public Health's recommendations in the report the Committee **AGREED** to:

- Explore the implications of government plans to stop the sale of diesel cars on air quality and how the County Council is planning to update its fleet;
- Write to Oxfordshire MPs asking for their support for more legislation to reduce the levels of salt and fat in food and drink in order to combat obesity and drink related diseases;
- Recommend that the Health Improvement Board has a focus on measures to prevent and reduce the prevalence of obesity;
- Encourage the adoption of the “daily mile” in schools;
- Committee to request that officers provide information to all Councillors on tackling loneliness and isolation;
- Recommend that best practice and research is sought from other countries achieving higher rates of breastfeeding to inform Oxfordshire’s approach in this area;
- Recommend that District/City councils routinely include health assessments in the development of their Local Plans. HOSC is also keen to scrutinise the ensuing work on this issue.”

Development of the Joint Strategic Needs Assessment for 2018-19

A report for discussion and decision at the Oxfordshire Health and Wellbeing Board, 9th November 2017

Introduction

Oxfordshire has a well-respected Joint Strategic Needs Assessment (JSNA) which is produced in partnership each year. The JSNA is owned and signed off by the Health and Wellbeing Board (HWB) on behalf of a wide range of partners.

In recent years Oxfordshire's JSNA has been used in the major planning processes in the county, including the writing of many strategic documents - County Council, Clinical Commissioning Group and NHS Trust strategies, consultation documents and as a basis for service commissioning.

It has also provides robust and up to date information for the independent Oxfordshire Health Inequalities Commission and is widely used by voluntary and community sector partnerships including neighbourhood Health and Wellbeing groups, Brighter Futures in Banbury, Oxfordshire Sport and Physical Activity and the Healthy New Towns programmes in Barton and Bicester.

The JSNA also informs the Director of Public Health Annual Report.

Development of the JSNA

The JSNA exists in many forms and formats, including an extensive interactive and web-based resource called Oxfordshire Insight which can be found here: <http://insight.oxfordshire.gov.uk/cms/> This makes a vast array of robust information and analysis available to all partners and the public. A summary report based on this wealth of information is produced annually and published following sign off by the HWB.

The production of the JSNA is steered by a multi-agency group which meets regularly. Members of this steering group have made proposals for JSNA development for 2018-19 for discussion by the HWB.

It is vital that the JSNA remains a fresh, vibrant and active process so that it keeps abreast of the planning needs of all partners. It is important, therefore, that it continually evolves.

The JSNA Steering Group will present its proposals to the HWB for discussion and amendment so that a way forward is agreed.

Recommendation: The HWB is asked to discuss proposals for the JSNA and to decide direction for 2018-19.

Jonathan McWilliam,
Strategic Director for People & Director of Public Health

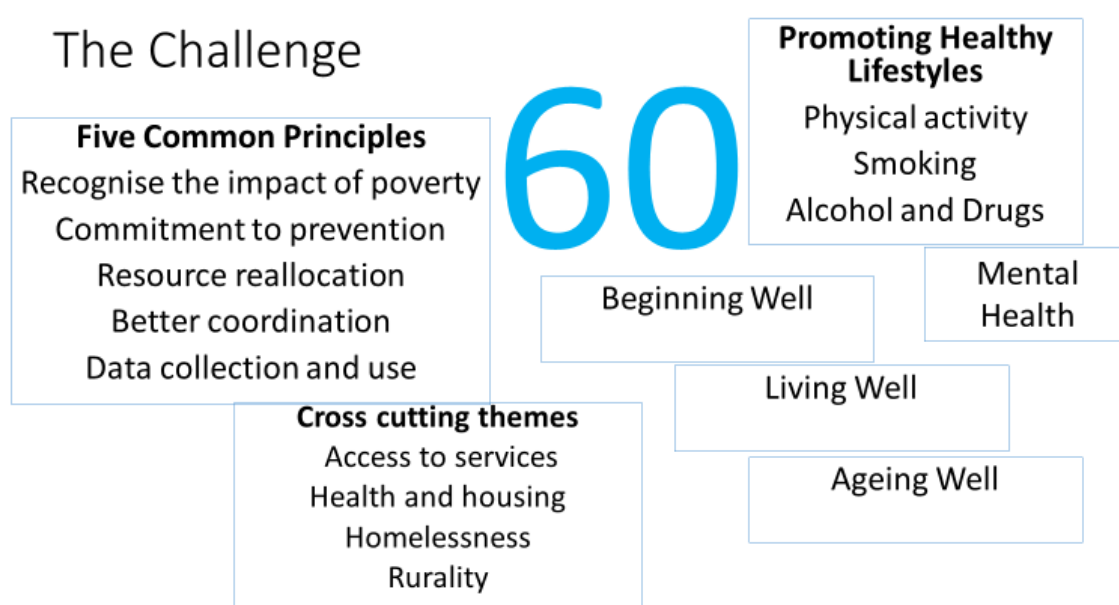
Health Inequalities Commission Implementation Plan

Report to the Oxfordshire Health and Wellbeing Board, November 2017

Background

The Oxfordshire Health Inequalities Commission report was presented to the Health and Wellbeing Board (HWB) in November 2016. Reports on progress were discussed by the HWB in March and July 2017.

The current report gives a comprehensive overview of progress against each of the 60 recommendations in the report. The recommendations are set out in various groups in the report as illustrated in the figure below:



Recommendation

The members of the Health and Wellbeing Board are asked to note the content of the report and nominate partner organisations to lead on issues which still need to be taken forward.

The work of the Health Inequalities Commission (HIC) Implementation Group

An Implementation Group has been convened under the leadership of the CCG and includes representatives from local authorities, voluntary sector and health services. Some members have links to other networks and partnerships who are also implementing this work.

The HIC Implementation Group has reviewed all the recommendations set out by the Commission and compiled a comprehensive overview of relevant work currently underway or in the planning stages. The resulting information shows considerable progress on most of the recommendations but also illustrated the need to coordinate and increase ambition in some of the areas of work. It was clear that it is impossible

to keep a detailed overview of all of the work being undertaken to address inequalities issues in Oxfordshire. However, it is also noted that the momentum gained from the publication of the report has had a positive effect and galvanised joint action in new areas of work.

The Implementation Group agreed to set out the recommendations in 3 main categories which are:

1. Priority business for the Implementation Group in 2017-18. This group of recommendations needs the coordination and input of the Implementation Group to be taken forward. These are set out in five areas of work which will deliver 26 of the recommendations. The 5 work areas are
 - a. Basket of Inequalities Indicators
 - b. Innovation Fund
 - c. Income Maximisation
 - d. Social Prescribing
 - e. Promoting Physical Activity as part of improving prevention of ill health.
2. Recommendations being taken forward by specific groups / organisations in 2017-18. Good progress is being made on work to implement 15 recommendations and some have been completed. Progress reports are set out in the second section of the action plan below.
3. Recommendations to be considered for future implementation. A further 19 recommendations are under consideration and not yet being fully implemented. These are listed in the third section of the action plan below with some notes on the current state of implementation.

Action Plans

Section 1: Priority business for the Implementation Group, 2017-18

There are five areas for action which is being led and coordinated through the HIC Implementation Group. These actions cover a range of recommendations which are listed in the descriptions below.

1. Basket of inequalities indicators (Recommendation 3¹)

Objectives

- Develop a set of local indicators which highlight health inequalities and which can be used to monitor progress in reducing variation.
- Publish these indicators as part of the JSNA.

¹ Also linked to other recommendations

- Monitor impact to ensure gap is not widened (5); Access more data on health inequalities (10) and ethnicity (11); Use NHS performance frameworks (15); DPH Annual Report recommendations (24); Use Child health profiles (43)

- Use these indicators to report regularly to the Health and Wellbeing Board.
- Develop collection of more local data on a range of subjects including ethnicity of service users where this is not yet robust. Also use NHS Outcomes Framework, Child Health Profiles and other appropriate data sources for targeting and monitoring performance as needed.
- Add more indicators to monitor mental wellbeing and mental health as well as the physical health indicators already included.

Progress to date

- A basket of indicators, showing variation across the county at ward level, has been produced and is attached at [Appendix 1](#).
- Subject to comment and suggestions for improvement, this set of indicators will be published on the JSNA website before December 2017.
- More work is underway to add mental wellbeing indicators to the basket.
- The JSNA steering group is continuing to develop the annual report which will be published in March 2018. Recommendations on use of wider data sources to highlight inequalities are being sought in that process.

2. Establish an Innovation Fund (Recommendation 7)

Objectives

The wording of recommendation 7 is:

“An Innovation Fund / Community Development and evidence fund should be created for sustainable community based projects including those which could support use of technology and self-care to have a measurable impact on health inequalities, and improve the health and wellbeing of the targeted populations.”

The objectives that have been defined are:

- Secure contributions from partners to establish the fund.
- Agree criteria for use of the funding which will have an impact on health inequalities.
- Report use of the funding to all stakeholders to attract further contributions.
- Ensure robust evaluation of outcomes.

Progress to Date

Work is progressing well and has included

- Oxfordshire Growth Board agreed to make contributions of £2k per local authority. This total is matched by the CCG. OUHFT have also agreed to contribute £2k giving a total of £30k to date.
- Discussions are in progress with Oxfordshire Community Foundation about managing the Innovation Fund.
- Initial ideas on using the money to support the Social Prescribing initiatives are being discussed e.g. a crowd sourced map of assets and services, digital support for front line workers and digital literacy initiatives for clients.
- Criteria for bids and a specification for the work will be finalised in the coming weeks and it is hoped the project can be completed by the end of 2017-18

- Further funds will be sought so that other innovative ideas can come to fruition.

3. Income maximisation (Recommendation 13²)

Objectives

- Establish a working group to coordinate and develop work to promote income maximisation for people on low incomes e.g. through promoting entitlement to benefits.
- Consider how to improve access to advice in health settings.
- Approach a range of funders and work to sustain advice services

Progress to Date

- Following discussion at the Implementation Group a working group is being convened. This includes local authorities, public health and other commissioners of benefits advice services and a range of current providers including Citizens' Advice, Mind and neighbourhood advice centres.
- Ideas for providing advice in the hospital setting have been proposed for discussion.
- Oxford City Council Executive Board approved a Financial Inclusion Strategy 2017-2020 on 16th October 2017.

4. Social Prescribing (Recommendation 17³)

Outcomes

Build on existing projects to expand and develop social prescribing in Oxfordshire.

Areas of work should target populations with worst outcomes and can include

- Primary prevention and healthy lifestyles
- Mental wellbeing, depression, anxiety, loneliness
- Frequent attenders in primary care
- People with complex long term conditions

Best practice on social prescribing

- a. General signposting by a range of agencies or access to activities for self-referral.
- b. Link workers (e.g. Care Navigators) with specific referral criteria. May include some specialists e.g. for autism

² Also linked to recommendations to:

- Expand Benefits in Practice (12); Engage district councils and other funders (14)

³ This also links to recommendations on

- Commitment of statutory bodies (1); New models of care (2); Investment in Prevention (4); Resource allocation (7); Address loneliness (54); Promote healthy lifestyles including smoking (31), alcohol (33); Increase resources for Prevention and lifestyles advice (46); Integrate health and social care for complex needs (50); Older people support to prevent isolation (54)

- c. Strategic coordination – an overview of the networks, directories and services available locally.

Progress to Date

Discussion at Implementation Group has led to:

1. CCG overview of current projects.
2. Literature review of models completed by Public Health.
3. Workshop held 19.9.17 with a wide range of stakeholders
4. Steering group convened and met 5.10.17

In addition:

- Cherwell DC are considering a VCS led bid to the national funding for social prescribing potentially across Cherwell and working with West Oxfordshire DC and Practices.
- West Oxon DC have shared a report on their methodology with village agents in Gloucestershire.
- Discussion with City Council on the use of £100k strategic pot for taking work forward.
- Consideration of use of Innovation Fund.

5. Increasing physical activity (Recommendation 28, 58⁴)

Objectives

- Develop opportunities for people who are inactive to increase their levels of physical activity and reduce their risk of preventable disease.
- This work should be linked to the Social Prescribing actions so that referrals and recommendations to appropriate activity can be made easily.
- This should be appropriate for the individual or particular group of people but also be accessible county wide.
- Particular target groups include mental health service users, people with disabilities, over 50s, children. Use social marketing to communicate effectively with each group.
- Make information on local opportunities to be physically active available to social prescribers and sign-posters.

Progress to Date

Several strands of work have been identified but there is no overview of all the bids and programmes going forward. Work that has been identified so far includes:

- a bid by OxSPA and Mind for Healthy Bodies Healthy Minds
- Mind is leading a bid to Health Education England to fund a combination of wellbeing and physical activity initiatives.

⁴ Also linked to other recommendations:

- Use of social marketing (29); Increase participation of people with disabilities, mental ill-health (30); Target over 50s (58)

- Analysis of the current situation for Exercise on Referral that was drawn up by OxSPA and district councils

OxSPA bid for Sport England funding to target inactive people from disadvantaged communities. The bid was unsuccessful but work to prepare the bid can still be used to take this work forward.

Section 2: Recommendations being taken forward by specific groups / organisations. 2017-18

There are 15 recommendations which are being taken forward or already completed by particular organisations. These are outlined in this section:

Recommendation being taken forward	Progress to date
Recommendation 6 Core preventative services such as Health Visiting, Family Nurse Partnership, School Health Nurses and the Public Health agenda should be maintained and developed	Complete: Public Health The Public Health Grant remains ring-fenced until at least the end of 2018-19 although with a reduction in the size of the grant each year. Health Visitor and Family Nurse Partnership services have been re-commissioned and plans are being taken forward to re-procure the School Health Nursing Service.
Recommendation 18 In 2014 9.1% of households were fuel poor. This should be reduced in line with the targets set by the Fuel Poverty Regulations of 2014.	In progress: Affordable Warmth Network Detailed plans ⁵ for developing work to tackle fuel poverty were approved by the Health Improvement Board in Sept 2017 following a workshop in July.
Recommendations 19 and 20 19. All public authorities are encouraged to continue their collaboration and invest in supporting rough sleepers into settled accommodation, analysing the best way of investing funding in the future. Homelessness pathways should be adequately resourced and no cut in resources made with all partners at the very least maintaining in real terms the level of dedicated annual budget for housing support. 20. The numbers of people sleeping rough in Oxfordshire should be actively monitored and reduced.	In Progress: Health Improvement Board, Housing Support Group, City Council, CCG. • Adult pathway for homeless people is currently pool-funded by councils and CCG for 3 years. • City Council funding for additional provision has been announced (Sept 17) including additional government funding. • Trailblazer project to prevent homelessness on hospital discharge and release from prison is being implemented. • CCG re-procuring homeless medical provision (Luther Street) • Health Improvement Board monitors reports of rough sleeping as part of the performance framework.
Recommendation 23 Reports of isolation and loneliness in	Some Progress: various agencies • Loneliness Summit held in July 2017 led by

⁵ <http://mycouncil.oxfordshire.gov.uk/documents/s38738/Item%2012%20-%20Setting%20a%20new%20strategic%20direction%20for%20fuel%20poverty%20and%20health%20HIB%20Sept%202017%20V2.pdf>

older people/people suffering from dementia in rural areas should be collated and monitored on an annual basis with a reduction achieved year on year utilizing advice in the Age UK publication "Evidence Review of loneliness and Isolation" .	Age UK Oxfordshire. • Proposal to set up a strategic Task and Finish group led by Age UK Oxon. • Healthwatch Oxfordshire published a report on Dementia Friendly Communities in 2015 and work is being picked up through social prescribing and Dementia Friendly training.
Recommendation 25 and 26 25. Funding for locally enhanced services for refugees and asylum-seekers should be made available to all GP practices, with the expectation that funding for this service would primarily be drawn on by practices seeing large numbers of refugees and asylum seekers. 26. Outreach work in communities with high numbers of refugees, asylum seekers and migrants, should be actively supported and resources maintained, if not increased, especially to the voluntary sector, to improve access to the NHS, face to face interpretation /advocacy and awareness raising amongst health care professionals.	Some progress: CCG OCCG has a Locally Commissioned Service for Deprivation and Inequalities. The criteria for additional payment is: • to support those Practices which have child protection plans and • to allow longer appointment times for patients who require use of interpreting services (Language Line) Good Progress: City Council / CCG and VCS partners A bid to the Controlling Migration Fund was successful and work to be implemented includes providing pre-entry English classes for speakers of other languages (ESOL), orientation and service information packs, mentoring and befriending scheme,
Recommendation 32 An alcohol liaison service should be developed in the OUHT	Some Progress: CCG Work has started on producing a business case for an alcohol liaison service in the hospital trust.
Recommendation 35. Support and develop schools interventions including support given to school health nurses as well as services such as those run by The Training Effect to increase capacity of young people to choose not to misuse substances.	Good progress: Public Health The Training Effect continue to deliver sessions in schools and collaborate with Aquarius (substance misuse services for young people) and School Health Nurses. They provide support for staff and emphasise the need for resilience and confident decision making. Future commissioning will build on this.
Recommendation 36 and 38 36. Resources in the public health budget should be maintained to provide services and support for drug misusers and their families 38. Policy and action should be targeted to continue to address - the rates of successful completion of drug treatment in non opiate users - the rate of parents in drug treatment - the rate of people in substance abuse programmes who inject drugs who have received a hep C vaccination - the rate of children facing a fixed	Good Progress: Public Health Drugs and Alcohol Treatment services in Oxfordshire are still fully resourced and there have been no changes made to the range of provision. The number of clients now successfully completing treatment for opiates, non-opiates and alcohol has improved markedly though this is still under surveillance to ensure the improvement is sustained. There has also been improvement in uptake of Hep C vaccination. Work on identifying the numbers of children who are excluded from school as a result of substance misuse is yet to be completed.

period of exclusion due to drugs/alcohol use - NPS use	
Recommendation 42 Use of food banks needs to be carefully monitored and reported to HWB	Complete: Good Food Oxford A map showing the location and accessibility of Food Banks and other providers was published on the Good Food Oxford website⁶ in summer 2017. This complements the Feeding the Gaps report and other work of Good Food Oxford.
Recommendation 45 The current plans for closures of Children's Centres should be reviewed by March 2017 to ensure prioritization of effective evidence-based investment and good practice in early intervention for children and to ensure that the change of investment and resource allocation to young children and their families does not disadvantage their opportunities especially for those children & families from deprived areas and identified disadvantaged groups	In progress: Oxfordshire County Council and other partners - Grants were made available by the County Council to local initiatives to continue provision of services. - Cherwell DC are working with the Sunshine Centre in Banbury to sustain local services. - Brighter Futures in Banbury continues to develop multi-agency work in 3 particular wards - A Community Impact Zone is being set up in Banbury to enable partners to work together to improve outcomes for children
Recommendation 47 Promoting the health of those in work should be a priority and examples of good practice shared by establishing a county wide network .	In Progress: Well at Work network and others • A network of businesses and other employers continues to champion well at work initiatives. They have recently established a Linked In network to increase their reach. • NHS employers have established a network of Workforce HWB leads • Brighter Futures in Banbury will be working with local employers to promote workforce wellbeing and Cherwell DC will work across the district to promote the Wellbeing Charter. • OxSPA promote the Workplace Challenge to increase physical activity • Unison and Oxfordshire County Council are holding a wellbeing conference in Nov 2017
Recommendation 53 The recommendations from the 2016 DPH annual report are endorsed and the Commission wishes to ensure they are targeted to reduce health inequalities and progress reviewed by HWB in 2017	Complete: Director of Public Health All recommendations from the 2016 report were reviewed and findings included in the 2017 report.
Recommendation 58 Promoting general health and wellbeing through a linked all ages approach to physical activity, targeting an increase in activity levels in the over 50s, especially in deprived areas, using innovative motivational approaches such as 'Good Gym' and Generation Games	Some progress: CCG, local authorities, Age UK • The CCG commission Generation Games and Dance to Health for older people and those at risk of a fall or who have had a fall • Cherwell DC work with Age UK to deliver activities in rural parts of the district. • District Council Sport and Activity Plan targets under-represented groups.

⁶ <http://goodfoodoxford.org/good-food-for-everyone/food-access-services-map/>

	OxSPA bid to target inactive people was unsuccessful but work can be taken forward and will be a focus of the Health Improvement Board.

Section 3: Recommendations for future implementation

A total of 20 recommendations will need more consideration so they can be taken forward. The recommendations are:

	Recommendation	Next Steps
7	Resource allocation should be reviewed and reshaped to deliver significant benefit in terms of reducing health inequalities. - The CCG should actively consider targeting investment at GP surgeries and primary care to provide better support to deprived groups, to support better access in higher need areas, and specifically address the needs of vulnerable populations. - The CCG should conduct an audit of NHS spend, mapping health spend generally and prevention activity particularly against higher need areas and groups, setting incremental increasing targets and monitoring progress against agreed outcomes. - The ring fenced funding pot for targeted prevention should be expanded in higher need communities, using a systemwide panel of stakeholders to assess evidence and effectiveness, with ongoing independent evaluation of impact, including quantification of impact on other health spend.	This recommendation has 4 sub sections and the parts listed in the column to the left still need to be fully addressed by the CCG. In working towards meeting this recommendation the CCG report that all Primary Care workplans are now required to address health inequalities. The fourth recommendation in this list concerns the Innovation Fund which is being taken forward and details are given in section 1 of this action plan. The wording of that part of the recommendation is: <i>An Innovation fund/Community development and evidence fund should be created for sustainable community based projects including those which could support use of technology and self care to have a measurable impact on health inequalities, and improve the health and wellbeing of the targeted populations.</i>
8	The Health in All Policies approach should be formally adopted and reported on across NHS and Local Authority organizations, engaging with voluntary and business sectors, to ensure the whole community is engaged in promoting health and tackling inequalities. Regular review of progress should be	There are already some good examples of Health In All Policies, e.g. Public Health working with Planners and Transport planners. Strategic leadership is needed if this is to be implemented across all organisations.

	undertaken by HWB	
9	The presence of the NHS and of the voluntary sector should be strengthened on the Health and Well Being Board	Governance will be discussed at HWB in November 2017
16	Public agencies, universities and health partners should work together to develop new models of funding and delivery of affordable homes for a range of tenures to meet the needs of vulnerable people and key workers. Specifically, public agencies should work together to maximise the potential to deliver affordable homes on public sector land, including provision of key worker housing and extra care and specialist housing by undertaking a strategic review of public assets underutilized or lying vacant .	Some districts have been reviewing Housing Strategy and plans but this work has not been done jointly to date. Some examples of current work include • Cherwell DC update of Strategic Housing Land Area Assessment • Establishment of a Housing Company in the City. • Involving people with disabilities in developing the City Local Plan.
21	An integrated community transport strategy should be developed	There is some coordination at district level. VCS groups are mapping current provision e.g. Communities First Flexible Transport Forum and Oxfordshire Research Partnerships looking at access to lifts and minibus services.
22	A digital inclusion strategy, which explicitly targets older people living in rural communities should be developed and the % of older people over 65 with access to on line support regularly reported	Work is needed to verify what is already available and link this to the social prescribing work in particular.
27	Robust pathways to community services for community rehabilitation (including Community Rehabilitation Companies) on release, particularly for short term offenders, need to be developed	Discussion will take place with partners who lead the Reducing Reoffending Strategy through the Safer Oxfordshire Partnership.
34	Building on experience from Wantage, Community Alcohol Partnerships should be established across the county to address the problems of teenage drinking, particularly in Banbury as A&E data shows high numbers of under 18s attending the Horton ED for alcohol related reasons. [The partnership model brings retailers, schools, youth and other services together to reduce under age sales and drinking.]	Data on attendance of under 18 year olds will be presented to the Community Safety Partnership in Cherwell for their consideration and a proposal for establishing a CAP will be discussed.
37	School based initiatives should be promoted for all age groups	There are currently programmes to promote physical activity, reduce substance misuse and improve resilience. Further coordination of offers is needed and one suggestion is that a conference could be held to share local knowledge and develop action plans.
39	The under provision of resources for	A review of Mental Health services is

	Mental health services should urgently be addressed	underway and further action will be based on the outcomes.
40	The implementation of the Five Year Forward Strategic View of mental health services for the county should explicitly state how it is addressing health inequalities and how additional resources have been allocated to reduce them.	
41	Perinatal mental health should be a priority with appropriate investment to improve access to perinatal mental health services across Oxfordshire	Further detail is needed on current provision and gaps. This may be available through the Mental Health service review (see above). Brookes and Mind are collaborating on a relevant research bid.
44	New and creative ways to work with schools, such as Oxford Academy, should be explored and initiatives funded and evaluated through the proposed CCG fund	Some good links with the community have been made by Oxford Academy. A more strategic approach is needed, as set out in recommendation 37 above. Oxford Academy is a partner on the Leys Health & Wellbeing Partnership group. The Back on Track project is a good example of work in this area (Mind and the Oxford Academy)
48	The NHS workforce should engage in equity audit and race equality standards should be routinely reported	All public bodies to be encouraged to undertake Equity Audit in addition to the statutory publication of race equality standards already in place. An example of good local practice is that Oxford Health are now engaged with the Workplace Equality Index with Stonewall.
49	The needs of adults with learning disabilities within the County should be reviewed in 2017 and targets set to reduce their health inequalities .	A review is planned in 2018. In the meanwhile there has been a focus on reducing hospital admissions and supporting discharge – plans are co-produced with service users and their carers.
51	Shared budgets for integrated care should be considered and how this fits with the broader care packages available to older people. For example, looking at how domiciliary care can be integrated into health and social care more effectively, and what can be done to provide more robust support for carers	More information on current work is needed by the Implementation Group
52	Support for carers , including their needs for respite care and short breaks , should be supported with resources by all agencies	
55	Strategic action should be taken to oversee increased access to support for older people in disadvantaged and remote situations: o physically through a better	These recommendations overlap with others to improve transport coordination (21), consider digital inclusion (22) and improve income maximisation (13). It is suggested that work on these topics is

	coordinated approach to transport across NHS, local authority and voluntary/community sectors ○ digitally through a determined programme to enable the older old in disadvantaged situations to get online ○ financially, through support to ensure older people, who are often unaware of their financial entitlements, are helped to access the benefits they are entitled to claim.	being taken forward and described above.
57	The current gap in provision of support for older people with mental health needs other than dementia needs to be addressed urgently.	The Implementation Group needs more information on current work.
60	The resources produced by PHE to support local action should be used as part of the formal review process.	Specific resources from PHE have to be identified but data has already been used to set up the Basket of Inequalities Indicators.

Appendix 1 Basket of Inequalities Indicators

Circulated as a separate document.

**HEALTH AND WELLBEING BOARD
UPDATE REPORT FROM CHILDREN'S TRUST BOARD
October 2017**

SUMMARY:

This is a summary update on the work of the Children's Trust Board, since the update report presented to the Health and Wellbeing Board in July 2017. The Children's Trust Board met on 26 September 2017.

The update focuses on the following areas:

- 1. Educational attainment for vulnerable groups of children: High Needs Review Progress Report**
 - 2. Prevention, Early Help and Early Intervention**
 - 3. Managing Transitions**
 - 4. Developing the Children and Young People's Plan 2018 -21**
 - 5. Children's Trust Board and OSCB dataset Performance Report for Quarter 1 March 2017 – June 2017**
 - 6. Joint meeting between Children's Trust Board and OSCB on 24 July 2017 – notes and discussion of way forward.**
 - 7. OSCB Annual Report and key issues emerging**
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UPDATE:

- 1. Educational attainment for vulnerable groups of children: High Needs Review Progress Report**

The Children and Families Act 2014, requires local authorities to keep provision for children and young people with special needs and disabilities (SEND) under review. The Department for Education has provided a one off grant for the local authority to carry out an in depth review. This review is being undertaken under significant changes to education funding policy and amidst growing concerns around the sufficiency of specialist provision and the educational progress of children with SEND. One of our key priorities is to improve the educational progress of vulnerable learners as set out in the Strategic Overview 2016-2020. The High Needs Review and action plans support the vulnerable learners' strategy.

At this stage in 2017 attainment data are provisional and comparisons with national figures for vulnerable learners will not be available until October/November. However, there are some indications that Oxfordshire's performance is improving.

Early figures indicate that the proportion of disadvantaged pupils reaching the expected standard in reading, writing and maths at key stage 2 has increased to 42% this year from 29% in 2016, and from 9% in 2016 to 17% in 2017 for children at SEN Support.

At Key stage 1, the attainment of pupils with a statement of SEN or Education, Health and Care plan in Oxfordshire has increased noticeably since 2016 (from 10%-23% in reading, from 5%-17% in writing and from 8%-21% in maths). However, this is a relatively small cohort. The attainment of pupils at SEN support has also increased this year, but not by such a noticeable amount. Pupils with EAL in Oxfordshire have also shown a relatively larger increase in attainment this year, particularly in writing where almost 2/3 (65%) reached the expected standard, compared with 57% last year.

The governance arrangements for this work are now in place. The 'golden thread' for the priority to improve the attainment of vulnerable learners runs through the Children's Trust, Education Strategy, Children and Young People's Transformation Programme and Strategic Schools Partnership Board. The Oxfordshire Safeguarding Children's Board (OSCB) is also focusing on the safeguarding risks if children are absent from school and the impact on their attainment. A project steering group has been established and colleagues from a range of services and schools are involved in the work streams. There are clear structures in place for monitoring and reporting to the various boards on a regular basis.

Updates on the workstreams:

- *Review of central services supporting vulnerable learners*

A survey 'Have your say on services to support vulnerable learners' was carried out in the summer term and there were 69 responses and over 80 pages of comments. The full report will be shared with the High Needs Review Project Group and then disseminated widely.

- *Development of a locality approach.*

The Children's Trust has confirmed the Banbury locality and an area in Oxford city as pilots for developing a locality approach and to achieve a step change for Oxfordshire's most disadvantaged communities. The approach will be community-led. The Banbury pilot is progressing well with key players across sectors coming together to focus on specific outcomes. A strategic mapping exercise of existing groups and structures that focus on prevention and community development has been undertaken. The pilot work is intended to provide a template for other areas with rollout across the county by September 2018.

Given the high number of managed moves and exclusions in the Banbury area a Primary In Year Fair Access Panel (IYFAP) is being trialed from September 2017. The commissioning arrangements for alternative provision across primary and secondary is also being investigated to explore the feasibility of locality commissioning arrangements.

- *Ensuring good quality local specialist provision*

We are currently developing plans in consultation with parents, carers and providers about how best to spend our allocation of the one-off capital grant from the DfE to be used to invest in creating new school places, improving facilities or creating new facilities. The final plan will be published on our Local Offer website by March 2018 in order to receive the first tranche of our allocation later in summer 2018. The plan will then be updated in March 2019 to receive the final tranche of funding in summer 2020. Detailed analysis of supply and demand of specialist provision is under way.

- *Leadership and research*

The Annual Inclusion Conference, Diminishing Difference was well attended. Several research projects are underway through systems leadership approaches, we are working in partnership as an Oxfordshire system to meet the current and future challenges. A substantive research project is being commissioned to identify the key enablers of, and barriers to, raising attainment levels in Oxfordshire, and to understand how the system as a whole can facilitate and support improvement.

- *Early Years*

There have been significant changes in Early Years entitlement and funding arrangements affecting vulnerable children. These changes have been introduced hastily, with limited time to consult, model, plan and communicate the changes. Further engagement with settings and refinements will be needed over the next 12 months to ensure that fair and transparent systems are in place, and outcomes are continuing to improve. Further modelling and monitoring of the Disability Access Funding, Inclusion Funding, and top-ups for those with Education, Health and Care plans is taking place.

- *Special Schools*

An aspect of the High Needs review includes considering whether the current special school funding arrangements are fit for purpose, and are either supporting or hampering the development of local specialist provision.

- *Post 16*

The high needs block covers funding for young people with high level needs aged 16 to 25 in further education and training. Meetings have been held with the three college principals in July to discuss the review and to consider ways to ensure that

- funding is fair, efficient, predictable, transparent and simple
- administrative burdens are minimised
- there are common approaches across colleges
- there is consistency with funding levels pre 16.

Four meetings are being planned over the next 12 months with representatives from each of the three colleges in Oxfordshire and a consultant with expertise in SEN funding arrangements, to explore and develop funding approaches. The intention is to implement any changes from September 2018. We will also be exploring opportunities to develop local residential experiences to reduce reliance on post 16 residential placements.

2. Prevention, Early Help and Early Intervention

The Locality and Community Support Service (LCSS) was created as part of the Children's Services Integration Programme to support partner agencies across Oxfordshire. The team is part of a cultural change, aiming to intervene at the earliest opportunity not wait for escalation. The service has had good feedback so far with an evaluation plan of the service in development. The data shows a steady increase in the use of Early Help processes.

What has been achieved so far?

- Link workers

LCSS Link workers are now assigned to areas and are meeting with key professionals in their link schools and settings to establish relationships and working practices. They are actively supporting schools, settings and professionals in identifying vulnerable children and their families where there are emerging concerns and helping to ensure the right services are being offered to those families to prevent deterioration of the family circumstance which could ultimately necessitate referral to statutory services.

- Training

LCSS have provided training to over 450 partners in the use of Early Help Assessment and 'Team Around the Family' processes.

- Information leaflets

Helpful tools for engaging with children, young people and families are now all easily available and accessible on OSCB website.

- LCSS staff based in the MASH

It became clear that LCSS also needed to have a presence in the MASH, to ensure smooth transition of those cases that require an immediate safeguarding response and to facilitate cases from MASH into early help. In recognition of this three new LCSS posts have been created to be based permanently in the MASH. Recruitment to these posts is underway.

- Community Around the School offer

The LCSS together with partner agencies are in the process of finalising a community support offer for schools designed to ensure that agencies working with schools have a co-ordinated approach. The purpose of the offer is to:

- Develop strong relationships across the agencies who are working with and within schools to provide clarity of roles and avoid duplication
- Offer coordinated multiagency support, consultation and training to schools
- Schools can use this offer in a variety of ways. All schools may have different ideas of how to use this offer and we want to be flexible, issues with individual children, or involving a number of children, can be considered.

- Community Impact Zones

The creation of a Community Impact Zone is progressing in Banbury. The first meeting was well attended and there was a strong commitment to creating a community led action plan, working collaboratively, recognising that this is the best

way forward. The response was that the community wanted this to work, and there has already been a good response regarding membership and chairing the group. Community Impact Zones are good examples of moving services down to a local level. Currently discussions are taking place with the City council to agree a pilot area for the City.

3. Managing Transitions

Members were advised that a report from the Strategic Transitions Group updating on its work will be presented at the December meeting of the Children's Trust Board. The paper is first being discussed at the joint meeting of the Oxfordshire Safeguarding Children Board and Oxfordshire Safeguarding Adults Board on 28 September.

4. Developing the Children and Young People's Plan (2018 -21)

Members received, and endorsed, the proposal for the new Children and Young People's Plan 2018 - 2021. The steering group had their inaugural meeting on 21 September and agreed a proposed vision and areas of focus.

- Vision: 'Oxfordshire – a great place to grow up and have the opportunity to become everything you want to be'
- Areas of Focus: be successful, be healthy, be safe, be supported

Wide consultation and engagement will take place with partners, parents/carers and young people on the proposed vision using a presentation pack requesting feedback on 3 specific questions.

Consultation and engagement will take place in November and December 2017 with a final draft on target to being presented to the Children's Trust Board for sign off in March 2018.

5. Children's Trust Board and OSCB dataset Performance Report for Quarter 1: March 2017 – June 2017

- This is the report for Q1 2017-18 on the combined Children's Trust, OSCB and Health & Wellbeing Board datasets.
- The priorities in the dashboard were chosen based on any issues identified in the Joint Strategic Needs Analysis, any areas where we can see that benchmark performance is below par and key areas where service delivery is primarily a partnership response. Therefore, the dashboard can focus on areas where performance is off target and can give a misleading impression of what growing up in Oxfordshire is like.

- Growing up overall in Oxfordshire remains a positive experience - and when wider datasets (such as the Public Health Profiles for School Aged Children) are reviewed Oxfordshire scores well. It does raise issues about the number of children involved in risky behaviours, which we may want to consider going forward.
- The key issues from the profiles are low levels of educational attainment and high levels of some risky behaviour (smoking, taking cannabis, drinking, chlamydia detection rate) and the low levels of school pupils with social, emotional and mental health needs
- In the Trust's dataset 10 measures overall are off target. These continue to relate to an increased demand on statutory services and an increasing educational gap for vulnerable children.
- Green Shoots are there and the priorities we have tie in with what the data shows are areas for improvement.

6. Joint meeting between Children's Trust Board and OSCB on 24 July 2017 – notes and discussion of way forward.

A Report was presented to the Board. The purpose of the meeting was to:

- consider the overall activity levels across the system following the OSCB/OSAB Impact Assessment in March 2017 and the Impower findings.
- agree a strategic response and joint vision including shared principles and objectives.
- agree key actions and governance arrangements.

A key issue was creating a joint vision and strategic response to whole system working. To move the agenda forward the following actions were proposed:

- A top level strategic group is set up to ensure ownership and buy in at the most senior level. This group will drive the strategic conversations necessary to do things differently.
- The Children's Trust should have strategic oversight of the development and delivery of the Children and Young People's Plan/Children's Transformation Plan. OSCB role is to contribute to the vision, agree the strategy and then step back to challenge and to check it is delivered.
- That a multiagency senior management group is formed to develop the joint vision and strategic response and deliver key elements of the programme.
- We need to ensure that there is representation from schools and multi-academy trusts perhaps via the Strategic Schools Partnership Board.

7. OSCB Annual Report and key issues emerging

Members received the OSCB Annual report, Executive Summary and a report on the key emerging issues for the OSCB.

The Annual Report measures performance of the OSCB against the priorities in the business plan. It reports on outcomes for children and young people in Oxfordshire.

The positive news is that the OSCB performs well in terms of governance and interaction. The infrastructure set up is good and there is positive work being done in terms of clarifying the thresholds for safeguarding e.g. toolkits and guidance documents. Awareness is increasing. There is good action planning being undertaken in response to areas of learning raised by Serious Case Reviews.

The data (page 2 of the Executive Summary) suggests a different picture. Green shoots are critical to developing and improving the overall safeguarding position. The quality assurance work highlights that partners must continue to input into the OSCB, and test multi-agency working, OSCB will increase its scrutiny of all member agencies. New legislation this year gives OCC the opportunity to review arrangements for OSCB.

Key Issues:

- Youth secure estate. Some of Oxfordshire's children are placed in institutions with low standards, as highlighted by inspector of prisons. OSCB has written to the Youth Justice Board and relevant institutions raising concern and asking for an action plan.
- Hospital beds for young people needing specialist provision after mental health inpatient treatment. This is on the agenda for discussion with local members and MPs.
- Maternity services when mother and baby are in hospital for extended periods of time while court hearings are awaited.
- Grenfell Safety checks have been completed by District colleagues. OSCB is confident all checks have been done.
- Green shoots in the educational progress of children with special educational needs and other vulnerable groups , national comparisons will not be available until November.

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**An update of the work of the Health Improvement Board
Report to the Oxfordshire Health and Wellbeing Board
November 2017**

Summary

Since the last report to the Health and Wellbeing Board, the Health Improvement Board (HIB) has held one meeting in public. Two workshops are planned in the coming months, along with a meeting to facilitate forward planning.

1. Meeting of the Health Improvement Board, September 2017.

The HIB discussed the following topics at this meeting:

1. The Director of Public Health presented his annual report. This stimulated discussion on a range of priorities and informed members of the Board on current issues. Board members were particularly keen to keep a watching brief on Oxfordshire's two Healthy New Town initiatives, to support the sharing of good practice. It was agreed that a workshop would be held to explore how health and planning can be further aligned.
2. The annual report from the Public Health Protection Forum was presented and was followed by detailed information on air quality in the County.
3. A report on Suicide Prevention led to a discussion on prevention initiatives and promotion of well-being. The Health Improvement Board agreed to host a workshop at which a range of partners can contribute to a county-wide framework to illustrate that mental well-being is everyone's job.
4. In a related item, Penny Thewlis from Age UK made a presentation on Loneliness to the Board, building on the progress achieved at the Loneliness Summit in July. Board members are keen to see more information about loneliness and wellbeing included in the Joint Strategic Needs Assessment.
5. An overview of the Exercise on Prescription schemes in the county was collated and presented by Ed Nicholas, an officer from Oxfordshire Sport and Physical Activity (OxSPA). He had worked with District Councils and leisure services providers in producing this paper. It was agreed that OxSPA would lead coordination and development of this work with partners.
6. The Affordable Warmth Network presented their plans for the year ahead, based on the outputs of the workshop held by the HIB in June 2017. These plans were approved by the Board.

All the papers for this meeting of the Board can be viewed here:

<http://mycouncil.oxfordshire.gov.uk/ieListDocuments.aspx?CId=899&MIId=5512>

The following meetings will be arranged in the next few months:

1. A meeting of members of the Board to discuss forward plans
2. A workshop on work to promote Mental Wellbeing and the role of all partners on this topic. A wide range of stakeholders will be invited to contribute to a framework detailing work to improve wellbeing.

3. A further workshop on Planning and Health, building on a learning event held in 2016 which was attended by local authority planners and representatives of health and public health organisations.

Jackie Wilderspin, October 2017

Oxfordshire Health and Wellbeing Board November 9th 2017

Pharmaceutical Needs Assessment – update on progress

Context

1. The Oxfordshire Health and Wellbeing Board received information on the process for revising the Pharmaceutical Needs Assessment (PNA) at their meeting in March 2017. That paper set out the process for completing the work and publishing the revised PNA by March 2018
2. This paper gives more detailed information on that process including giving notice of a public consultation on the content of the revised draft for 60 days before the end of February 2018.

Why do we need a PNA?

3. The Health and Social Care Act 2012 gave Health and Wellbeing Boards the statutory duty to develop and publish Pharmaceutical Needs Assessments (PNA) for their areas by April 1st 2015.
4. The PNA is a key commissioning tool to ensure that local areas have high quality pharmaceutical services that meet needs. The PNA sets out the community pharmaceutical services that are currently provided and gives recommendations to address any identified gaps, taking into account future needs. It supports the commissioning intentions for pharmaceutical services and other services that could be delivered by community pharmacies and other providers. The PNA informs commissioning decisions by local authorities, NHS England and Clinical Commissioning Groups.
5. It is a statutory requirement that the PNA itself is revised every three years. This revision will incorporate all the approved changes made over the last three years but also incorporate up to date information on the population and new housing growth.

Progress to date

6. A steering group has been convened, comprising representatives from the County Council, NHS England, Local Pharmaceutical Committee and led by Public Health. Advice has been given by the Clinical Commissioning Group.
7. Work already completed includes the following:
 - Information on expected housing growth in the next 3 years has been mapped. This will indicate geographical areas where population is expected to increase during the life of the PNA.
 - Details on current pharmacy services have been updated, including location, opening hours and additional services provided in existing

pharmacies. Prospective changes in contracts that will come into effect in April 2018 have also been noted.

- Pharmacies in neighbouring counties that are within 1.6 km of the Oxfordshire border have been included on maps.
- The narrative information in the PNA has been updated in line with national and local policy.
- Plans for public and stakeholder consultation on the draft PNA have been drawn up.

Consultation plans

The draft document will be approved by the Director of Public Health on behalf of the Health and Wellbeing Board then circulated and made available for comment for 60 days before the end of February 2018.

Stakeholders to be consulted include

- Current providers of all community pharmacy services in Oxfordshire and members of the Local Pharmaceutical Committee
- Oxfordshire GPs including dispensing doctors
- The Local Medical Committee
- NHS provider organisations
- NHS England and the Clinical Commissioning Group
- Members of the Health and Wellbeing Board
- Healthwatch Oxfordshire
- Health and Wellbeing Boards of neighbouring counties.
- Members of the public.

The document will be available through a consultation website and printed copies will be made available as needed. Healthwatch Oxfordshire will help to promote the consultation to a wide audience and young people will be engaged through VOXY or other recommended routes.

If members of the Health and Wellbeing Board have any comments on this proposal or would like any more information, please contact jackie.wilderspin@oxfordshire.gov.uk