Public Document Pack

To: Members of the Oxfordshire Health & Wellbeing Board

Notice of a Meeting of the Oxfordshire Health & Wellbeing Board

Thursday, 16 December 2021 at 2.00 pm

THIS MEETING HAS BEEN CHANGED TO A VIRTUAL MEETING

If you wish to view proceedings, please click on this Live Stream Link. However, that will not allow you to participate in the meeting.

Yvonne Rees
Chief Executive

December 2021

Contact Officer: ***Colm Ó Caomhánaigh, Tel 07393 001096***
colm.ocaomhanaigh@oxfordshire.gov.uk

Membership

Chair – Cllr Liz Leffman (Leader, Oxfordshire County Council)
Vice Chair – Dr David Chapman (Clinical Chair, Oxfordshire Clinical Commissioning Group)

Board Members:

Ansaf Azhar *(Oxfordshire County Council)*	Corporate Director of Public Health & Wellbeing
Councillor Liz Brighouse OBE *(Oxfordshire County Council)*	Deputy Leader and Cabinet Member for Children, Education & Young People's Services
Dr Nick Broughton	Chief Executive, Oxford Health Foundation Trust
Sylvia Buckingham	Chair, Healthwatch Oxfordshire
Stephen Chandler *(Oxfordshire County Council)*	Corporate Director for Adults & Housing Services
Councillor Maggie Filipova-Rivers *(South Oxfordshire District Council)*	Vice-Chair, Health Improvement Partnership Board
Kevin Gordon *(Oxfordshire County Council)*	Corporate Director for Children's Services
Councillor Jenny Hannaby *(Oxfordshire County Council)*	Cabinet Member for Adult Social Care
Dr James Kent	Chief Executive, Oxfordshire Clinical Commissioning Group
Councillor Mark Lygo *(Oxfordshire County Council)*	Cabinet Member for Public Health & Equality
Kerrin Masterman *(Oxfordshire GP Federation)*	GP Representative
Professor Sir Jonathan Montgomery	Chair, Oxford University Hospitals NHS Foundation Trust

David Radbourne *(NHS England)*	Director of Commissioning Operations (South Central)
Yvonne Rees *(Oxfordshire County Council & Cherwell District Council)*	Chief Executive, Oxfordshire County Council & Cherwell District Council (District Representative)
Councillor Louise Upton *(Oxford City Council)*	Chair, Health Improvement Partnership Board

Notes:• Date of next meeting: 17 March 2022

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 Chair, Councillor Liz Leffman

2. Apologies for Absence and Temporary Appointments

3. Declarations of Interest - see guidance note opposite

4. Petitions and Public Address

Currently council meetings are taking place in-person (not virtually) with Covid safety procedures operating in the venues. However, members of the public who wish to speak at this meeting can attend the meeting 'virtually' through an online connection. While you can ask to attend the meeting in person, you are strongly encouraged to attend 'virtually' to minimise the risk of Covid-19 infection.

Please also note that in line with current government guidance all attendees are strongly encouraged to take a lateral flow test in advance of the meeting.

Normally requests to speak at this public meeting are required by 9 am on the day preceding the published date of the meeting. However, during the current situation and to facilitate these new arrangements we are asking that requests to speak are submitted by no later than 9am four working days before the meeting i.e. 9 am on Friday 10 December 2021 Requests to speak should be sent to colm.ocaomhanaigh@oxfordshire.gov.uk . You will be contacted by the officer regarding the arrangements for speaking.

If you ask to attend in person, the officer will also advise you regarding Covid-19 safety at the meeting. If you are speaking 'virtually', you may submit a written statement of your presentation to ensure that if the technology fails, then your views can still be taken into account. A written copy of your statement can be provided no later than 9 am 2 working days before the meeting. Written submissions should be no longer than 1 A4 sheet.

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

To approve the Note of Decisions of the meeting held on 7 October 2021 (**HWB5**) and to receive information arising from them.

6. Covid-19 briefing (To Follow)

2:05

To provide the Board with latest information on the pandemic in Oxfordshire. To be published shortly before the meeting.

7. Update on establishment of BOB Integrated Care System (Pages 9 - 26)

2:20

A presentation on development of the Buckinghamshire Oxfordshire Berkshire West – Integrated Care System (BOB-ICS) including the governance arrangements and how it links to the Health and Wellbeing Board.

8. Oxfordshire Safeguarding Adults Board Annual Report (Pages 27 - 56)

2:40

The OSAB report provides an overview of the work of the Safeguarding Board and its partners during 2020-21. It is a statutory requirement that an annual report is produced and shared with partners. Some partners, such as the Local Authority, have specific expectations placed upon them within the Care Act guidance about how they will respond to the report.

The Health & Wellbeing Board is RECOMMENDED to note the content of the report, particularly the findings of the Vulnerable Adults Mortality group (page 15), the merging findings from the Homeless Mortality Review group (page 16) and the overall summary of progress during the year including the outstanding work (page 24).

9. Oxfordshire Safeguarding Children Board Annual Report (Pages 57 - 84)

2:55

This paper highlights findings from the Board's annual report on the effectiveness of local arrangements to safeguard and promote the welfare of children in Oxfordshire.

The Health & Wellbeing Board is RECOMMENDED to note the annual report of the Oxfordshire Safeguarding Children Board senior safeguarding partners and to consider the key messages.

10. Community Services Strategy (Pages 85 - 116)

3:10

The community strategy work continues to progress, clinical workshops have been held and members will recall the engagement process on case for change and principles to inform decision making has concluded.

The Board is asked to:

a) agree the proposed final principles for the community services strategy based on feedback from the engagement exercise;

b) note the update on the strategy work.

11. Making Every Contact Count (MECC) to Support Health and Wellbeing Strategy Priorities (Pages 117 - 122)

3:25

This report summarises the implementation of MECC in Oxfordshire so far and describes how it can support delivery of the some of the priorities within the Health and Wellbeing Strategy. It also suggests next steps in expanding further implementation of this initiative.

The Health and Wellbeing Board is RECOMMENDED to:

(a) note implementation of MECC in Oxfordshire to date

(b) agree to the arrangement of a MECC training workshop for the Board in early 2022 to support it in championing further implementation of this initiative

12. Children and Young People Emotional and mental wellbeing (Pages 123 - 136)

3:40

This report summarises the work completed to date on the development of a shared strategic approach to children and young people's emotional wellbeing and mental health in Oxfordshire.

The Health and Wellbeing Board is RECOMMENDED to:

a) Note the summary of activity taken place to date

b) Agree to the indicative strategic approach for children and young people's emotional wellbeing and mental health in Oxfordshire

c) Endorse and support the work outlined in the forward plan

13. Update on Delivery of Duties Under the Domestic Abuse Act (Pages 137 - 140)

3:55

The Domestic Abuse Act 2021 was introduced in April this year and requires a needs assessment and strategic review of safe accommodation to be led by each Tier 1 local

authority area. This paper summarises the actions being taken in Oxfordshire to meet the requirements of the Act, including the production of both a Safe Accommodation Strategy and an overarching Domestic Abuse Strategy.

The Health and Wellbeing Board is RECOMMENDED to

a) Note the update on statutory duties under the Domestic Abuse Act following publication of guidance for Part 4 of the Domestic Abuse Act

b) Note the publication of the draft Safe Accommodation Strategy for consultation and plans for final publication.

c) Note the plans for renewing the overarching strategy for domestic abuse

14. Better Care Fund Plan 2021/22 (Pages 141 - 174)

4:10

The Better Care Fund planning round for 2021/22 commenced on 30 September for submission 16 November. Given the brevity of the planning and submission cycle for 2021/22 the national conditions allow for the plan to be submitted by the deadline and ratified at the next available meeting of the Health & Wellbeing Board.

The Health & Wellbeing Board is RECOMMENDED to

a) Approve the Oxfordshire Better Care Fund Plan for 2021/22

b) Approve the planned investment and schemes designed to deliver the metrics within the Plan

c) Approve the proposed trajectories for the metrics as set out in the Plan

15. Joint Strategic Needs Assessment Plans for 2022/23 (Pages 175 - 178)

4:20

The production of the Joint Strategic Needs Assessment is a statutory duty, however the content and timing of the JSNA is a decision for the Health and Wellbeing Board.

The Health and Wellbeing Board is RECOMMENDED to

a) agree the proposed six-month delay to the release of Oxfordshire's 2022 Joint Strategic Needs Assessment (JSNA), to allow for inclusion of the Census 2021 results.

b) contribute information and intelligence to further the development of the JSNA (through the Steering Group) and participate in making information more accessible to everyone.

16. Outcomes of joint workshop with Future Oxfordshire Partnership (Pages 179 - 182)

4:25

This report provides a summary of the discussion and feedback gathered as part of a recent workshop held between the Oxfordshire Health and Wellbeing Board and the Future Oxfordshire Partnership.

17. Report from Healthwatch (Pages 183 - 190)

4:35

To report on views of health care gathered by Healthwatch Oxfordshire.

18. Performance Report (Pages 191 - 196)

4:45

To monitor progress on agreed outcome measures.

19. Reports from Partnership Boards (Pages 197 - 200)

4:50

To receive updates from partnership boards including details of performance issues rated red or amber in the performance report:

- Health Improvement Board

Note: the latest meeting of the Children's Trust Board was too close to this the HWB meeting to be able to produce a report in time for inclusion.

20. Meeting dates

4:55

The meeting scheduled 30 June 2022 clashes with the Local Government Association Annual Conference.

RECOMMENDED: to agree to move the 30 June 2022 meeting to 7 July 2022 at 10am.

OXFORDSHIRE HEALTH & WELLBEING BOARD

OUTCOMES of the meeting held on Thursday, 7 October 2021 commencing at 2.00 pm and finishing at 3.50 pm

Present:

Board Members:	Councillor Mark Lygo (in the Chair) Ansaf Azhar Sylvia Buckingham Kevin Gordon Councillor Jenny Hannaby Councillor Louise Upton Michelle Brennan (In place of Kerrin Masterman) Diane Hedges (In place of Dr James Kent)
Participating remotely:	Councillor Liz Leffman (Chair) Dr David Chapman (Deputy Chair) Councillor Liz Brighouse OBE Stephen Chandler Councillor Maggie Filipova-Rivers Dr Ben Riley (In place of Dr Nick Broughton Yvonne Rees
By Invitation:	Rosalind Pearce, Executive Director, Healthwatch Oxfordshire
Officers:	
Whole of meeting	David Munday, Consultant in Public Health; Colm Ó Caomhánaigh, Committee Officer
Part of meeting	
Agenda Item	**Officer Attending**
6	Lily O'Connor, Deputy Director of Urgent Care, Oxford University Hospitals
8	Dr Katherine Arbuthnot, Public Health Team

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 Colm Ó Caomhánaigh, Tel 07393 001096 (colm.ocaomhanaigh@oxfordshire.gov.uk)

1 Welcome by the Chair, Councillor Liz Leffman
(Agenda No. 1)

As neither the Chair nor Vice Chair were able to be present in the meeting room, Members of the Board were invited to nominate a Chair for the meeting.

Councillor Jenny Hannaby nominated Councillor Mark Lygo. City Councillor Louise Upton seconded. Councillor Lygo was elected Chair nem con.

Councillor Liz Leffman explained that she was unable to attend in person as she was awaiting the result of a PCR test. She welcomed David Chapman, Councillor Mark Lygo and District Councillor Maggie Filipova-Rivers to their first meeting, noting that they had already attended a recent Board workshop.

2 Apologies for Absence and Temporary Appointments
(Agenda No. 2)

Apologies were received from Dr Nick Broughton (substituted by Dr Ben Riley), Dr James Kent (substituted by Diane Hedges) and Professor Sir Jonathan Montgomery.

3 Declarations of Interest - see guidance note opposite
(Agenda No. 3)

In relation to item 9, Oxfordshire Community Services, Councillor Jenny Hannaby declared a non-pecuniary interest as Chairman of Wantage Community Hospital League of Friends.

4 Note of Decisions of Last Meeting
(Agenda No. 5)

The notes of the meeting held on 17 June 2021 were approved and signed with one amendment:

Item 8, Oxfordshire Community Services Strategy Update, agenda page 6 in the paragraph commencing “Diane Hedges added”, insert after “a higher usage of hospital beds” the words “on acute hospital discharge”.

City Councillor Louise Upton noted that under Item 7, NHS Recovery, in the final paragraph it was recorded that it had been agreed that children’s mental health services should be a full agenda item at the next meeting. It was not on the agenda for this meeting and she asked that it still be considered for a future meeting.

Ansaf Azhar in agreeing added that the Mental Wellbeing Health Needs Assessment was on the agenda for this meeting and an item on children’s mental health services would flow naturally after that.

5 Covid-19 System Recovery and Resilience

(Agenda No. 6)

A presentation updating on the vaccination programme and Health & Care had been circulated in the Agenda and further slides with the latest Covid-19 case rates had been circulated on the eve of the meeting.

Ansaf Azhar, Corporate Director for Public Health, noted how case rates were higher than one year ago during the lockdown. However, the difference was the successful vaccination programme which greatly reduced the proportion of cases requiring hospital treatment. The future for case rates remained uncertain and continued vigilance and precautions against infection were still required. There was more focus now on the Health and Care system as more people were dying of other causes than Covid.

Asked if a spike in RSV (Respiratory syncytial virus) cases indicated that there could be a problem this winter, Ansaf Azhar responded that it was too early to say. The precautions that people take against Covid will reduce the chances of other infections as well.

Lily O'Connor, Deputy Director of Urgent Care, Oxford University Hospitals (OUH), presented the slides on Health and Care.

Councillor Liz Brighouse noted the high rates of eating disorders and self-harm among children and young people. She believed this was linked to the problems in responding to child and mental health needs and would like to see these issues brought together in a piece of work. Otherwise, there was a danger we would fail our young people.

Lily O'Connor responded that eating disorders were a problem across the county and there was a need to identify cases earlier. They were working with schools on this. People who self-harm were only admitted to secondary care in the case of significant overdoses requiring treatment. OUH worked very closely with Oxford Health and CAMHS Crisis and tried to get patients out of acute hospital as soon as possible.

Diane Hedges, Deputy Chief Executive, OCCG, presented the slides on elective care. She noted that the Chief Executives across the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS) had agreed to work to open all specialities to referral so that the emerging waiting lists numbers could be seen and patient risk managed. The reopening needed to be achieved through collaboration across the BOB ICS. There were processes to be gone through to achieve that and she did not have a date yet as to when the remaining services would reopen. The plan required the system to balance waiting lists with Buckinghamshire and Berkshire West with a single point of entry to manage patients. This meant that although referred into the system, the patient would not always be able to have their appointment with the Oxfordshire provider as the waiting times needed to be balanced.

Members raised issues and officers responded as follows:

- The staff shortages were largely related to Covid – household contacts, sickness

from Covid and children being off school needing parental care were all factors.
- The increase in evening referrals may be related to people who have contacted 999 earlier in the day but their condition was not as acute as others, so they were not brought in until evening.

Ansaf Azhar presented slides on vaccinations including the booster programme. He particularly noted how the vaccination roll-out to 16 and 17 year olds had really brought down the case rates in that age group and he congratulated the team on this work.

The programme with 12 to 15 year olds was challenging but the evidence was clear and the need to reduce the loss of school time was important.

The Chair concluded by reiterating the thanks to everyone in the health and care services including volunteers.

6 Health and Wellbeing Strategy Review
(Agenda No. 7)

The Board considered a report summarising a review of the current Health and Wellbeing Strategy for Oxfordshire in light of the Covid-19 pandemic. This was undertaken at a recent workshop held by Board members.

Councillor Liz Leffman, Leader of the Council, introduced the discussion. The workshop had looked at realigning strategic priorities in the light of the Covid pandemic. There had been agreement to focus on health inequalities and prevention.

David Munday, Consultant in Public Health, summarised the report. The three key points were that the strategy was right, the 'life course' approach was helpful but that everything had become more urgent because of the pandemic.

The cross-cutting themes identified were that inequalities had been exacerbated, the community capacity had been a crucial part of the pandemic response and there needed to be a particular focus on mental wellbeing.

The report asked partners to prioritize work in their organisations in accordance with the strategy and this Board to plan its work programme accordingly.

Diane Hedges, Deputy Chief Executive, Oxfordshire Clinical Commissioning Group, agreed that the report was a good summary of the workshop. She had taken the report to their executive meeting where it was well received. The request from that was to identify a) clear actions that would make the difference and b) the communities that needed the focus.

Diane Hedges also reported that GPs had been very enthusiastic around the 'make every contact count' idea but were concerned that it would be a challenge given the short appointments that they had. We need to find other means to support this messaging in contacts. Again, the call was to identify actions to make it work. Perhaps taking different themes over quarters of the year might be a useful approach.

Members agreed that the report reflected the discussions at the workshop, noted the importance of the Joint Strategic Needs Assessment in providing impartial data across the system and in particular welcomed the inclusion of the consideration of 'dying well'.

Councillor Leffman thanked all for the positive response and looked forward to applying the priorities to the development of the work programme later in the meeting.

7 Mental Health & Wellbeing: Mental Wellbeing Needs Assessment
(Agenda No. 8)

The Board had before it a paper presenting the Mental Wellbeing Needs Assessment, which aimed to broadly understand the mental wellbeing needs of people living in Oxfordshire.

Dr Katherine Arbuthnott of the Public Health Team introduced the report, acknowledging that a wide range of people had been involved in putting the assessment together. The full assessment will be made available on the Council website by the end of the month. She took the meeting through a presentation on the findings of the needs assessment.

Ansaf Azhar, Corporate Director for Public Health, added that the approach being taken was that mental health and wellbeing was everybody's business. This will help ensure that action is taken early. It was important to normalise talk about mental wellbeing. It was not all about intervention.

Councillor Liz Brighouse, Cabinet Member for Children, Education and Young People's Services, commented that data and monitoring was key. There was evidence that mental health issues were particularly increasing in girls. She believed that many women experiencing violence were more likely to talk about it at their sexual health clinic than go to the police.

Councillor Brighouse also observed that there were a lot of services available but often people just did not know about them. There needed to be more signposting of services.

City Councillor Louise Upton suggested that mass intervention was needed given the scale of the problem. Schools were one area where that might be possible but she asked what scope was there for the Council to promote that, now that so many schools were academies.

Kevin Gordon, Corporate Director for Children's Services, responded that Oxfordshire was fortunate in having a very good relationship with schools. There have been mental health support teams working in schools for some years. The key question was how to scale-up efforts. Schools would definitely be part of that but the there was a need to identify other touchpoints.

Dr David Chapman, Clinical Lead, OCCG and a GP, estimated that about 60% of his patients had a mental health issue of some kind. Some practices had people trained in mental wellbeing available to spend time talking to people. Much of this was done over

the telephone. While telephone did not work so well with some older people, many younger people actually preferred it. Much of the improvement in CAMHS (Child and Adolescent Mental Health Service) had been achieved through greater use of remote access.

District Councillor Maggie Filipova-Rivers added that the Young Minds charity had proposed an idea for early intervention hubs.

The Chair concluded by encouraging councillors to do the mental health first aiders course so that they could all be mental health champions.

8 Oxfordshire Community Services

(Agenda No. 9)

The Board considered a report from the Oxfordshire Clinical Commissioning Group (OCCG) and Oxford Health NHS Foundation Trust updating on the Oxfordshire Community Services project. The report was summarised by Dr Ben Riley, Executive Managing Director for Community, Primary and Dental Care, Oxford Health. The project was on track. There had been two online public engagement events with another one to be held the following day.

A census of community hospitals was being carried out as well as a benchmarking exercise against other counties' systems. Most of the attention so far had been at county level but there would be more local focus going forward which may include open days at community hospitals.

Diane Hedges, Deputy Chief Executive OCCG, added that a lot of the discussion so far had centred around workforce issues and the increased use of digital and possible digital exclusion.

Councillor Jenny Hannaby, Cabinet Member for Adult Social Services, noted that maternity services in Wantage Community Hospital had been closed due to staff shortages only months after being reopened. Those in need of services had to go to Wallingford or the John Radcliffe in Oxford.

Diane Hedges responded that there was a shortage of midwives and other services had also been affected in the north of the county. The situation would be reviewed in mid-October but they had to put safety first.

Ansaf Azhar, Corporate Director for Public Health, emphasised that the review was about more than bed numbers but took a wider population perspective, including looking at preventive measures to reduce the demand for services in the first place.

9 Report from Healthwatch Oxfordshire

(Agenda No. 10)

The Board had before it a summary of the activities of Healthwatch Oxfordshire. Executive Director Rosalind Pearce highlighted in particular the changes to parking

recently introduced at Oxford University Hospitals sites. Healthwatch's report on this issue was published in 2017.

She believed that the example emphasised the importance of hearing from the service users and she hoped this would be taken on board in the Community Services Strategy.

The Chair thanked Healthwatch and its volunteers for the work they are doing especially with emerging communities.

10 Performance Report
(Agenda No. 11)

The Board considered the report which monitors progress on agreed outcome measures.

Councillor Liz Leffman, Leader of the Council, reported on issues that came up at a recent meeting of the Oxfordshire Joint Health Overview and Scrutiny Committee where she had been presenting the Board's annual report. It had been noted that women's services had been particularly impacted by the pandemic. She also noted Red ratings in relation to reablement and dementia diagnosis. She asked that gender and age be taken into account when looking at health inequalities.

Ansaf Azhar, Corporate Director for Public Health, agreed that preventive and screening programmes had been particularly hit during the pandemic. Most services had reopened but there was a backlog. This would need to be watched closely but he believed that the next report will show some improvement.

Councillor Liz Brighouse, Cabinet Member for Children, Education and Young People's Services, noted that the increase in young people self-harming appeared to be more prevalent among girls. She added that there was a need for better data on CAMHS (Child and Adolescent Mental Health Service) waits for assessment.

Dr David Chapman, Clinical Lead, OCCG, reported that while figures for CAMHS were improving overall, there was a particular shortage of people qualified to assess for Autism Spectrum Disorder and ADHD.

Dr Chapman added that he believed that the figure in the report for annual health checks for those with Learning Disabilities (2.11) was out of date. His latest information indicated that it should be 82%.

Dr Chapman noted that the report monitored the proportion of those at risk and under 65 that have had the flu vaccine (1.18). He believed that the most important figure to watch was the proportion of children vaccinated as this was seen to be the most important factor in reducing transmission. The Board should consider including that figure in the reports.

11 Reports from Partnership Boards
(Agenda No. 12)

Children's Trust Board
Councillor Liz Brighouse, Cabinet Member for Children, Education and Young People's Services, thanked in particular Jodie Lloyd-Jones, Chief Executive, Oxfordshire Youth for stepping in to Chair the Board's June meeting. We rely very heavily on voluntary youth services across the county.

Councillor Brighouse noted that many of the same issues had come up at the Children's Trust meeting as had come up at this meeting. She would like to see more discussion around neuro-diversity and not just around assessments but on how people were supported when their assessment was known.

Kevin Gordon, Corporate Director for Children's Services, agreed that there was a need to make mainstream services more aware and responsive with neuro-diversity.

Health Improvement Board
City Councillor Louise Upton, Chair, HIB, reported that they had set three priorities for 2021/22: obesity, smoking and mental wellbeing. They were looking at updating their dashboard to reflect current priorities. The red indicators were mainly due to Covid resulting in fewer screenings and lower physical activity.

The review board on domestic abuse has had its membership enlarged to add people who have experienced abuse themselves which she believed would strengthen it.

Ansaf Azhar, Corporate Director for Public Health, invited feedback on what would be the best indicators for the new priorities and noted that they wanted qualitative data as well.

The Chairman welcomed the removal of cigarette bins from outside council buildings as another measure to encourage people to smoke less. He thanked Councillors Brighouse and Upton for their work on the partner Boards.

..... in the Chair

Date of signing .....

BOB Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

NHS

Developing our Integrated Care System

Discussion with Oxfordshire Health and Wellbeing Board

16 December 2021

Contents

Before we start: context (1)

Prime Minister asked NHS to come forward with proposals for legislation that would improve the speed and effectiveness of delivery of the Long Term Plan (June 2018)

NHSE undertook extensive engagement and published a number of proposals key elements (Nov 2019)

NHSE published Integrating care: Next steps to building strong and effective integrated care systems across England (Nov 2020)

- Building on learnings from the pandemic

DHSC published white paper Working together to improve health and social care for all (Feb 2021)

Before we start: context (2)

First reading of Health and Care bill (Commons) July 2021

- Significant guidance coming down based on draft legislation

Aim is to put this on a statutory footing for April 2022

- But it will take 12-18 months to evolve to fully functioning

That evolution needs to occur in dialogue with system partners

- Along with developing the system strategy with partners, broader stakeholders and the public

Today is the start of the conversation…

Purpose of an ICS

Four goals:

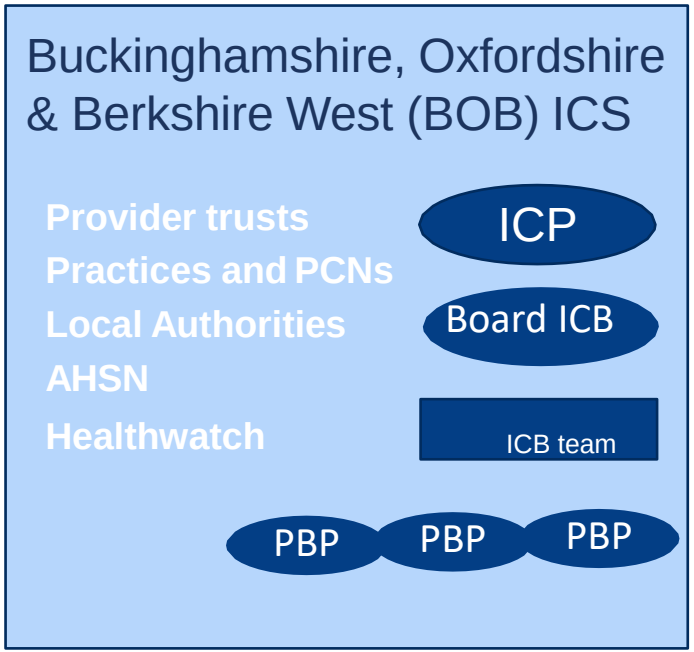
- **improve outcomes** in population health and healthcare
- **tackle inequalities** in outcomes, experience and access
- enhance **productivity and value for money**
- help the NHS support broader **social and economic development**

…these were all goals set out in the Long Term Plan…

…it is how we organise to deliver that is changing

Key components and terminology

- **Integrated Care System (ICS)**
- **Integrated Care Partnership (ICP)**
- **Integrated Care Board (ICB)**
- **Board of the ICB**
- **Place-based Partnerships (PBP)**



From April 2022, Clinical Commissioning Groups will no longer exist
All CCG staff will transfer into the ICB

Three recent national changes to terminology

Health and Care Partnership -> Integrated Care Partnership

- So ICP is now a system level acronym!

Integrated Care Partnership -> Place-based Partnership

- So PBP replaces ICP at Place level

Integrated Care System Body -> Integrated Care Board

- Teams and resources in the ICB will support system and Place

System and Place

We are a system made of three Places

- We do not have the single focal point of other SE ICSs

Most care delivery will be managed at Place

- System orchestrate overall strategy and delegations
- Place manages pooled budgets and delivers on Urgent and Emergency Care (UEC), Long Term Conditions (LTC) and integrated care
- Localities deliver on inequalities
- Provider collaboratives deliver services beyond a Place

We need to work together to evolve system and Place

- Signed off by the Integrated Care Partnership

Places

Today's ICP / Unified Exec -> Place-based partnership (PBP)

- Sub-committee of the Integrated Care Board

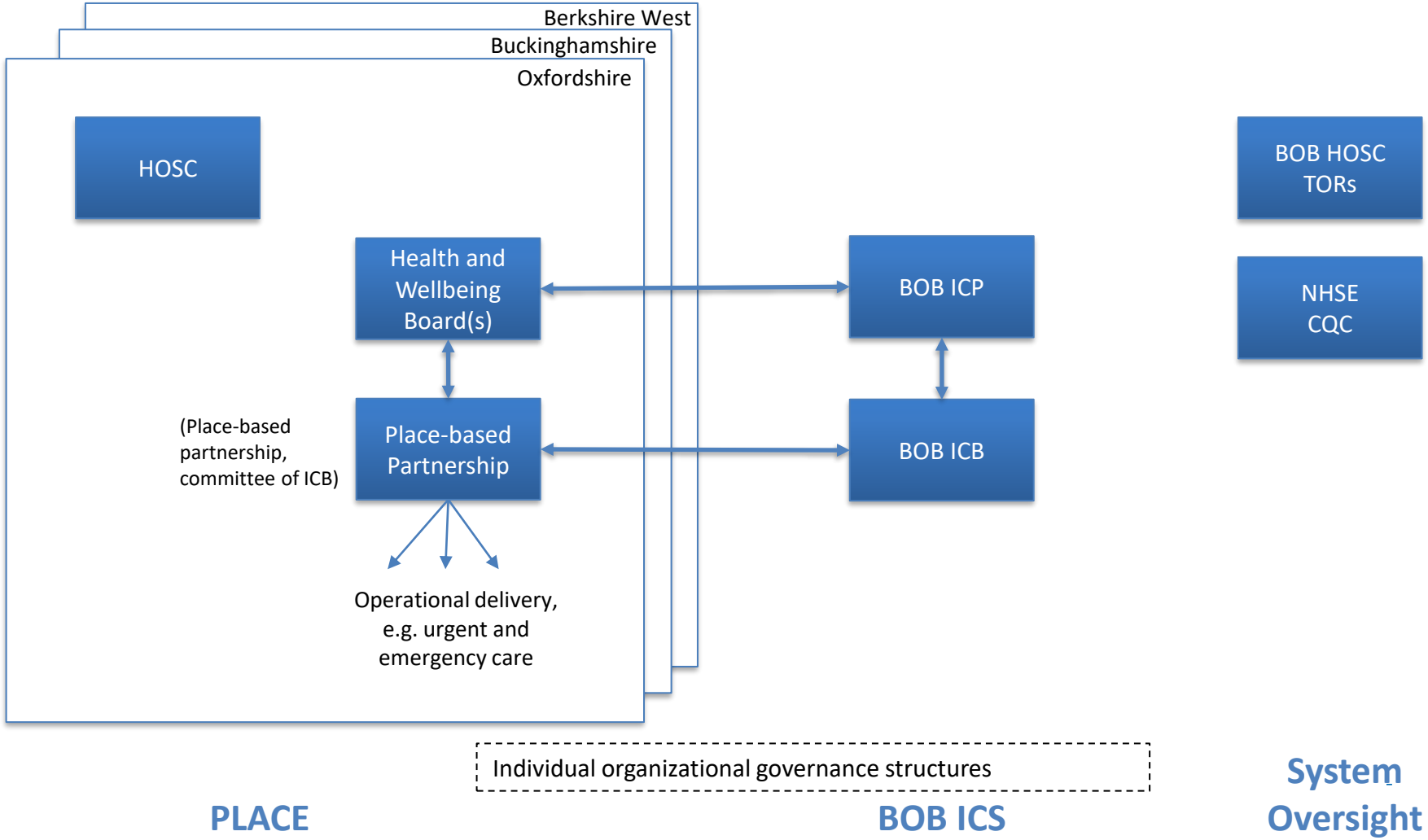
PBP will take many of the decisions that lie in CCGs today

- Eg, resources / capacities across UEC and LTC pathways

They will also drive the changes to enable integrated care

- Eg cardiology, MSK pathways

ICB Place teams will support the PBP – as they do for CCGs today


Berkshire West
Buckinghamshire
Oxfordshire
HOSC
Health and Wellbeing Board(s)
(Place-based partnership, committee of ICB)
Place-based Partnership
Operational delivery, e.g. urgent and emergency care
BOB ICP
BOB ICB
BOB HOSC TORs
NHSE CQC
Individual organizational governance structures
PLACE
BOB ICS
System Oversight

Governance: ICB Board membership

- Proposing statutory/mandatory membership and review when ICB established
- Membership of 10
  - 1 x Chair
  - 2 x Independent Non-Executive Directors
  - 1 x Chief Executive of Integrated Care Board
  - 3 x Partner Members
    - 1 x Local Authority Officer
    - 1 x Primary Care
    - 1 x NHS Provider
  - 1 x Finance Director
  - 1 x Medical Director
  - 1 x Nursing Director

Discussion

How can the Health and Wellbeing Board best oversee Place strategy

- How will it need to adapt?

Appendix – detail on elements of ICS

1. What is an ICS?

- **Integrated Care System (ICS):** Partnerships of health and care organisations that come together...

…to plan and deliver more joined up services and improve the health of people who live in their area

There is no change to the system partners we have today.

Buckinghamshire, Oxfordshire & Berkshire West (BOB) ICS

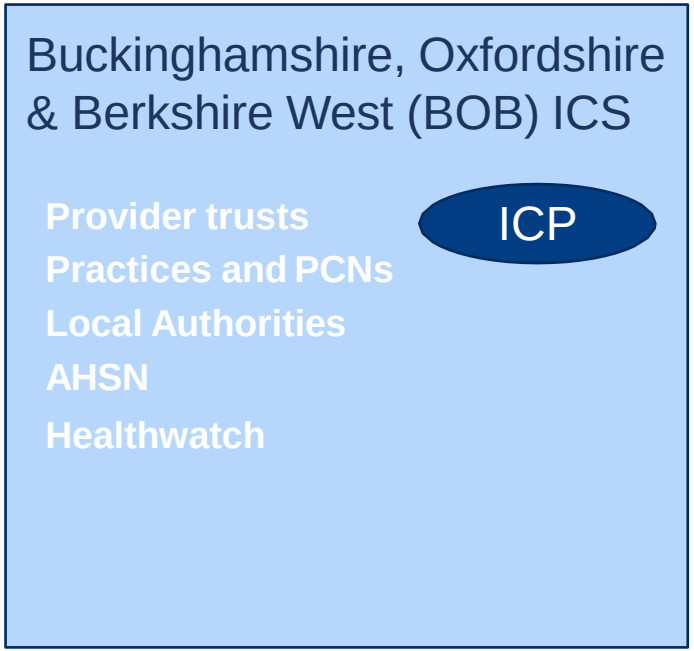
Provider trusts
Practices and PCNs
Local Authorities
AHSN
Healthwatch

1. Components of an ICS?

- Integrated Care System (ICS)

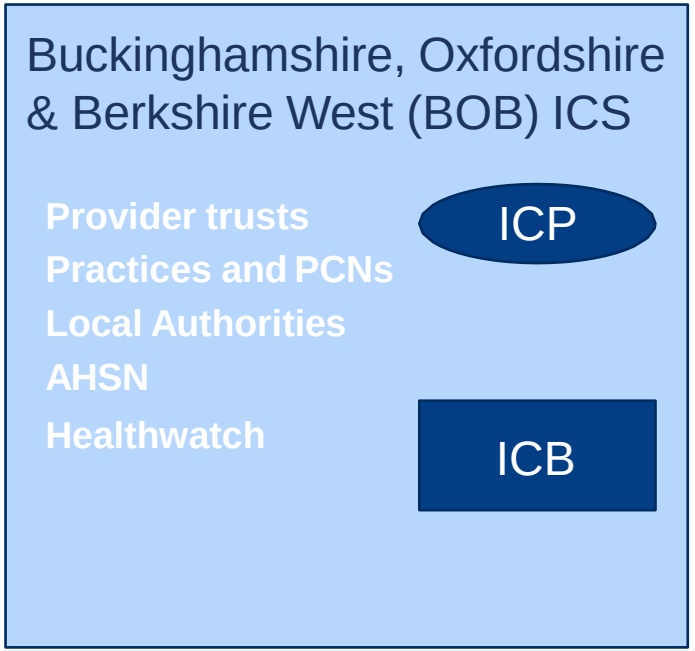
- **Integrated Care Partnership (ICP):** Broad alliance of organisations concerned with improving the care, health and wellbeing of the population, jointly convened by the ICB and local authorities in the area

  Role to develop an integrated care strategy for its whole population



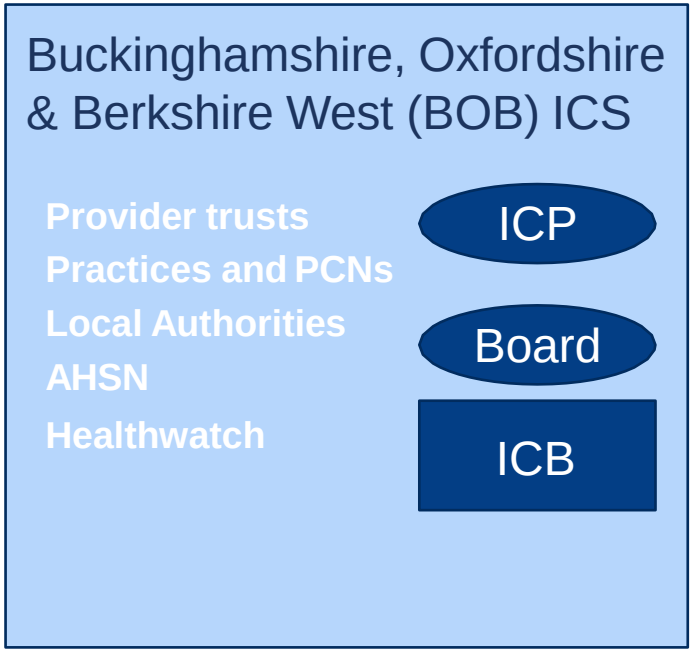
1. What is an ICS?

- Integrated Care System (ICS)
- Integrated Care Partnership (ICP)
- **Integrated Care Board (ICB):** Team that develops the plan, allocate resources, establishes joint working and governance arrangements to ensure health provision for the population. Lead system-wide action on data, digital, workforce and estates as well as EPPR for major incidents



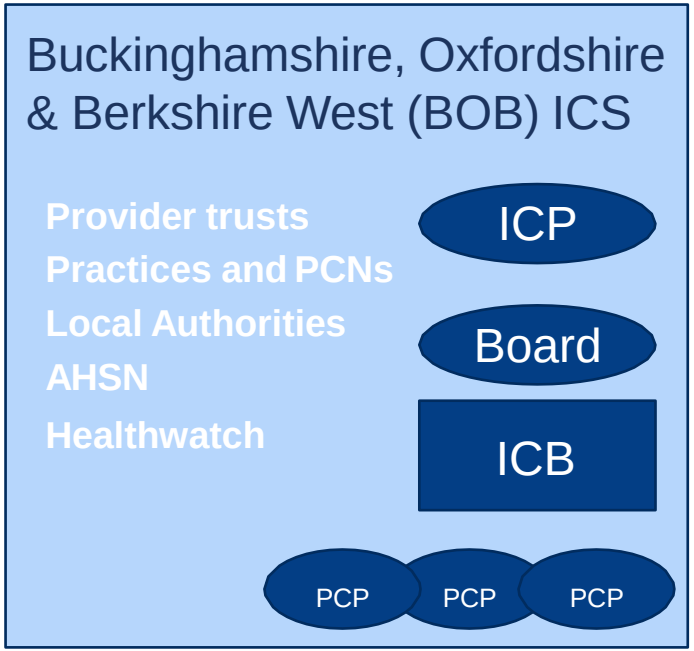
1. What is an ICS?

- Integrated Care System (ICS)
- Integrated Care Partnership (ICP)
- Integrated Care Board (ICB)
- **Board of the ICB**: a board that includes Chair, Chief Exec, CFO, CNO, CMO, and at a minimum one member each from Trusts, PC and LA and minimum two NEDs



1. What is an ICS?

- Integrated Care System (ICS)
- Integrated Care Partnership (ICP)
- Integrated Care Board (ICB)
- Board of the ICB
- **Place-based Partnerships (PBP):** partnerships in each Place that will take on local delegation and replace the current ICPs in Place



Divisions Affected - All

OXFORDSHIRE HEALTH & WELLBEING BOARD
14 December 2021

OSAB ANNUAL REPORT – 2020-21

Report by Corporate Director for Adult and Housing Services

RECOMMENDATION

1. **The Health & Wellbeing Board is RECOMMENDED to** note the content of the report, particularly the findings of the Vulnerable Adults Mortality group (page 15), the merging findings from the Homeless Mortality Review group (page 16) and the overall summary of progress during the year including the outstanding work (page 24).

Executive Summary

2. The OSAB report provides an overview of the work of the Safeguarding Board and its partners during 2020-21. It is a statutory requirement that an annual report is produced and shared with partners. Some partners, such as the Local Authority, have specific expectations placed upon them within the Care Act guidance about how they will respond to the report.

   The local safeguarding partnership has continued to maintain a high standard of work during a difficult year that has affected all partner organisations. There has been no increase in safeguarding concerns that point towards any failings of organisations to work together. Despite difficult working conditions, levels of safeguarding work have been maintained during this year, with the number of concerns raised being similar to previous years. The significant rise in safeguarding enquiries is due to a change in process within the Local Authority rather than an indicator there are significantly more safeguarding issues.

   The report notes three key areas of work going forward.

   The Making Safeguarding Personal approach has been championed throughout the year and there has been an improvement in the number of people who have defined what they wanted to happen as a result of the safeguarding work and who were satisfied with the work that was undertaken. This is excellent progress during a difficult year and demonstrates professionals are continuing to keep the person at the centre of their work with them, empowering them to make the decisions that are important to them and honouring that as much as they are able to whilst seeking to protect them.

The annual Practitioner survey of Frontline workers has indicated that the majority of workers have felt there was clear leadership in regard to safeguarding during the last year. Workers have valued the safeguarding consultation service and its use has risen over the period.

Most Organisations have maintained levels of safeguarding training amongst staff comparable with the previous two years. Health agencies have understandably reported under compliance due to their frontline role during COVID-19. The huge increase in training taken up by the voluntary sector during this period has been particularly welcome and we hope to maintain this level of interest and engagement with safeguarding training within voluntary and community groups.

The report highlights three key messages for local leaders that were relevant at the end of the year (31st March 2021). The County Council and the other statutory organisations have worked together to address all three areas. Below are the findings of the report as well as an update on the current progress with all three issues.

Leadership on homelessness – *"Organisations must come together to agree the governance of homelessness at a countywide level. Operationally partners are doing a lot of things to improve work within their own organisations, there are areas of multi-agency work underway and a countywide strategy has been produced however, the governance and senior strategic leadership across the county has yet to be agreed."*

Update for Health & Wellbeing Board – The OSAB and Countywide Homelessness Steering Group (CHSG) have worked together to develop terms of reference for the Homelessness Governance Board (HGB). The HGB had their first meeting in November 2021, chaired by Stephen Chandler. The purpose of the group is to oversee the implementation of the homelessness strategy and act as an escalation route for issues that cannot be resolved within the CHSG.

Working with complexity – *"the feedback from Board Members and frontline workers has highlighted for the last two years that the people that are being referred into services have increasingly complex issues. For some, these may not individually trigger a statutory response but when viewed holistically the issues clearly indicate there are risks. For others, they may trigger a response but are unwilling to engage with the services that could help them, thus leaving them at risk to themselves or from others. Multi-agency partnership work is underway to develop more integrated approaches and shared processes. It will require commitment from senior managers to enable frontline professionals to actively contribute provide their professional expertise, in order to support other teams develop skills and knowledge. The goal is to enable all services to work more effectively, proactively on improving outcomes for those they are working with."*

Update for Health & Wellbeing Board – The Safeguarding Board has developed the Multi-agency Risk Management (MARM) Framework which will look to address the risks inherent with the increasing levels of complex cases seen across organisations. Funding has been agreed for a post to support this process, learning from the experience of other areas who have already successfully embedded similar processes. The first MARM meeting was held in November 2021.

Refreshing the links between strategic partnerships – *"during COVID-19 the focus of organisations has rightly been diverted to ensuring those most vulnerable in our society are protected as much possible. This had the effect of reducing the focus on strategic partnership work during this period. The relationship between the strategic partnership groups within Oxfordshire (Children's Board, Health & Wellbeing Board and the Safer Oxfordshire Partnership) needs to be reviewed and refreshed."*

Update for Health & Wellbeing Board – in June 2021 the Chairs of the partnership boards met for their first strategic partnerships conference, chaired by the Independent Chair of the OSCB. A follow-up meeting is being arranged and it is proposed that these conferences are held twice a year.

The full published report can be accessed here: OSAB Annual Report 2020-21

Exempt Information

3. None.

OSAB Report Summary

4. A summary of the full report is provided below, along with an update of the three key issues highlighted for further work. The published report can be accessed here: OSAB Annual Report 2020-21.

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Corporate Policies and Priorities

17. None.

Financial Implications

18. None

Comments checked by:

Danny Doherty, Finance Business Partner (Interim) Adult Social Care & Public Health

Legal Implications

19. There are no direct legal implications arising from this report.

Comments checked by:

Sukdave Ghuman, Head of Legal Services & Deputy Monitoring Officer

Staff Implications

20. None.

Equality & Inclusion Implications

21. The report highlights that the Board will be analysing equality and inclusion data as part of its future work to better understand the accessibility of safeguarding services.

Sustainability Implications

22. None.

Risk Management

23. None.

Consultations

24. None.

Stephen Chandler, Corporate Director Adult and Housing Services

Annex:	Oxfordshire Safeguarding Adults Board Annual Report 2020-21
Background papers:	N/A
[Other Documents:]	N/A
Contact Officer:	Steven Turner, OSAB Board Manager, 07917 534230, steven.turner@oxfordshire.gov.uk

December 2021

Oxfordshire Safeguarding Adults Board

Annual Report 2020-21

Foreword

Joint statement from Karen Fuller and Alison Chapman, Vice-Chairs of the Oxfordshire Safeguarding Adults Board

"This report outlines the role and function of the Board, highlights the achievements of the Board and its partners during the year and shares lessons from our work that are vital for all organisations in Oxfordshire.

The current COVID-19 pandemic must be acknowledged. This year has been unprecedented and has impacted the lives of those in Oxfordshire and across the country in many ways. The public have experienced repeated lockdowns and restrictions, which we continue to live with as this report is being written. Many have experienced bereavements during this time. The loss of physical contact with friends and family has had a devastating impact on the mental health of many people. Professionals providing services to adults needing support and protection rose to the challenge and showed huge dedication to keep things running whilst also being subject to the same pressures as the general public. This commitment to the people of Oxfordshire from all sectors, both statutory services and voluntary and community groups, must be recognised and celebrated by the Leaders of organisations all across the County."

Statement from Rosalind Pearce, Executive Director, Healthwatch Oxfordshire

"Over the year Healthwatch Oxfordshire raised safeguarding alerts on two occasions and on both occasions, these were acted upon. Due to the nature of the alerts, we did not approach the people concerned to understand how their experience was. In the future we will further explore whether this is possible on occasions.

We fully understood the need for the OSAB to revert to an Extended Executive Group due to pressures on staff during the early months of the COVID-19 pandemic. Whilst the Extended Executive Group appeared to ensure that the work of the Board continued papers were not shared with the wider Board members. Towards the end of 2020 Healthwatch Oxfordshire wrote to the Chair of the OSAB asking when the Board was going to reconvene. In response invitations were sent to all Board members to the December Extended Executive Group and the Board met in full online in March 2021.

In June 2019 Healthwatch Oxfordshire carried out an exercise to see how easy it was for a member of the public to raise a concern about another adult – 'Safeguarding is every body's business.' Our report to the Board highlighted how difficult it was to reach the right access point using web searches, lack of single telephone number for people to a call and the complexity and length of the online form. Changes agreed by the Board were to be checked through a similar exercise in June 2020 which was delayed due to COVID-19 pressures until June 2021.

Healthwatch Oxfordshire continues to attend the OSAB, and joint chaired the Engagement Group with AgeUK Oxon during this period."

Contents

Introduction

The Care Act (2014) requires each local authority to set up a Safeguarding Adults Board (SAB). The main objective of a SAB is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area who:

- have needs for care and support (whether or not the local authority is meeting any of those needs)
- are experiencing, or at risk of, abuse or neglect
- as a result of those care and support needs are unable to protect themselves from either the risk of, or the experience of abuse or neglect

The SAB has 3 core duties:

- it must publish a strategic plan for each financial year;
- it must publish an annual report of Safeguarding Adults Board activities; this should include information on the findings of Safeguarding Adults Reviews (SAR) completed during the year and the progress of any SARs still ongoing;
- it must conduct Safeguarding Adults Reviews in accordance with Section 44 of the Act.

Each SAB should:

- identify the role, responsibility, authority and accountability with regard to the action each agency and professional group should take to ensure the protection of adults
- establish ways of analysing and interrogating data on safeguarding notifications that increase the Safeguarding Adults Board's understanding of prevalence of abuse and neglect locally that builds up a picture over time
- establish how it will hold partners to account and gain assurance of the effectiveness of its arrangements
- determine its arrangements for peer review and self-audit
- establish mechanisms for developing policies and strategies for protecting adults which should be formulated, not only in collaboration and consultation with all relevant agencies but also take account of the views of adults who have needs for care and support, their families, advocates and carer representatives
- develop preventative strategies that aim to reduce instances of abuse and neglect in its area
- identify types of circumstances giving grounds for concern and when they should be considered as a referral to the local authority as an enquiry
- formulate guidance about the arrangements for managing adult safeguarding, and dealing with complaints, grievances and professional and administrative malpractice in relation to safeguarding adults
- develop strategies to deal with the impact of issues of race, ethnicity, religion, gender and gender orientation, sexual orientation, age, disadvantage and disability on abuse and neglect
- balance the requirements of confidentiality with the consideration that, to protect adults, it may be necessary to share information on a 'need-to-know basis'
- identify mechanisms for monitoring and reviewing the implementation and impact of policy and training
- carry out safeguarding adult reviews and determine any publication arrangements;
- produce a strategic plan and an annual report
- evidence how SAB members have challenged one another and held other boards to account
- promote multi-agency training and consider any specialist training that may be required. Consider any scope to jointly commission some training with other partnerships, such as the Community Safety Partnership

COVID-19 and Safeguarding Adults Boards

The Department of Health & Social Care wrote to all Boards at the start of the pandemic to outline their expectations of the strategic partnership work they do during the pandemic.

In essence, the letter offered SABs the opportunity to suspend its core duties (as outlined above) for the period of the pandemic if there was a reasonable cause to do so. While these duties could be delayed, they were not removed and any missed work would have to be picked up eventually.

Within Oxfordshire, the Board Chair and Board Members felt that the continuation of the work of the Board was vital and that strategic leadership was needed more than ever during this period, so while there were slightly altered arrangements, the Board continued with its core duties throughout the year. The Board even added to its responsibilities by creating a new subgroup to review the deaths of anyone who is rough sleeping or is in temporary accommodation, an area of work that is explored in more detail later in this report. The Board meetings were held virtually throughout the year to ensure that the work continued as safely as possible, operating with an Extended Executive group in place of the Full Board group. The Extended Executive brought together the statutory partners as well as representatives from the two hospital Trusts and the lay member for the Board.

Who are we Safeguarding? ***Demographic Information***

This information is taken from the Joint Strategic Needs Assessment for Oxfordshire, which can be accessed here: https://insight.oxfordshire.gov.uk/cms/joint-strategic-needs-assessment

The Office of National Statistics (ONS) estimate of the population of Oxfordshire this year was 691,700. Of these,

- There are an estimated 131,400 people in Oxfordshire with a disability (19%).
- There are an estimated 128,126 people over 65 in the county (18.5%), 18,422 of which are over 85 years of age.

These figures are not mutually exclusive and there will be older people who have a disability.

As of April 2020, there were 6,197 adults in Oxfordshire receiving care from adult social care services. 60% of these were older people aged 65 or over. 15% were aged 90 or over. 27% of those receiving care were people with a learning disability. There are 127 residential and nursing home settings in Oxfordshire.

In the population, nearly 91% are white, 2% of mixed ethnicity, 5% Asian, 1.5% Black and 0.5% other groups (from the 2011 census). Within safeguarding this year, it appears all other ethnicities are represented within safeguarding proportionate to their representation in the general public, other than within those identified as Asian where this is a 2% difference. However, reviewing the percentages of concerns that go on to become enquiries, all ethnicities have a conversion rate around 58%, which suggests there is no bias in formal safeguarding processes.

This data will continue to be scrutinised in 2021-22, along with ethnicity data of service users and the census 2021 data to ensure an accurate comparison can be made.

Providing Leadership for Effective Safeguarding Practice: *How the Board Works*

Much like the Oxfordshire Safeguarding Children's Board, the Safer Oxfordshire Partnership, and the Health & Wellbeing Board, the Safeguarding Adults Board is a strategic partnership group made up of senior staff from member agencies.

The Board is facilitated by an Independent Chair and supported by a small team. During COVID-19, the Learning & Engagement Officer was asked to return to frontline work within the operational safeguarding team, with their Board duties picked up by the Board Manager. The Independent Chair completed their tenure in March 2021 and the Board are actively recruiting a new Chair at the time this report was being prepared.

The partnership is made up of:

Completing the membership of the Board is a Lay Member, who provides another level of scrutiny and challenge to the work of the Board partners. As someone outside of the organisations represented at the Board, they offer another independent view on how services work together and help to ensure that our work is as accessible as possible to the broadest audience.

Structure of the Safeguarding Board

The structure of the Safeguarding Adults Board is outlined in the table below:

<table>
<tr><td colspan="2">Full Board
Multi-agency partnership group, bringing together senior leaders from member agencies to agree on strategic safeguarding work and hold each other accountable for safeguarding practice
Provides direction to all subgroups</td></tr>
<tr><td>Executive Group
Drives the work of the Full Board between meetings
Discusses urgent and emerging issues, problem solving as required to provide a clear direction and offer leadership support.</td><td>Safeguarding Adults Review Group
Considers incidents and situations that require a multi-agency review called a Safeguarding Adults Review
Manages the reviews once they are commissioned
Leads on sharing the lessons from reviews</td></tr>
<tr><td>Vulnerable Adults Mortality Group
Oversees the Learning Disabilities Mortality Review (LeDeR) process
Leads on sharing the lessons from LeDeR</td><td>Training Group
Shared with the Children’s Board
Oversees the safeguarding training for the Board
Provides multi-agency training to Board partners and supports training for non-Board partners, such as community and volunteer groups</td></tr>
<tr><td>Procedures Group
Oversees the multi-agency procedures
Offers advice & guidance on single agency procedures</td><td>Engagement Group
Oversees how the Board interacts with the wider community of people working with adults
Inputs on Board publications</td></tr>
<tr><td>Performance, Information & Quality Assurance Group
Scrutinises performance information from across the partnership, identifying emerging issues and concerns for the board within services
Manages the quality assurance processes, such as the annual Safeguarding Self-assessment and the Supportive Learning Visits</td><td>Homeless Mortality Review Group
Reviews the deaths of all people identified as homeless or in homeless accommodation at the time of their death.
Provides lessons from these deaths to partnership groups, particularly the safeguarding board and the Countywide Homelessness Steering Group</td></tr>
</table>

Priorities for the year 2020-21

Boards are expected to set priorities for the year and work towards these through its partner agencies. These priorities must also be reported on within the Board's annual report.

The four priorities set last year were:

1. Move training to an accessible e-learning and webinar format
2. Improving our communication links with non-Board members
3. Sharing the learning from Safeguarding Adults Reviews
4. Maintaining high standards of strategic safeguarding work during COVID-19

The impact of the pandemic could not have been foreseen at the time the priorities for the Board were set. However, this report demonstrates that while COVID-19 has impacted how organisations have operated, these four priorities have been maintained and progress has been made in all areas. Evidence of this can be found throughout this report.

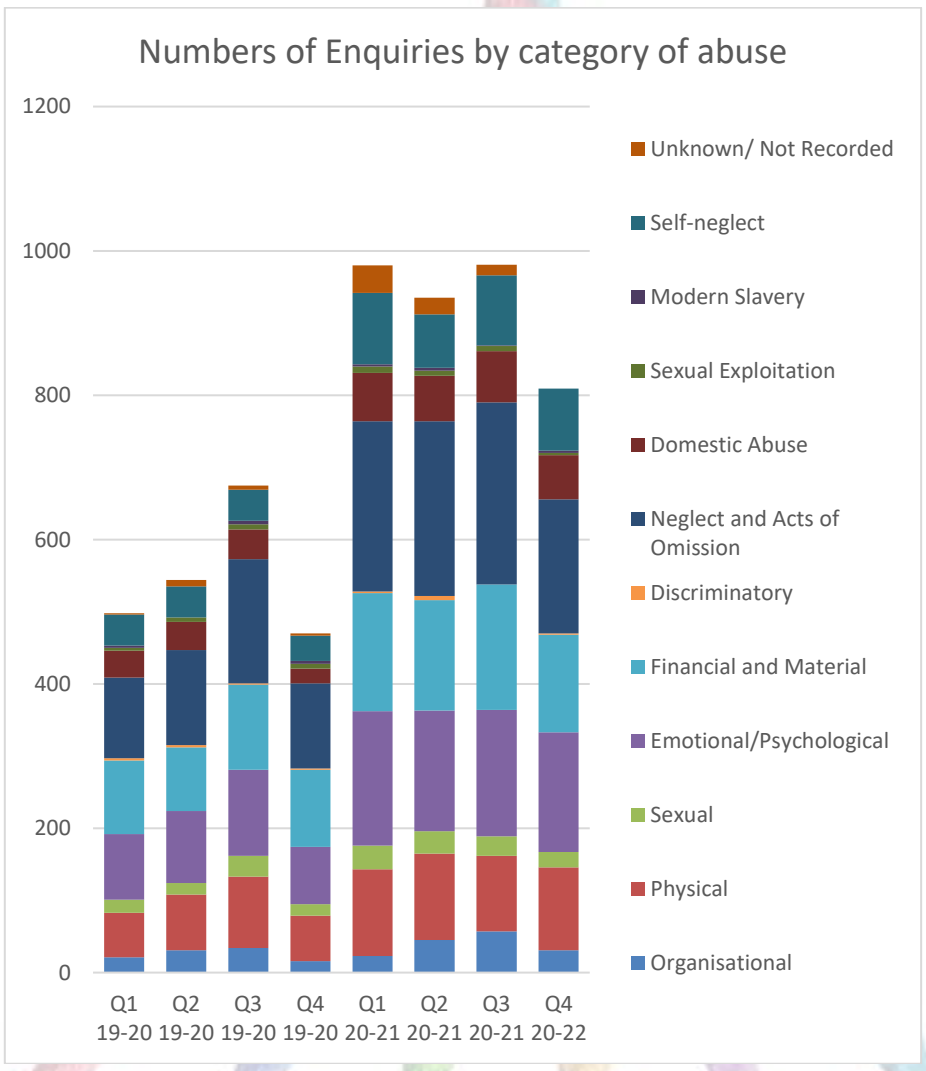
The Effectiveness of Safeguarding Arrangements

Safeguarding data

There are two stages to reporting a concern about abuse or neglect. These are referred to as a safeguarding concern and a safeguarding enquiry. Safeguarding concerns about abuse and neglect can be raised by anyone - the person themselves, their family, friends, a member of the public such as a neighbour, or a paid worker. These concerns are then assessed by the Safeguarding Team in the County Council who decide if it meets the legal criteria for a safeguarding enquiry. Where the adult is currently receiving services from Oxford Health NHS Foundation Trust, the safeguarding concern will be followed up by them as they have a Social Work Team embedded within their organisation

In Oxfordshire, there were 4,941 safeguarding concerns raised in 2020-21. This is a slight decrease from the previous year (5,116). Of these concerns, 2,254 went on to be safeguarding enquiries. Locally, there was a significant change to the safeguarding process at the start of the year as Oxfordshire implemented the Local Government Association safeguarding process, which meant more concerns became safeguarding enquiries, which led to the large change in conversion rate of concerns into enquiries (25% in 2019-20 to 46% in 2020-21).

The chart below breaks down the enquiries by the types of abuse. You may notice that the numbers for quarter 1 to 4 amount to more than 2,254. This is because an enquiry may involve multiple forms of abuse.



Making Safeguarding Personal data

Where it is possible, an adult at the centre of the enquiry, or their representative, should always be empowered to make decisions about their own lives and define what they want to happen. This includes when there are safeguarding concerns and how the person would like these addressed. This is referred to as Making Safeguarding Personal.

- 96% of adults who were involved in a safeguarding enquiry defined the outcome they wanted

- 98% of those adults reported that they were satisfied with the outcome of the safeguarding enquiry

- 92.5% of safeguarding enquiries resulted in the risks being removed or reduced

In 0.75% of cases the adult not satisfied with the enquiry **and** the risk remained (11 cases). In all these cases an audit was conducted by senior staff independent of the safeguarding enquiry to ensure that everything possible had been done to remove or reduce the risk and to satisfy the adult. In all cases, these adults had outcomes that could not be achieved by services (such as wishing to move to a different area, finding an exploitative adult child their own home, etc) and were not prepared to accept what help could be offered.

For those who struggle to be involved in the safeguarding process themselves, services are expected to ensure that an appropriate advocate is able to represent them through the process.

- 81% of those who were judged to lack capacity, as laid out in the Mental Capacity Act 2005, were supported by an advocate. It is a requirement of The Care Act 2014 that anyone lacking capacity is supported through the safeguarding process and where there is no-one appropriate within their family or friends it should be an independent advocate. The remaining 19% of people not supported by an independent advocate were supported by either family, friends or a trusted carer to act as advocate for the person.

Annual Safeguarding Self-assessment

The annual Safeguarding Self-assessment is a joint piece of work between the Adults Board and Children's Board. The purpose of the Safeguarding Self-Assessment is to formally request and gather information from member agencies on the safeguarding arrangements made in line with section 11 of the Children Act 2004, as well as the standards developed by the Local Government Association for Adult Safeguarding Services.

The assessment tool provides agencies with the opportunity to highlight areas of strengths in practice, identify areas for development, and provide evidence of the impact of policies and practice on children and adults with care and support needs in Oxfordshire. It is intended to be useful as a self-assessment tool to measure and provide assurance on the quality of the safeguarding arrangements that agencies have in place.

The self-assessment is supported by a peer review event, where the standards that have received the most mixed ratings are analysed in detail. For 2020, the peer review meeting focused on the following standards;

1. **Senior management have commitment to the importance of safeguarding and there is a clear line of accountability and a clear statement of the agency's responsibility towards children and adults with care and support needs**

2. **Effective complaints systems are in place, in line with current statutory guidance, for children and adults with care and support needs, staff & other people to make complaints and themes of these complaints are addressed.**

3. **Child / Service User friendly complaints information is used, which includes information on what safeguarding issues are and how to raise a safeguarding concern. This includes ensuring there are interpreting services available, if needed**

4. **Service delivery & development takes into account the need to safeguard and promote welfare and is informed, where appropriate, by the views of service users and their families.**

5. **Safeguarding and promoting the welfare of children and adults with care and support needs is central to all service development and these groups are actively involved in the design and development of services.**

6. **Children and adults with care and support needs from black and minority ethnic backgrounds and other diversity strands are appropriately consulted in the development of services.**

7. **There is a responsive process in place to act on unmet need, identifying where there are gaps and how these will be addressed**

Summary of Red, Amber, Green (RAG) ratings

Overall, the self-assessment returns submitted provide assurance that board member agencies across Oxfordshire have procedures in place to safeguard children and adults with care and support needs, are compliant with the standards examined, and committed to ensuring safeguarding practice is embedded in their day to day practice. For those areas where more work is required, there was a clear action plan provided by organisations.

Overview of Red, Amber, Green (RAG) ratings

Section	Questions	Red	Amber	Green
Leadership, Strategy and Working Together	13	0	15%	85%
Service Delivery and Effective Practice	7	3%	16%	81%
Commissioning Arrangements are Robust and Effective	6	3%	12%	85%

Peer Review

The Peer Review event is held each year for organisations to explain their return responses to a small group of their peers and to receive constructive challenge from them on how they could improve and to provide some moderation to the self-assessment ratings. The event was held virtually, due to the coronavirus pandemic, and there was good discussion in groups, both to provide scrutiny of evidence submitted in relation to ratings given, and in higlighting examples of good practice. There was also some discussion around the challenges and opportunities resulting from the pandemic, examples of how organisations and practitioners have worked creatively to provide support to vulnerable children and adults, and the high level of commitment shown to safeguarding in challenging circumstances.

The Peer Review groupings agreed the majority of submissions RAG ratings. Two agencies were unable to attend the peer review event itself but as their written submissions were agreed to be of a high quality, offering sufficient evidence to establish that an additional peer review event was not necessary.

Summary of findings from practitioner questionnaire

A questionnaire about safeguarding was sent to all Board Members for them to share with their frontline workers and we received 781 responses. Although this was a considerable reduction on the 1,764 responses the previous year, these came from a broad range of organisations and so it still provides a useful snapshot of the views of frontline workers about how safeguarding works within Oxfordshire. Agencies cited the demand on frontline staff during the COVID-19 crisis as a reason for not chasing responses to the same level as the previous year.

The key findings were as follows:

- 95% had undertaken safeguarding training within the last 3 years, the gap primarily due to staff turnover and new starters
- When making decisions regarding safeguarding concerns;
    - 63% refer to internal safeguarding policies
    - 45% consult with the safeguarding leads in their own agency
    - 39% use the local authority consultation service
    - 20% refer to the safeguarding board's policies/procedures

  (answers were not mutually exclusive, professionals were asked to tick as many as applicable)
- Slightly less than half of practitioners (48%) knew how to escalate an issue to one of the Safeguarding Boards.
- 75% felt that the leadership in safeguarding had been visible during the COVID-19 crisis.

Practitioner responses are consistent with assurances given in agency returns regarding compliance with the standards on training and internal policies and procedures.

Few practitioners report using multi-agency tools when making decisions in relation to safeguarding concerns they have, with only 13% referring to the Child Exploitation/Child Sexual Exploitation (CE/CSE) screening tool and the neglect tool, 14% to the domestic abuse pathway and 16% to multi-agency chronologies (which is a list of all agency involvements in chronological order), although the latter represents 100% increase on the number who reported using the chronologies last year (8%).

The boards challenged partners as to whether the low level of use of multi-agency tools was due to the majority of responses coming from statutory agencies who already have their own tools/assessments, or if there is further work for board members in raising awareness of, and promoting the use of multi-agency tools across the network. Members reported that it was predominantly due to them having their own tools, usually based on the multi-agency tools.

Overall responses to the questionnaire indicate that the work of the Boards is becoming more integrated into standard working practice and safeguarding is seen less as something done separately to our day jobs.

Summary of findings from the Impact Assessment

The Impact Assessment was amalgamated into the self-assessment in 2018, following a recommendation from the previous year's Peer Review. While the rest of the self-assessment is a check on an organisations' internal processes and procedures, the Impact Assessment is used to understand the issues facing organisations as a system.

Organisations were asked to identify the three key financial and organisational pressures in relation to safeguarding children and their families and adults with care and support needs. The top six are listed below:

1. **Increasingly complex individuals**
2. **Increasing volume of demand on services**
3. **Working with homelessness and the accompanying issues**
4. **Staffing issues – recruitment, retention and resilience**
5. **Restructuring services to meet needs**
6. **Securing the funding for the service**

Partners were asked to identify three key safeguarding themes from performance data. The six most common responses are listed below:

1. **Supporting people who fall outside statutory services' eligibility criteria or were not engaged with effectively**
2. **Financial abuse**
3. **Homelessness**
4. **Mental ill-health**
5. **Hoarding & Self-neglect**
6. **Neglect**

These issues have been shared with Directors within partner organisations for consideration during service review and development.

Overall Conclusions of the Self-assessment

Overall, the peer review groups felt that returns showed a strong level of critical self-analysis. There were some excellent examples of good practice and a very high level of evidence uploaded. The following were most commonly highlighted areas for actions to improve practice within agency returns;

- **Training -** Nearly all agencies highlighted a training need for their staff, although there was no common theme to these needs.
- **Policy & Procedure -** A number of the agencies highlighted an internal need to either review or develop policies or procedures on a variety of topics. Where there were multi-agency procedures already available, organisations stated that their reviews/developments would be in line with the expectations of the multi-agency procedure.
- **Multi-agency Procedures and Tools -** As in previous years, a number of agencies recorded an action to improve knowledge of or use of the multi-agency tools.
- **Monitoring Arrangements -** In light of the COVID-19 crisis, a number of organisations noted actions to monitor current arrangements to ensure they are fit for purpose and high levels of safeguarding and other service delivery can be maintained.

Vulnerable Adults Mortality Group work

This year has seen continued commitment to ensure effective communication and maintain good working relationships. The panel has supported a new rapid review process that critically reviews and seeks to identify any local issues and learning. It is through this scrutiny and constructive challenge, that we will continue to jointly work to improve services across Oxfordshire for those living with a learning disability.

Activity this year has been sustained and enhanced, using reviewers forced to work at home due to the pandemic. 41 notifications have been received and 61 case reviews have been completed, resulting an improvement in timeliness of review completion. 97% of reviews notified to Oxfordshire in 2020-21 were completed within the 6 monthly target set by NHS England.

The average number of notifications of deaths per month in 2019-20 was less than 4 and this has remained consistent in 2020-21. This represents a variance to the nationally reported data that has suggested an increase in deaths among the learning disability community. Locally the data has been cross referenced to ensure no individual was missed from the review process. Whilst there has been no specific learning identified to account for this the steering group has acknowledged that there are a very high number of small supported living settings, more family like units, which may have been a factor. In 2021-2022 living environments may be a feature of some more detailed analysis.

Learning from the LeDeR process has been a regular report component of the Learning Disability and Autism system wide group, that was set up as part of the COVID-19 reporting structures (bronze cell) and will be sustained to create a forum for ensuring providers and commissioners regularly review quality and effectiveness through a range of perspectives.

Hospital admissions in 2020-21 have been a challenge for all. During the pandemic it was necessary to ensure that there were adjustments made to support those living with a learning disability requiring hospital care. The rapid reviews undertaken led to changed visiting arrangements for those requiring additional support, changes to communications with care providers and families and the development of COVID-19 passports.

Learning has been shared in webinars, through a series called " Wednesday at One". This series consisted of 10 sessions, each with a key focus that explored healthy lifestyle issues, advanced/ proactive care planning and health care plans, understanding the individuals' experience and supporting health needs such as epilepsy. On average 80 delegates joined each session from across the south east region from a diverse range of settings.

Key areas identified as requiring further improvement are:

1. Annual Health Checks (AHCs) and Health Action Plans (HAPs) / Education and Health Care Plans (EHCPs) need to be more closely aligned and linked so they inform each other, both being valued by all.
2. Transition from child to adult services needs to start with earlier discussions across teams and service, including primary care. This needs to include hearing the voice of the individual, their views and choices more consistently, whilst not excluding families.
3. Anticipatory care plans, and preparing for lifestyle changes needs to be more proactively supported across the system, including end of life choices, best interest decisions, advocacy and family roles.

A full annual report is published on the OSAB website: https://www.osab.co.uk/wp-content/uploads/2021/07/ITEM-05-LeDeR-Annual-Report-FINAL.pdf

Homeless Mortality Review Group work

In November 2020 OSAB received the report on the Thematic Review into Deaths of Homeless People. OSAB commissioned this review which focussed on the deaths of 9 people between November 2018 and June 2019 in Oxford.

One of the recommendations in this report was that a Homelessness Mortality Review (HMR) Process be set up that would look at all deaths of homeless people including people who had been homeless in the last 6 months. This would ensure that agencies reflected on their actions in all cases and that the systems learning was extracted and acted on in order to reduce the risks that may contribute to a premature death.

The Mortality Review panel was set up in December 2020 and has met monthly since. 27 deaths of homeless people were identified between March 2020 and February 2021. The Panel has therefore been working through these reviews. In the case of one person a full Safeguarding Adults Review has been conducted by external assessors. This report isn't yet complete but early learning is identified in this report.

A research piece conducted by the Museum of Homelessness asked every local authority area in the country for the deaths they were aware of between 1st Jan 2020 and 31st November 2020. From the 46 Authorities that responded, Oxfordshire's rate was ranked 5th highest.

Emerging Findings

There are some statistics outlined below:

- 85% were male, 15% female.
- 7% were street homeless at the time of their death. The others were in homeless accommodation.
- 68% were British, 25% were European and 7% were from outside Europe.
- 50% were under 43 when they died. The youngest was 23, the eldest was 65.
- 'Natural Causes' was the most frequent recording by the Coroner for those cases that were subject to an inquest. All bar two of these were under 50 years old at the time of their death.
- COVID-19 was not noted as contributing to any of the deaths.

The themes from the cases were as follows:

- Alcohol addiction was a feature for the majority of people and in some cases was a very long-term issue.
- Efforts to work with the person were often hampered by threats of and/or acts of violence while inebriated and some services that could offer help are not available to people while they are intoxicated.
- While a majority of these people attended the Emergency department with varying levels of frequency, the follow-up with the services outside of the hospital, such as addiction services, could be improved.
- More could be done to ensure these adults all have a registered GP.
- The use of interpreters for those for whom English is not a first language was inconsistent, particularly out of office hours.
- The reason for the increase in deaths from data reported by the Office of National Statistics for previous years is not obvious as none of the deaths were COVID-19-related. None of the deaths were attributable to the person being homeless, but rather related to the reasons they struggled to maintain accommodation e.g. excessive alcohol consumption, drug use, mental ill-health, etc.

The mortality review process is relatively new and requires significant commitment from all agencies involved, both in leading reviews but also in providing information to other lead reviewers. We will be able to make further conclusions once the process is better established and the Safeguarding Board will continue to receive regular updates on the work of this group.

Learning from Safeguarding Adult Reviews

There were three Safeguarding Adult Reviews active during 2020-21, two of which were completed and published that year, one of which is still on-going.

SAR 1 - Review of Nine Homeless Deaths

The published report can be accessed here https://www.osab.co.uk/wp-content/uploads/2020/11/Review-of-Homeless-Deaths-Full-Report.pdf

The SAR was commissioned following the deaths of nine homeless people in Oxford between November 2018 and June 2019. The ages of the people ranged from 26 to 57. The decision to undertake this discretionary review reflected the concern of OSAB members about the loss of lives of these individuals who all died in very difficult circumstances and at far too young an age, and a commitment to implement any safeguarding lessons across the health and social care system in Oxfordshire. A wide range of agencies who had directly served these individuals were involved in the review. Families of those that died were approached and several chose to add their perspectives to the review.

The review identified a lack of understanding of the needs of people who self-neglect, with practitioners not recognising or not understanding **repeated patterns of behaviour** and individuals were just offered more of the same. - There was concern about whether sufficient recognition was given to the impact of trauma and adverse childhood experiences and how these might be affecting current behaviour. The reviewers also wondered to what extent drug and/or alcohol abuse was being seen as an issue of lifestyle choice and unwise decision-making, with insufficient consideration given to mental capacity and possible mental health needs.

Case records revealed very few **mental capacity** assessments, despite their relevance to heavy users of drugs or alcohol as well as to other diagnoses held by some of these individuals (e.g. global cerebral atrophy). The reviewers also questioned the level of understanding shown by agencies into "executive capacity" (the ability to carry out decisions and intentions) which is often an issue for people who are seen as neglecting themselves.

The review found limited evidence of **risk assessment and mitigation** plans, especially multi-agency ones, for example, when someone was evicted from their hostel accommodation. Other transition points were also noted as requiring more careful multi-agency risk assessment and planning, such as leaving hospital or prison. Reviewers note "the need to consider what wrap-around support was necessary in order to support those who were trying to recover from the impact of trauma and adverse experiences and trying to manage their emotional responses".

The review identifies that many of the individuals potentially had eligible care and support needs (under the Care Act 2014), yet most had not been referred for an **Adult Social Care assessment**. Possible barriers to referral for Adult Social Care, , need to be understood by the board.

Some of the individuals were known to have suffered **domestic abuse** and some were also perpetrators. It was not clear whether the usual channels for supporting victims of domestic abuse and managing perpetrators were available to them as homeless people, and the reviewers challenged the partnership to ask: "when domestic abuse happens on the street, rather than in a home, is this considered a safeguarding concern?"

The reviewers found examples where agencies worked together well, but also examples of **poor collaboration and fragmentation of services**, with a perception that too much responsibility was placed on accommodation providers to engage with other services and to coordinate their involvement. The clearest example of where improved multi-agency collaboration was needed was in relation to hospital discharge.

The report also refers to "**referral bouncing**", with a perceived reluctance to be "part of the solution". This sometimes resulted in the least formally qualified and experienced workers being left to deal with the most challenging and complex individuals.

There was no agreed format for convening or conducting **multi-agency meetings** nor a standardised approach to **risk assessment and management** plans. There were examples of plans developed without all relevant agencies involved, of plans formulated but not followed, and plans that were not reviewed or reformulated when events disrupted what had been agreed. In none of the nine cases did there appear to have been a nominated lead agency and/or keyworker to coordinate the multi-agency input for these complex individuals.

The review highlighted front-line staff were not recognising when a **safeguarding referral** was warranted. These clients had a range of physical and mental health problems that potentially translated into eligible 'care and support needs' (under the Care Act 2014) and, despite the services provided, these individuals remained in high risk and unsafe situations. Yet none of the nine people had been subject to a safeguarding enquiry. Alongside this, concern was expressed by operational staff of 'not being heard' when they did attempt safeguarding referrals.

The report recommends improving staff confidence in applying the **Homelessness Reduction Act 2017** and notes the absence of assessment under the **Human Rights Act 1998** for at least one individual with no recourse to public funds, who might then have been eligible for some support.

The review found a **lack of strategic agreement** between housing, adult social care and health agencies across Oxfordshire about priorities, and a lack of 'ownership' of homelessness as a shared responsibility of these agencies. The evidence reviewers found of the strategic approach being followed, often referred to locally as "the homeless pathway", was too crisis focussed and lacking support for recovery of the person.

There were difficulties with the commissioning of services for people experiencing homelessness which affected their access to mental health services in general, and especially to **services for 'dual diagnosis'** (substance misuse and mental health). The report references commissioning approaches in other areas that deliver integrated provision, and calls for a greater number of specialist multidisciplinary services offering more flexible and proactive support, some of which needs to be available out of standard office hours.

Recommendations

There were 15 recommendations, with an initial 22 actions being created to meet the recommendations. As the work of the group evolved, several actions were amalgamated. All the recommendations are laid out in the full report that is published on our website.

A summary of progress against the recommendations is provided below, and further details will be reported separately as part of learning and development updates from the board.

Leadership and ownership was required and a Countywide Homelessness Steering Group was tasked with developing potential governance options, this work is complex and ongoing because it crosses a number of multi-agency partnerships and boards. After the publication of this report, the homelessness services contracts were re-tendered and the recommendations and findings were built into contracts. The Board are also investing in a programme of training on trauma-informed practice that will be open to all practitioners.

Crisis have led a housing-led feasibility study for Oxfordshire (https://www.crisis.org.uk/about-us/media-centre/ground-breaking-approach-in-tackling-homelessness-to-be-adopted-across-oxfordshire/) which also recommended "a senior and multi-agency Homelessness Reduction Board operating at countywide level."

Work on updating the multi-agency policies and procedures that are relevant to the homeless community, including the self-neglect policy and the hard to engage policy has been progressing though a task and finish group supported by many partner agencies. A multi-agency process referred to as a Multi-agency Assessment & Risk Management (MARM) is being considered.

The Homeless Mortality Review group was established in December 2020. Much like the LeDeR process, the group reviews the deaths of all homeless people regardless of the cause of death, which may be entirely unrelated to their homelessness status. It's activity is reported within this annual report.

Work was completed on mapping existing services and identifying any gaps, this was used to inform the countywide strategy. The Strategic Lead for Domestic Abuse has been tasked with reviewing the services for women experiencing or at risk of homelessness due to domestic abuse in order to assure the board that they are supported and cared for equitably.

PIQA has been monitoring the outcomes of those safeguarding concerns and safeguarding enquiries that involve people who are recorded as being homeless. The proportion of concerns being made into an enquiry is being monitored closely to ensure that it aligns with those in the rest of the population. Over the next year any trends and issues will be raised with the Homelessness Steering group and the Board..

Key outstanding issues and relation to other work

Governance – as indicated earlier in this report, the issue of governance is still not resolved. The Countywide Homelessness Steering Group has been tasked with developing option. We are nine months on from the publication of the SAR where this was identified and while it is important the strands of work are aligned, it is vital that this is resolved as soon as possible. In the interim, any issues are being raised to the regular Chief Executives Meeting, although it is understood this is only the CEOs of the County and District Councils and doesn't involve other partners relevant to homelessness.

Domestic abuse and homelessness – at the time of its last meeting, there was still no report produced in regards to domestic abuse and homelessness. It was noted that the arrangements within the County Council around domestic abuse had undergone changes and that it is now overseen by Public Health.

Multi-agency Assessment & Risk Management – as was noted in this review, and is a feature of reviews nationally, there is often a lack of engagement or struggles to maintain engagement for some of our most vulnerable adults (this is not limited to those who are homeless). This is often coupled with a person bouncing between services, where they are willing to engage, to be told they do not meet service thresholds for assistance. The latest best practice model being shared nationally among Boards should go some way to assisting with this issue but it must be supported by the senior members at Board level. It requires allowing staff the time to attend the panel meetings where the cases may not be someone they are working work but where their professional expertise, whether that's mental health, social care, housing or any other service,

are vital to ensuring the options are fully understood and the risks for the person are fully explored and shared.

Conclusion

While there has been significant progress in most areas of the work, there are still some gaps that need to be addressed, particularly the issue of Governance. There is a huge amount of work being done by frontline workers and as reported by the Homeless Mortality Review group, there has been a significant drop in the rate of deaths since the start of this year. However, without the Governance issues sorted, the issues encountered by the frontline workers are primarily still being left with that organisation to resolve, which is not good multi-agency working.

The PIQA audit of the work around the recommendations will come to the December 2021 meeting, which should offer assurance to the Board that not only have the majority of the actions been completed but that they have had a positive impact on the partnership and how we work together on this complex, multi-faceted issue of homelessness.

SAR 2 - Adult J

The published report can be accessed here: https://www.osab.co.uk/wp-content/uploads/2020/08/SAR-Adult-J-Learning-Summary.pdf. Please note that this is just a summary report in respect of the family's wishes that the full report is not made public.

Background

Adult J resided on a canal boat and had lived in Oxfordshire on and off for several years since splitting with his partner who lived elsewhere in the Country. He self-reported to professionals that he was drinking heavily from the summer of 2016 and that he occasionally suffered from a low mood. In early 2016 Adult J got into a relationship with Adult K. There were clear indications of domestic abuse between partners, with both alternating the role of perpetrator and victim. This pattern repeated multiple times until his death in late 2018.

Adult J's history with services was described as challenging by professionals, with a noted unwillingness to engage with services or accept help that was offered. In the summer of 2017 Adult J suffered life-changing injuries which left him with severe injuries to his hands and impaired his mobility. He was hospitalised until he self-discharged towards the end of 2017 (against medical advice and without a care package being in place).

In late 2018 Adult J was found deceased. The cause of death was found to be acute alcohol intoxication. At the request of the family, the Oxfordshire Safeguarding Adults Board (OSAB) are only publishing a learning synopsis.

Findings and Recommendations

In Adult J's case, it may have been preferable to consider an approach outside the confines of expected policy responses and adopt a '**team around the adult**' approach. This approach (referred to a Team Around the Family in Children's work) focusses on assessing and meeting needs in order to prevent concerns escalating whilst also drawing upon the strengths of the family.

The aims of the Team Around the Family approach were incorporated into the Working With Those Who Won't Engage policy. This work is being further developed under the recommendations of the SAR into the deaths of homeless people.

Adult J's **self-neglecting behaviour** may not have received sufficient attention from agencies. In this case, Adult J's self-neglect appeared to arise from a complex interplay of factors including a sense of loss arising from reduced contact with his children, excessive use of alcohol, the impact of the severe injuries he sustained on his physical and mental health, the difficulty in re-adjusting to life on his houseboat and his exposure to violence, coercion and control in his relationship with Adult K.

The Board uses this case as a self-neglect case study in training to ensure that the lessons are learnt and shared. The Oxfordshire Clinical Commissioning Group has also used the case in their training sessions with GPs.

The issue of the **Domestic Violence Protection Order (DVPO)** provided a valuable 'breathing space' during which much positive work was done to support Adult J. However, to capitalise on this opportunity, it does require fairly rapid and sustained single agency and partnership working which may not always be achievable given the pressures of competing demands. Additionally, although the police quickly made a safeguarding referral to Adult Social Care, which was entirely appropriate, there is no indication that they actively managed or monitored the DVPO.

This report was shared with the countywide Safer Oxfordshire Partnership group that brings together the Community Safety Partnerships across Oxfordshire. The purpose of sharing the case was to ensure that professionals understood the circumstances which contributed to successfully exploiting the opportunities provided by the DVPO. It was also shared to highlight the issue below of information gathering for the Domestic Abuse Stalking & Harassment (DASH) risk assessment.

There were occasions when opportunities to conduct **DASH risk assessments** may have been missed. Additionally, the DASH risk assessment conducted by the Thames Valley Police was not informed by the Warwickshire incident, the details of which would have been available from PNC.

There were several missed opportunities in GP records to **record the name of Adult J's partner** and/or carer which, if had he been willing to divulge this information, would have been helpful in gaining as full an understanding as possible of the risk of domestic violence and abuse he faced. This was also included in the GP training sessions mentioned earlier.

The **Canal and River Trust** made two safeguarding referrals in this case which indicated positive levels of awareness of domestic violence and abuse, including coercion and control. However, the potential benefits of working in partnership with the Canal and River Trust were not fully utilised in this case. For example, the Trust appear to have had the authority both to allow Adult J to moor his houseboat in Oxfordshire for an extended period because of his level of disability and the authority to insist on Adult K moving her houseboat elsewhere when the DVPO prevented her from contacting Adult J and therefore fulfilling the role of his carer. Working more collaboratively with the Canal and River Trust may have helped to safeguard

Adult J. The Safeguarding Adults Board approached the Canal and River Trust to explore opportunities to further engage them in safeguarding vulnerable boaters from abuse or neglect. Issues which were explored included the flagging of houseboats by the police and overcoming difficulties in demonstrating a local connection when a boater might wish to leave the canals and move into supported housing.

Reasonable adjustments, as required by law, were not always considered for Adult J. The Oxfordshire Safeguarding Adults Board sought assurance that the agencies involved in this SAR had reviewed the reasonable adjustments made for people with disabilities in the light of the learning which has emerged from this review.

The delay in formally notifying Thames Valley Police of the serious incident that occurred in Warwickshire had the potential to increase the risk of domestic violence and abuse faced by Adult J following his discharge from Hospital. The Safeguarding Adults Board shared this report with **Warwickshire Safeguarding Adults Board** for any action they wish to consider relating to cross border communication of high risk domestic violence and abuse victims.

SAR 3 - Adult V

The following SAR is not finalised at the end of 31st March 2021. The learning and recommendations may not be the same as those that appear in the final published report but it is expected in the Care Act guidance that Boards report on unpublished SARs and learning to date.

It has been established from the details contained within the multi-agency chronology that V was a gentleman who had periods of time in his life when he struggled to maintain his health and well-being to an acceptable standard and was offered support on several occasions to achieve this.

He had not had any active ongoing involvement with services over this period of time and it is evident from the detail contained within the documentation that he did not to respond to professionals despite the numerous contacts they made via phone calls, letters and text messages, in respect of his health and well-being.

V stated to a professional on one occasion that he found it hard to keep “on top of things” and in October 2014 a referral to Adult Social Care highlighted areas of serious concern relating to self-neglect, which included his personal hygiene, his lack of food consumption and extremely poor living conditions.

There were occasions when V had to be prompted to pay his rent and the chronology verified that he was evicted on one occasion due to the condition of the property.

The period from 2014 to April 2020 highlights the general ongoing theme of professional concern for V regarding his general well being which included his ability to attend to his basic needs, his health, and his ability to sustain a tenancy. The aim of the Appreciative Inquiry was to look at where, how and why events took place and use professional hindsight and wisdom to design practice improvements.
The method of an Appreciative Inquiry uses a systemic methodology which refers to focussing on the interactions and relationships between professionals to help them address any interactions and to move on. It gives those involved with the process the chance to explore the circumstances and say what they think in a safe, non-judgmental environment. Professionals at the workshop came to a consensus regarding the learning points to be endorsed by the Oxfordshire Safeguarding Adult Board for all agencies involved with V

Board members to ensure that frontline professionals are mindful of the following learning points from this review:

- **Professional curiosity** – remembering to explore with an individual what is happening in their life and challenging when necessary.
- **Professional overreliance** - from the individual without exploring the presenting information from professionals.
- **Professional judgment** - applying the knowledge, skills and experience of professionals to develop an opinion.
- **Multi-agency working** - revisiting the benefits of shared responsibility, improving outcomes, problem solving and working within a holistic framework.
- **Mental capacity** - the existence of capacity should not preclude further investigation into a person's circumstances and choices.
- **Self-neglect** - partnership knowledge of self-neglect needs improving through training to address the fundamental principles of this behaviour.
- **Understanding professional roles and responsibilities** - in respect of ”duty of care". Who “owns” the case and is taking the lead?

1. The Board should assure itself that the training offered to frontline workers includes the **fundamental principles of Self-neglecting behaviour and is clear and understood.**
2. The Board should consider producing a **7 minute briefing of the lessons** highlighted above for publication with the report.
3. The Board should consider a partnership audit that addresses the fundamental question of Mental Capacity and its application.
4. The Board should consider an audit to establish the level of partnership training that is offered to professionals.
5. The Board should assure itself that multi agency working is embedded across all services and is clear and understood.

OSAB Training Programme

Due to COVID-19, all training was moved to e-learning. This allowed professionals to continue to maintain high levels of training adherence without the risks associated with bringing large groups of people together. It also improved the accessibility to training as it could be done at the pace and time of the delegate rather than attending a face-to-face training session.

The training figures have risen from 1,146 delegates to 2,144 delegates. This is likely to rise again in 2021-22 as new NICE guidance places a greater requirements on care home staff to attend safeguarding training and to do so on an annual basis. The expectation of the Board and of most other organisations, including health bodies and council staff is that training is refreshed three-yearly.

Satisfaction rates with the training have not decreased despite the move to only providing training in an e-learning format (96% approval rating for the reporting year as well as the previous reporting year).
There was a huge increase in the number of volunteers undertaking the training this year, from less than 20 in 2019-20 to over 500 in 2020-21. This is suspected to be due to the number of voluntary and community groups that were set up to support those isolating at home during the pandemic. The Board worked with Oxfordshire All In, the central hub for community support groups within Oxfordshire, to promote the training to volunteers. The training was also made free for everyone to remove as many barriers as possible for accessing the training.

Conclusion

The Board Member partnership knows:

- The local safeguarding partnership has continued to maintain a high standard of work during a difficult year that has affected all partner organisations. There has been no increase in safeguarding concerns that point towards any failings of organisations to work together. Despite difficult working conditions, levels of safeguarding work have been maintained during this year, with the number of concerns raised being similar to previous years. The significant rise in safeguarding enquiries is due to a change in process within the Local Authority rather than an indicator there are significantly more safeguarding issues.
- The Making Safeguarding Personal approach has been championed throughout the year and there has been an improvement in the number of people who have defined what they wanted to happen as a result of the safeguarding work and who were satisfied with the work that was undertaken. This is excellent progress during a difficult year and demonstrates professionals are continuing to keep the person at the centre of their work with them, empowering them to make the decisions that are important to them and honouring that as much as they are able to whilst seeking to protect them.
- The annual Practitioner survey of Frontline workers has indicated that the majority of workers have felt there was clear leadership in regards to safeguarding during the last year. Workers have valued the safeguarding consultation service and its use has risen over the period.
- Most Organisations have maintained levels of safeguarding training amongst staff comparable with the previous two years. Health agencies have understandably reported under compliance due to their frontline role during COVID-19. The huge increase in training taken up by the voluntary sector during this period has been particularly welcome and we hope to maintain this level of interest and engagement with safeguarding training within voluntary and community groups.

There is still work to be done and these are the key messages for local leaders reading this report:

- **Leadership on homelessness** – Organisations must come together to agree the governance of homelessness at a countywide level. Operationally partners are doing a lot of things to improve work within their own organisations, there are areas of multi-agency work underway and a countywide strategy has been produced however, the governance and senior strategic leadership across the county has yet to be agreed.
- **Working with complexity** – the feedback from Board Members and frontline workers has highlighted for the last two years that the people that are being referred into services have increasingly complex issues. For some, these may not individually trigger a statutory response but when viewed holistically the issues clearly indicate there are risks. For others, they may trigger a response but are unwilling to engage with the services that could help them, thus leaving them at risk to themselves or from others. Multi-agency partnership work is underway to develop more integrated approaches and shared processes. It will require commitment from senior managers to enable frontline professionals to actively contribute provide their professional expertise, in order to support other teams develop skills and knowledge. The goal is to enable all services to work more effectively, proactively on improving outcomes for those they are working with..
- **Refreshing the links between strategic partnerships** – during COVID-19 the focus of organisations has rightly been diverted to ensuring those most vulnerable in our society are protected as much possible. This had the effect of reducing the focus on strategic partnership work during this period. The relationship between the strategic partnership groups within Oxfordshire (Children's Board, Health & Wellbeing Board and the Safer Oxfordshire Partnership) needs to be reviewed and refreshed.

Divisions Affected -

The Health & Wellbeing Board – 16 December 2021

Oxfordshire Safeguarding Children Board (OSCB) Annual Report

Report by Corporate Director for Children's Services

RECOMMENDATION

1. **The Health & Wellbeing Board is RECOMMENDED to** note the annual report of the Oxfordshire Safeguarding Children Board senior safeguarding partners and to consider the key messages.

Executive Summary

2. This paper highlights findings from the Board's annual report on the effectiveness of local arrangements to safeguard and promote the welfare of children in Oxfordshire.

Background

3. Local multi-agency safeguarding arrangements are the collective responsibility of chief officers in the county council, the NHS clinical commissioning group and the police.

4. These three senior safeguarding partners agree ways to co-ordinate their safeguarding services for children; act as a strategic leadership group in supporting and engaging others; and implement local and national learning including from serious child safeguarding incidents. They work with relevant partners through the Oxfordshire Safeguarding Children Board', under the leadership of an Independent Chair. The arrangement is referred to as the "Oxfordshire Safeguarding Children Board (OSCB)'.

5. The report can be accessed in full on the OSCB website.

Key Issues

6. The OSCB Annual Report sets out the safeguarding challenges in Oxfordshire. The local safeguarding issues where collective **action** can make a difference are:

    1) Working to identify and act where we see neglect
    2) Improving our strategic efforts to deal with the exploitation of children
    3) Better connectivity with schools and shared sign up to the same safeguarding principles

7. There are four key messages for system leaders to bring a collective **focus** to:

a) **'Oxfordshire needs traction on changing practice'.** The whole system must work together to effect change, which means each organisation must take responsibility for embedding change and learning. We are doing a lot of things to improve how we work together but the challenge is making it sustainable.

b) **'The Jacob CSPR shows that we need to improve how we work together across our whole partnership'.** This includes community safety, children's safeguarding, education and health. We need to bring strategic leadership and direction to this work to make it easier to keep children safe from harm outside the home.

c) **'Post-pandemic interventions will need to be at scale and volume'.** Pace and purpose is needed to deal with the emerging issues such as increased safeguarding referrals, visibility of children through school attendance, increased referrals for mental health and domestic abuse concerns.

d) **'Education settings are key partners'.** Whilst they are not named as senior safeguarding partners in the guidance 'Working Together 2018', we are clear in Oxfordshire that our education colleagues are central to keeping children safe. They must be part of our conversations and actions for us to work better together. The report should be aimed at the general reader but assuming a reasonable knowledge of the service and budget and of the local government context.

Corporate Policies and Priorities

8. The report outlines the Safeguarding Children Board priorities, the learning from case review work, the outcomes of quality assurance work and the summarised findings with respect to the unexpected child deaths in Oxfordshire. The report supports the Vision, Values, Objectives and Strategic Priorities in the County Council's Corporate Plan (see Corporate Plan).

Financial Implications

9. The Oxfordshire Safeguarding Children Board is funded by the local safeguarding partnership including the county council, district councils, the NHS Clinical Commissioning Group, Thames Valley Police and the National Probation Service. The budget contributions and expenditure is outlined in full detail in appendix B of the report.

Comments checked by:

Thomas James, Finance Business Partner

Legal Implications

10. There are no legal implications for the Local Authority. Checked by: Sukdave Ghuman, Head of Legal Services & Deputy Monitoring Officer sukdave.ghuman@oxfordshire.gov.uk

Sukdave Ghuman
Head of Legal Services)

Annex: Oxfordshire Safeguarding Children Board Annual Report 2020-21

Kevin Gordon
Director of Children's Services

Contact Officer: Tan Lea. Strategic Safeguarding Partnerships Officer

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OSCB
Oxfordshire
Safeguarding
Children Board

Annual Report
2020/2021

Foreword by the Senior Safeguarding Partners

This is the second year of our revised partnership arrangements and has been a year shaped by the pandemic. Our focus has been to ensure that vulnerable children 'have been kept in sight' and that all risks and opportunities have been considered.

We welcomed the Jacob CSPR, which took a constructive look at our local systems and has helped define the work that we need to do to keep children safe from harm outside the family home. Reviews have shown us the compassion and commitment that local practitioners have to keep children safe. We share this ambition.

It is clear from our analysis that system change is still needed to improve our working to address neglect, child exploitation and to keep children safe in education. We are committed to achieving system change in the year ahead.

The need to listen and communicate well with children in section 7 stood out. This will be something to improve on, with the guidance of our young Safeguarding Ambassadors, in 2021/22.

Observations of the OSCB Independent Chair, Derek Benson

Since taking on the role of Independent Chair in November 2020 I have seen evidence of a strong and effective partnership that has the wellbeing of children and young people at the heart of what it does.

The impact of the pandemic required a flexible and agile response, and the partners in Oxfordshire have responded positively to that challenge. There is a shared determination from the practitioners through to senior leaders to drive further improvements and the learning identified through the recently published reviews is central to that. The OSCB will continue to hold partners to account so that our children are as safe and well as they can be.

Derek Benson,
OSCB Independent Chair

Contents

APPENDICES

1. Introduction

The government guidance, 'Working Together 2018', requires safeguarding partners to publish an annual report. The intention is to 'bring transparency for children, families and all practitioners about the activity undertaken' (by the safeguarding partners).

The Senior Safeguarding Partners and the OSCB have three aims: to provide leadership for effective safeguarding practice; to drive forward practice improvement and to challenge in order to ensure that children are kept safe.

This report sets out what we have done as a result of the vision and arrangements, as well as how effective we have been in practice.

2. **Children in Oxfordshire:** what we know about safeguarding needs

- **146,123** young people are estimated in live in Oxfordshire. This is an increase of 7% over the last ten years and sits alongside a high demand on the statutory system.
  11% of children and young people are living in poverty before housing costs which rises to **21%** once housing costs are included
- **10,127** children are eligible for free school meals
- **26%** of the school age population are from ethnic minority groups. They are more likely to be represented in the social care system, however this is driven by the fact that they are more likely to live in areas of economic deprivation.

At the end of March 2021:

- **475** children were the subject of a child protection plan
- **66%** of child protection plans have neglect as the main reason
- **776** children were cared for
- **933** children were electively home educated

The last year has been dominated by the impact of Covid and lockdowns. Our partnership has focused on children's wellbeing. We saw an increase in:

domestic incidents and domestic crimes involving children

mental health issues including rise in self-harm attendances at A&E

referrals to the multiagency safeguarding hub

We saw a decrease in **early help assessments** due to the closure of schools to the majority of their pupils

Provisional data on **care leavers** shows improvements for children who remained looked after till their 18th birthday in terms of education, employment and training and those in suitable accommodation. However, the level of care leavers in education employment and training remains below the national level.

Safeguarding partners have developed their priorities with this context in mind.

[1] Source ONS Mid-Year Estimates for Oxfordshire for people aged 0-17 2007 & 20

3. Providing leadership for effective safeguarding practice

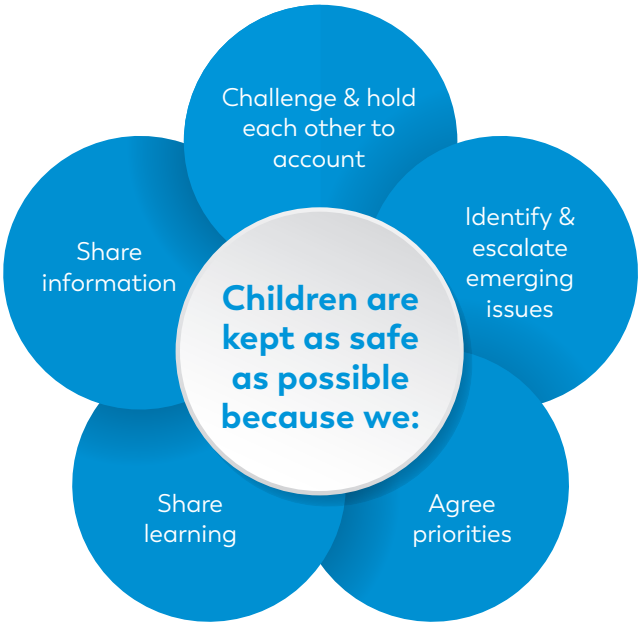
Yvonne Rees,
Chief Executive of
Oxfordshire County Council

James Kent, Accountable Officer and Executive Integrated Care System Lead, Buckinghamshire, Oxfordshire and Berkshire West Clinical Commissioning Group

John Campbell,
Chief Constable,
Thames Valley Police.

The leadership of safeguarding arrangements is at chief executive level across the local authority, health and police. They are the Executive. They are responsible for, and oversee, these arrangements even where they may have delegated direct input to senior officers to attend the Executive Group.

The Oxfordshire Safeguarding Children Board (OSCB) sits beneath the local leaders. Led by an independent chair it brings together the local organisations, which deliver services that affect families' and children's lives.



Our **membership, structure, partnership links** and funding can be accessed online via links at the end of this report. OSCB work is driven through a series of subgroups. The people on these groups are from our partner organisations.

The **partnership** is not responsible or accountable for delivering child protection services, but it does need to know how well the safeguarding system is working.

The **Executive Group**, chaired by the Chief Executive Officer of the County Council, has:

- ✓ responded quickly to the issues emerging from Covid through a risk and opportunities register
- ✓ worked effectively through increased online meetings
- ✓ brought strategic ownership from our agencies to this work
- ✓ overseen the arrangements for learning from the Child Safeguarding Practice Review on child exploitation
- ✓ worked with young people to recruit a new independent chair to lead the board
- ✓ commended five practitioners for good safeguarding practice
- ✓ challenged and improved the information sharing process for the licensing of taxi drivers
- ✓ reviewed the local safeguarding arrangements to include membership from the local military
- ✓ recruited a board member from the local community

EFFECTIVENESS OF LEADERSHIP IN SUMMARY:

- ☑ strategic ownership of safeguarding
- ☑ added value in terms of direction, decision making and connection
- ☑ raised profile of safeguarding work
- ☑ momentum generated by leadership through Covid

4. The effectiveness of safeguarding arrangements: priorities, progress & escalation

PRIORITIES FOR PRACTICE IMPROVEMENT

- **Neglect:** We knew that this was the main reason that children are subject to a child protection plan and that it is not always picked up early enough.
- **Safeguarding in (and out of) Education:** We knew that we needed to develop a shared vision with all partners.
- **Child exploitation & keeping children safe outside of the home:** We knew that the local arrangements needed to be improved.

NEGLECT

What went well	Even better if
✓ Early help training run for GPs, police ✓ Neglect e-learning course developed ✓ Work with schools on developing kits and resources – audit tool, good practice case studies, guidance ✓ Improvement seen in virtual case conference attendance ✓ New online system for sharing chronologies ✓ Agency actions in place to improve how they each identify and address neglect	• The system for monitoring case conference attendance functioned better • More practitioners used the OSCB resources and the online system for chronologies • More organisations did early help assessments • Challenge Event can evidence a change in the way of working by individual agencies as well as in partnership

SAFEGUARDING IN (& OUT OF) EDUCATION

What went well	Even better if
✓ Additional capacity into home education service leading to some children returning to school (mediation process for parents and schools) ✓ Information pack for parents on home education ✓ Improvements leading to speedier resolution for children missing education ✓ Good learning points identified through the Jacob CSPR	• Improved relations to speed up requests for direct admissions to academies • Sign up by whole education community that children cannot remain out of school • The recently established 'child missing education' assurance panels prove that they are effective

CONTEXTUAL SAFEGUARDING AND CHILD EXPLOITATION	
What went well	**Even better if**
✓ New Youth Justice and Exploitation service ✓ Improvements in joint working when supporting children going missing / being exploited ✓ New multi-agency action groups to respond to Jacob CSPR	• 'Contextual safeguarding' is more widely understood and services were able to adjust to addressing risk and harm outside of the family • There is a shared vision and strategy for this work • There is greater consistency re best practice across community safety partnerships • More practitioners use the exploitation screening tool • The evaluation of local processes leads to greater improvement in 2021/22 • The new prevalence and intervention reporting leads to a more targeted way of working

EFFECTIVENESS OF DRIVING FORWARD PRACTICE IN SUMMARY:

- ☑ Improvements made in all three priority areas
- ☑ Limitations of progress also noted - a push is needed by all partners to keep these gains
- ☑ Neglect, safeguarding in education and child exploitation should remain priorities

5. Learning from Reviews

RAPID REVIEWS

A Rapid Review is triggered when a child is involved in a serious incident, which is notified to Ofsted. Local organisations quickly collate information, analyse how well they worked together and tie down actions and learning points as clearly as possible to bring about improvements.

The OSCB has looked at nine serious incidents or cases of concern to consider if an in-depth child safeguarding practice review (CSPR) should take place.

A case may refer to more than one child e.g. a sibling group.

OVER THE YEAR 2020/21	OUTCOME
• 8 were 'serious incidents' for a 'Rapid Review' and 1 was a case of concern	• 2 Child Safeguarding Practice Reviews and 1 Partnership Learning Review

This is very small cohort of incidents. However the pattern and themes are reflected at national level in the National Panel's **Annual Report 2020**.

Learning points from the last 12 months:

- Maintain face to face contacts where possible
- Ensure that professionals maintain good contact with each other when making decisions on risk
- Think about the whole family e.g. share information across different parts of the health service
- Safeguarding risks on co-sleeping should be explained to both parents
- Look for 'reachable moments in adolescent children's lives'
- Children are safer when they are in education

Themes for children up to 5 ys

Co-sleeping, physical abuse, parental substance misuse.

Themes for children aged 15-17ys

Children being vulnerable to abuse or exploitation from outside their families, missing from home and school, not engaging well in school life and being electively home educated. Long-term impact of neglectful parenting as children grow older.

CHILD SAFEGUARDING PRACTICE REVIEWS

The OSCB has worked on ten reviews. Some of the reviews started before 2020. They concerned twelve children. Four were female and six were male. Two of these children were transgender. The local pattern and themes are reflected in the National CSPR Panel's **Annual Report 2020**.

Babies & children up to 5 ys:

In two of the three reviews on children under 5 years the child suffered physical abuse.

Children aged 10 - 15ys:

In three of the reviews on adolescent young people, mental wellbeing and suicidal behaviours were contributory factors. Sadly, two of the reviews concerned children who are deceased. In three of the reviews on adolescent young people, mental wellbeing and suicidal behaviours were contributory factors.

SAFEGUARDING THEMES AND MESSAGES FOR LOCAL LEADERS FROM THE RECOMMENDATIONS:

Early help for families

Messaging needs to be clear. A combination of risk factors can build up over time in family homes (mental health, domestic abuse and drug and alcohol misuse).

'Help at an early point across all services can make a difference. An early help assessment is the means to do this.

Addressing neglect of children in the family home

We need to respond collectively to neglect.

Practitioners should be supported to name, discuss and respond to neglect confidently.

Minimising Risks to children outside the home

Oxfordshire organisations need a 'system response' to work better together on the safeguarding risks that exist in the child's environment.

Children can become trapped in a world that they cannot escape.

We must look for 'reachable moments'

Keeping children safe in schools and settings

Schools should be supported to keep children safe

...to notice potential harm

... to alert other agencies

.... to challenge decisions.

In total there were over 30 recommendations being monitored and challenged through partnership meetings.

FEEDBACK

We involve families directly in all of our reviews. Their experiences tell us how our safeguarding system works in practice. Grandparents, parents, siblings, carers and children have talked to us.

Their views have shaped: the new child exploitation framework; our conversations with young people; training on consent and sexual behaviour.

'A local child who suffered extreme neglect would like professionals to remember that: ...the future will always change'

Families have said that they want to take part to ... 'help another child in the same situation'

Two reviews were published: **Child K** and the **Jacob CSPR**. They had local and national recommendations which are detailed in full in both reports.

REGIONAL AND NATIONAL LEARNING INCLUDES:

- There is a lack of homes (placements) for children with a range of complex needs. These children are often the most vulnerable that we care for and are unable to be close to their family home.
- The legislation concerning children educated at home places barriers in the way of keeping children safe
- We need 'sign-up' from the whole education community that children cannot remain out of school

EXAMPLES OF ACTIONS TAKEN BY THE PARTNERS TO IMPLEMENT THE RECOMMENDATIONS:

- ✓ Sharing concerns with the Dept for Education, MPs and local politicians regarding national policy and guidance (stated above)
- ✓ Launching an online system for 'Multi-agency chronologies' to build a full picture of what is happening in the life of a child /family who is subject to child protection planning
- ✓ Improving the system use to work out the thresholds of need for a child by including more family background information and making connections between services
- ✓ Improving how the police communicate and feedback to children who disclose sexual abuse so that children know that they have been listened to
- ✓ Developing the multi-agency bruising protocol so that practitioners know what to look out for when caring for babies and don't miss key signs
- ✓ Creating a kit for schools to help them understand what 'good looks like' when supporting a child who is at risk of experiencing neglect; the kit includes a checklist and good practice case study
- ✓ Improving the system used to 'screen' risk factors of child exploitation
- ✓ Setting up Youth Justice and Exploitation Service within the County Council
- ✓ Development of county-wide missing and exploitation panel and area based multi-agency networks

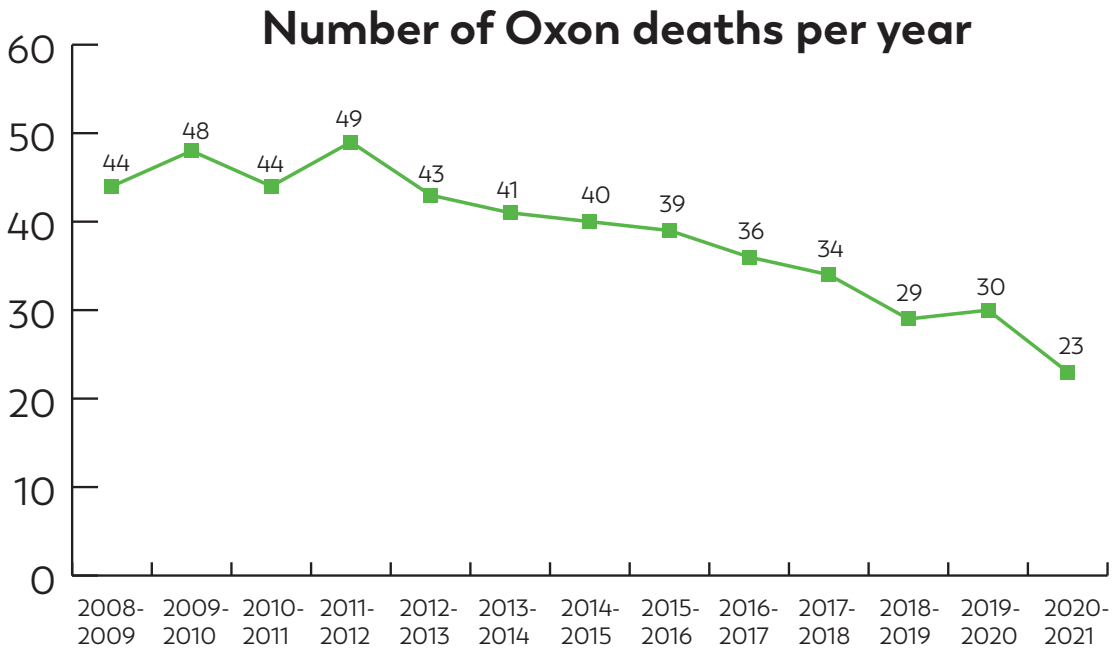
EFFECTIVENESS OF LEARNING FROM PRACTICE REVIEWS

- ☑ 100% reviews directly involve families and practitioners
- ☑ Analysis is independent and constructive
- ☑ Families and practitioners are directly involved
- ☑ Learning points apply to both systems and practice
- ☑ Recommendations can be evidenced as changing systems and services
- ☑ An annual report summarises the learning and aspects for improvement

CHILD DEATH OVERVIEW PANEL (CDOP)

In 2020/21 the Oxfordshire and Buckinghamshire CDOP system received 23 notifications for children who lived in Oxfordshire.

The aim of the Child Death review process is to prevent future child deaths. It is encouraging to see that the number of deaths of Oxfordshire children has almost halved in the last 13 years.



The Oxfordshire CDOP panel met on four separate occasions in 2020/21 to review child deaths. The deaths of 28 children whose usual residence was in Oxfordshire were reviewed.

THEMES RAISED BY THESE REVIEWS INCLUDED:

The complexity of coordinating bereavement support when a child dies in another regional hospital. The Designated Doctor will liaise with key service areas to develop a pathway to improve the coordination.

A number of Sudden Unexpected Deaths in Infancy, where although the total number had not increased, there were more cases where co-sleeping was a factor. This was in spite of clear evidence that advice had been given about the risks of co-sleeping. Services have re- shared the information and resources widely and committed to using all contacts with families to discuss this issue.

6. Impact of learning and improvement framework

ANALYSIS OF KEY MESSAGES

Messages for practitioners are set out in this poster and in an OSCB short-animated film

Recorded webinars on Jacob CSPR and Child K are online. Approx. 300 practitioners attended. Feedback included:

"it enabled me to think more about how the voice of the child can be captured and used to inform practice. It cemented my view that open joined up practice is the key to safeguarding children."

"confidence to ask about a lead professional in health if a child has significant health needs. Better understanding of elective home education - overall better professional knowledge of 'how these things work' so more able to challenge and question"

LEARNING	
1	Jacob CSPR (2021)
2	Young parent with complex needs (2021)
3	Child K (2020)
4	Understanding a child's lived experience (2020)
5	A child's identity needs (2020)
6	Neglect (2020)
7	Understanding a child's world (2020)
8	Parental vulnerability (2020)
9	Physical abuse (2020)

Learning summaries have common themes which lead to new resources e.g.

Use of chronologies
Single and Multi-Agency Chronology Practice Guidance
MAC 7-minute guide and MAC Tutorial for Agency Professionals

Reflective thinking, supervision and meeting as professionals
Safeguarding Conversations poster
Professionals Only Meeting guidance

Physical abuse
A Protocol for management of bruising in pre-mobile babies/children and leaflet for parents and carers

Working with fathers
Top tips for working with fathers and male carers

EMBEDDING LEARNING THROUGH TRAINING

The OSCB responded rapidly to the impact of Covid. Training moved online and never stopped.

New safeguarding e-learning courses from April 2020

Over 12,500 e-learners in total

New Covid volunteers course May 2020

Over 600 covid volunteer learners within 3 months of launch

Trainers 'trained' to work online from June 2020

Over 40 volunteers learnt how to train online

New safeguarding webinars from September 2020

Over 2,500 webinar learners in total

15,000 + trained overall

Impact: "A phrase used to describe what happens at Case Conferences stuck out for me: **"What can be done to improve or sustain the journey of change?"** I will use this perspective when discussing specific cases in school."

Impact: As a GP trainee **I plan to take an active role in more safeguarding referrals and helping junior staff/ medical students** etc.

Impact: "Working as a volunteer in a Youth Cafe **I have learnt that safeguarding is everyone's responsibility.** Everyone has the responsibility to report a concern"

SPECIALIST COURSES HAVE BEEN DEVELOPED IN RESPONSE TO LEARNING FROM OUR REVIEW WORK:

- Child Exploitation
- Safeguarding disabled children
- Sexual Abuse
- Healthy & Unhealthy sexual Behaviours
- Supporting LGBT young people
- Overview of Mental Health Difficulties for young people
- Self-harm workshop

IMPACT: 'LEARNING GAIN'

Every learner evaluates their confidence in safeguarding knowledge **before & after** training.

We consistently see a confident starting point and an even better end point which is called 'Learning gain'.

Impact: "...I have already identified a couple of students where I need to explore further with them around them being online ...and gaming".

OSCB training is delivered by **volunteers**.
They work in the health services, early years settings, schools, in local charities, the community and local authorities amongst others.

They give time out of their working day to train others in the safeguarding network.

Very special people. Thank you.

EFFECTIVENESS OF EMBEDDING LEARNING IN SUMMARY:

- ☑ Learner gain is recorded
- ☑ Feedback can evidence how learning will be applied
- ☑ Multiple resources demonstrate how partners share key messages
- ☑ Training is delivered by local volunteers, with pace and volume, so that learning is embedded through the local network
- ☑ The partnership is responsiveness to training need e.g. launch of the volunteers' course within 5 weeks of lockdown

7. Evidence and assurance

The OSCB gets a system-wide view on safeguarding work through the lens of audits, assessments, data and the views of practitioners, children, young people, families.

Audits	Assessments	Data
12 local services **2** multi-agency audits focused on • neglect • young people and domestic abuse (experiencing or witnessing)	**15** local services undertook high quality evaluations **1** challenge event for **15** services to evidence and evaluate their assessment	The OSCB regularly checks the facts and figures against local targets for Oxfordshire's most vulnerable children

WHAT DID THESE LENS HIGHLIGHT?

Issue	What does the OSCB need assurance on?
Issues emerging from Covid	...that issues regarding mental health and domestic abuse are addressed with pace and purpose. The 'deficits' from Covid need swift and decisive action e.g. school attendance and learning.
Neglect	... that health, police and social care and other safeguarding partners support early identification of neglect. The OSCB Neglect challenge event in September 2021 should check what shift there is in the underlying issues around neglect, poverty, economic drivers, housing etc.
Case conferences	... that health, police and social care partners consistently contribute to decision making for the care of the most vulnerable children. Monitoring of attendance should be a key metric in individual agencies performance reporting and assurance governance.
Increased safeguarding and domestic abuse referrals	... that there will continue be enough resources in the Multi-agency Safeguarding Hub to respond to this increase in need. An increase in the volume of domestic abuse incidents will need tackling by a system wide including - Increasing reach and volume by county & district councils working together - Potential further investment into the system - Recognising the impact of the domestic abuse workers in the new county council team and securing long term sustainable funding
Waiting times for children needing mental health	... that children are not waiting longer than the expected timeframes to access mental health support. The volume of mental health needs in children & young people will need a system wide strategy to meet the scale of need, which has been exacerbated by the pandemic.

HOW HAVE WE USED FEEDBACK FROM CHILDREN AND YOUNG PEOPLE THROUGH THIS PROCESS?

We involve young people wherever possible in service evaluation.
We have examples of where their feedback:

- is informing those working with young people who experience or witness domestic abuse
- has shaped parental experiences when caring for sick children in local hospital
- is informing information and accessibility to GPS and remote consultations

WHAT HAVE PRACTITIONERS SAID?

An annual survey of practitioners asks them to assess what is impacting on their capacity to deliver.

Practitioner have told us that group supervision is helpful to reflect on practice and good decision making

Positive findings were as follows:

✓ **75%** felt that there had been visible safeguarding leadership during Covid

✓ **95%** had undertaken safeguarding training within the last 3 years

Areas for improvement were

- Use of multi-agency tools when making decisions. However we could see that awareness of the multi-agency chronology has increased by 100%.

WHAT HAVE AGENCIES HAVE TOLD US FROM THE ANNUAL IMPACT ASSESSMENT?

Top three financial and organisational pressures	Top three things that would make it easier
• Increasingly vulnerable people and complex cases • Increasing volume of work and demand on services • Service funding (gathering, securing as well as income generation)	• Improved joint working (e.g. communication between agencies) • Space for frank conversations and consultations • Understanding of operational pressures across agencies

EFFECTIVENESS OF QUALITY ASSURANCE:

- Qualitative and quantitative evidence which brings a full picture of the system
- Progress is evidenced: use of new resources; escalation of issues to strategic safeguarding partners e.g. increase in domestic abuse.
- Improvements and concerns are known e.g. Case Conferences, mental health waiting times, identification of neglect
- Partners are sighted on potential safeguarding issues emerging from Covid e.g. mental health, stresses in home life manifesting in domestic abuse

8. In conclusion the partnership knows

The local safeguarding issues where collective action can make a difference

- ✓ Working to identify and act where we see neglect
- ✓ Improving our strategic efforts to deal with the exploitation of children
- ✓ Better connectivity with schools and shared sign up to the same safeguarding principles

The bigger safeguarding issues which we need to escalate regionally and nationally

- ✓ Availability of homes close to Oxfordshire for children who have a complex set of safeguarding needs
- ✓ Legislation regarding home-schooling, which would assist identifying any safeguarding concerns.

The ongoing concerns in our system

- ✓ Waiting lists for children's mental health services
- ✓ Multi-agency contribution to decision making meetings for the most vulnerable
- ✓ Attendance at school of the most vulnerable children

Areas for learning

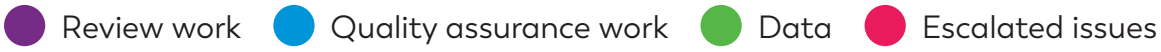
- ✓ Over 15,000 people have been trained on safeguarding topics over the last year

The report sets out evidence of progress made and impact that the safeguarding arrangements have had over the last 12 months.

There is still work to be done. These are the key messages for local leaders reading this report:

1. **We need traction on changing practice.** The whole system must work together to effect change, which means each organisation must take responsibility for embedding change and learning. We are doing a lot of things to improve how we work together but the challenge is making it sustainable.
2. **The Jacob CSPR shows that we need to improve how we work together across our whole partnership.** This includes community safety, children's safeguarding, education and health. We need to bring strategic leadership and direction to this work to make it easier to keep children safe from harm outside the home.
3. **Post-pandemic interventions will need to be at scale and volume.** Pace and purpose is needed to deal with the emerging issues such as increased safeguarding referrals, visibility of children through school attendance, increased referrals for mental health and domestic abuse concerns.
4. **Education settings are key partners.** Whilst they are not named as senior safeguarding partners in the guidance 'Working Together 2018', we are clear in Oxfordshire that our education colleagues are central to keeping children safe. They must be part of our conversations and actions for us to work better together.

Appendix A: Matrix of safeguarding concerns



Safeguarding concerns that need regional and national attention	
Availability of homes close to Oxfordshire for children who have a complex set of safeguarding needs and cannot live at home	
Legislation regarding home-schooling which would assist in identifying any safeguarding concerns	
...that are about our systems and how we work together as a whole	
Shared vision and connectivity with schools about keeping children safe	
County-wide effort to deal with the exploitation of children outside of their home	
Cultural shift in helping families at an early stage collectively to tackle neglect in the family home	
Shorter waiting times for children who need help with mental health problems	
Multi-agency contribution to decision making meetings for the most vulnerable (known as Case Conferences)	
...that are about our practice	
Straight talking with families to identify and name neglect	
Using the same resources to help families at an early stage e.g., early help assessment	
Thinking about safeguarding all family members – parents, children, siblings – when you may have contact with just one family member	
Better sharing of safeguarding information across different health information systems	
...that are repeat themes	
Lower exam grades for the most disadvantaged children	
Children being visible to others and kept safe in early years settings and education during the day	
Complex range of safeguarding issues that children face	
...that have come to the fore through the pandemic	
Importance of keeping sight of the most vulnerable children	
Emerging issues of domestic abuse and mental health concerns following lockdowns	
Increased volumes on frontline services as demand increases post lockdown	

Appendix B: The Oxfordshire Safeguarding Children Board budget

	End of year figures
Funding streams	
Public Health	-£30,000.00
Income	
Foster carer training	-£2,500.00
Non-attending delegates	
Contributions	
OCC Children, Education & Families	-£198,100.00
OCC Dedicated schools grant	-£64,000.00
NHS Oxfordshire CCG*	-£60,000.00
Thames Valley Police	-£21,000.00
National Probation Service	-£1,410.00
CRC	-£2,500.00
Oxford City Council	-£10,000.00
Cherwell DC	-£5,000.00
South Oxfordshire DC	-£5,000.00
West Oxfordshire DC	-£5,000.00
Vale of White Horse DC	-£5,000.00
Cafcass	£0.00
Public Health (see above)	£0.00
TOTAL INCOME	**-£409,510.00**
Expenditure	
Independent Chair	£35,548.00
Business unit	£287,125.00
L & I work	£7,451.00
Training & learning	£37,299.00
Subgroups	£9,523.00
All case reviews	£31,662.00
TOTAL	**£408,608.00**
Available reserves	£63,013.00
Drawdown	£0.00
Add to reserves	£902.00
Reserves Balance	£63,915.00

* NHS Oxfordshire CCG also funds the Child Death Overview Process at a cost of £76,774 per annum

Appendix C: Links to information about the board

OSCB
Oxfordshire
Safeguarding
Children Board

oscb@oxfordshire.gov.uk
www.oscb.org.uk

Images used in this annual report are stock images

Agenda Item: 10

Meeting: Oxfordshire Health and Well Being Board

Date of Meeting	16 December 2021
Title of Paper	Agreement of final Principles of Community Strategy
Lead Directors	Ben Riley, OHFT
Author(s)	Diane Hedges, Deputy Chief Executive, OCCG Ben Riley, OHFT
Paper Type	• **Decision**
Action Required	The Board is asked to: a) agree the proposed final principles for the community services strategy based on; feedback from the engagement exercise b) note the update on the strategy work.

Executive Summary

The community strategy work continues to progress, clinical workshops have been held and members will recall the engagement process on case for change and principles to inform decision making has concluded. The document published can be found here

Improving Community Health and Care Services - Oxfordshire Clinical Commissioning Group (oxfordshireccg.nhs.uk)

The feedback from the engagement process is attached as Appendix 1. Reflecting on this feedback we have made some proposals for adjustment clarifying some wording and reducing the principles down from 12 to 11.

This paper proposes some amendments to the principles in response to feedback from our public engagement exercise and asks the Health and Well-being Board for final sign off. These can then be used to inform the direction of travel and evaluate approaches for delivering community services. Should any changes to services be

proposed, these would also form the basis of this process and for developing criteria for options appraisal.

The table attached to this paper identifies the original principle described in the public engagement. It then lays next to it the summary of the comments that we have received and the column on the right hand side describes the proposed revisions to the principles. The final recommended set of principles are then repeated for clarity at the end of the paper.

Health and Well Being Board is asked to confirm that the engagement feedback has been considered in the revised principles and agree to support these as the final principles.

Programme update
Overall, the system community services strategy work continues to progress as planned. Risks have been identified around resourcing and allowing sufficient time to complete effective engagement and these are currently being worked through. An update on the community strategy was provided to HOSC on Thursday 25th November and the committee supported the work that had been done to date including the development of the principles.

Key next steps for the project between now and January are:
- Finalise and sign off the principles
- Development of the clinical model

Project workstreams updates
In order to develop the clinical model, two workshops have been completed. Against the backdrop of patient feedback to date and the emerging principles, these explored the role of community hospital beds, when a bed is the best place for a patient and current challenges to address to ensure patients are treated in the optimum setting. Both sessions were well attended by a range of clinicians from Oxford Health, Oxford University Hospital, primary care and social care.

The first of the two workshops focused on national benchmarking and exploring data around the current use of our community beds. It was noted that there is comparatively little national best practice evidence however the work by John Bolton which looks at discharge pathways supports the system ambition to focus on supporting patients to return home as the first consideration at the point of discharge. Work is now underway to develop a clinical model that describes the pathways that should be supported by our beds and how we can ensure we are meeting patient needs effectively.

There are also active workstreams on care pathways and estates. A system estates group has also been initiated to explore opportunities to optimise our community sites. This work is focused on delivering the principles around improving equality of opportunity, using resources effectively (developing our buildings to achieve the best outcomes for the people of Oxfordshire) and joining up services. This working group also includes representatives from across community services and social care including both operational leads and estate leads. The aims of this group will be to link in with work being completed under the one public estates initiative and to develop an improved understanding of the operational requirements for our community estate, ensuring this aligns with wider proposals to strengthen public estate such as redevelopment plans for central Abingdon and improving sustainability.

As a next step this group has agreed to look at developing a blueprint that will identify the level at which services should be provided (county-wide, by region or locality level). The ambition is then to work with partners across the system to map current services to this blueprint to identify where there is a need to strengthen or develop our estate to meet the local population need. As part of this each community hospital will be reviewed to understand current constraints on the estate and identify opportunities to strengthen our offer for the local community.

Financial and resource implications	No costs directly arising from this paper however these principles will be used to determine future decisions, informing our approach to option appraisal, so do need to drive sound financial decision making
Risk and Assurance	Principles will support the delivery of our public engagement duties
Legal implications/regulatory requirements	As above.
Consultation, public engagement & partnership working implications/impact	The engagement with the public on the principles for this work has been concluded and the outcomes from this engagement are attached. Depending on the clinical model and approaches for delivering this, there may be changes identified that would require formal public consultation. This work, and any changes we take on board, will constitute an important part of the engagement process prior to any consultation.
Public Sector Equality/Equity Duty	This will be undertaken once the clinical model has been developed.

Oxfordshire Community Services Strategy
Proposed amendments to Principles based on public engagement meetings and feedback

Original principle	Feedback comments / observations	Suggestions for new wording from public	Development group recommendation	Updated principle for HWBB review
Provide a better experience for people who are seeking or receiving care in their community. We will include patient feedback in decision making as well as information about outcomes. We will recognise the significant role of carers. We will provide support to carers to help them maintain their own health and wellbeing, and balance their role as a carer with life, work and family commitments. We will do more to reach those from under-represented groups where we anticipate people have needs but don't currently present to services in the numbers we would expect. This includes helping those who have difficulties accessing services.	Provide a better experience for people who are seeking or receiving care in their community we believe is correct and the foundation of integrating these services.	We strongly recommend that you add, in second place, the following Principle: "During the design and development of integrated Health and Care services, we will involve users throughout the process."	Agreed – will add as second bullet point to the document.	**Principle 1: Provide a better experience for people who are seeking or receiving care in their community.** We will include patient feedback in decision making as well as information about outcomes. We will involve service users throughout the design and development of integrated Health and Care services. We will recognise the significant role of carers. We will provide support to carers to help them maintain their own health and wellbeing, and balance their role as a carer with life, work and family commitments. We will do more to reach those from under-represented groups where we anticipate people have needs but don't currently present to services in the numbers we would expect. This includes helping those who have difficulties accessing services.
Principle 1 – further feedback	This principle should include providing upstream planning ahead for care opportunities and for the process of moving from active/invasive/life sustaining treatment		Agreed – added to principle 3 and will be included in service planning in due course	

	to end of life care. It should also include services to address the mild cognitive changes, pre changes to any dementia pathology, such as how to manage changes in cognitive processing and decision making for everyday life and living.			
Principle 2: Ensure equality of opportunities to improve health and wellbeing are consistent across the county. We will work together to tackle the differences experienced in health outcomes (health inequalities). We will adopt approaches that support people to achieve consistently good health outcomes wherever they live in the county, tailored to individual and local circumstances. We will provide consistent opening hours for services. We will look to put resources in areas with the greatest need.	This is a vague, poorly worded, sweeping statement. Whilst supporting the underlying message interpreted as 'fair distribution of services;' as stated there is no sign of how it will be achieved and is currently undermined by the inequitable distribution of resources and services across the county. As such it is not very convincing. We know that many of the services that our patients need are not available locally. It is so frustrating to be repeating the same complaints about so	Suggestion of Would something like setting a minimum common standard of service across the county be a better principle?	Agreed - amended text added to subpoints	**Principle 2: Ensure opportunities to improve health and wellbeing are consistent and equitable across the county.** We will work together to tackle the differences experienced in health outcomes ('health inequalities') and put more resources in areas with the greatest need. We will adopt approaches that support people to achieve consistently good health outcomes wherever they live in the county, tailored to individual and local circumstances. We will develop minimum common standards to ensure access to services is equitable across Oxfordshire. This will include providing consistent, resilient and reliable opening hours for services matched to need.

	many people being unable to access services only available in Abingdon, Wallingford and Oxford. Also It would also be good it there was a standard which stated that certain services should be available within a certain distance (or travel time on public transport) from home.			
Principle 3: Enable people to stay well for longer in their own homes. We will work with our residents to lengthen the time that people remain in good health and delay the point in their life when they become dependent on services or need to move to a care home. We will make sure that people of all backgrounds can access our services rapidly when they need them, before their health deteriorates.	Whilst recognising that this is a principle that should be applied to people of any age (not just older people) we are not convinced that it can be achieved in practice, given the lack of staffing in Primary Care and Social Services as well as the shortage of care workers. Not achieving an objective is worse than not having the objective at all if it means that the back-up services required when health deteriorates do not exist.	A statement that "we will make sure that people can access our services rapidly" is a very definite statement but "rapidly" needs further definition.	Amendments made in line with feedback above. We will expect these Principles to apply to all ages	Principle 3: Enable people to stay well for longer in their own homes. We will work with our residents to lengthen the time that people remain in good health and delay the point in their life when they become dependent on services or need to move to a care home. We will develop services that plan ahead and respond earlier in the course of an illness, maximising the opportunities to prevent a long-term deterioration in health or wellbeing. We will make sure that people of all backgrounds can access our services rapidly when they need them (e.g. to offer alternative appropriate support before a hospital admission is required). We support the process of moving from active treatment to palliative care and enable more people to experience the best possible end of life.

Principle 4: Use digital approaches to improve health and independence We will harness the potential of digital technology to enable people to strengthen their social connections and maintain their independence and wellbeing. We will offer more options and support for how people use digital services including online; at home; and within the community. We will support people to develop their digital literacy and minimise inequalities.	There needs to be clarity as between what digital means for patients/people and services. There needs to be acknowledgement that 'digital' is not always an option for people		See comments – add overcome barriers to access….and minimise equalities. Add – in a sentence about geographical boundaries etc See amendments.	**Principle 4: Use digital approaches to improve health and independence** We will harness the potential of digital technology to enable people to strengthen their social connections, reduce geographical barriers to access and maintain their independence and wellbeing. We will offer more options and support for how people use digital services including online; at home; and within the community. We will support people to develop their digital literacy, overcome barriers to access and minimise inequalities.
Principle 5: Offer more joined up services to improve their effectiveness and quality. We will support effective working between teams and services. We will reduce duplication and poor communication between services, especially when patients move from one service to another. We will make sure all services have access to the support they need to deliver to their best ability. For example, access to community-based diagnostic tests.	This statement falls within the overall objective of the exercise; so really is not a principle. Unsure what 'offer more joined up services' means. Is this more in quantity or is it about ensuring that existing and new services work in a joined-up way?		Merge with Principle 8 Feedback noted – reworded to clarify meaning. ~~No further amendment~~	Principle 5 has been merged.
Principle 6: Ensure our use of beds in the community maximises people's long-term health. We will focus on what people can do and make sure we're not prematurely putting them into a hospital bed or institutional setting.	These are all things which the community beds in Wantage hospital used to do. We believe that re-enablement or reablement can often	Too vague a statement and use of language excludes people's understanding	Given the comments about jargon, this principle has been reworded to	**Principle 5: Ensure our use of beds in the community maximises improvements in people's long-term health.** We will only use a hospital bed if this is in the patient's best interests and their treatment can't

We will only use a hospital bed to offer treatment if it can't be provided in another setting, especially the person's own home. When a patient needs a community hospital bed, we will ensure they are able to access the clinical expertise, environment and staffing they need to get the best long-term health benefit. We will reduce the time spent in a hospital bed by more efficient bed management, improving our ability to get people home when ready with timely therapy input. When people are in beds, we will ensure they have access to other community services such as testing and consultant expertise.	best be provided in a community setting where patients (of any age) who have recently spent time in acute settings are encouraged to get out of bed and join in simple communal activities such as preparing meals or making hot drinks. This enables people to regain confidence in their abilities in a safe environment throughout the day not just in the 15 minutes that a care worker or physiotherapist is spending in their home. We have yet to see evidence of outcomes from home care services which match those of community hospital re-enablement. Better co-ordination of care at home is required. We have heard of instances where patients have been sent home without support (or even checking if heating has been turned on or there is food in the house) and other	of the statement. No talk here of working with patients. Words in paragraph 3 "when a patient needs a community bed " what does this actually mean"? Plain English please. Can be interpreted to mean you won't get a community hospital bed and to ensure I don't understand what is being said it is put in jargon!	clarify meaning and definitions	be provided safely and effectively in another setting, especially the person's own home. When a person uses a community hospital bed, we will ensure this provides the professional expertise, environment and staffing they need to get the best long-term health benefit. This includes enabling people to build on their strengths and take part in communal activities when able to do so. When people are in community beds, we will ensure they have access to good clinical care, including tests, investigations and consultant expertise. We will reduce the time spent in a hospital bed by providing sufficiently resourced therapy and other timely care and by improving our ability to support people to transfer home when they are ready.

	examples where patients are sent home when the only support is an elderly partner incapable of providing care. We're also not sure about the consistent opening hours for services when combined with putting resources in areas with the greatest need. We know that when there is a shortage of Midwives, our maternity services are closed and resources moved to Wallingford, Witney or Oxford thus opening hours are definitely not consistent across the county so how will this principle will be applied?			
Principle 7: Base service design on best practice and clinical evidence We will work with research teams to identify best practice both nationally and internationally. We will seek advice from expert clinicians on how we can apply this best practice evidence to our services.	Phrases like "we will consider" and "clinical evidence" are not sufficient for principles. What about service design based on listening to patients and carers as well? This is best practice, needs more clearly	This should be rephrased to "We will ensure that the services we provide meet clinical, social and environmental best practice for all of our communities."	User experience added. The development group considered that the rest of the original wording was more balanced and reflected the need to take an evidence-based	**Principle 6: Base service design on best practice, clinical evidence and user experience** We will work with research teams to identify best practice both nationally and internationally. We will seek advice from experts on how we can apply this best practice evidence to our services. We will work with service users and communities to ensure that their experience is heard and reflected in service design and implementation.

We will ensure that the services we provide meet quality and regulatory standards. When thinking about how we use our resources, we will consider things that are not traditionally reflected in financial statements. This includes thinking about how social, economic and environmental factors can create value for communities.	stating what best practice is e.g. evidence, patient centred design, what has worked well elsewhere etc. Inclusion of listening to patients and carers in service design needs to be stated.		approach while also incorporating local considerations, resources and service user priorities for how funding is allocated to services	We will ensure that the services we provide meet quality and regulatory standards. When thinking about how we use our resources, we will consider things that are not traditionally reflected in financial statements. This includes thinking about how social, economic and environmental factors can create value for communities.
Principle 8: Organise services so staff operate in effective teams, with appropriate skills, that use resources effectively We will develop our community hospitals into vibrant centres of excellence that provide the greatest benefit for residents, taking into account local need and the amount of service use. We will share and develop our buildings to achieve the best outcomes for the people of Oxfordshire. We will design services to be flexible so they can respond to changing needs. For example, additional pressure in winter or infection control changes. We will ensure our services are resilient so people can rely on them always being there and not risk service gaps due to staffing issues.	Only mentions staff, but should be expanded to include buildings as described in the supporting statements. This principle should be expanded to not just share and develop assets within the Trust but also to utilise other buildings (or other assets) available in the community.	This is not a separate principle and better sits within Principle 5.	Merge with Principle 5 Feedback noted – clarified and points about use of buildings added. Agree that supporting statements do not reflect the main principle re: staff teams, so added. The development group agree it is important to have a principle reflecting the importance of well-led, team-based	**Principle 7: Organise services so staff operate in teams with appropriate skills and in buildings that enable them to work more effectively** We will develop well-led teams with the skills, leadership and experience to deliver effective multi-disciplinary care, reducing duplication and poor communication between services, especially when patients move from one service to another. We will develop our community hospitals into vibrant centres of excellence that provide the greatest benefit for residents, taking into account local need and the amount of service use. We will share and develop our buildings to achieve the best outcomes for the people of Oxfordshire. We will design services to be flexible so they can respond to changing needs. For example, additional pressure in winter or infection control changes. Also to have access to the support they need to deliver to their best ability. For example, access to community-based diagnostic tests.

			approaches to care provision	We will ensure our services are resilient so people can rely on them always being there and not risk service gaps due to staffing issues.
Principle 9: Be a great place to work for the health and social care workforce. We will improve the career and skills development opportunities for all our health and social care staff. We will work collaboratively to support the recruitment, retention and development of staff. We will promote equality, diversity, teamwork and empowerment to provide the best possible staff experience and working environment.		Change to talk about Management empowering the community staff to help them provide improved joined-up services	Feedback noted and discussed – no amendments made as many healthcare staff strongly support inclusion of this principle and were involved in developing it through staff workshops.	**Principle 8: Be a great place to work for the health and social care workforce.** We will improve the career and skills development opportunities for all our health and social care staff. We will work collaboratively to support the recruitment, retention and development of staff. We will promote equality, diversity, teamwork and empowerment to provide the best possible staff experience and working environment.
Principle 9: Be a great place to work for the health and social care workforce.	Only mentions the Health and Social Care workforce, but should be expanded to include supporting voluntary and community sector groups working with the Health and Care organisations.	Suggest either: a) change to talk about Management empowering the community staff to help them provide improved joined-up services, or b) or fits better under Principle		

		5 and merge with Principle 8		
Principle 10: Deliver the locally and nationally agreed priorities for our health and care system We will ensure our locally agreed priorities drive all service changes and national 'must-dos' are delivered.	This is not a principle; it is a given as this is the way policy works. Deliver the locally and nationally agreed priorities for our health and care system. What are the locally agreed priorities?		The decision-making principles will determine which solutions deliver the greatest benefit for residents. We need to know actions will deliver our national must do's and local priorities as an essential part of any decision-making process. We will work to describe the local and national local priorities more clearly in future communications with the public	**Principle 9: Deliver the locally and nationally agreed priorities for our health and care system** We will ensure our locally agreed priorities drive all service changes and national 'must-dos' are delivered.
Principle 11: Contribute to sustainability and the environment. We will make sure services are sustainable both financially and for the environment.	This should be embedded in all services, therefore not a standalone principle		Add in 2050 plan/Oxfordshire Infrastructure - see amended wording	**Principle 10: Contribute to sustainability and the environment.** We will make sure services are sustainable both financially and for the environment.

We will reduce the unnecessary use of limited resources and consider the impact on the environment. We will minimise unnecessary travel. For example, by providing more outpatient services locally.				We will reduce the unnecessary use of limited resources and consider the impact on the environment. We will minimise unnecessary travel. For example, by providing more outpatient services locally. We will work with partners to maximise the use of available and planned infrastructure capacity to improve health, as detailed in the Oxfordshire Infrastructure Strategy, and support the Oxfordshire Plan 2050.
Principle 12: Maximise the positive impact on health and wellbeing for our population, within the limitations of our resources We will develop services that have the maximum positive impact on the health and wellbeing of the population within the resources we have available.	This sounds nice but is not measurable and therefore should not be included. and as a result, conveys little meaning.		Feedback noted but believe we have not conveyed the significance of this The meaning is that we need to deliver health services within our fixed budget allocation, available capital or assets. We cannot plan to use resources we cannot credibly access. So in making choices we take those that will give the greatest benefit	**Principle 11: Maximise the positive impact on health and wellbeing for our population, within the limitations of our resources** We will develop services that have the maximum positive impact on the health and wellbeing of the population within the resources we have available.

Revised Principles

Updated principle for HWBB review
Principle 1: Provide a better experience for people who are seeking or receiving care in their community. We will include patient feedback in decision making as well as information about outcomes. We will involve service users throughout the design and development of integrated Health and Care services. We will recognise the significant role of carers. We will provide support to carers to help them maintain their own health and wellbeing, and balance their role as a carer with life, work and family commitments. We will do more to reach those from under-represented groups where we anticipate people have needs but don't currently present to services in the numbers we would expect. This includes helping those who have difficulties accessing services.
Principle 2: Ensure opportunities to improve health and wellbeing are consistent and equitable across the county. We will work together to tackle the differences experienced in health outcomes ('health inequalities') and put more resources in areas with the greatest need. We will adopt approaches that support people to achieve consistently good health outcomes wherever they live in the county, tailored to individual and local circumstances. We will develop minimum common standards to ensure access to services is equitable across Oxfordshire. This will include providing consistent, resilient and reliable opening hours for services matched to need.
Principle 3: Enable people to stay well for longer in their own homes. We will work with our residents to lengthen the time that people remain in good health and delay the point in their life when they become dependent on services or need to move to a care home. We will develop services that plan ahead and respond earlier in the course of an illness, maximising the opportunities to prevent a long-term deterioration in health or wellbeing. We will make sure that people of all backgrounds can access our services rapidly when they need them (e.g. to offer alternative appropriate support before a hospital admission is required). We support the process of moving from active treatment to palliative care and enable more people to experience the best possible end of life.

Principle 4: Use digital approaches to improve health and independence

We will harness the potential of digital technology to enable people to strengthen their social connections, reduce geographical barriers to access and maintain their independence and wellbeing.

We will offer more options and support for how people use digital services including online; at home; and within the community.

We will support people to develop their digital literacy, overcome barriers to access and minimise inequalities.

Principle 5: Ensure our use of beds in the community maximises improvements in people's long-term health.

We will only use a hospital bed if this is in the patient's best interests and their treatment can't be provided safely and effectively in another setting, especially the person's own home.

When a person uses a community hospital bed, we will ensure this provides the professional expertise, environment and staffing they need to get the best long-term health benefit. This includes enabling people to build on their strengths and take part in communal activities when able to do so.

When people are in community beds, we will ensure they have access to good clinical care, including tests, investigations and consultant expertise.

We will reduce the time spent in a hospital bed by providing sufficiently resourced therapy and other timely care and by improving our ability to support people to transfer home when they are ready.

Principle 6: Base service design on best practice, clinical evidence and user experience

We will work with research teams to identify best practice both nationally and internationally. We will seek advice from experts on how we can apply this best practice evidence to our services.

We will work with service users and communities to ensure that their experience is heard and reflected in service design and implementation.

We will ensure that the services we provide meet quality and regulatory standards.

When thinking about how we use our resources, we will consider things that are not traditionally reflected in financial statements. This includes thinking about how social, economic and environmental factors can create value for communities.

Principle 7: Organise services so staff operate in teams with appropriate skills and in buildings that enable them to work more effectively

We will develop well-led teams with the skills, leadership and experience to deliver effective multi-disciplinary care, reducing duplication and poor communication between services, especially when patients move from one service to another.

We will develop our community hospitals into vibrant centres of excellence that provide the greatest benefit for residents, taking into account local need and the amount of service use.

We will share and develop our buildings to achieve the best outcomes for the people of Oxfordshire.

We will design services to be flexible so they can respond to changing needs. For example, additional pressure in winter or infection control changes. Also to have access to the support they need to deliver to their best ability. For example, access to community-based diagnostic tests

We will ensure our services are resilient so people can rely on them always being there and not risk service gaps due to staffing issues.

Principle 8: Be a great place to work for the health and social care workforce.

We will improve the career and skills development opportunities for all our health and social care staff.

We will work collaboratively to support the recruitment, retention, and development of staff.

We will promote equality, diversity, teamwork and empowerment to provide the best possible staff experience and working environment.

Principle 9: Deliver the locally and nationally agreed priorities for our health and care system

We will ensure our locally agreed priorities drive all service changes and national 'must-dos' are delivered.

Principle 10: Contribute to sustainability and the environment.

We will make sure services are sustainable both financially and for the environment.

We will reduce the unnecessary use of limited resources and consider the impact on the environment.

We will minimise unnecessary travel. For example, by providing more outpatient services locally.

We will work with partners to maximise the use of available and planned infrastructure capacity to improve health, as detailed in the Oxfordshire Infrastructure Strategy, and support the Oxfordshire Plan 2050.

Principle 11: Maximise the positive impact on health and wellbeing for our population, within the limitations of our resources, including the delivery of local and national priorities.

We will develop services that have the maximum positive impact on the health and wellbeing of the population within the resources we have available.

Improving Community Health and Care Services

Developing our principles engagement report

November 2021

Contents

1. Purpose of report

The purpose of this report is to outline the public engagement undertaken from 7 September to 10 10 October 2021 around draft principles to help shape how we design and develop services for our ageing population. It describes the engagement, outlines key themes, and identifies concerns and issues expressed by members of the public around community health and care service for older people.

This is not, however, the start of the conversation. Over the last few years, we have undertaken a range of surveys, focus groups and informal conversations with our communities. You can read more about what people have told us so far here.

2. Background

Oxfordshire's health organisations and councils are working together with voluntary and community sector groups to modernise our community services. We want to improve health and wellbeing outcomes for everyone in Oxfordshire and increase independence for older people.

Current services have developed over time and do not always reflect what we now know about how health and care services are best delivered. We want to do more to prevent people getting ill or losing their independence and respond more rapidly when they do. To do this, we are moving many multi-agency services into local areas to work alongside GPs and introducing new services that can respond more quickly.

With modern advances in healthcare, it is possible to provide more care than ever before in people's own homes. This is better for the individual and their families and frequently leads to improved health outcomes. Advances in digital technology can also help people remain independent at home and receive more services in their local area.

We have an ageing population. More people are enjoying longer lives but often living with more complex health conditions. We need to meet this increased demand for services. We plan to do this by improving how we work across organisational boundaries and by working with residents to grow strong and supportive communities able to help each other.

This might require us to change the way we currently provide some services. We have, therefore, developed twelve principles to guide any decisions we make. We had a public engagement period on these draft principles with our wider partners and Oxfordshire residents to seek feedback.

Community services for older people include help accessing local activities and support to prevent isolation, equipment to help people live independently, out of hours GP services, primary care visiting services, homecare, community nursing and therapy services, urgent community response services, centres for treating people with frailty, community tests and x-rays, short-stay and community hospital beds, and support workers who help people get their confidence and mobility back after an illness or fall.

We are looking at these services to ensure they are working together in the most effective way – although this does not mean that every service will need to change if it is working well. We are also considering how these services link to other aligned services which are more specialised, such as stroke rehabilitation, or hospice and end of life care services.

To keep our work focused, we are not looking at services for mental health, learning disabilities or autism, hospital emergency care, A&E services (also known as 'ED'), or the everyday work of your local GP practice (known as core 'General Medical Services'). We will continue to develop these services through other projects.

Improvements to community services will be made through:

- more focus on prevention
- provision of more care closer to home and more active use of community hospitals
- more use of digital technology
- introduction of new services
- work across organisations to meet demand

More information is available here.

3. Purpose of the public engagement

We are committed to working collaboratively with our population. The purpose of public engagement was to continue our conversation with the local community and key stakeholders to inform the final principles to support development of a Community Services Strategy and inform thinking around development of services to better support older people to age well.

4. Process and methodology

A document was developed to explain the rationale for change; who was involved in the work; what services we would be looking at; our approach; developing services with associated case studies and the draft principles. The document is available here and includes a short questionnaire.

The document was made available on the CCG website and was signposted from partner websites. A shorten version was made available and an easy read version was also available.

A short survey was developed asking the following:

1. Do you understand why change is needed?
2. We will use these principles to guide decisions on the development of health and care services for the future. Are these the right principles? Which are the most important to you?
3. Have we missed anything? Are there any other principles we need to think about as we develop our plans?
4. Any other comments?

The survey was available online and paper format. People were also invited to send through their feedback via email or hard copy by post. Fifty-three responses to the survey were received.

Three virtual public events were held to share information about the project and for participants to ask questions. Eighty people attended the three events.

Date	Number of attendees
Tuesday 28 September	24
Thursday 30 September	25
Thursday 30 September	31

The project was also discussed at the Oxfordshire 'Team-Up' Co-production Board meeting on 14 September and at a meeting of Age UK with the Voluntary Community Sector Coalition on 20 September.

Oxford Health NHS Foundation Trust held several workshops in the summer months with 16 individuals representing patients, Governors, and a GP.

5. Promotion

The engagement was promoted in several ways across partner organisations.

- Press release launching the engagement
- Dedicated Oxfordshire Clinical Commissioning Group (OCCG) web pages sharing information about the project via content and with three versions of the engagement document including an easy read version
- Oxford Health shared information on its website
- Invitation to Talking Health (OCCG's online consultation tool) members (2500)
- Oxford Health sent invitation to complete questionnaire and attend events to 10,000 members
- Advert in the Oxford Mail (circulation 6,377 between January to June 2021)
- Information in several briefings and newsletters including the Oxfordshire GP Bulletin, system stakeholder briefing and Healthwatch Oxfordshire Briefing Newsletter
- Direct briefing information sent to local MPs and Oxfordshire Council Leaders and Chief Executives to cascade to councillors with information and invitation/joining details to attend virtual events
- Direct communication to key stakeholders
- 300 copies of the short version of the engagement document distributed to all Oxfordshire libraries
- Social Media
    - Extensive OCCG Facebook paid for advertising inviting people to join the engagement and virtual events (188,500 reach)
    - OCCG Twitter (over 4000 impressions)
    - Oxford Health posted information and invitation to events on Twitter and on its own Facebook pages

6. Key Themes

6.1. Survey Feedback

Overall, most people who responded to the feedback form understood the drivers for change, presented in the document. The main reasons cited by respondents were:

- funding/budgets
- capacity of services within the health and care system and
- demand on services

There was also recognition that change was needed to join up services which would provide a better patient experience. The main principles which were important to people were:

- Accessibility – which includes access to primary care, diagnostics, location, and transport
- Importance of care at home with support from step down beds, to aid independence and wellbeing
- Integration of health and social care – expectation is that this should already be happening but is not. This would improve the patient experience.

People identified the following gaps in the principles:

- Social Care provision and care homes
- Improving continuity of care
- Reliance on digital – concern about the digital literacy of patients and lack of progress to join up patient records
- Accessibility – which includes access to primary care, diagnostics, location, and transport
- Mental health provision

Throughout the questions there were comments about whether the principles could be delivered, for some it felt as though these are ambitious proposals. Others felt that further information was needed and that more engagement was required with people who use the services. Comments were made that the principles needed to reflect the patient voice more.

From a strategic perspective there were three comments around the alignment of the principles with wider strategic agendas, which should be addressed further:

- Clarification and understanding of how these proposals fit with the wider Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System, and potential impact on cross boundary working and services.
- How these principles align to the Oxfordshire 2050 plan, which is currently out for consultation and has a section: Theme 3 Creating strong and healthy communities.
- The role of Primary Care Networks in delivering the principles.

Overall, however, there was recognition that care in the community and at home is best for elderly patients. However, this was heavily caveated with the need for good joined up services, providing accessible wrap around care to support people to be at home.

6.2. Written Feedback

Written submissions were received from:

- Healthwatch Oxfordshire
- Age UK & VCS Coalition
- Wantage and Grove Campaign Group
- OX12 Stakeholder Reference Group
- Newbury Street Patient Group (Wantage)
- Oxford Health NHS Foundation Trust patients and Governors[1]
- Ashbury Parish Council
- Oxfordshire 'Team-up' Co-Production Board

The feedback received raised confusion about how this work is aligned to:

- Oxfordshire Community Service Strategy
- The Oxfordshire 2050 Plan
- Oxfordshire Infrastructure Strategy
- The development of the Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care System

It is recommended that further clarification is required to contextualise this work. This was also raised in the survey responses.

There was specific feedback about the wording of the principles and for some felt there were too many principles, which were not quantified, or had insufficient detail to support them. More detail is shown in Appendix 2.

Addressing the survey questions, the themes raised broadly reflected those raised through the responses received through the online survey, with, additional comments which included:

- Accessibility – need to consider equity of access, location of services, digital literacy and how that impacts on access to services
- Importance of understanding patient experience, change impacts people differently
- Need to ensure the needs of people with disabilities are reflected
- Consideration should be given to staff engagement, and the impact on staff
- Documents should be accessible and remove jargon

In addition, the specific feedback above there was a strong offer of engagement from across the 15 voluntary and community sector leaders to be involved further in this work, they are keen to see a greater emphasis on prevention being developed within this work.

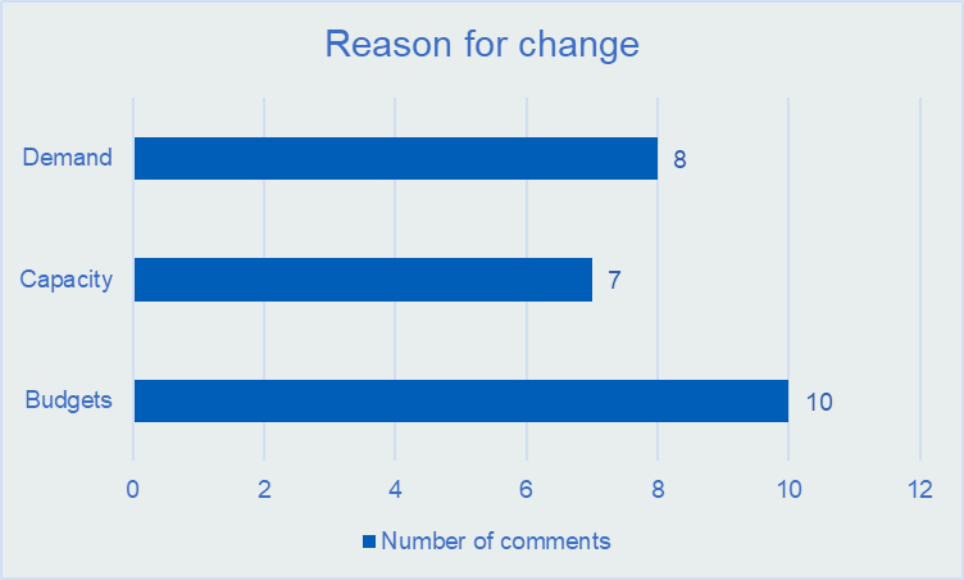
[1] Feedback via Oxford Health from workshops undertaken by them with patients and Governors

Appendix 1: Analysis of survey responses

In total, 53 responses were received online via the Talking Health Platform. Responses were anonymous, so it was not possible to ascertain any demographic information from the respondents. Responses are broken down by question, where possible we have quantified the comments in each theme area.

Question 1: Do you understand why change is needed?

This question was answered 54 times. In total 49 people stated that they understood why change was needed, four people did not.



Some of those who agreed with the principles qualified their feedback stating that capacity in the system and staffing challenges were one reason why change is needed.

Yes, budgets are being squeezed and there is insufficient capacity locally to meet rising demand for care and support needs. Staffing is a particular challenge locally

In addition to the main reasons above, people also stated that change needed to happen to ensure progress, to join up services, because technology has improved and because being in your own bed is the best place as it encourages independence and wellbeing.

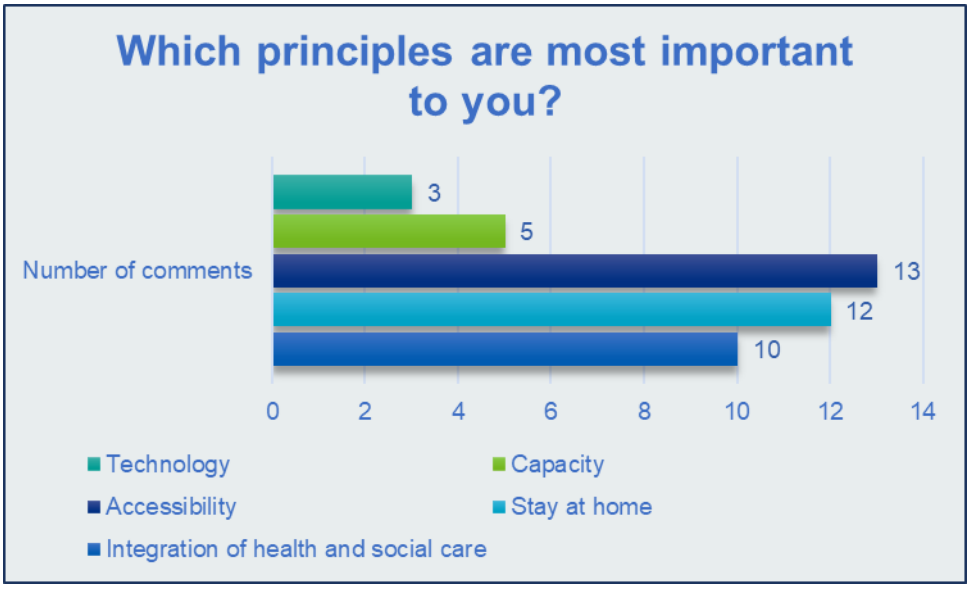
An ageing population with complex health needs means change is necessary. Inpatient bed care is bad for old people - risk of infection, loss of mobility etc. Changes in technology mean more can be done in home.

Yes, the idea of joined up thinking across health and social care is vital and needs implementing as soon as possible.

Without change things stay the same, and that's not sustainable or desirable. But we don't want change for the sake of change, we need progress.

Question 2: We will use these principles to guide decisions on the development of health and care services. Are these the right principles? Which are the most important to you?

This question was answered 55 times. Forty-four people stated that they agreed that these were the right principles. Seven people felt that they were not the right principles.



The chart above shows that the most comments related to accessibility of services, specifically access to primary care and being able to get face-to-face appointments with GPs. There were comments about timely referrals to diagnostic services and specialisms and opportunity for these to be delivered in the community more locally, which would support accessibility issues with transport, parking and travelling into Oxford.

Having access to GP

Enabling direct access to specialties needed by individuals eg exercise groups, and medical specialities for follow up and for information

Effective and efficient services are very important and avoiding non-essential traveling to promote sustainability are also vitally needed principles.

People also commented on the importance of care at home and bed provision locally.

The most important of which is that individuals are able to stay or return to their own homes with support wherever possible - even when this is just for palliative care (no one should have to die in a hospital)

Keeping people in their own homes as long as possible with adequate support, but also providing wrap around services to cope with periods of deterioration that require more intensive support (eg hospital at home and local community hospitals are excellent services).

Keeping people out of hospital and treating them as close to home are essential. Providing local beds and outpatient clinics are important to all age groups but particularly the elderly.

The third main theme related to the integration of health and social care. This was an area where people felt frustrated that this was not already happening, or in some cases had assumed that this was happening but not very well. There was recognition that for the principles to be delivered,

there needed to be an improvement in the joining up of services, so health services and care were provided more seamlessly for the patient.

My priorities are joining up care, patients are incredibly frustrated by the different trusts and lack of IT systems.

Yes. "Provide a better experience", "Organise services so staff operate in effective teams".

Better, joined-up care HAS to come - it is happening in other countries, and if handled efficiently should not cost more than inefficient services currently.

A smaller number of comments were received relating to:

- Increasing capacity in the community
- Technology – specifically improving access to patient records
- Upskilling of staff to address staffing issues
- Improving wrap-around care and support
- need for improved communication about how to access services and patient information

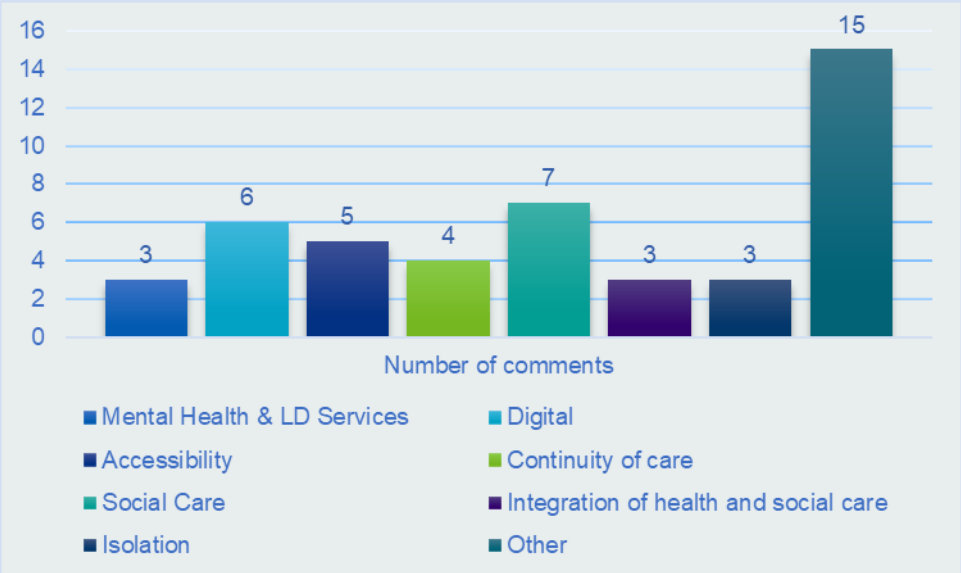
Seven people commented on the content of the engagement document, stating that there was insufficient information, proposals were nothing new, potentially too ambitious and lacked detail and specificity about how and when change might happen.

They disagreed for a variety of reasons. Comments included that community care does not support elderly people and increases isolation. They felt the principles were vague and did not address the infrastructure to deliver them. They also acknowledged that services are not working together currently and that this is a barrier to implementing the principles.

Question 3: Have we missed anything? Are there any other principles we need to think about as we develop our plans?

This question was answered 53 times.

The chart below shows the main areas that people felt had not been addressed or needed to be considered further in the development of the plans.



Comments were received about Social Care and addressing the impact of the COVID pandemic on social care and care homes. Specifically, these were around the shortage of staff in social care, costs relating to social care and the impact of a failing social care system on the NHS and patients.

Greater emphasis should be given to the role of care homes in supporting patients in the community, and families should be encouraged to care for their loved ones.

The plans also have not mentioned the link between health and social care, the staffing and funding crisis in social care, and how the problems accessing social care needs, affect older people's health (& need for hospital admission/ "bed blocking").

Concern was also raised about the reliance on digital technologies with comments about the digital literacy of elderly people and lack of joined up health care records.

Does technology relate to hospital ways of working and include non-face-to-face consultations. the latter must be flexible as not every service user is technology savvy.

Accessibility was another area where people commented, reflecting concerns already made about access to primary care, mobility, and physical accessibility to services, where services are located, how people get them and the lack of rural transport provision and infrastructure.

Make services more accessible to people outside working hours.

The time cost and inconvenience of the need to travel to central hospitals

We need more GP's and face to face appointments need to be reinstated.

People also commented on the importance of continuity of care, suggesting that there needs to be greater emphasis on a single point of contact for care, potentially not a GP, but a go-to person who has oversight of a patient's care needs, such as the role of district nursing, a care navigator, or an alternative.

Capacity of Community Clinicians to manage the burgeoning demand. As with dedicated Chest Heart and Stroke Services there will need to be a dedicated Community Care Support Service (community matron, district nurse, phlebotomy, nurse practitioner/ECP, social worker). Single Point of Access is a great pathway but need to ensure has sufficient personnel to be act in timely fashion.

There were seven comments that related to confidence in the proposals, again these echoed comments already made, about more information and detail about the proposals, keep information simple and comprehensive. Some felt that the patient voice was not reflected strongly enough in the principles and that more work was needed to engage the patient in this process.

There were several individual comments that were also received, including:

- consideration of the impact of isolation, and living alone
- the need to improve footcare services to support independence
- reflecting the role of PCNs in the document
- lack of mention of end-of-life care
- lack of clarity around neurological rehabilitation and residential care
- improving training and development for staff
- addressing cross border issues with services
- reflecting a person-centred approach to services, and including this in the narrative
- increasing patient and public education on how to manage their conditions, health, and wellbeing
- a gap around mental health provision, autism and Learning disabilities and that impact that poor mental health provision has on the wider NHS both in children and young people, adults, and older adults.

Question 4: Any other comments?

This question was answered 46 times. Most comments were in response to the content and style of the document and feedback survey. There were comments around people's confidence that the principles could be delivered, alongside a lack of confidence around whether change needs to happen, and if it is consultation for the sake of consultation. There were two specific comments that should be highlighted and reflected in future engagement or the response to this engagement exercise:

- Clarification and understanding of how these proposals fit with the wider Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System, and potential impact on cross boundary working and services.
- How these principles align to the Oxfordshire 2050 plan, which is currently out for consultation and has a section: Theme 3 Creating strong and healthy communities.

In addition to this, comments were also received around the need for more emphasis on social care within the principles.

It is essential to have streamlined provision between community and acute care. Older people often require both at different times. Care home and home care provision continues to be patchy in terms of quality.

There were several individual comments, which included:

- A request to review patient transport costs
- A request to include volunteer services in any engagement/consultation
- Consider prevention services in these proposals
- Expand services such as hospital at home, neurological rehabilitation
- Recruit dedicated geriatrician to co-ordinate care at home
- Address cost savings from missed appointments
- Consider digital literacy of patients in future service provision
- Address the staffing challenge – support staff better, training and development
- Maximise community hospitals and the services that can provided from them.

Appendix 2: Analysis of written feedback responses

In addition to the survey responses, feedback was also received from:

- Patients/Services users and carers at Oxford Health NHS Foundation Trust
- Healthwatch Oxfordshire
- Wantage and Grove Campaign Group
- OX12 Stakeholder Reference Group
- Newbury Street Patient Group
- Two individual responses by email
- Team-Up, Oxfordshire's Co-Production Board

The written responses provided comments relating to the documentation, noting the use of jargon and the lack of specific detail. There were suggestions for re-wording some of the principles these included:

Principle 1:

- ***Provide a better experience for people who are seeking or receiving care in their community we believe is correct and the foundation of integrating these services. We strongly recommend that you add, in second place, the following Principle: "During the design and development of integrated Health and Care services, we will involve users of them throughout the process."***
- ***This principle should include providing upstream planning ahead for care opportunities and for the process of moving from active/invasive/life sustaining treatment to end of life care. It should also include services to address the mild cognitive changes, pre changes to any dementia pathology, such as how to manage changes in cognitive processing and decision making for everyday life and living.***

Principle 6:

- ***Too vague a statement and use of language excludes people's understanding of the statement. No talk here of working with patients. Words in paragraph 3 "when a patient needs a community bed " what does this actually mean "? Plain English please. Can be interpreted to mean you won't get a community hospital bed and to ensure I don't understand what is being said it is put in jargon!***

Principle 7:

- ***Phrases like "we will consider" and "clinical evidence" are not sufficient for principles. This should be rephrased to "We will ensure that the services we provide meet clinical, social and environmental best practice for all of our communities."***

Principle 8:

- ***Only mentions staff but should be expanded to include buildings as described in the supporting statements. This principle should be expanded to not just share and develop assets within the Trust but also to utilise other buildings (or other assets) available in the community.***

Principle 9:

- ***Change to talk about Management empowering the community staff to help them provide improved joined-up services***
- ***Only mentions the Health and Social Care workforce but should be expanded to include supporting voluntary and community sector groups working with the Health and Care organisations.***

- ***Suggest either:***
    - ***a) change to talk about Management empowering the community staff to help them provide improved joined-up services***
    - ***b) or fits better under Principle 5 and merge with Principle 8***

Three of the seven written submissions received were either critical of the number of principles, reflecting that there were too many, or felt that some were more statements of fact, or required further quantifying, for example:

Principle 2: Ensure equality of opportunities to improve health and wellbeing are consistent across the county.
Suggestion of Would something like setting a minimum common standard of service across the county be a better principle? -- I like this – another word for service?

Also, it would also be good it there was a standard which stated that certain services should be available within a certain distance (or travel time on public transport) from home.

Principle 3:
A statement that "we will make sure that people can access our services rapidly" is a very definite statement but "rapidly" needs further definition.

Principle 7:
Phrases like "we will consider" and "clinical evidence" are not sufficient for principles. This should be rephrased to "We will ensure that the services we provide meet clinical, social and environmental best practice for all of our communities."

Principle 10:
Deliver the locally and nationally agreed priorities for our health and care system. What are the locally agreed priorities?

There were concerns about the accessibility of the document with the suggestion that an easy read version should have been developed and more engagement with those individuals currently using the services.

The full written responses provide detailed feedback on each of the principles and are included in the Appendix 3 (see separate document).

Written response to questions:
In response to the questions raised in the feedback survey, the themes raised in the written responses were as follows:

1. Do you understand why change is needed?
The written submissions agreed that that they understood why change was needed, due to the demand on services, need to join up services and the ageing population.

There was concern that the approach does not cover all services, such as housing, transport, and voluntary and community services. It is also encouraged that the principles should align themselves to the Oxfordshire 2050 Plan and the Oxfordshire Infrastructure Strategy.

2. We will use these principles to guide decisions on the development of health and care services. Are these the right principles? Which are the most important to you?

There was concern that there are too many principles and that the patient voice is not reflected. For those submissions from the Southwest of Oxfordshire the most important priorities were:

- providing more outpatient services locally
- providing good re-enablement services locally
- providing inpatient palliative care locally
- providing x-ray and minor injuries locally.

3. Have we missed anything? Are there any other principles we need to think about as we develop our plans?

There were comments that the patient voice is not reflected strongly enough within the principles. There was also concern that this work should be aimed at all residents, not just older adults.

Where is the positive statement (even principle) about the role of patients, carers and Oxfordshire residents informing service development, improvement and patient centred care- recognising joined up pathways.

There is concern that these principles do not go far enough to align themselves to the Oxfordshire 2050 Plan and the Oxfordshire Infrastructure Strategy. It is also noted that there needs to be a more joined up approach with the District Councils and Oxford City Council, to address housing and health prevention issues. An example was provided, below:

For example, older people with a range of long-term conditions could be supported to live and be cared for in their own homes if there were, downsizing for housing opportunities, builds that include the flexible option to have downstairs bathrooms and bedrooms on the ground floor and equally more accessible housing input to make adjustments to current homes beyond the OT brief. There needs to be a much better link to Prevention and Public Health services.

4. Any other comments?

There were a range of comments specific to Wantage and the surrounding area, including the bed provision at Wantage Hospital and the development of the new GP practice.

Feedback from Oxford Health NHS Foundation Trust:

Workshops were held with 16 individuals representing patients/Governors and a GP. The points raised included:

- Accessibility – need to consider equity of access, location of services, digital literacy and how that impacts on access to services
- Importance of understanding patient experience, change impacts people differently
- Need to ensure the needs of people with disabilities are reflected
- Consideration should be given to staff engagement, and the impact on staff
- Documents should be accessible and remove jargon

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Divisions Affected - All

HEALTH AND WELLBEING BOARD
16 DECEMBER 2021

MAKING EVERY CONTACT COUNT (MECC) TO SUPPORT HEALTH AND WELLBEING STRATEGY PRIORITIES

Report by Corporate Director of Public Health, Oxfordshire County Council

RECOMMENDATION

1. **The Health and Wellbeing Board is RECOMMENDED to:**

   (a) note implementation of MECC in Oxfordshire to date

   (b) agree to the arrangement of a MECC training workshop for the Board in early 2022 to support it in championing further implementation of this initiative

Executive Summary

2. This report summarises the implementation of MECC in Oxfordshire so far and describes how it can support delivery of the some of the priorities within the Health and Wellbeing Strategy. It also suggests next steps in expanding further implementation of this initiative.

Background

3. Making Every Contact Count is a programme which originally developed in the NHS. MECC utilises opportunistic conversations in everyday life to talk about health and wellbeing. It involves responding appropriately to cues from others to encourage them to think about behaviour change and steps that they could take to improve their health and wellbeing. The recognition of the value of MECC in prevention is its inclusion in the prevention framework.

4. MECC is an 'upstream' intervention that can apply to a range of settings within the community, beyond the NHS. Conversations are based on a 'peer to peer' approach to encourage people to be more comfortable to talk about health as

part of everyday conversations. More general information about MECC can be found here: http://www.makingeverycontactcount.co.uk/

MECC in Oxfordshire

5. We have an Oxfordshire MECC Partnership which is part of a wider MECC system in the region. The Oxfordshire MECC Partnership reports into the BOB (Buckinghamshire, Oxfordshire, Berkshire West) MECC Oversight Group and into the South East MECC Network. The local group shares learning with other MECC groups which enables a consistent approach to MECC within the BOB region.

6. A key strength of the Oxfordshire MECC Partnership is seen in the collaborative partnership working between the various organisations involved. The Oxfordshire MECC Partnership is Chaired by Oxfordshire County Council and membership includes the Oxfordshire CCG, Oxford Health, Oxford University Hospitals NHS Trust, Cherwell District Council, Carers Oxfordshire and others.

7. A range of organisations within Oxfordshire are already engaging with MECC training but there is potential to scale this up and increase the reach to other organisations that have contact with the public. The level and stage of engagement varies, but some examples of organisations engaged with so far include; the Oxfordshire Library Service, Carers Oxfordshire, Refugee Resource, Oxfordshire Fire and Rescue Service.

MECC and the Joint Health and Wellbeing Strategy Delivery

8. The Health and Wellbeing Board recently reviewed its strategy in light of the COVID-19 pandemic and a paper summarising this review was presented at the last Health and Wellbeing Board in October 2021. It is important the Board now ensures that the strategy priorities are implemented in Oxfordshire.

9. The role of MECC is already captured as one of the “live well” priorities of the Health and Wellbeing Strategy. However, it is an initiative with significant potential and broad scope. For example, it has application to any stage of the life course and can be used by a range of professionals within the local system. It might therefore be an initiative than can be included as a cross cutting theme of the strategy as opposed to sitting within one part of the life course.

Expanding MECC in Oxfordshire

10. There is an opportunity to develop the MECC approach with a deeper community focus, helping to contribute to addressing health inequalities, and developing community resilience by enabling a number of people who are skilled in engaging with local residents to be having conversations about wellbeing and health.

11. Training is available to enable people to gain the skills and confidence to have MECC conversations about health and wellbeing with others and to then to be able to follow up with signposting to support available. In Oxfordshire the BOB MECC training programme is available and we encourage people to signpost to the Oxfordshire Live Well website for further information and support. https://livewell.oxfordshire.gov.uk/ A virtual training model was developed and piloted in 2020. This virtual training can be delivered as a stand-alone training session with groups or for more sustainability, as a cascade training approach embedded within organisations.

12. To achieve an increased reach into communities, consideration of a more localised community approach to MECC is required. An essential element of this will be the support and endorsement from the Oxfordshire Health and Wellbeing Board.

13. To achieve this the Board is asked to consider undergoing a 2 hours MECC training workshop to help it more fully understand the nature and potential of the programme. If agreed, this would help the board to champion the initiative, explore how their organisations can further expand the work and to provide leadership to the Oxfordshire system on this.

Conclusion

14. The Joint Health and Wellbeing Strategy adopted by the Oxfordshire Health and Wellbeing Board in 2018 has agreed priority areas. A wider adoption of the MECC approach will help with the implementation of this strategy. The Board has a key leadership role to play to support this.

Financial Implications

15. There are no specific financial implications associated with this report, although engagement with training will require organisations to commit some staff time to attend.

Legal Implications

16. There are no specific legal implications associated with this report

ANSAF AZHAR
CORPORATE DIRECTOR FOR PUBLIC HEALTH

Annex: Annex 1- PowerPoint slides summary of HWB Strategy priorities and MECC approach

Contact Officer: David Munday
Consultant in Public Health
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December 2021

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Oxfordshire Health and Wellbeing Strategy- agreed priorities

CROSS CUTTING THEMES

- Addressing health inequalities;
- A preventative approach- prevent, reduce, delay and recover
- Community centred approaches

START WELL

- Best start in life and improvements in school readiness
- Early help and early intervention
- Mental health and wellbeing of children and parents

LIVE WELL

- Healthy weight and physical activity
- Tobacco control
- Make every contact count
- Physical health of those with SMI and LD
- Promoting mental wellbeing

AGE WELL

- Social isolation, loneliness and mental wellbeing
- Support for carers,, Falls prevention
- Promoting self care and a strengths based approach
- Immunisation

Paper on HWB strategy priorities from Oct 21 HWB Board meeting available here

Making Every Contact Count (MECC)

Aim	MECC utilises opportunistic conversations in everyday life to talk about health and wellbeing. It involves responding appropriately to cues from others to encourage them to think about behaviour change and steps that they could take to improve their health and wellbeing
Local Progress	A range of organisations locally are already engaging with MECC and it is part of our local Prevention Framework but there is potential to scale this up and increase the reach to local residents by developing a deeper community focus and helping addressing health inequalities
Next steps	MECC could become a central plank to delivery of the priorities of the HWB strategy. The HWB could champion an expansion of MECC across the Oxfordshire system to support implementation of the strategy. A MECC training session for Board members in early 2022 would be an opportunity to more fully understand the potential of MECC in Oxfordshire
More information on MECC available at http://www.makingeverycontactcount.co.uk/ and local case studies at https://vimeo.com/534378786	

Divisions Affected - All

OXFORDSHIRE HEALTH AND WELLBEING BOARD
16 DECEMBER 2021

CHILDREN AND YOUNG PEOPLE EMOTIONAL WELLBEING AND MENTAL HEALTH – STRATEGIC APPROACH

Report by Corporate Director of Children's Services, Oxfordshire County Council

RECOMMENDATION

1. **The Health and Wellbeing Board is RECOMMENDED to;**

   (a) Note the summary of activity taken place to date
   (b) Agree to the indicative strategic approach for children and young people's emotional wellbeing and mental health in Oxfordshire
   (c) Endorse and support the work outlined in the forward plan

Executive summary

2. This report summarises the work completed to date on the development of a shared strategic approach to children and young people's emotional wellbeing and mental health in Oxfordshire.

3. Following a workshop that reviewed Oxfordshire's current Health and Wellbeing Strategy that took place in September, a focus on the mental health and wellbeing of children and parents was selected as a priority area under the Start Well programme.[1] Alongside this, there was recognition that the 16-24 age group has been particularly adversely impacted by the pandemic and specific interventions might be needed from across the system to address their needs.

4. Oxfordshire's Joint Commissioning Executive (JCE) selected Children and Young People's (CYP) emotional mental health and wellbeing as a strategic priority in the first year work plan following the COVID-19 pandemic, via Oxfordshire's Health, Education, and Social Care (HESC) partnership. The reasons for this were in response to new funding opportunities, an increased prevalence rate due to impact of pandemic, that the work is cross-cutting across all tiers and requires a whole-system solution.

[1] Health and Wellbeing Strategy review paper, Oxfordshire Health and Wellbeing Board (October 2021)

5. So far, we have begun to build a picture of services and projects that are available locally and have drawn together prevalence and needs from a variety of sources. We are advocating a prevention approach across the local CYP emotional mental health and wellbeing system so that children, young people, and families can access the support they need when they need it, which will prevent children and young people from becoming more ill and reduce their need to access specialist services.

6. Applying a prevention approach across the whole CYP emotional wellbeing and mental health system will be the cornerstone of this work. The prevention principals adopted by the Health and Wellbeing Board in the Oxfordshire Prevention Framework (2019-24) will be applied to prevent illness, reduce the need for treatment, and delay the need for care.

7. Children and young people's outcomes and needs will be at the centre of this work. In light of this, we will apply principles from the THRIVE framework. The THRIVE framework – developed by Tavistock and Portman NHS Foundation Trust and the Anna Freud National Centre for Children and Families and adopted by local CAMHS – is a set of principles built on child and young person need.

8. We will work with children and young people to define what constitutes as good emotional wellbeing and mental health, and what they believe helps support them. We are advocating a definition of children and young people from 0 to up to 25 years old to include the key transition point into adulthood. The approach will consider the full continuum of emotional wellbeing and mental wealth, from continuing to support children and young people who are thriving to those that require specialist mental health support.

9. We are advocating a system-wide partnership approach, to include a wide stakeholder group including children and young people and their families, as well as the spectrum of people and organisations involved in providing care and support, including the local authority, health, and voluntary and community sector organisations. Engagement and partnership work is already underway between the organisations described above.

10. The scope of this work is to include interventions and services that directly support children and young people's emotional wellbeing and mental health, or targeted services aimed at those who are most at risk at developing poor wellbeing and mental health. Outside of scope are the wider determinants of health. The wider determinants of health – where we live, learn, work, and play – are fundamental to wellbeing and mental health, and this is covered by Oxfordshire's Healthy Place Shaping programme, among other cross-cutting programmes of work (see appendix 1 for a broad overview of the wider determinants of health)

11. The new strategic approach will seek to address issues relating to increased prevalence and acuity in Oxfordshire over the last few years and following the impact of COVID-19 on wellbeing and mental health (see appendix 2).

12. This report has been prepared in partnership with the local Health Education and Social Care (HESC) structure (Oxfordshire County Council and Oxfordshire Clinical Commissioning Group), and Oxford Health NHS Foundation Trust.

Strategic Context

National strategies

13. NHS Long Term Plan aims to expand mental health services for children and young people, reduce unnecessary delays and deliver care in ways that young people, their families and carers have told us work better for them (this includes the NHS-funded school-based Mental Health Support Teams).

14. Future in Mind (2015) highlighted the need to build resilience, promote good mental health, and promote prevention, and to provide early identification and co-ordinated support.

15. The Five Year Forward View for Mental Health (2016) set out an ambition for transforming mental health services to achieve greater parity of esteem between mental and physical health for children, young people, adults and older people.

16. In 2017 The Department for Health and Social Care (DHSC) and the Department for Education (DfE) jointly published 'Transforming children and young people's mental health provision':
    - designated mental health leads in all schools,
    - new mental health support teams prioritised in working with children experiencing mild to moderate mental health problems
    - trialling reduced waiting times for specialist mental health services.

Local Strategies

17. There are several key local strategies and plans that support children and young people's emotional wellbeing and mental health:

    - CAMHS LTP Refresh 2020-22
    - Joint Health and Wellbeing Strategy 2018-23
    - Prevention Framework 2019-24
    - Suicide and Self-Harm Prevention Strategy 2020-24
    - Mental Health Prevention Framework 2020-23
    - Children and Young People's Plan 2018-23

18. There are also a number of local strategies and partnerships across the county that impact on the wider determinants of emotional wellbeing and mental health.

THRIVE framework

19. The THRIVE framework – developed by Tavistock and Portman NHS Foundation Trust and the Anna Freud National Centre for Children and Families (see figure 1 below). The framework has been adopted by local CAMHS and is a set of principles built on child and young person need. It can also be used to present information about the range and diversity of services and interventions already in place in Oxfordshire, and how they link together. Using the THRIVE framework in this way will allow us to clearly analyse and identify gaps in need and inform recommendations on what the local offer should be.

Figure 1: *The THRIVE framework*

20. The framework is a set of principles built on child and young person need, described as the following:

- **Thriving:** Around 80% of children at any one time are experiencing the normal ups and downs of life but do not need individualised advice or support around their mental health issues. They are considered to be in the Thriving group. Universal promotion and prevention interventions support this group such as School Based Health Nursing Services and some VCS services.

- **Getting advice:** This group includes both those with mild or temporary difficulties and those with fluctuating or ongoing severe difficulties, who are managing their own health and not wanting goals-based specialist input. Information is shared such that it empowers young people and families to find the best ways of supporting their mental health and wellbeing. The best interventions here are within the community with the possible addition of self-support, such as the Five Ways to Wellbeing.
- **Getting help:** This grouping comprises those children, young people and families who would benefit from focused, evidence-based help and support, with clear aims, and criteria for assessing whether these aims have been achieved. An intervention is any form of help related to a mental health need in which a paid-for professional takes responsibility directly with a specified individual or group.
- **Getting more help:** This is not conceptually different from Getting Help. It is a separate needs-based grouping only because need for extensive resource allocation for a small number of individuals may require particular attention and coordination from those providing services across the locality. Young people and families in here benefit from extensive intervention. It might include children and young people with a range of overlapping needs, such as the coexistence of major trauma, autistic spectrum disorder (ASD), or broken attachments.
- **Getting risk support**: This grouping comprises those children, young people and families who are currently unable to benefit from evidence-based treatment but remain a significant concern and risk. This group might include children and young people who routinely go into crisis but are not able to make use of help offered, or where help offered has not been able to make a difference; who self-harm; or who have emerging personality disorders or ongoing issues that have not yet responded to interventions. Children and young people in this grouping are likely to have contact with multiple-agency inputs such as social services or youth justice. [2]

21. One of the fundamental principles is that children and young people are at the centre of the decision making around their own mental wellbeing and mental health and may be accessing more than one intervention or service at any given time.

Prevention

22. Applying a prevention approach across the whole CYP emotional wellbeing and mental health system will be the cornerstone of this work. The prevention principals adopted by the Health and Wellbeing Board in the Oxfordshire Prevention Framework (2019-24) will be applied in order to:

    - prevent illness – preventing illness and keeping people physically and mentally well (primary prevention)

[2] THRIVE framework for system change

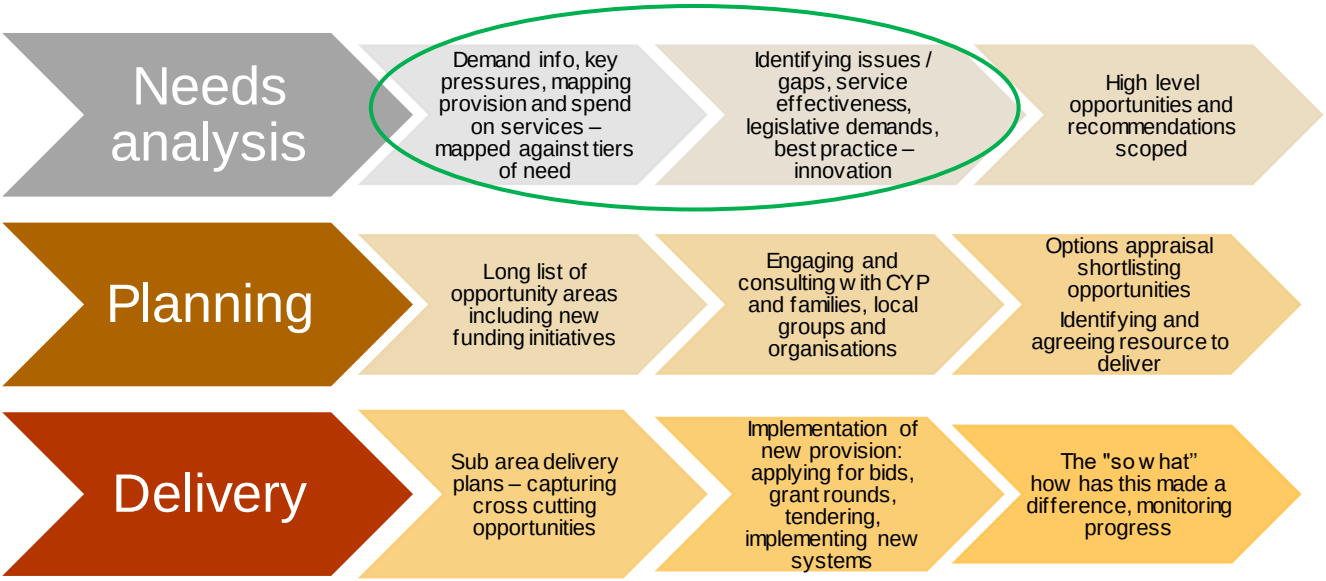
- reduce the need for treatment – reducing impact of an illness by early detection (secondary prevention)
- and delay the need for care – soften the impact of an ongoing illness and keep people independent for longer (tertiary prevention).

23. Taking a prevention approach will require investing strategically across the system – primary, secondary and tertiary prevention – so that children and young people can access a range of services to meet a range of needs from a range of settings and locations.

Progress to date and next steps

24. We are in the 'needs analysis' phase of developing a strategic approach to CYP emotional mental health and wellbeing (see figure 2 below). We have started to map statutory and non-statutory service provision engaging with health and voluntary sector organisations across the county.

Figure 2: *Strategic approach to CYP emotional mental health and wellbeing*



25. There are many partners from the health and voluntary and community sector delivering services and projects to support children and young people's emotional wellbeing and mental health in Oxfordshire. The annual Oxfordshire Youth in Mind Guide is put together by Oxfordshire Youth and Oxfordshire Mind and lists services across the county.[3] Approximately one-third of VCS organisations contacted so far have responded which accounts for 40 projects or services. Not all organisations provided budget figures or service capacity.

26. We have an overall budget position from Oxford Health CAMHS – including a breakdown at services level.

[3] Oxfordshire Youth in Mind guide 2020

27. Alongside the emerging service provision mapping, an assessment of prevalence, local needs, access, and priorities has been developed (see appendix 1).

28. Next steps:

Table 1: *Indicative forward plan*

Phase	Activity	Completion date
Needs analysis	Complete service provision mapping across the CYP emotional mental health and wellbeing system	**January 2022**
	Identify gaps, service effectiveness, and explore best practice	**February 2022**
	High level opportunities and recommendations	**February 2022**
Planning	Engage with CYP and families, and people and organisations involved in providing care and support	**March 2022**
	Long list of opportunity areas including new funding initiatives	
	Options appraisal shortlisting opportunities / portfolio evidence-based interventions	
	Identifying and agreeing resource to deliver	
Delivery	Sub area delivery plans – capturing cross cutting opportunities	**2022/23**
	Implementation of new provision: applying for bids, grant rounds, tendering, implementing new systems	
	The "so what'' how has this made a difference, monitoring progress	

Conclusion

29. Progress has been made in the development of a shared strategic approach to children and young people's emotional wellbeing and mental health in Oxfordshire.

Themes that have emerged so far are:

- The importance of taking a prevention approach across the system to support earlier intervention at every stage to give children and young people the help and resources they need to manage their emotional wellbeing and mental health.
- Ensuring that the interventions at every level are evidence-based and effective, to prevent higher level interventions being required.

- Focusing on promoting good mental health for all while targeting support to those who need it most.
- Focus on health inequalities and services delivered (by geography and/or demography).
- We do not yet have a full system picture; this is required before moving onto the next phase outlined in the indicative forward plan in table 1.
- We want to ensure that strategic commissioning priorities are linked to the Joint Health and Wellbeing Strategy, Prevention Framework, CAMHS Transformation Plan, local needs of children and young people, and prevalence. This should include a balance of in-person interventions with emerging digital provision, and fully explore how technology could be used as an adjunct to support wellbeing outcomes and current services.

30. There is more work to do on this important agenda which will require continued engagement from across the system if we are going to achieve the transformational change that we want for children and young people's emotional mental health and wellbeing in Oxfordshire.

Financial implications

31. There are no specific financial implications associated with this report

Legal implications

32. There are no specific legal implications associated with this report

KEVIN GORDON
CORPORATE DIRECTOR FOR CHILDREN'S SERVICES

Annex:

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December 2021

Appendix 1: The Wider Determinants of Health

1. Positive mental health and wellbeing are vital for building population good health. Our social circumstances, environment where we live, learn, work and play, economic factors, physical and mental health can all support good mental wellbeing.

2. Our mental wellbeing enables us to get the most from life and feel connected to friends, family and neighbours, fulfil our potential, contribute to communities and to adopt healthy lifestyles.

3. Conversely, poor mental health and serious mental illness can be a significant burden to individuals, families and communities, affecting the quality of lives lived and leading to preventable early deaths. People with severe and enduring mental illness are at greater risk of poor physical health and reduced life expectancy compared to the general population.

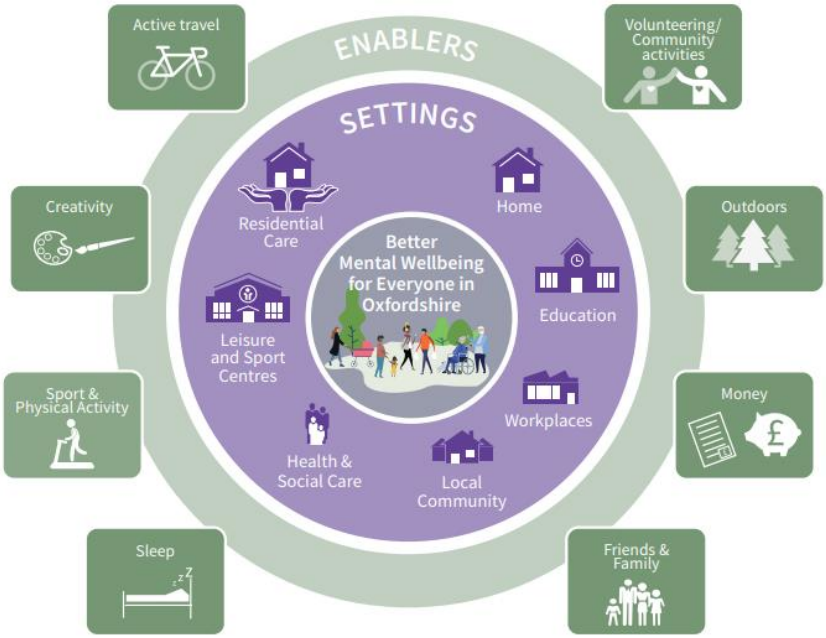
4. Mental illness is closely associated with many forms of inequalities. Health inequalities are avoidable and unfair differences in health status and determinants between groups of people due to demographic, socioeconomic, geographical and other factors.

5. Inequalities in health are largely due to inequalities in society, meaning the conditions in which people are born, grow, live, work and age. It is the unequal distribution of the social determinants of health, such as education, housing and employment, which drives inequalities in physical and mental health, although the mechanisms by which this happens can be complex and inter-related.

6. Disadvantage can start even before a child is born and can accumulate over time and impact on future generations. Factors include:
    - adverse childhood events such as being a victim of abuse
    - poor housing
    - poverty
    - traumatic events
    - poor working conditions
    - Children facing multiple risks have a heightened risk of multiple and sustained childhood mental health difficulties.[4]

[4] Points 5-19 from: Health matters: reducing health inequalities in mental illness

Figure 2: *The wider determinants of wellbeing and mental health*



7. Our social circumstances, the environment where we live, learn, work and play, and economic factors – often referred to as the wider determinants of health – all impact wellbeing and mental health.

Appendix 2: Prevalence, needs and access

Prevalence

1. Applying the 2020 national prevalence rates of children and young people who have a probable mental disorder – 16% of 5-16 year olds and 20% of 17-22 year olds – to the mid 2020 estimated Oxfordshire population there are 16,159 children aged 5-16 years old and 11,069 children and young people aged 17-22 years old with a probable mental disorder in Oxfordshire.[5]

2. Emotional disorders and anxiety orders are the two most probable mental disorders in children and young people across ages 5-19 in Oxfordshire (see table 2 below).[6]

Table 2: *Count of top five probable mental disorders in Oxfordshire, across age ranges*

	5-10 years	11-16 years	17-19 years	All
Emotional disorders	2,124	4,435	3,711	10,163
Anxiety disorders	2,022	3,922	3,250	9,104
Behavioural disorders	2,579	3,087	197	5,848
Depressive disorders	156	1,347	1,198	2,649
Hyperactivity disorders	2,124	4,435	3,711	2,069

Needs

3. In 2020, Oxfordshire had a higher proportion of school age pupils with social emotional and mental health needs (3.11%) compared to the England average (2.7%).[7]

4. In 2020, a social, emotional and mental health need was the third highest need identified for EHCP and SEN support. Those requiring social, emotional, and mental health support is above average compared to England and has increased by 31% since 2016.[8]

5. From local intelligence, in the calendar years 2014 to November 2021, there have been twelve unexpected deaths of young people aged 13 to 18 years. It is

[5] National data applied to Oxfordshire mid 2020 population. Nationally, rates of probable mental disorders have increased since 2017. In 2020, one in six (16.0%) children aged 5 to 16 years were identified as having a probable mental disorder, increasing from one in nine (10.8%) in 2017. The increase was evident in both boys and girls Mental Health of Children and Young People in England, 2020: Wave 1 follow up to the 2017 survey - NHS Digital

[6] National data 2017 survey applied to Oxfordshire mid 2020 population, Mental health of children and young people 2017 - key facts. Given that overall probable prevalence has increased in 2020 it is likely that all disorders have increased.

[7] Children and Young People's Mental Health and Wellbeing – PHE Fingertips

[8] Special Educational Needs statistics January 2020 (published 2 July 2020)

important to note that not all of these deaths were recorded as suicide by the coroner.

6. The OxWell School survey 2021 collected data from over 30,000 children and young people aged between 8 and 18 years across Oxfordshire, Berkshire, Liverpool and Buckinghamshire. The survey asks questions on general wellbeing, highlights risk groups and populations of concern.

7. OxWell School survey 2021 key highlights:

    - **Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS)** score – similarly to previous surveys, self-reported wellbeing gets worse with age with 49% and 44% of those in years 12 and 13 (16-18 year olds) reporting low wellbeing compared to 20% in year 5 (9-10 year olds).
    - **Revised Children's Anxiety and Depression Scale (RCADS)** – a clinical measure for depressions and anxiety – is closer across age groups (years 8-13), with a range of those with a more serious outcome from 18% in year 8 to 26% in year 13.
    - As with WEMWBS, **loneliness** scores generally get worse with age. From year 5, where 13% often feel lonely, to year 12 and 13, where 24% and 20% often feel lonely, respectively. Over half feel lonely sometimes or often across all age groups.
    - **Self-image** – ~75% of females across all ages were worried/extremely worried about appearance and ~50%+ of males across all ages were worried/extremely worried about appearance.
    - Of the respondents from year 8–13 (ages 12-18) 6.7% reported as having **self-harmed** within a month of the survey, further analysis of the data needs to be completed to before conclusions can be made on intention and ongoing risk.
    - **Exercise** – students across most age ranges are doing more exercise compared to before the first lockdown
    - **Social media/gaming** – 48% are playing computer games for four hours a day / 37% on social media for four hours a day
    - **Sleep** – range across ages 22% - 37% that are too worried to sleep often – for year 12s (16-17 year olds) 37% are too worried to sleep often
    - **Bullying** – decreases with age 9% in year 5 to less than ~5% in year 12[9]

Access

8. In the four year period, 2016/17 to 2019/20, the number of referrals of Oxfordshire patients to Oxford Health for mental health services increased by 38% overall and by:

    i. +83% for people aged 0-9
    ii. +58% for people aged 10-19
    iii. +36% for people aged 20-24

[9] OxWell School Survey 2021 – preliminary summary report – University of Oxfordshire

iv. +22% for people aged 25 and over.[10]

9. The median number of days of all children and young people waiting for CAMHS appointments peaked in August 2019 at 169 and had dropped to 36 by December 2020.[11]

10. The rate of those with a probable mental disorder see point 22) accessing CAMHS in 2020/21 was 60.3% compared to a national target of 35%. This equates to 9,700 CYP and demonstrates the continued increased demand to Oxfordshire CAMHS.[12]

11. In 2019/20, Oxfordshire had a higher proportion of hospital admissions as a result of self-harm in 10-24 year olds (462.1 per 100,000) compared to the England average (439.2 per 100,000).[13]

Impact of COVID-19 on needs and access

12. National research indicates that there has not been an escalation in suicide figures during the pandemic. A subset of local areas (population coverage ~9million) has not shown a significant rise in average number of suicides when comparing pre- and post- lockdown periods.[14]

13. Early indications from local data show that self-harm presentations to A&E across age ranges has fluctuated over the pandemic. Overall presentations reduced in the first lockdown period (April – July 2020), and returned to pre-pandemic levels out of lockdowns.[15] We will continue to monitor this data as it becomes available.

14. However, risk factors for self-harm and suicide that have or have likely been adversely impacted by COVID-19 include unemployment, self-reported wellbeing, domestic abuse, depression, anxiety, social isolation, and loneliness.

15. The 2020 OxWell survey conducted across the South-East during the first lockdown, showed that for respondents in years 9-13, the highest proportion reported that their general happiness and sleep had worsened, and that they were lonelier during lockdown.[16]

16. Across Oxfordshire, the number of unemployment claimants rose significantly at the start of the pandemic. The highest proportion of unemployment claimants in

[10] Joint Strategic Needs Assessment | Oxfordshire Insight
[11] As above.
[12] CAMHS Transformation Plan 2021/22 (draft)
[13] Children and Young People's Mental Health and Wellbeing – PHE Fingertips
[14] Preventing suicide in England: Fifth progress report of the cross-government outcomes strategy to save lives (publishing.service.gov.uk)
[15] In the absence of recent 2020/2021 Public Health Outcomes Framework data on self-harm rates (latest available is 2019/20) we have consulted with the Oxford Monitoring System for Self-harm, Department of Psychiatry (University of Oxford)[15] which suggests that there has not been a significant increase in self harm presentations to A&E in the John Radcliffe Hospital, Oxford.
[16] OxWell school mental health summary report 2020

Oxfordshire between December 2019 and December 2020, was in 16-24 year olds, rising from 945 to 3020.[17]

17. There is anecdotal evidence from engaging with health and voluntary sector partners that the pandemic impacted on service delivery and saw an increase in demand for some services. For example, there has been a 72% rise in eating disorder referrals from 2019/20 to 2020/21 (yearly increase from 172 in 2019/20 to 295 in 2020/21).[24]

18. In 2020/21 the number of pupils requiring support (SEN/EHCP) where the primary need was social, emotional or mental health increased by around 6% compared to the previous year (from 3,027 to 3,206).[25]

19. The performance report from the most recent Oxfordshire Health Improvement Board contained a number of indicators across the life-course focusing on mental wellbeing – available here: Item 8 18 November 2021 Health Improvement Board meeting - Performance Report.

[17] Workbook: Oxfordshire Unemployment Dashboard (tableau.com) (data from nomis web – official labour market statistics)

Divisions Affected - All

HEALTH AND WELLBEING BOARD

30 November 2021

UPDATE ON DELIVERY OF DUTIES UNDER THE DOMESTIC ABUSE ACT

Report by Corporate Director of Public Health, Oxfordshire County Council

RECOMMENDATION

1. **The Health and wellbeing board is RECOMMENDED to**

   a) Note the update on statutory duties under the Domestic Abuse Act following publication of guidance for Part 4 of the Domestic Abuse Act

   b) Note the publication of the draft Safe Accommodation Strategy for consultation and plans for final publication.

   c) Note the plans for renewing the overarching strategy for domestic abuse.

Executive Summary

1. The Domestic Abuse Act 2021 was introduced in April this year and requires a needs assessment and strategic review of safe accommodation to be led by each Tier 1 local authority area. This should be overseen and evaluated by a strategic partnership board consisting of a range of partners. MHCLG (Ministry of Housing Communities and Local Government, now renamed to DLUHC, Department of Levelling Up, Housing and Communities) have provided a grant to support the delivery of the strategy. This paper summarises the actions being taken in Oxfordshire to meet the requirements of the Act, including the production of both a Safe Accommodation Strategy and an overarching Domestic Abuse Strategy.

Domestic Abuse Act 2021

2. The Domestic Abuse Act 2021 was introduced in April this year. It requires each Tier 1 local authority to lead a strategic board consisting of membership from a range of organisations from the system, including Tier 2 local authorities. The local authority and strategic board are required to organise a local needs assessment with the following scope: “comprehensive assessment of need for support in safe accommodation in your area”. and then use this to inform a safe

accommodation strategy. There is also a requirement to monitor and evaluate the effectiveness of the strategy.

3. Statutory guidance[1i] from the Department for Levelling Up, Housing and Communities (DLUHC) for English local authorities on their functions pursuant to Part 4 of the 2021 Domestic Abuse Act ("the Act") was published on 1st October 2021, when the duty came into force.

Oxfordshire Domestic Abuse Strategic Board

4. The Terms of Reference of this board were reviewed in line with the introduction of the Domestic Abuse Act. This resulted in additional members being added to the membership, including providers and the voice of lived experience. The frequency of the board has been increased to monthly whilst we plan actions to meet the requirements of the Act and allocate related funding. The board is currently chaired by Public Health.

Domestic Abuse Safe Accommodation Strategy

5. Following the publication of the statutory guidance for Part 4 of the Act, which provided details of the required scope and content of the "domestic abuse support in safe accommodation" strategy, and use of MHCLG funding, the Oxfordshire Domestic Abuse Strategic Board agreed to publish a separate strategy to meet these requirements.
6. The strategy was informed by an assessment of need for support in safe accommodation, which was achieved using a template from MHCLG. A proportion of this data was not available from partners to the granularity requested, and we understand this has been a challenge in other areas too. Any gaps in available data will inform future data collection strategies for services across the system.
7. The Domestic Abuse Safe Accommodation Strategy was produced in draft on 26th October 2021, and was consulted on according to the guidance, which states "Tier 1 authorities must consult with the Board, Tier 2 authorities within the area and such other persons as they consider appropriate, before publishing their strategy."
8. The consultation[2] was live from 27th October to 24th November 2021. Feedback from the consultation is now being reviewed and the final Safe Accommodation Strategy will be published by 5th January 2021.
9. One recommendation from the draft strategy is to form a Safe Accommodation Working Group' (SAWG) as a sub-group to the Domestic Abuse Strategic Board. This group will produce a delivery plan for the Safe Accommodation Strategy to be approved by the Oxfordshire Domestic Abuse Strategic Board in 2021/22. This will include developing and agreeing baseline measures and targets to monitor the impact of the Safe Accommodation Strategy. This will

[1] Delivery of support to victims of domestic abuse in domestic abuse safe accommodation services - GOV.UK (www.gov.uk)

[2] https://letstalk.oxfordshire.gov.uk/domestic-abuse-safe-accommodation-strategy-2021

also work to address the gaps in data which have been highlighted in the needs assessment.

Overarching Domestic Abuse Needs Assessment and Strategy

10. The Board agreed to undertake a needs assessment and strategy review with a wider remit than the Act requirement around Safe Accommodation. This work is being undertaken by an external Public Health agency, PHAST, and is supported by a local expert, to ensure the strategy reflects a good understanding the Oxfordshire system.

11. The overarching strategy will be published in draft by February 2022, for consultation.

Corporate Policies and Priorities

12. The overarching Domestic Abuse Strategy will identify priorities to meet the needs of Oxfordshire residents. The Domestic Abuse Strategic Board will agree, monitor and evaluate the delivery of these priorities. The delivery plan will identify outcomes to be monitored.
13. This work will support the Vision, in the County Council's Corporate Plan to "Tackle inequality, help people live safe and healthy lives and enable everyone to play an active part in their community."

Financial Implications

14. A grant of £1.1million has been awarded by MHCLG (now known as DLUHC) to OCC for delivery of the duties under the Act. Further grants have been awarded to Tier 2 local authorities.
15. The funding allocation should be used to support the implementation of the statutory duties, as defined in the guidance. The publication of the guidance has provided clarity on the scope of activities that can be funded. A subgroup of the Tier 1 and Tier 2 local authorities are working to agree how the funding will be spent.

Legal Implications

16. There are statutory duties in Part 4 of the Domestic Abuse Act 2021, for Tier 1 Local Authorities[1]. These have been summarised earlier in this report.

Staff Implications

17. The Public Health team have provided resource to lead the Domestic Abuse work on behalf of OCC. In addition, further resource has been funded from the MHCLG grant, working on the requirements of the Domestic Abuse Act. The Domestic Abuse Strategic Board is a partnership, attended by partners across the system, who also provide resource to this work.

Equality & Inclusion Implications

18. The Act states there should be dedicated provision of specialist support for people with protected characteristics, or needs in drug and alcohol, mental health, physical health, interpreting, and specialist counselling. This will be reflected in the Safe Accommodation strategy and overarching Domestic Abuse strategy.

Sustainability Implications

19. No sustainability implications arise from this paper

Risk Management

Risk	Action
Data: The safe accommodation needs assessment highlighted the difficulty in collecting data which helps to identify specific need.	The Safe Accommodation Working Group, will be tasked with identifying and addressing this challenge.
Delivery: Following publication of the guidance, providing clear scope for use of the MHCLG funding, there is a very short timeframe to allocate and spend the funding.	Further discussions are being held to allocate funding from Tier 1 to Tier 2. Short timeframe flagged with MHCLG, and clarity requested on future funding plans.

Consultations

20. The consultation for the draft Safe Accommodation Strategy closed on 24th November 2021[2]. Feedback is currently being reviewed, and will inform the final strategy.
21. A consultation on the draft overarching Domestic Abuse Strategy will be undertaken during February 2022, and feedback from this consultation will be fed into the final strategy

Ansaf Azhar, Director of Public Health

Contact Officer: Kate Holburn, kate.holburn@oxfordshire.gov.uk **07825 052768**
November 2021

Divisions Affected -

Oxfordshire Health & Wellbeing Board
16 December 2021

Oxfordshire Better Care Fund Plan 2021/22

Report by Corporate Director of Adults and Housing Services

RECOMMENDATION

1. **The Health & Wellbeing Board is RECOMMENDED to**
   (a) Approve the Oxfordshire Better Care Fund Plan for 2021/22
   (b) Approve the planned investment and schemes designed to deliver the metrics within the Plan
   (c) Approve the proposed trajectories for the metrics as set out in the Plan

Executive Summary

2. The national conditions for the Better Care Fund in 2021/22 are:
   (a) a jointly agreed plan between local health and social care commissioners, signed off by the Health & Wellbeing Board
   (b) NHS contribution to adult social care to be maintained in line with the uplift to CCG minimum contribution
   (c) invest in NHS-commissioned out-of-hospital services
   (d) a plan for improving outcomes for people being discharged from hospital
3. The Better Care Fund planning round for 2021/22 commenced on 30 September for submission 16 November. Given the brevity of the planning and submission cycle for 2021/22 the national conditions allow for the plan to be submitted by the deadline and ratified at the next available meeting of the Health & Wellbeing Board.
4. The Oxfordshire Better Care Fund plan meets the national conditions and reflects those strategic plans that have been agreed by the County Council, Clinical Commissioning Group, and system partners.
5. The Oxfordshire Better Care Fund plan meets and exceeds the minimum investment criteria
6. The Better Care Fund is intended to support integration and our plan provides evidence of that both in respect of commissioning and operations. The Fund is designed to deliver improved performance against several metrics and these trajectories for these have been considered by Urgent Care Delivery Group and the Joint Commissioning Executive and are recommended here to Health & Wellbeing Board for approval.

Better Care Fund planning guidance 2021/22

7. The Better Care Fund planning guidance was published on 30 September 2021 https://www.england.nhs.uk/publication/better-care-fund-planning-requirements-2021-22/ .
8. The Better Care Fund [BCF] is designed to support integration of commissioning and operational delivery and specifically to support the management of demand in the urgent and emergency care system across health and social care. Plans for 2021/22 need to
   (a) Be agreed by CCGs and local authorities and be signed off by Health & Wellbeing Boards
   (b) Demonstrate how Better Care Fund funding streams will be spent to meet the planning requirements. The Better Care Fund consists of
      (1) The CCG mandatory minimum contribution (set nationally by area) which has increased by 5.3% in 2021/22 (equivalent to £1.3m in Oxfordshire)
      (2) The improved Better Care Fund (which includes the provision for Winter plans of £1.2m)
      (3) The Disabled Facilities Grant which is distributed to district council housing teams
   (c) Reflect local health and social care plans and priorities
   (d) Set "stretching targets" for the BCF metrics (see para 17ff below)
9. The guidance that has been issued from NHSEI re the scope and emphasis of the plan has emphasised that the plans need to be aligned to and support delivery of local winter/surge plans and that also they should support recovery from the pandemic.

Oxfordshire Better Care plan 2021/22

10. The Better Care Fund Plan as submitted to NHS England is attached at Appendix A (main submission) and Appendix B (narrative). The main submission sets out
   (a) The income within the Plan
   (b) The expenditure on specific schemes funded through the Plan
   (c) The proposed trajectories for the metrics required for the Plan
   (d) Confirmation that we have met the national planning requirements
11. The narrative plan highlights the progress Oxfordshire has made and its future plans in respect of the key requirements in the Planning Guidance:
   (a) Prevention and enablement: supporting people in their own community to manage their own needs through information and advice, strengths-based approaches and innovation
   (b) Avoidance: where people are at risk of increased ill-health and loss of independence, Home First approaches and services that will help them remain safely at home and avoid either unnecessary conveyance for assessment, or admission to hospital or escalation to long-term care
   (c) Home First approaches to supporting discharge from acute hospital settings through an improved and extended intervention to support people get safely back home where their short and long terms needs

can be assessed, and personalised plans developed for recovery and/or care

(d) A comprehensive model of assessment, and rehabilitation and reablement where people need to go home from hospital via a step-down bed in community hospital or nursing home.

(e) Support for the provider market at times of great pressure around workforce and increased costs

(f) Surge planning for winter and other risks

12. The Plan builds on the redesign and integration of commissioning across the County Council and CCG in 2020/21 and is aligned to other key strategic initiatives such as the *Oxfordshire Way*; *Home First* and the *Live Well at Home* reablement and domiciliary care model; and the development of the *Community Services Strategy*

13. **Health & Wellbeing Board is asked to approve the Oxfordshire Better Care Fund Plan for 2021/22.**

Investment in Better Care Fund 2021/22

14. The Plan as submitted meets the requirements of the Planning Guidance:

Funding stream	**Investment 2021/22 £**
Disabled Facilities Grant	6,658,544
Improved Better Care Fund	10,390,597
CCG minimum contribution	44,195,030
CCG additional contribution	8,414,380
Total	**69,658,551**

15. The investment in schemes is set out in the template submission at tab 5a. There are 31 schemes designed to deliver the priorities set out at para 11 above.

16. **Health & Wellbeing Board is asked to approve the investment plan for Oxfordshire Better Care Fund Plan for 2021/22.**

Trajectories against the national Better Care Fund metrics

17. The metrics in the Better Care Fund have been changed to reflect the move away from *Delayed transfers of care* to a focus on long length of hospital stay (whether or not due to delay) and to the requirements of the NHS Hospital Discharge Policy to ensure that 95% of all people admitted to hospital are discharged home with or without support. There are 5 metrics, and our proposed targets are set out in para 18-24

18. **BCF metric 8.1**. The plan sets out a range of *preventative* and *avoidance* measures which will increase our capacity to manage the risk of non-elective admissions to hospital. The 2019/20 baseline for non-elective admissions was low owing to the impact of the pandemic response. There was a steep increase in Q1 2021/22, and these pressures have continued. **In view of this we have set a target to reduce by 5% from the 2018/19 performance and achieve a rate of no more than 705 unplanned admissions per 100,000 population over the year.**

19. **BCF metric 8.2.** Oxfordshire Accident & Emergency Delivery Board manages progress towards the acute hospital metric that no more than 12% of open

acute beds should be occupied by people with length of stay >21 days. This target represents a reduction from the March 21 baseline from 14%.

20. The BCF metric is not one that has been monitored before and the average length of stay approach needs to be understood in terms of its sensitivity to the measures that we have outlined here in terms of avoidance and supporting safe discharge.

21. We therefore propose a reduction to the BCF metric baseline in the same proportion to the reduction that is required for the acute measure (i.e by 2/14 or 14% by end of Q4 2021/22. We will develop monitoring approaches that support our understanding of progress, barriers and opportunities in delivery of this metric.

	March 21	June 21	Sep 21	Dec 21	Mar 22
Proportion of patients resident in acute beds 14 days or more	8.6%	8.8%	8.4%	**8.0%**	**7.4%**
Proportion of patients resident in acute beds 21 days or more	3.9%	4.2%	3.8%	**3.7%**	**3.4%**

22. **BCF metric 8.3.** The current proportion of people discharged home from acute hospital stay in Oxfordshire is 91% with a further 7.2% going into pathway 2 step down beds in the community; however, if we break that down into people aged over 65 the proportion is 88% going home and 10% going into pathway 2. Within the Plan we have funded increased reablement capacity which will positively impact these numbers. Oxfordshire retains a large bed base and so anticipate that we will not achieve the 95% national expectation in 2021/22. **We therefore plan to achieve 93% of people admitted to hospital returning directly home on discharge in 2021/22**.

23. **BCF metric 8.4.** Permanent council-funded residential admissions to nursing homes are driven both from the community and as part of hospital discharge. We are continuing to work with housing provider partners to develop Extra Care Housing and have designed a new care approach into those flats as part of Live Well at Home. We will continue to drive our Home First approach for discharge and exploring all alternatives to permanent admission (eg in our community equipment and assistive technology schemes). We are therefore looking to fund no more than 11 permanent admissions to care homes per week. **We plan for 429 admissions in 2021/22 per 100k of population over the age of 65**.

24. **BCF metric 8.5.** The impact of reablement on longer-term care needs is set out above and with the Home First and strengths-based prevention work we anticipate that this will mean a **recovery in the numbers of people still at home 90 days after reablement episode to 77%**.

25. **Health & Wellbeing Board is asked to approve the trajectories for the Better Care Fund metrics for 2021/22.**

Governance, assurance and engagement for Better Care Fund Plan

26. The development of the BCF plan has been led by officers from the Oxfordshire CCG and Oxfordshire County Council integrated commissioning team and has been approved for submission on behalf of the Health & Wellbeing Board by the Oxfordshire Joint Commissioning Executive. The Accountable Officer for Oxfordshire Clinical Group has agreed the plan as submitted.
27. The detail of the winter planning initiatives in the improved Better Care Fund for 2021/22 has been developed by the Oxfordshire Urgent Care Delivery Group delegated from the AEDB. The Group is led by Oxford University Hospitals NHS FT and comprises Oxfordshire County Council and CCG, Oxford Health NHS FT, South Central Ambulance Service, Age UK Oxfordshire, Principle Medical Limited and so covers acute and community health, primary care, social care and the voluntary and community sector. Urgent Community Delivery Group has also reviewed this submission and provided comments prior to Joint Commissioning Executive sign off.
28. The Better Care Fund plan builds out from a range of existing system wide plans and initiatives which have been developed through different levels of system working.
29. The target metrics in the plan have been reviewed by Urgent Care Delivery Group and recommended to the Joint Commissioning Executive and Oxfordshire Accident & Emergency Delivery Board.
30. The Disabled Facilities Grant narrative builds on the discussions held between District Councils and Oxfordshire County Council's therapy lead and integrated housing occupational therapists.

Financial Implications

31. The investment in the Better Care Fund is made up of agreed budgets contributed to the s75 NHS Act 2006 pooled commissioning budget by the County Council and Oxfordshire Clinical Commissioning Group. The spending plan have been agreed by the County Council and the CCG in the Joint Commissioning Executive. The winter funding element is agreed by the Corporate Director for Adult Services and the Chief Nurse Oxford University Hospitals NHS FT delegated from the Joint Commissioning Executive.

    Comments checked by:

    Danny Doherty Finance Business Partner danny.doherty@oxfordshire.gov.uk

Equality & Inclusion Implications

32. We have completed an Equality and Climate Impact Assessment to support the Better Care Fund Plan and this will be reviewed in Q4 2021/22 especially in relation to an improved understanding of the impact of our performance on Better Care Fund metrics in relation to protected characteristics.
33. The Oxfordshire JSNA has identified both geographical populations (in parts of Banbury and Oxford) and areas of need where Oxfordshire performs worse

than baseline, especially in relation to younger people and older people, where prevalence of depression, loneliness and falls are above average and the dementia diagnosis rate is below.

34. These findings have informed the Better Care Fund Plan for 2021/22 with a range of specific schemes that are detailed in the template, and which include

(a) A new community paediatric care pathway funded through improved Better Care Fund that is designed to avoid unnecessary attendance and admission for vulnerable young people

(b) Increased mental health capacity in minor injury units

(c) New dementia and carer support services, and a focus on the falls' pathway

(d) The focus in the deployment of the Disabled Facilities Grant and Housing Improvement on supporting people with behaviours that challenge with emotionally sustainable building design which supports sensory needs

(e) A range of preventative services delivered in partnership with community services that we are seeking to target in areas of greatest need as defined by the JSNA

Stephen Chandler, Corporate Director of Adult Services

Annexes: A. Oxfordshire HWB FINAL BCF 2021-22 Planning Template
B. Oxfordshire HWB Better Care Fund Plan 2021-22 Narrative

Contact Officer: Ian Bottomley Lead Commissioner Age Well 07532 132975
ian.bottomley@oxfordshire.gov.uk

December 2021

Better Care Fund 2021-22 Template

2. Cover

HM Government

NHS

Version 1.0

Please Note:
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- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".
- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2021-22.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Oxfordshire
Completed by:	Ian Bottomley
E-mail:	ian.bottomley@oxfordshire.gov.uk
Contact number:	07532 132975

Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Corporate Director of Adult Services
Name:	Stephen Chandler

Has this plan been signed off by the HWB at the time of submission?	Delegated authority pending full HWB meeting
If no, or if sign-off is under delegated authority, please indicate when the HWB is expected to sign off the plan:	Thu 16/12/2021

<< Please enter using the format, DD/MM/YYYY
Please note that plans cannot be formally approved and Section 75 agreements cannot be finalised until a plan, signed off by the HWB has been submitted.

	Role:	Professional Title (where applicable)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Liz	Leffnan	liz.leffnan@oxfordshire.gov.uk
	Clinical Commissioning Group Accountable Officer (Lead)	Dr	James	Kent	jameskent99@nhs.net
	Additional Clinical Commissioning Group(s) Accountable Officers	Dr	James	Kent	jameskent99@nhs.net
	Local Authority Chief Executive		Yvonne	Rees	yvonne.rees@oxfordshire.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)		Stephen	Chandler	stephen.chandler@oxfordshire.gov.uk
	Better Care Fund Lead Official		Pippa	Corner	pippa.corner@oxfordshire.gov.uk
	LA Section 151 Officer		Lorna	Baxter	lorna.baxter@oxfordshire.gov.uk
Please add further area contacts that you would wish to be included in official correspondence -->					

**Only those identified will be addressed in official correspondence (such as approval letters). Please ensure all individuals are satisfied with the information entered above as this is exactly how they will appear in correspondence.*

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Template Completed

	Complete:
2. Cover	Yes
4. Income	Yes
5a. Expenditure	Yes
6. Metrics	Yes
7. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2021-22 Template

2. Cover

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NHS

Version 1.0

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- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2021-22.
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Health and Wellbeing Board:	Oxfordshire
Completed by:	Ian Bottomley
E-mail:	ian.bottomley@oxfordshire.gov.uk
Contact number:	07532 132975

Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Corporate Director of Adult Services
Name:	Stephen Chandler

Has this plan been signed off by the HWB at the time of submission?	Delegated authority pending full HWB meeting
If no, or if sign-off is under delegated authority, please indicate when the HWB is expected to sign off the plan:	Thu 16/12/2021

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Please note that plans cannot be formally approved and Section 75 agreements cannot be finalised until a plan, signed off by the HWB has been submitted.

	Role:	Professional Title (where applicable)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Liz	Leffnan	liz.leffnan@oxfordshire.gov.uk
	Clinical Commissioning Group Accountable Officer (Lead)	Dr	James	Kent	jameskent99@nhs.net
	Additional Clinical Commissioning Group(s) Accountable Officers	Dr	James	Kent	jameskent99@nhs.net
	Local Authority Chief Executive		Yvonne	Rees	yvonne.rees@oxfordshire.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)		Stephen	Chandler	stephen.chandler@oxfordshire.gov.uk
	Better Care Fund Lead Official		Pippa	Corner	pippa.corner@oxfordshire.gov.uk
	LA Section 151 Officer		Lorna	Baxter	lorna.baxter@oxfordshire.gov.uk
Please add further area contacts that you would wish to be included in official correspondence -->					

**Only those identified will be addressed in official correspondence (such as approval letters). Please ensure all individuals are satisfied with the information entered above as this is exactly how they will appear in correspondence.*

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Template Completed

	Complete:
2. Cover	Yes
4. Income	Yes
5a. Expenditure	Yes
6. Metrics	Yes
7. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2021-22 Template

4. Income

Selected Health and Wellbeing Board: Oxfordshire

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Oxfordshire	£6,658,544
DFG breakerdown for two-tier areas only (where applicable)	
Cherwell	£1,239,940
Oxford	£1,421,433
South Oxfordshire	£1,550,448
Vale of White Horse	£1,638,973
West Oxfordshire	£807,750
Total Minimum LA Contribution (exc iBCF)	**£6,658,544**

iBCF Contribution	Contribution
Oxfordshire	£10,390,597
Total iBCF Contribution	**£10,390,597**

Are any additional LA Contributions being made in 2021-22? If yes, please detail below	No

Local Authority Additional Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional Local Authority Contribution	**£0**	

CCG Minimum Contribution	Contribution
NHS Buckinghamshire CCG	£568,603
NHS Oxfordshire CCG	£43,202,670
NHS Swindon CCG	£423,757
Total Minimum CCG Contribution	**£44,195,030**

Are any additional CCG Contributions being made in 2021-22? If yes, please detail below	Yes

Additional CCG Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
NHS Oxfordshire CCG	£8,414,380	OCCG investment in BCF
Total Additional CCG Contribution	**£8,414,380**	
Total CCG Contribution	**£52,609,410**	

	2021-22
Total BCF Pooled Budget	**£69,658,551**

Funding Contributions Comments Optional for any useful detail e.g. Carry over

Better Care Fund 2021-22 Template

5. Expenditure

Selected Health and Wellbeing Board: Oxfordshire

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£6,658,544	£6,658,544	£0
Minimum CCG Contribution	£44,195,030	£44,195,030	£0
iBCF	£10,390,597	£10,390,597	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£8,414,380	£8,414,380	£0
Total	**£69,658,551**	**£69,658,551**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum CCG Contribution (on row 31 above).

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£12,556,315	£28,603,530	£0
Adult Social Care services spend from the minimum CCG allocations	£27,750,478	£27,751,110	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Sheet complete

						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	Prevention: Disabled Facilities Grant	DFG for adaptations and for integrated housing OT capacity	DFG Related Schemes	Adaptations, including statutory DFG		Other	Community	LA			Local Authority	DFG	6658544	Existing
2	Prevention: Home Improvement Agency	Coordination of DFG and minor works	DFG Related Schemes	Discretionary use of DFG - including small adaptations		Social Care		LA			Local Authority	Minimum CCG Contribution	£711,000	Existing
3	Prevention: community equipment	Equipment to support people in own home	Assistive Technologies and Equipment	Community based equipment		Social Care		Joint	44.0%	56.0%	Private Sector	Minimum CCG Contribution	£5,176,000	Existing
4	Prevention: assistive technology	Telecare and other devices to support people independence	Assistive Technologies and Equipment	Telecare		Social Care		LA			Private Sector	Minimum CCG Contribution	£400,000	Existing
5	Prevention: innovation grants	Grants pot to support local VCSE and micro providers in community	Community Based Schemes	Other	VCSE schemes that support community	Other	Community organizations	LA			Charity / Voluntary Sector	iBCF	£250,000	Existing
6	Prevention: community capacity	Community catalyst-enabling provision in people's own homes	Community Based Schemes	Other	Community support as alternatives to	Other	Microproviders	LA			Private Sector	iBCF	£250,000	Existing
7	Prevention: Support for Carers	Advice, information practical support includng grants	Carers Services	Other	Advice, support and grants	Social Care		Joint	36.0%	64.0%	Charity / Voluntary Sector	Minimum CCG Contribution	£1,165,710	New

8	Prevention: falls prevention	assessment and support for people at risk of falls	Community Based Schemes	Other	Assessment and s	Community Health		CCG			NHS Community Provider	Additional CCG Contribution	£391,000	Existing
9	Prevention: Generation Games	Strenght and posture support from exercise and balance classes	Community Based Schemes	Other	Exercise and balar	Social Care		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£200,000	Existing
10	Prevention: Live Well Oxfordshire	Advice and information to support personal resilience	Prevention / Early Intervention	Other	Personalised information and advice	Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£1,130,000	Existing
11	Prevention: proactive dementia services	advice, memory assessment, support inc for carers	Prevention / Early Intervention	Other	dementia support and advice	Social Care		Joint	29.0%	71.0%	Charity / Voluntary Sector	Minimum CCG Contribution	£622,020	New
12	Avoidance: front door advice	24/7 advice to prevent escalation	Care Act Implementation Related Duties	Other	Assessment and advice for people in crisis	Social Care		LA			Local Authority	Minimum CCG Contribution	£1,071,300	Existing
13	Avoidance: urgent response	Same day urgent dom care to avoid escalation and/or hospital	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Local Authority	Minimum CCG Contribution	£1,232,000	Existing
14	Avoidance: Community SDEC and support at	Walk-in and step up community capacity and hospital at home	Community Based Schemes	Other	Ambulatory assessment	Community Health		CCG			NHS Community Provider	Additional CCG Contribution	£2,292,300	Existing
15	Avoidance: extended consultant	Extended hours consultant line (to 0200)	High Impact Change Model for Managing	Other	Consultant advice service	Acute		CCG			NHS Acute Provider	iBCF	£117,597	New
16	Avoidance: extended front door	Increased therapy and pharmacy support to ED and ambulatory settings	High Impact Change Model for Managing	Early Discharge Planning		Acute		CCG			NHS Acute Provider	iBCF	£290,000	New
17	Avoidance: MH support to UTC	Outreach from ED Psychological services	Other		Mental health support to ambulatory	Community Health		CCG			NHS Community Provider	iBCF	£108,000	Existing
18	Avoidance: CYP ambulatory pathway	Community paediatric pathway to avoid conveyance/admission	Prevention / Early Intervention	Other	Community paediatric pathway	Community Health		LA			NHS Community Provider	iBCF	£143,000	New
19	Avoidance: enhanced support to care homes	Extended local services to enhance the national EHCH DES avoiding	High Impact Change Model for Managing	Improved discharge to Care Homes		Community Health		LA			NHS Community Provider	Additional CCG Contribution	£1,400,000	Existing
20	Avoidance: short stay step up beds	Respite and other alternatives to admission	Bed based intermediate Care Services	Other	Respite and escalation beds for social	Social Care		CCG			Private Sector	Minimum CCG Contribution	£3,004,000	Existing
21	Pathway 0/1: Trusted assessor	Trusted assessor servcie to improve timeliness of return to long term dom	High Impact Change Model for Managing	Trusted Assessment		Social Care		LA			Private Sector	Minimum CCG Contribution	£110,000	New
22	Pathway 0/1: settling in service	Patient transport to support people on return home	Other	Assessment teams/joint assessment	Transport	Community Health		LA			NHS Community Provider	iBCF	£20,000	New
23	Pathway 0/1: getting people home-VCSE	VCSE support to Home First MDT	Community Based Schemes	Low level support for simple hospital discharges		Other	VCSE support for discharge	LA			Charity / Voluntary Sector	iBCF	£512,000	Existing
24	Pathway 1: Home First MDT	MDT assessing and deployment reablement	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Social Care		LA			Local Authority	iBCF	£1,200,000	New
25	Pathway1: Live Well at Home reablement	Strategic reablement providers	Reablement in a persons own home	Reablement to support discharge - step down		Social Care		Joint	43.0%	57.0%	Private Sector	Minimum CCG Contribution	£3,443,880	New
26	Pathway 1: Home First MDT expansion	increased investment in HF MDT	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Social Care		LA			Local Authority	Minimum CCG Contribution	£116,000	New

27	Pathway 1: contingency home care	Additional dom care to support Home First flow	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	Minimum CCG Contribution	£434,000	Existing
28	Pathway 2: community hospital step	Community hospital step down beds (130)	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£16,443,920	Existing
29	Pathway 2: community hospital step	Community hospital step down beds (130)	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Community Health		CCG			NHS Community Provider	Additional CCG Contribution	£3,406,080	Existing
30	Pathway 2: step down nursing home beds	Nursing Home step down beds (97)	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		Joint	69.0%	31.0%	Private Sector	Minimum CCG Contribution	£4,754,000	Existing
31	Pathway 2: MDT supporting step down beds	Integrated discharge co-ordination and therapy into NH step down beds	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Other	Acute, community and social care team	CCG			NHS Acute Provider	Additional CCG Contribution	£925,000	Existing
32	Pathway 2- additional investment in step	Additional step down NH capacity	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		LA			Local Authority	iBCF	£360,000	Existing
33	Pathway1/2/3: social care discharge support	Support into long-term care and pathway 2 beds	High Impact Change Model for Managing	Improved discharge to Care Homes		Social Care		LA			Local Authority	Minimum CCG Contribution	£2,864,200	Existing
34	Surge capacity	Additional reablement and bed-based capacity through winter 21/22	Other		winter capacity	Social Care		CCG			Private Sector	Minimum CCG Contribution	£1,317,000	New
35	Market Capacity	Support for workforce and increased dom care capacity	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	iBCF	£2,740,000	Existing
36	Market Resilience	Fee uplifts to support dom care provision	Home Care or Domiciliary Care	Other	Fee uplifts	Social Care		LA			Private Sector	iBCF	£4,400,000	Existing

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Better Care Fund 2021-22 Template

6. Metrics

Selected Health and Wellbeing Board: Oxfordshire

8.1 Avoidable admissions

	19-20 Actual	20-21 Actual	21-22 Plan	Overview Narrative	
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	Available from NHS Digital (link below) at local authority level. Please use as guideline only	622.3	705.0	Current performance in 21/22 suggests a significant increase in pressure over 20/21 where NEL for ACS were suppressed by the pandemic. With the implementation of AW UCR and measures in our winter plan we expect to deliver 95% of the 2018/19 baseline	**Please set out the overall plan in the HWB area for reducing rates of unplanned hospitalisation for chronic ambulatory sensitive conditions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.**

>> link to NHS Digital webpage

8.2 Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan	Comments	
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SUS data - available on the Better Care Exchange)	Proportion of inpatients resident for 14 days or more	8.0%	7.4%	Oxfordshire AEDB manages progress towards the Oxford University Hospital metric of no more than 12% of open acute beds occupied by people with length of stay >21 days. This target represents a reduction from the March 21 baseline from 14%. The BCF metric is not one that has been monitored before and the average length of stay approach needs to be understood in terms of its sensitivity to the measures	**Please set out the overall plan in the HWB area for reducing the percentage of hospital inpatients with a long length of stay (14 days or over and 21 days and over) including a rationale for the ambitions that sets out how these have been reached in partnership with local hospital trusts, and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.**
	Proportion of inpatients resident for 21 days or more	3.7%	3.4%		

8.3 Discharge to normal place of residence

	21-22 Plan	Comments	
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	93.0%	The current proportion of people discharged home is 91% with 7.2% going into pathway 2 step down beds; however, if we break that down into people aged over 65 the proportion is 88% going home and 10% going into pathway 2. The increased reablement capacity funded as part of our surge plan will positively impact these	**Please set out the overall plan in the HWB area for improving the percentage of people who return to their normal place of residence on discharge from acute hospital, including a rationale for how the ambition was reached and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.**

8.4 Residential Admissions

		19-20 Plan	19-20 Actual	20-21 Actual	21-22 Plan	Comments
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	567	466	442	429	Residential admissions to nursing homes are driven both from the community and as part of hospital discharge. We are continuing to work with housing provider partners to develop Extra Care Housing and have designed a new care approach into those flats as part of Live Well at Home. We will continue to drive our Home
	Numerator	724	597	576	570	
	Denominator	127,705	128,126	130,189	132,728	

Please set out the overall plan in the HWB area for reducing rates of admission to residential and nursing homes for people over the age of 65, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		19-20 Plan	19-20 Actual	21-22 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	85.0%	67.2%	77.0%	The impact of reablement on longer-term care needs is set out in the narrative and with the Home First and strengths-based prevention work we anticipate that this will mean a recovery in the numbers of people still at home 90 days after reablement episode to 77%
	Numerator	1,700	184	308	
	Denominator	2,000	274	400	

Please set out the overall plan in the HWB area for increasing the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Please note that due to the splitting of Northamptonshire, information from previous years will not reflect the present geographies. As such, all pre-populated figures above for Northamptonshire have been combined.

For North Northamptonshire HWB and West Northamptonshire HWB, please comment on individual HWBs rather than Northamptonshire as a whole.

Better Care Fund 2021-22 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Oxfordshire

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between CCG(s) and LA; been submitted? Has the HWB approved the plan/delegated approval pending its next meeting? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned?	Cover sheet Cover sheet Narrative plan Validation of submitted plans	Yes	See BCF narrative template		
	PR2	**A clear narrative for the integration of health and social care**	**Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes:** • How the area will continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally. • The approach to collaborative commissioning • The overarching approach to support people to remain independent at home, and how BCF funding will be used to support this. • How the plan will contribute to reducing health inequalities and inequalities for people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered, - Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the BCF plan will address these	Narrative plan assurance	Yes	See BCF narrative template		
	PR3	**A strategic, joined up plan for DFG spending**	**Is there confirmation that use of DFG has been agreed with housing authorities?** • Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home? • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory Disabled Facilities Grants? or - The funding been passed in its entirety to district councils?	Narrative plan Confirmation sheet	Yes	See BCF narrative template		
NC2: Social Care Maintenance	**PR4**	**A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the CCG minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC3: NHS commissioned Out of Hospital Services	**PR5**	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?**	Does the total spend from the CCG minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC4: Plan for improving outcomes for people being discharged from hospital	**PR6**	**Is there an agreed approach to support safe and timely discharge from hospital and continuing to embed a home first approach?**	• Does the BCF plan demonstrate an agreed approach to commissioning services to support discharge and home first including: - support for safe and timely discharge, and - implementation of home first? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? • Is there confirmation that plans for discharge have been developed and agreed with Hospital Trusts?	Narrative plan assurance Expenditure tab Narrative plan	Yes	See BCF narrative template		

Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	• Do expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) • Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (see paragraphs 32 – 43 of Planning Requirements) (tick-box) • Has funding for the following from the CCG contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Expenditure tab Expenditure plans and confirmation sheet Narrative plans and confirmation sheet	Yes	See BCF narrative template		
Metrics	**PR8**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	• Have stretching metrics been agreed locally for all BCF metrics? • Is there a clear narrative for each metric describing the approach locally to meeting the ambition set for that metric, including how BCF expenditure will support performance against each metric? • Are ambitions across hospital trusts and HWBs for reducing the proportion of inpatients that have been in hospital for 21 days aligned, and is this set out in the rationale? • Have hospital trusts and HWBs developed and agreed plans jointly for reducing the proportion of inpatients that have been in hospital for 14 days or more and 21 days or more?	Metrics tab	Yes	See BCF narrative template		

Oxfordshire Better Care Fund Plan 2021/22

Health & Wellbeing Board: Oxfordshire

Introduction

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, district councils)

How have you gone about involving these stakeholders?

The development of the BCF plan has been led by officers from the Oxfordshire CCG and Oxfordshire County Council integrated commissioning team and has been approved on behalf of the Health & Wellbeing Board by the Oxfordshire Joint Commissioning Executive.

The detail of the winter planning initiatives in the iBCF for 2021/22 has been developed by the Oxfordshire Urgent Care Delivery Group delegated from the AEDB. The Group is led by Oxford University Hospitals NHS FT and comprises Oxfordshire County Council and CCG, Oxford Health NHS FT, South Central Ambulance Service, Age UK Oxfordshire, Principle Medical Limited and so covers acute and community health, primary care, social care and the voluntary and community sector. Urgent Community Delivery Group has also reviewed this submission and provided comments prior to Joint Commissioning Executive sign off.

The Better Care Fund plan builds out from a range of existing system wide plans and initiatives that are detailed in the Executive Summary below and which have been developed through different levels of system working.

The target metrics in the plan have been reviewed by Urgent Care Delivery Group and recommended to the Joint Commissioning Executive and AEDB.

The Disabled Facilities Grant narrative builds on the discussions held between District Councils and Oxfordshire County Council's therapy lead and integrated housing occupational therapists.

The Plan will be reviewed and signed off by the Oxfordshire Health & Wellbeing Board at its meeting on 16 December 2021

Executive Summary: Oxfordshire's key priorities for 2021/22

This plan brings together a number of strategic and operational initiatives to deliver

- A reduction in the number of unnecessary conveyances and admissions to hospital
- A reduction in long length of stay in acute hospital settings
- An increase in the proportion of people discharged to their own home after an acute hospital stay
- A reduction in the rate of permanent admission to long-term residential care

- An increase in the number of people who are still in their home after a period of reablement

We will deliver these outcomes via the the following improved objectives which frame the initiatives in our Better Care Fund Plan:

- Prevention and enablement: supporting people in their own community to manage their own needs through information and advice, strengths-based approaches and innovation
- Avoidance: where people are at risk of increased ill-health and loss of independence, Home First approaches and services that will help them remain safely at home and avoid either unnecessary conveyance for assessment, or admission to hospital or escalation to long-term care
- Home First approaches to supporting discharge from acute hospital settings through an improved and extended intervention to support people get safely back home where their short and long terms needs can be assessed and personalised plans developed for recovery and/or care
- A comprehensive model of assessment, and rehabilitation and reablement where people need to go home from hospital via a step-down bed in community hospital or nursing home. We are reviewing this pathway during 2021/22 to increase the number of people able to go directly home from hospital
- Support for the provider market at times of great pressure around workforce and cost
- Surge planning for winter and other risks

The key initiatives that will deliver these objectives are

- Implementation of Home First to support preventative services in the community and discharge to assess approaches to help people home from hospital via Pathway 0 and 1 as set out in Hospital Discharge Policy
- Implementation of Ageing Well Urgent Community Response to deliver a 7-day 2 hour and 2 day response to people at risk of conveyance and/or admission to hospital in the community or from ED
- An Integrated Care Improvement Plan developed by the Urgent Care Delivery Group on behalf of AEDB to assure delivery of the national UEC agenda
- Development of a Community Services Strategy that addresses
    - Those health inequalities identified in the Director of Public Health's JSNA
    - Prevention-building on learning from the Oxfordshire covid response and the Adult Social Care *Oxfordshire Way* re strengths-based approaches to increase resilience amongst our residents and communities
    - Alignment of community health services to the NHS Long-Term Plan in relation especially in relation to Anticipatory Care Planning, use of digital and estates to support planned personalised care around the needs of the individual
    - a review of community step down beds to improve the flow out of acute hospital via Pathway 2 of the Hospital Discharge Policy for implementation of a new model in 2022/23

- Development of Joint Commissioning Priorities
    - An emotional, mental health and wellbeing strategy for children and younger people
    - An Early Help Strategy and integrated therapies app model for young people
    - A Learning Disability and Autism Plan focussed on prevention, quality and the Provider Market relationship and designed to deliver the national strategy
    - The Community Services Strategy (above)
    - Building back and on from the pandemic response to assure quality and to develop our provider market relationship
- Development of our s75 NHS Act 2006 pooled budget agreement to deliver our integrated commissioning approach in an expanded pool from April 22 and to commission for outcomes that reflect a life course and tiers of need approach to supporting our population. This agreement will incorporate the Better Care Fund pooled budget from April 2022 and will enable a refresh of the specific plans and alignments necessary to deliver further integration of prevention, assessment and care from 2022/23. The agreement will also map our place-based approach to integrated commissioning with the ICS, and support opportunities to manage demand across the ICS footprint when that is the most appropriate way forward.

Better Care Fund Metrics 2021/22

BCF metric 8.1. Taken together we believe that the range of *preventative* and *avoidance* measures set out at pages 7-9 below will increase our capacity to manage the risk of non-elective admissions to hospital. Further we anticipate that the roll out of Ageing Well Urgent Community Response from October 2021 will increase this resilience with the 2HH and 2DD response delivered 0800-2000 7 days a week. The 2019/20 baseline for NEL was artificially low owing to the impact of the pandemic response. There was a steep increase in Q1 2021/22, and these pressures have continued. In view of this we have set a target to reduce by 5% from the 2018/19 performance.

BCF metric 8.2. Oxfordshire AEDB manages progress towards the Oxford University Hospital metric of no more than 12% of open acute beds occupied by people with length of stay >21 days. This target represents a reduction from the March 21 baseline from 14%.

The BCF metric is not one that has been monitored before and the average length of stay approach needs to be understood in terms of its sensitivity to the measures that we have outlined here in terms of avoidance and supporting safe discharge. We also note that this planned reduction is on the face of it deeper than the acute trust metric and we do not have any information on how the 2 metrics relate to each other.

We therefore propose a reduction to the BCF metric baseline in the same proportion to the reduction that is required for the acute measure (i.e by 2/14 or 14% by end of Q4 2021/22. We will develop monitoring approaches that support our understanding of progress, barriers and opportunities in delivery of this metric.

BCF metric 8.3. The current proportion of people discharged home is 91% with 7.2% going into pathway 2 step down beds; however, if we break that down into people aged over 65 the proportion is 88% going home and 10% going into pathway 2. The increased reablement capacity funded as part of our surge plan will positively impact these numbers, together with the impact of avoidance (well over 95% of all patients in step down beds were non-elective admissions to acute settings). However, we retain a large bed base and so anticipate that we will not achieve the 95% national expectation in 2021/22. **We therefore plan to achieve 93% in 2021/22**.

BCF metric 8.4. Residential admissions to nursing homes are driven both from the community and as part of hospital discharge. We are continuing to work with housing provider partners to develop Extra Care Housing and have designed a new care approach into those flats as part of Live Well at Home. We will continue to drive our Home First approach for discharge and exploring all alternatives to permanent admission (eg in our community equipment and assistive technology schemes). We are therefore looking to fund no more than 11 permanent admissions to care homes per week. **We plan for 429 admissions in 2021/22 per 100k of population over the age of 65**.

BCF metric 8.5. The impact of reablement on longer-term care needs is set out above and with the Home First and strengths-based prevention work we anticipate that this will mean a **recovery in the numbers of people still at home 90 days after reablement episode to 77%**.

Key changes since 2019/20 Plan

Oxfordshire used the impact of the covid pandemic to develop a range of responses that improved prevention, avoidance, integrated infrastructure and system flow. These were developed directly out of our experience of system escalation with senior strategic leadership, and of mobilising a wider range of community and other services to manage the needs of our population. These initiatives have been implemented as business as usual and form a large part of our Better Care Plan:

- Oxfordshire has implemented an integrated commissioning team across Health, Social Care (children and adults) and Public Health. This went live on March 1 2021
- Oxfordshire has developed a new Home First MDT to support discharge home from hospital and management of people at risk in the community. The new team went live on 1 October 2021
- The Home First MDT is working in partnership with new strategic providers of reablement and domiciliary care commissioned by the County Council and CCG under Live Well at Home contracts. Live Well at Home also went live on 1 October 2021
- The Live Well at Home model also includes a new approach to supporting people in Extra Care Housing with a zonal domiciliary care model where contracts will expand over time to pick up new schemes that open in the geography

- Oxfordshire has begun delivery of the Ageing Well Urgent Community Response from 1 October 2021. This programme is funded externally to BCF but we are working to align the interface between Home First and Ageing Well
- Oxfordshire has commissioned new integrated Dementia and Carers services from April 2021. Delivered by partnerships in the voluntary and community sector these services extend advice, information and personalised support to our population
- Adult Social Care has introduced a Transformation Programme called *The Oxfordshire Way* in 2021 to develop strengths-based approaches to assessing and planning support for people in the community within adult social care teams. This template is being used to develop the prevention approach within the Community Services Strategy
- Oxfordshire is refreshing our relationships with the independent provider market to reflect the challenges that they have experienced during the pandemic. We are seeking to move to a more strategic relationship with key providers (evidenced in our new Live Well at Home contracts) and to support them through an improved Trusted Assessor and other initiatives, such as support to Care Homes at an Enhanced level beyond the national Ageing Well Direct Enhanced Service

Governance

The Oxfordshire Health and Well-Being Board has overall responsibility for the Better Care Fund Plan and will review the plan at its meeting in December 2021. The Board is familiar with several elements of the Plan and has endorsed the new Community Services Strategy.

Commissioning oversight of the Plan and pooled budgets in the s75 NHS Act 2006 is delegated to the Joint Commissioning Executive. The Deputy Director, Commissioning is the Pooled Budget Manager for the s75 (including the Better Care Fund) and reports to the Joint Commissioning Executive.

The Home First model has been developed and its implementation is assured on behalf of the system by the Home First Strategic Group. This group reports into both AEDB (for operational performance and impact) and to the Joint Commissioning Executive (for assurance for spend).

The specific surge/winter planning elements to the plan funded from the iBCF by the Joint Commissioning Executive are delegated to the Director of Adult Services, Oxfordshire County Council and the Chief Nurse, Oxford University Hospitals NHS FT. These have been developed by the Urgent Care Delivery Group reporting to AEDB.

Plans in respect of the Disabled Facilities Grant are developed by the County Housing Forum, a joint meeting of District Council leads and the Lead Occupational Therapist Oxfordshire County Council and the integrated housing OTs and lead commissioners.

In 2021/22 Oxfordshire has developed and initiated a range of projects and programmes at the same time as we are developing new structures at Place and ICS

level in line with the developing NHS ambition. During the remainder of this year these structures will be formed and we will identify the best place to locate the development of our future Better Care Fund plans.

Overall approach to integration

In 2021-22 health, social care and public health commissioning has been brought together in one integrated joint commissioning team hosted by the County Council. Headed by a new Deputy Director post reporting to Directors of Adults, Children and Public Health in the County Council and the Deputy CEO for the CCG, there are 17 joint funded posts commissioning support and outcomes across a life stage (start, live, age well) and tiers of need (prevent, enable, support and protect) approach. This team deploys the budgets in Oxfordshire's s75 NHS Act 2006 pooled budget (value £300m) including the Better Care Fund. The pooled budget arrangements are being developed in a new s75 to be effective from April 22 which will increase the impact of these pooled funds by improved alignments/elimination of silos derived from the preventative, enabling and outcomes-focussed ambition in the integrated model. Commissioning of services deployed within the Better Care Fund is now fully integrated across health and social care.

The overall approach set out in this plan covers the following domains

- Prevention and enablement: supporting people in their own community to manage their own needs through information and advice, strengths-based approaches and innovation
- Avoidance: where people are at risk of increased ill-health and loss of independence, Home First approaches and services that will help them remain safely at home and avoid either unnecessary conveyance for assessment, or admission to hospital or escalation to long-term care
- Home First approaches to supporting discharge from acute hospital settings through an improved and extended intervention to support people get safely back home where their short and long terms needs can be assessed and personalised plans developed for recovery and/or care
- A comprehensive model of assessment, and rehabilitation and reablement where people need to go home from hospital via a step-down bed in community hospital or nursing home. We are reviewing this pathway during 2021/22 to increase the number of people able to go directly home from hospital
- Support for the provider market at times of great pressure around workforce and cost
- Surge planning for winter and other risks

These schemes are delivered across the minimum CCG contribution, iBCF and in externally funded schemes as set out below. The plan covers both existing and 2021/22 new schemes.

Prevention
Housing and adaptations: see below.

In 2021 Adult Social Care has introduced a Transformation Programme called *The Oxfordshire Way* to develop strengths-based approaches to assessing and planning support for people in the community within adult social care teams. Working with Age UK Oxfordshire and Active Oxfordshire this has sought to identify different, more enabling and personalised ways of supporting people in their own homes, both increasing independence and wellbeing and reducing the need for formal care.

This initiative currently is resourced outside of the BCF but much of the resources available to it are funded from the BCF: Live Well Oxfordshire, an information, advice and on-line self-help resource for people and agencies; Community Catalysts, a series of micro-providers who can provide targeted and personalised support within someone's own community; and a range of innovation grants to local community groups to support prevention and resilience. These services also work closely with primary care social prescribing and District Council advice and information hubs. This template is being used to develop the prevention approach within the Community Services Strategy which seeks to build on the mobilised community response which we mobilised to support people during the pandemic lockdown. Oxfordshire also invests BCF funding in our joint health and social care equipment budget to support people in their own home and in telecare and assistive technology to develop new ways of supporting people to live independently and without restriction.

In April 2021 we launched an integrated health and social care new service funded by BCF for Carers which brings together advice, information, practical support and a grants programme administered by the voluntary sector partnership that is delivering this.

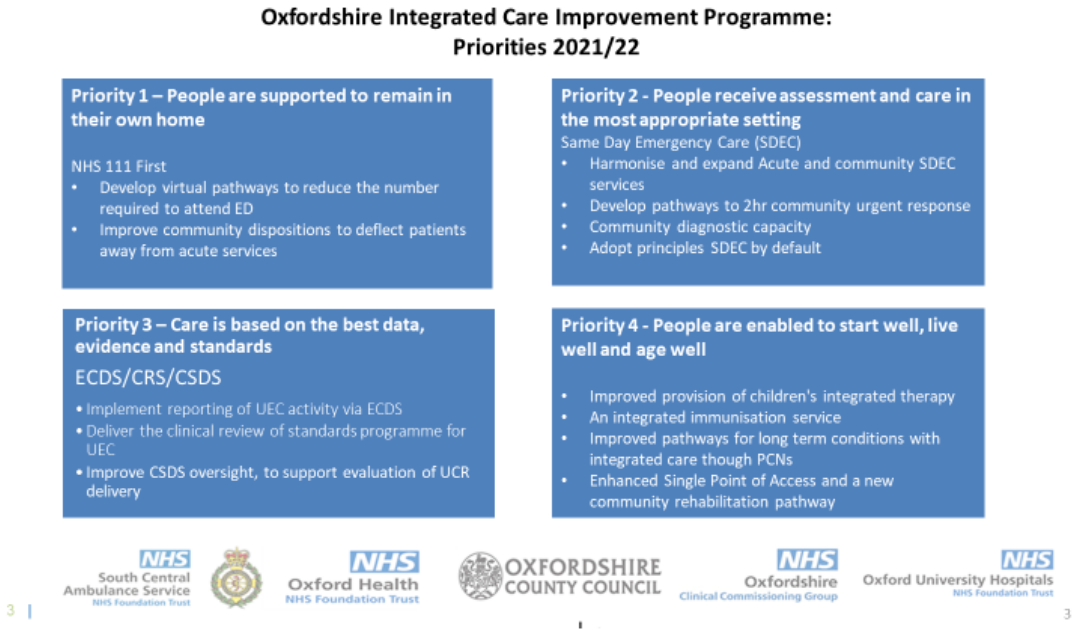
In April 2021 we also launched an integrated advice, information and support service Dementia Oxfordshire again delivered by a voluntary sector partnership. The service works closely with primary care

Finally, the prevention programme includes our local falls service delivered by Oxford Health which works closely with Generation Games (Age UK Oxfordshire | Generation Games), another Age UK initiative that offers strength and balance classes (now on-line as well as in person) to help people reduce the risk of falls. Parts of Oxfordshire are significant outliers in terms of admissions to hospital due to falls and this will form one of the key work streams in developing Community Services Strategy.

Taken together with initiatives under Home First (next section) our preventative approach underpins our approach to BCF metrics 8.3, 8.4 and 8.5.

Avoidance
In this domain the BCF plan is aligned to two key system plans and together these are working to reduce the number of non-elective admissions (BCF metric 8.1):

The Oxfordshire Integrated Care Improvement Programme



This is led by Oxford University Hospitals NHS FT via the Urgent Care Delivery Group reporting to AEDB. It is designed to implement the national UEC standards in Oxfordshire. It is built around Home First and preventative approaches to create alternatives to conveyance and/or admission to hospital. It includes-in Priority 4-a pilot to develop a PCN based approach to anticipatory care planning which integrate primary, community and acute health physicians with support from social care and the voluntary sector to avoid unnecessary exacerbations.

The second key system initiative is *Ageing Well Urgent Community Response.* As part of the BOB ICS accelerator site Oxford Health NHS FT is leading on the implementation of an extended single point of access and a 2-hour and 2-day response to people at home or in ED. This provides assessment and intervention from 0800-2000 7 days a week from October 2021. We are working on the interface between this service and Home First and a BCF funded social worker from the hospital team will work into the new service through to March 22 to support this and implementation.

The Urgent Care Delivery Group has developed a number of related schemes for 2021/22. that will support hospital avoidance and which are funded from the iBCF. The plan is that if these are evaluated as being successful that we will move to make them business as usual and identify a funding stream to support that:

- Extended consultant support and advice to 0200 am to paramedics and other clinicians to support decisions on conveyance
- Extended support into front door of ED and acute ambulatory settings: an expansion of the front door therapy team to work with people in assessment and link with Ageing Well Urgent Community Response and Home First teams to create safe plans to transfer home; and an expansion of medicines capability to support timely turnaround and discharge

- Expansion of the Emergency Department Psychology Service into minor injuries units
- Development of a community-based paediatric response linked to acute clinicians to enable children and their parents to be safely supported at home

These initiatives will work with existing health and social care front door assessment and intervention services delivered under BCF: the Oxford Health Emergency Multidisciplinary and Rapid Assessment and Care Units at sites around the county which support patients and with medically led assessment and care and step up bed provision if indicated for short stay and turnaround in community hospital sites; and the County Council Front door and emergency duty teams and allied urgent domiciliary care response delivered by the new Live Well at Home strategic reablement and domiciliary care providers. They also work with the local extended support to care homes which goes beyond the national Ageing Well Urgent Community Response DES to provide additional support to MDT around mental health, speech and language therapy, nutrition and dietetics and in supporting homes with training and other quality assurance processes. This is delivered in partnership by Primary Care Networks and Oxford Health's Care Home Support Service.

BCF metric 8.1. Taken together we believe that the range of *preventative* and *avoidance* measures set out above will increase our capacity to manage the risk of non-elective admissions to hospital. Further we anticipate that the roll out of Ageing Well Urgent Community Response from October 2021 will increase this resilience with the 2HH and 2DD response delivered 0800-2000 7 days a week. The 2019/20 baseline for NEL was artificially low owing to the impact of the pandemic response. There was a steep increase in Q1 2021/22, and these pressures have continued. In view of this we have set a target to reduce by 5% from the 2018/19 performance

Supporting Discharge: see next section

Support for the provider market

We are seeking to develop a more strategic relationship with our provider market, both from the integrated commissioning team and in operational settings. This will reflect learning from the pandemic response and recognise our common challenges in relation to workforce, increased acuity of patients and the need to develop responses that reflect our JSNA and equality impact assessments.

Within the BCF we are funding

- The new Live Well at Home reablement and domiciliary care contract with strategic providers to develop a more integrated approach with assessment and review and provide a funding approach that supports the employment of staff on full-time rather than zero hours contracts. These staff will also be supported and developed by working alongside the Home First MDT as part of "one team"
- Workforce support and initiatives on recruitment and retention, including the Proud to Care website jointly with the Oxfordshire Association of Care Providers Home - Proud To Care (proudtocareoxfordshire.org.uk)
- Fee uplifts and provision for new business to reflect increasing demand

- The locally enhanced care home support offer set out above which assists residents but also the home and its staff in developing quality approaches
- A revised and extended Trusted Assessor programme to improve the conversation and understanding between hospital discharge teams and providers. This is being developed with and will be delivered by Oxfordshire Association of Care Providers.

Surge planning

For winter 2021/22 we have set aside £1.3m for additional capacity. The plan is to use this to supplement Hospital Discharge Funding.

At this stage we plan to expand our reablement capacity from the planned 75 pick ups per week by 50-75% from Dec 21 to Mar 22 by retaining the outgoing service alongside the new Live Well at Home strategic providers.

We will also use this fund to support additional interim step-down bed capacity where indicated.

Supporting Discharge (national condition four)

Oxfordshire's discharge approach is funded through the BCF. It comprises support to people going home and people going home via step down beds. Overall Oxfordshire's approach is *Home First.*

Oxfordshire has developed a new integrated Home First MDT to support discharge home from hospital and management of people at risk in the community. The new team has been funded by the iBCF and the uplift to the minimum CCG contribution. Hosted by the County Council the team includes physiotherapists from Oxford Health and aligned staff from Age UK Oxfordshire. The Age UK team review people on the reablement list and identify and support those who can be helped home without or in advance of formal support. This service is funded from iBCF. The new team went live on 1 October 2021.

The Home First MDT is working in partnership with new strategic providers of reablement and domiciliary care commissioned by the County Council and CCG

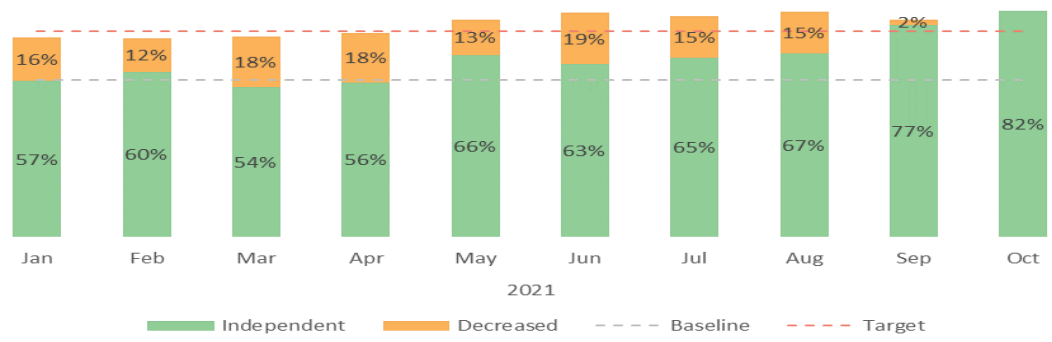
under *Live Well at Home* contracts. The reablement capacity will be deployed by the MDT and is funded in part by BCF. The funding model has been set to support the employment of staff on salaries rather than zero hours contracts. Live Well at Home also went live on 1 October 2021. The implementation of this approach is overseen by a system wide Home First Strategic Group.

Our surge plan for winter is to expand the reablement offer from 75 pick ups per week by 50-75% from December to March 22. This is funded (as above from the BCF minimum CCG contribution). This is a key element in increasing pick and reducing length of stay.

Oxfordshire has a comprehensive Pathway 2 comprising (currently) 130 community hospital beds delivered by Oxford Health NHS FT and 97 step-down beds in nursing homes supported by the Hub team within Oxford University Hospitals NHS FT Discharge Liaison service. The Hub allocates patients to Pathway 2 and provides nursing and therapy support to the nursing home beds to support discharge to assess and reablement approaches. In some homes the therapy is provided by Oxford Health community therapy. All of this activity is funded by the BCF, with additional funding from the CCG to support medical cover to community hospitals and nursing homes. The BCF also funds the social work input to both pathway 2 and pathway 3.

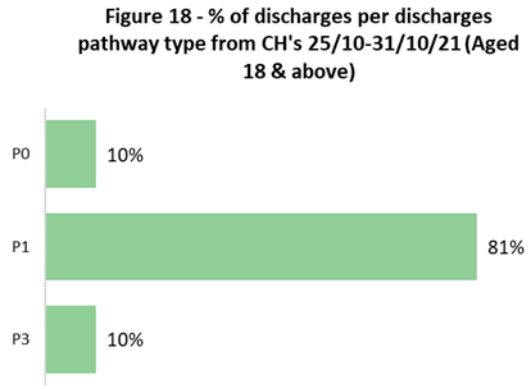
Although the Home First approach has been formalised in new contracts and services from 1 October, the model has been developed and implemented over time and we can see the impact of reablement in returning people to independence or reduced packages of care:

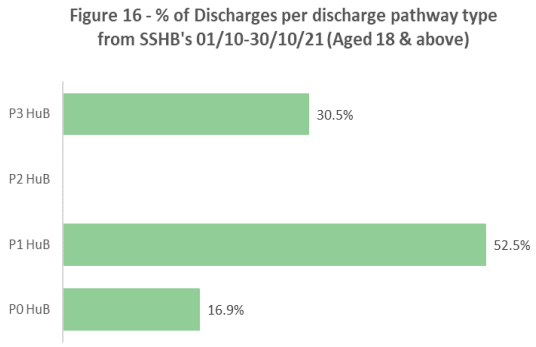
Figure 10 - % reablement patients discharged inde[pendent or decreased POC (Reablement Start Date)



The introduction of the Hospital Discharge Policy has highlighted the proportion of people discharged via Pathway 2 rather than home and our new Home First approach is designed to address this. We are also within the Community Services Strategy reviewing the inputs and outcomes within our step-down beds to identify those people who can be diverted from step down beds and/or can go home from those beds earlier in their stay. This will help us understand the scope to reduce or repurpose beds through greater throughput and more targeted and personalised interventions.

Currently over 90% of people supported in community hospital settings are discharged home with or without support; and 69% from short stay hub beds in nursing homes.





BCF metric 8.2. Oxfordshire AEDB manages progress towards the Oxford University Hospital metric of no more than 12% of open acute beds occupied by people with length of stay >21 days. This target represents a reduction from the March 21 baseline from 14%.

The BCF metric is not one that has been monitored before and the average length of stay approach needs to be understood in terms of its sensitivity to the measures that we have outlined here in terms of avoidance and supporting safe discharge. We also note that this planned reduction is on the face of it deeper than the acute trust metric and we do not have any information on how the 2 metrics relate to each other.

We therefore propose a reduction to the BCF metric baseline in the same proportion to the reduction that is required for the acute measure (i.e by 2/14 or 14% by end of Q4 2021/22. We will develop monitoring approaches that support our understanding of progress, barriers and opportunities in delivery of this metric.

	March 21	June 21	Sep 21	Dec 21	Mar 22
Proportion of patients resident in acute beds 14 days or more	8.6%	8.8%	8.4%	**8.0%**	**7.4%**
Proportion of patients resident in acute beds 21 days or more	3.9%	4.2%	3.8%	**3.7%**	**3.4%**

BCF metric 8.3. The current proportion of people discharged home is 91% with 7.2% going into pathway 2 step down beds; however, if we break that down into people aged over 65 the proportion is 88% going home and 10% going into pathway 2. The increased reablement capacity funded as part of our surge plan will positively impact these numbers, together with the impact of avoidance (well over 95% of all patients in step down beds were non-elective admissions to acute settings). However, we retain a large bed base and so anticipate that we will not achieve the

95% national expectation in 2021/22. **We therefore plan to achieve 93% in 2021/22**.

BCF metric 8.4. Residential admissions to nursing homes are driven both from the community and as part of hospital discharge. We are continuing to work with housing provider partners to develop Extra Care Housing and have designed a new care approach into those flats as part of Live Well at Home. We will continue to drive our Home First approach for discharge and exploring all alternatives to permanent admission (eg in our community equipment and assistive technology schemes). We are therefore looking to fund no more than 11 permanent admissions to care homes per week. **We plan for 429 admissions in 2021/22 per 100k of population over the age of 65**.

BCF metric 8.5. The impact of reablement on longer-term care needs is set out above and with the Home First and strengths-based prevention work we anticipate that this will mean a **recovery in the numbers of people still at home 90 days after reablement episode to 77%**.

Disabled Facilities Grant (DFG) and wider services

Oxfordshire County Council has integrated functions with Cherwell District Council and the Director of Adult Services is also the Director of Housing. This creates perspectives that support a better understanding of how housing and social care can be aligned to deliver best value and better outcomes for our population. In addition, the integrated commissioning structure now means that health can be built into this planning. The current Interim Director of Housing is reviewing our DFG and Home Improvement Agency services to develop recommendations for 2022/23.

Spend of DFG and the implementation of Home Improvement Agency is overseen by the County Housing Group chaired by the Lead for Occupational Therapy at the County Council. 4 of the 5 district councils use part of their allocation to pay for dedicated housing OTs in the County working both with children and with adults. These OTs work alongside Home Improvement teams and housing officers to identify the best way forward in each case: whether there is an equipment alternative; whether the DFG represents the best use of resources and/or whether alternative accommodation may be more viable and in the longer-term interest.

There is scope to develop this work into a view of the inter-relation between care costs (health and social care), housing (tenancy) costs, equipment and adaptation costs to determine whether there is (for instance) the opportunity to create more bespoke and personalised packages. These may identify opportunities for efficiency as well as meet user need. These ideas will the considered as part of the current review.

Equality and health inequalities

We have completed an Equality and Climate Impact Assessment to support the Better Care Fund Plan and this will be reviewed in Q4 2021/22 especially in relation

to an improved understanding of the impact of our performance on BCF metrics in relation to protected characteristics. .

The Oxfordshire JSNA has identified both geographical populations (in parts of Banbury and Oxford) and areas of need where Oxfordshire does worse than baseline, especially in relation to younger people and older people, where prevalence of depression, loneliness and falls are above average and the dementia diagnosis rate is below.

These findings have informed the Better Care Fund Plan for 2021/22 with a range of specific schemes that are detailed above and in the template but which include

- A new community paediatric care pathway funded through iBCF that is designed to avoid unnecessary attendance and admission for vulnerable young people
- Increased mental health capacity in minor injury units
- New dementia and carer support services, and a focus on the falls pathway
- The focus in the deployment of the DFG and Housing Improvement on supporting people with behaviours that challenge with emotionally sustainable building design which supports sensory needs
- A range of preventative services delivered in partnership with community services that we are seeking to target in areas of greatest need as defined by the JSNA

Divisions Affected - All

Oxfordshire Health and Wellbeing Board
16 December 2021

Plan for the 2022 update of the Oxfordshire Joint Strategic Needs Assessment

Report by Corporate Director of Public Health, Oxfordshire County Council

RECOMMENDATION

1. **The Health and Wellbeing Board is RECOMMENDED to**

   a) agree the proposed six-month delay to the release of Oxfordshire's 2022 Joint Strategic Needs Assessment (JSNA), to allow for inclusion of the Census 2021 results.

   b) contribute information and intelligence to further the development of the JSNA (through the Steering Group) and participate in making information more accessible to everyone.

Executive Summary

2. The production of the Joint Strategic Needs Assessment is a statutory duty, however the content and timing of the JSNA is a decision for the Health and Wellbeing Board.

3. The Office for National Statistics plans to publish Census 2021 results from May/June 2022 onwards (provisional date), this will provide a rich picture of health and inequalities data at a local level to include in the JSNA.

4. It is proposed, therefore, that the JSNA annual report is delayed by around 6 months to allow for inclusion of the Census 2021 data, moving the JSNA item from the agenda of the Board meeting in March 2022 to the Board meeting in early October 2022.

5. The JSNA team will continue to share evidence about the impact of the COVID-19 pandemic, develop interactive content and provide support to partners in accessing JSNA resources.

6. There will be a "call out" for evidence for the 2022 JSNA report and partners are asked to continue to support this work with information and data and make use of this shared evidence base.

Background

7. The continuous process of developing and sharing the Joint Strategic Needs Assessment is a statutory duty of Health and Wellbeing boards[1]. The guidance states that the format and content of the JSNA will be *"unique to each local area"* and that *"Health and wellbeing boards will need to decide for themselves when to update or refresh JSNAs…"*

8. The Oxfordshire JSNA annual report is usually submitted to the March meeting of the Oxfordshire Health and Wellbeing Board and then disseminated to partnerships and teams to support the planning and commissioning of services.

Timing

9. From (the provisional date of) May/June 2022[2], the Office for National Statistics plans to release results from the national 2021 Census, carried out on 21 March 2021. This data will provide a rich source of demographic and social statistics, including the health and caring responsibilities of Oxfordshire's population, that we will be able to analyse and visualise by age, location, ethnicity and other factors.

10. In order to include this Census 2021 data, it is proposed to delay the timing of the 2022 JSNA report to the Oxfordshire Health and Wellbeing Board from March 2022 to the board meeting in early October 2022.

11. The JSNA annual update process, overseen by the JSNA steering group, includes research, analysis, reporting and peer review. The update work starts around 4-5 months before submission of the annual report to the board meeting, so this proposal gives a revised start month of May 2022.

Developing the 2022 JSNA report

12. The delay to the annual report will enable the JSNA team to continue to develop:

    (a) More information on the impact of COVID on health and wellbeing;

    (b) A clearer picture of inequalities within the JSNA, extending the interactive inequalities dashboard and incorporating the "most deprived" ward profiles;

    (c) More data, where available, on climate change and environmental impacts on health and wellbeing;

    (d) Content designed to meet web accessibility standards.

13. In addition, the team will continue to publish and share JSNA-related content (for example through the short "bitesize" reports) and provide support to partners in accessing JSNA resources.

[1] Statutory guidance on joint strategic needs assessments and joint health and wellbeing strategies (publishing.service.gov.uk)
[2] First results from the 2021 Census in England and Wales - Office for National Statistics (ons.gov.uk)

Gathering data

14. The JSNA team is supported by partner agencies in the process of planning research, gathering and sharing evidence.

15. This collaborative effort relies on the willingness of partners to participate in deciding which information is relevant and useful and making their information available.

16. As in previous years, the JSNA will issue a "call for evidence" as part of the update process and will continue to encourage participation through formal and informal networks.

Financial Implications

17. There are no financial implications relating to this report as the publishing of an annual JSNA is already accounted for within business as usual service planning.

Legal Implications

18. The proposed delay to the JSNA in 2022 does not breach the Health and Wellbeing Board's statutory duty to publish a JSNA each year.

ANSAF AZHAR
CORPORATE DIRECTOR FOR PUBLIC HEALTH

Contact Officer: David Munday
Consultant in Public Health
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December 2021

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To:	**Future Oxfordshire Partnership (formerly the Oxfordshire Growth Board)**
Title of Report:	**Feedback from the 14 October Joint Future Oxfordshire Partnership and Health and Wellbeing Board Workshop**
Date:	**25 January 2022**
Report of:	***Rosie Rowe, Head of Healthy Place Shaping, on behalf of Oxfordshire County Council.***
	Stefan Robinson, Future Oxfordshire Partnership Manager
Status:	**Open**

Executive Summary and Purpose:
This report provides a summary of the discussion and feedback gathered as part of a recent workshop held between the Oxfordshire Health and Wellbeing Board and the Future Oxfordshire Partnership.

How this report contributes to the Oxfordshire Strategic Vision Outcomes:
Improving the health and wellbeing of Oxfordshire's residents sits at the heart of recently agreed Strategic Vision, which also features a guiding principle to maximise the benefits of strong collaboration within Oxfordshire. Regular engagements between these two strategic bodies offers the opportunity to share information, align priorities and identify actions to support delivery.

Recommendation:
That the Future Oxfordshire Partnership notes this report and the date of the next joint meeting on 9 March 2022 from 15:00-17:30.

Introduction

1. A networking and workshop event was held between members of the Future Oxfordshire Partnership and the Oxfordshire Health and Wellbeing Board on 14 October 2021. The purpose of this event was to provide an informal opportunity for system leaders to discuss areas of common interest and priorities, and to consider how they might work together to address such issues. It also provided an opportunity to brief key stakeholders on the strategic landscape with respect to the Oxfordshire Health and Wellbeing Strategy, local recovery from the Pandemic, the developing Oxfordshire Plan 2050, and the Oxford to Cambridge Arc.

Key Areas of Discussion

2. The meeting heard from the Director of Public Health about the long term impacts of Covid-19 in Oxfordshire, including the significant impact that the

pandemic has had on young people aged 16-24 as well as on some residents who now have "long Covid." The priorities for the coming years, as agreed in a recent review of the Oxfordshire Health and Wellbeing Strategy, included:

- Retain the life course approach of start well, live well and age well – noting the importance of good end of life care and 'dying well'
- Renewed focus on reducing inequalities which have been exacerbated by the pandemic
- Need to improve mental wellbeing throughout the life course
- Focus on healthy weight, physical activity, and tobacco control as being central to our prevention strategy
- Address the needs of 16-24 age group
- Sustain and build community capacity to enable independence and to create a strong voluntary and community sector that can support people's health and wellbeing
- Upskilling our staff so that they can signpost people to local resources and organisations that promote health and wellbeing using training such as Make Every Contact Count (MECC) and mental health awareness

3. The meeting identified the interrelated and cross-cutting nature of personal health and wellbeing with healthy place shaping which seeks to create a healthy, sustainable, and accessible environment. Specifically, healthy communities are more likely to thrive if they have easy access to high quality green space and clean air, as well as integrated active travel options which are developed through a planning system that prioritises healthy and sustainable travel modes. This was identified as a golden thread which runs through the ambitions of both committees and is featured throughout the Oxfordshire Strategic Vision and NHS/OCC Prevention Framework. The meeting also identified the importance of healthy and sustainable food choices as a means for supporting healthy eating and climate action.

4. There was a strong consensus among the meeting that the wider social determinants of health must be tackled at source. Improved housing, employment, education, infrastructure, and connectivity would help to reduce some of the significant health inequalities that exist within Oxfordshire, and Covid-19 has served to highlight and exacerbate these challenges in some areas. An increased focus on prevention through intelligent planning is needed alongside closer collaboration to meet the challenges of the future, building on some of the lessons learnt from the pandemic to address the twin challenges of the climate emergency and the need to address health inequalities.

5. The meeting identified the need to continue to lobby for greater freedoms and flexibilities with respect to land use planning, higher building standards and building genuinely affordable homes. The high cost of housing was creating challenges for recruiting and retaining key workers, and more generally is a key issue for inequalities in Oxfordshire.

6. In receiving updates on both the developing Oxfordshire Plan 2050 and the Arc Spatial Framework, the meeting agreed that these were two priory routes

through which to secure greater powers and freedoms to deliver on local health priorities. Whilst there were structured routes for council leaders and university leaders to influence the Arc's development, there was not an equivalent space for health system leaders to input, despite the health of residents being a priority within the Oxfordshire Strategic Vision.

7. Continued collaboration between the two committees would provide a route to feed into the Arc discussions, though a more direct space for health leaders to input would be preferable. A first step to providing direct public health input into development of the Arc has been taken with a workshop of public health directors from across the Arc providing a collective response to the consultation on its Vision statement. However, a formal mechanism is needed to ensure that the Arc embeds healthy place shaping principles into its approach and takes account of integrated care system geographies and digital healthcare.

8. A key theme emerging from the meeting concerned the need to be bold and realistic in any propositions to HM Government regarding the powers and flexibilities we need to deliver on local and national priorities. Oxfordshire's unique assets and its close partnership networks should be utilised to ensure that a clear message is delivered to HM Government in this respect. Cross sectoral discussion will continue to be important to draw together common themes of delivering the health and wellbeing of our residents.

9. It was agreed that the two groups should meet again in six months; the date of the next workshop has been scheduled for 15:00-17:30 on 9 March 2022.

Report Authors:

Rosie Rowe, Head of Healthy Place Shaping, on behalf of Oxfordshire County Council.

Stefan Robinson, Future Oxfordshire Partnership Manager

Contact information: *rosie.rowe@oxfordshire.gov.uk*

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Healthwatch Oxfordshire

Report to the Oxfordshire Health and Wellbeing Board

December 2021

Contents

1 Healthwatch Oxfordshire Reports to external bodies

During October to end November 2021 we published the following:

- Reports to the Oxfordshire Health and Wellbeing Board in October (published September).
- Report to the Health Improvement Board November.
- Reports to the Oxfordshire Joint Health Overview Scrutiny Committee in October.
- Verbal update report to the Oxfordshire Children's Trust Board in December
- Response to the Community Services Review was published on our website here https://healthwatchoxfordshire.co.uk/news-and-events/correspondence/

All the above reports are available online
https://healthwatchoxfordshire.co.uk/our-reports/reports-to-other-bodies/

Note:

- The Healthwatch Oxfordshire Chair sits on the Health and Wellbeing Board, the Executive Director is in attendance to take questions about our report.
- The Healthwatch Oxfordshire Chair attends the Oxfordshire Joint Health Overview Scrutiny Committee (HOSC), and the Executive Director presents our report to the committee.
- Two Healthwatch Ambassadors attend the Children's Trust Board, supported by a member of the Healthwatch staff team.
- A Healthwatch Oxfordshire Ambassador attends the Health Improvement Board supported by a member of the Healthwatch Oxfordshire staff team.
- The Healthwatch Oxfordshire Executive Director attends the following:
    - Oxfordshire Safeguarding Adults Board (OSAB)
    - Oxfordshire Quality Committee
    - Buckinghamshire Oxfordshire Berkshire West Integrated Care System (BOB ICS):
        - Primary Care Commissioning Committee Meetings in Common
        - System Quality Group

2 Healthwatch Oxfordshire Ambassador Reports November 2021

Children's Trust Ambassadors Update

The next Children's Trust board meeting takes place on the 2nd December. The only real update is that on 20th October the ambassadors, Lisa Hughes and Dan Knowles, met with the Oxfordshire Wellbeing Network. Kevin Gordon, the Corporate Director for Children's Services at Oxfordshire County Council (OCC),

came for part of the meeting to share his update on how OCC is progressing against the issues raised in our Healthwatch Oxfordshire report in September 2020. The members of the network were able to ask him questions and engage in discussions on the report and as ambassadors we agreed that it was a useful discussion and worth continuing to meet with this network.

Health Improvement Board Ambassadors Update

I have been representing Healthwatch Oxfordshire as an ambassador for the Health Improvement Board Oxfordshire for a year. It's an opportunity to deliver the people's views and experience to the board to reach the authorities for further improvement. I have recently presented the annual report to the board, which covers all the dynamic work done by Healthwatch Oxfordshire during the last year. The meeting was informative in general and Councillor Upton congratulated Healthwatch Oxfordshire on an annual report that shows the breadth of the activities undertaken and the concerns that are brought to the Board most of which are heard and followed up. Overall, our reports feed into and spark debate e.g. interest in GP waiting times and access, work with diverse communities etc. and I believe the board is playing a vital role in terms of the health and social care improvement.

3 Communications

An external communications and social media contractor started on 15th March 2021 contracted until 14th November 2021. Vicky Tilley, our communications lead, has day-to-day responsibility with a monthly monitoring and review meeting between the contractor, Vicky and the Executive Director. This additional resource, focussed on social media and the website, was tasked with the following measurements of success:

Outcomes

- Improved maintenance of website, timely updates of existing pages
- Increased presence and effectiveness on social media platforms
- Increased brand awareness in the population

Key Performance Indicators

- Increased reach via social media channels of at least 50% by the end of the project using 2020-21 data as a benchmark
- Increased website hits by at least 50% by the end of the project using 2020-21 data as a benchmark

The final report from the contractor has been accepted by Healthwatch Oxfordshire and shows that:

- Facebook, Twitter, LinkedIn, and Instagram growth have exceeded the 50% increase target

- Website hits are also on target to achieve the 2021-22 Key Performance indicator of increase by 100% by the end of March 2022.
- **Importantly** these measures are being reflected in more people being aware of Healthwatch Oxfordshire (brand awareness) and are driving people to complete our online surveys, leave Feedback Reviews and use our signposting service.

Healthwatch Oxfordshire continues to respond to requests for interviews and comment on current health and care news, including live and pre-recorded radio and television interviews about ambulance service, and hospital waiting times. Community researcher Omotunde Coker was interviewed by BBC Radio Oxford about the event she held to ask black women about their experiences of maternity services in Oxfordshire.

Newspaper, parish magazines, GP surgery notice boards, and targeted printed media continue to promote our work. Over this period of time, we have featured in voluntary sector news sheets, local newspapers including Banbury Guardian, Oxford Mail, and Witney Gazette, and community/parish newsletters. A new development has been to link into a school newsletter – and this has generated interest in our online survey supporting our work in Chipping Norton.

4 Oxfordshire Wellbeing Network (OWN)

Since April 2021 we have facilitated two Oxfordshire Wellbeing Network (OWN) events.

In May 2021 an event for community outreach and development officers of third sector groups and 31 people attended. Mia Waldock from Achieve Oxfordshire explained the reasoning behind the meeting; that there is a need to build on communication and networking with organisations as so much good work happening across Oxfordshire where organisations were targeting the same groups. This would enable groups to better support one another, share best practice and to start to hear more from the communities themselves. The top three concerns around health and wellbeing that face the communities were identified as isolation and loneliness, mental health of all ages, and COVID-19. The group agreed to continue to meet and Healthwatch Oxfordshire will facilitate a further meeting in the new year.

October 2021 event focussed on hearing from groups supporting parents in Oxfordshire. Representatives from 12 organisations attended and Kevin Gordon, Director of Children Service's at Oxfordshire County Council, attended to hear from these groups and gave an update on children's services and plans for development.

More details of both events, including video recordings, can be found on our website here https://healthwatchoxfordshire.co.uk/partners/own/

5 Focus on Feedback Centre

Over the past year we have increasingly sent reviews posted on our Feedback Centre directly to services for a response. This response is then posted below the review and where possible the reviewer receives notification that a response has been received. In addition, we have directly linked reviewers (with their consent) with service providers where there have been concerns about the content of the review thus enabling services to communicate with the service user / patient directly. This approach has been warmly welcomed by services as it enables them to respond in a more informed way, and by the reviewer as it proves that contacting Healthwatch Oxfordshire can result in being heard and in prompt action.

Between July and end September 2021 we received 34 responses from service providers that were posted below the review. A more detailed report can be found in the Executive Director's report to the Healthwatch Oxfordshire Board papers 30th November 2021. A sample of service responses to reviews below:

1. 'Thank you for taking the time to bring this to our attention. Patient care and experience is one of our top priorities, and I am disappointed to hear that your father had difficulties contacting us and arranging an appointment. Please contact me on Fiona.giles@healthshare.org.uk to arrange a call if you would like to discuss this matter further. Thank you again for your honest feedback and I look forward to hearing from you.' Healthshare Oxfordshire.

2. 'Thank you so much for your feedback. It is so good for the team to hear when they are doing well and helps encourage best practice for everyone.' **GP surgery**.

3. 'Thank you for your feedback. I am sorry that your experience at our vaccination centre was not a positive one. I am sure you can appreciate that the clinics are running in a marquee whilst we have all our usual clinics running in the Health Centre. It is difficult to be able to offer a private room, however we have done it if patients have called in advance to make the arrangements and we are able to offer an alternative time that means we can offer the room. We have also added a screen and a fold out bed into the marquee to assist in these situations.' **GP response to negative feedback from visit to vaccination centre.**

4. 'I apologise for the waiting time on the phones. We are having unprecedented demand at the moment and are doing our best to recruit more staff to answer the phones. We have taken on extra GP resources via the online LIVI app, so more appointments are now available.' **GP response to two reviews about how hard it is to contact the surgery and make an appointment.**

5. ‘Thank you so much for taking the time to leave such lovely feedback. All the team work extremely hard to provide the best patient care that we can and to read how much our care is appreciated is really heart lifting. Thank you again.’ **GP response to a positive review.**

Sometimes we get more information from the service provider that gives an insight into their challenges and what they are trying to do to improve their service:

‘Thank you for your feedback. I am sorry that you had such a long wait for your call to be answered when you telephoned us recently. We continue to do all we can to improve that situation and are monitoring our daily calls and times callers are waiting.

We encourage our patients who can, to use our E Consult service as a way to get a timely response from a health care professional, thus freeing our phone lines for those for whom this is not an option.

We have recently welcomed a new member to the Patient Care Advisor (PCA) team, she is presently receiving training. We continue to recruit new staff to the PCA team whose numbers have recently been depleted. We are pleased to welcome back another member of the team, who has worked with us before during the School holidays, who will start with us next week.

Whilst not wanting to use Covid as an excuse, it is a fact that we have had a large number of our staff recently told to isolate by the test & trace service. We try to minimise the impact of this by using the technology available to us but as this technology often brings up technical issues for the staff working from home, it can lead to a less than efficient service for our patients. Again, I can only apologise for this.

I hope this reassures you that although we are still experiencing problems with the time patients have to wait on the telephone, we are doing all we can to improve the situation.

Do please contact me directly if I can be of further assistance.’ ***Response from Practice Manager to negative feedback regarding waiting time on the phone being ‘unacceptable’.***

6 Human resources update

We welcomed Amier Al Agab to the team in October as our lead on Enter & View. Amier is new to the team but not to Healthwatch Oxfordshire having been our Ambassador to the Health Improvement Board for the past year. Sadly, for personal reasons Nuha Abdo is leaving us at the end of November. Nuha has worked as our Outreach Worker for the past eight months and will be missed, we wish her well.

7 2021-22 Activity Quarter 2 Key Performance Indicators

The full report on our Quarter 2 activity against agreed Key Performance Indicators (KPIs) is included in the Executive Director's Report to the Healthwatch Oxfordshire Board meeting on 30th November 2021. This can be found on our website https://healthwatchoxfordshire.co.uk/about-us/board-papers-and-minutes/ . A summary show:

- Hospital stands at Oxford University Hospitals NHS Trust are still on hold due to the COVID-19 community outreach restrictions. We are waiting confirmation that we can stand outside the hospital entrances.
- The planned outreach activity in Chipping Norton has been delayed (again) until October/November 2021 due to staff capacity.
- Feedback Centre posts are more than the 55 target – 59 received. We received 34 responses from services to the posts (up from 29 last quarter) and continue to link people who post to the services they are reporting their experiences about. We are continuing to go directly to services when feedback is of concern.
- The number of signposting / advice activity was 220% higher than the quarter 2 target with access NHS dentists and access to GPs again being the two main concerns. If this increase in activity rate continues, we will have to review staff resources to continue to respond in a timely manner.
- There were no surveys closed in this period.
- All media targets were exceeded as expected. Website and Facebook are performing exceptionally well, a direct result of our investment in social media support. We expect this increase to level off from Q3 onwards except for specific radio / tv activity.
- We reached 3,861 people via face-to-face meetings, Feedback Centre, 'Tell us' forms, E&V, signposting, voluntary & community sector, surveys, Facebook (no. of people engaged with page), PPG support, and OWN.

Health & Wellbeing Performance Framework: 2021/22
September 2021 Performance report

A good start in life

Measure	Target	Update	Q4 20/21		Q1 21/22		Q2 21/22		Notes
			No.	RAG	No.	RAG	No.	RAG	
1.1 Reduce the number of looked after children to 750 by March 2022	750	Q2 2021/22	776	A	786	A	790	A	Rise in the year as fewer children left the cared for system
1.2 Maintain the number of children who are the subject of a child protection plan	500	Q2 2021/22	475	G	510	A	548	R	Increase in numbers though rise has taken Oxfordshire to the rate of similar authorities
1.3.1 Mean waiting days for CAMHS	tbc	Q2 2021/22			106		132		Figure rose in September against a general trend of reducing. Average wait is 21% lower than 12 months ago
1.3.2 Median waiting days for CAMHS	tbc	Q2 2021/22			99		97		Figure rose in September against a general trend of reducing. Median wait is 9% lower than 12 months ago
1.5 Reduce the number of hospital admissions as a result of self-harm (15-19 year) to the national average (rate: 617 actual admissions 260 or fewer)	260	Q2 2021/22	242	G	85	R	146	R	146 admissions in the first quarter; 292 pro rate for the year; 260 (target) is national average. 12% above target
1.12 Reduce the level of smoking in pregnancy	7%	Q4 2020/21	6.7%	G	6.9%	G	6.9%	G	Oxon rates lower than national average, but significant ward-level variation. Work to support pregnant women to quit should accelerate the rate of decline
1.13 Increase the levels of Measles, Mumps and Rubella immunisations dose 1	95%	Q1 2021/22	93.5%	A	93.1%	A	93.7%	A	Covid impact as GP practices (wrongly) presumed closed. Uptake now stable. Thames Valley focus on MMR uptake on areas with low uptake of preschool and MMR booster vaccines.
1.14 Increase the levels of Measles, Mumps and Rubella immunisations dose 2	95%	Q4 2020/21	92.9%	A	92.5%	A	92.4%	A	See 1.14
1.15 Reduce the levels of children obese in reception class	7%	2019/20	6.7%	A	6.7%	A	6.7%	A	19/20 data. Next update due by next meeting. We expect this to show a further increase in line with national trends during COVID. Cherwell 7.1%; Oxford 6.5%; South Oxon 7.9%; Vale 5.5%; West Oxon 7.4%
1.16 Reduce the levels of children obese in year 6	16%	2019/20	16.2%	A	16.2%	A			19/20 data. Next update due by next meeting. We expect this to show a further increase in line with national trends during COVID. Cherwell 19.9%; Oxford 16.4%; South Oxon 14.7%; Vale 15.6%; West Oxon 3.6%
Increase the number of early help assessments to 2000 in 2020/21	2000	Q2 2021/22	1794		801	G	1352	G	Target of 2000 for year. Strategy to increase to 10,000. In Oxfordshire you are between 2 & 3 times more likely to have a social care than early help assessment
1.18 Monitor the number of children missing from home	Monitor only	Q2 2021/22	1261		464		953		49% increase compared with last year; 17% reduction on 2 years ago
1.19 Monitor the number of Domestic incidents involving children reported to the police.	Monitor only	Q2 2021/22	6619		1782		3577		3% increase compared with last year; 14% increase in 2 years ago

Living well

	Target	Update	Q4 20/21		Q1 21/22		Q2 21/22		Notes
			No.	RAG	No.	RAG	No.	RAG	
2.2 Proportion of all providers described as outstanding or good by CQC remains above the national average	86%	Q2 2021/22	93%	G	94%	G	93%	G	Routine inspection on hold, inspecting only where a concern is raised. National average currently 86%
2.3 Improving access to psychological therapies: The % of people who have depression and/or anxiety disorders who receive psychological therapies	22%	Aug-21	19%	R	27%	G	24%	G	Nationally set target. Figures to August. 24% year to date. 19% August
2.6 The % of people who received their first IAPT treatment appointment within 6 weeks of referral.	75%	Jul-21			99%	G	99%	G	Figures to July. 99% in the year to date. 99% in July
2.11 Increase the number of people with learning disability having annual health checks in primary care to 75% of all registered patients by March 2020	75%								Figure being reviewed across BOB. Concern over accuracy of national reporting. Local reporting suggests target being met. Work in hand to reconcile national and local reporting to get an agreed figure
2.12 The number of people with severe mental illness in employment	18%	Q2 2021/22	19%	G	20%	G	21%	G	
2.13 Number of new permanent care home admissions for people aged 18-64	< 39	Q2 2021/22	17	G	5	G	10	G	Increase around autism more than learning disabilities. Intensive reviews on all in patients by end Jan 2022. Plan in place being over seen by a BOB
2.14 The number of people with learning disabilities and/or autism admitted to specialist in-patient beds by March 2020	10	Q2 2021/22	5	G	5	G	10	A	

2.15 Reduce the number of people with learning disability and/or autism placed/living out of county	< 175	Q2 2021/22	158	G	157	G	158	G	
2.16 Reduce the Percentage of the population aged 16+ who are inactive (less than 30 mins / week moderate intensity activity)	18.6%	May-21	21.3%	R	21.3%	R	22.4%	R	Decreased nationally (covid affect). Local range17%-28%. Cherwell 28.4%; Oxford; 17.1%; South Oxon 20.8%; VoWH 23.8%; West Oxon 22.1%
2.17 Increase the number of smoking quitters per 100,000 smokers in the adult population	> 1146 per 100,000*	Q1 2021/22					678	R	Q1 of new provider & new model. Projected that the annual rate of >1146 will be achieved. Due to the change in Model, comparisons in quitters per 100,000 in previous years is not directly applicable.
2.18 Increase the level of flu immunisation for at risk groups under 65 years	75%	Sep 20 to Feb 21	58.9%	R	58.9%	R	58.9%	R	Uptake increased from previous years & above national average. Focused work for 21/22 season, includes OUH renal services administering vaccine & NHSE initiative of eligibility cards for patients to use at provider of choice without having to disclose their medical history.
2.19 % of the eligible population aged 40-74 years invited for an NHS Health Check (Q1 2015/16 to Q4 2019/20)	Monitor only	Q2 2021/22	81.4%		67.0%		69.6%		Programme paused in 2020/21 to focus on Covid response. Reviewing other service delivery options to support Primary Care settings to address the current NHS Health Check backlog caused by COVID-19.
2.20 % of the eligible population aged 40-74 years receiving a NHS Health Check (Q1 2015/16 to Q4 2019/20)	Monitor only	Q2 2021/22	40.0%		31.7%		32.6%		Programme paused in 2020/21 to focus on Covid response. Reviewing other service delivery options to support Primary Care settings to address the current NHS Health Check backlog caused by COVID-19.
2.21 Increase the level of Cervical Screening (Percentage of the eligible population women aged 25-49) screened in the last 3.5)	80%	Q4 2020/21	65.9%	R	65.9%	R	67.1%	R	Programmes paused in 2020. In recovery phase all programmes undertook targeted work to maximise uptake. Work is now underway to support programme resilience during the winter period.
2.21 Increase the level of cervical Screening (Percentage of the eligible population women aged 25-64) screened in the last 5.5 years	80%	Q4 2020/21	75.7%	R	75.7%	R	75.3%	R	Programmes paused in 2020. In recovery phase all programmes undertook targeted work to maximise uptake. Work is now underway to support programme resilience during the winter period.

Aging Well

Measure	Target	Update	Q4 20/21		Q1 21/22		Q2 21/22		Notes
			No.	RAG	No.	RAG			
3.1 Increase the number of people supported to leave hospital via reablement in the year	133	Q2 2021/22	156		186		174		Figures are the average number per month for the year. Contract now ended. Target as per Better Care fund
3.2 Increase the number of hours from the hospital discharge and reablement services per month	Monitor only	Q2 2021/22	7208		7596		7351		Figures are the average number per month for the year. Contract now ended
3.3 Increase the number of hours of reablement provided per month	Monitor only	Q2 2021/22	5502		6076		5447		Figures are the average number per month for the year. Contract now ended
3.4 Increase the proportion of discharges (following emergency admissions) which occur at the weekend	>18.8%	Q2 2021/22	20%	G	20%	G	20%	G	20% for the year to September, 19% for September
3.5 Ensure the proportion of people who use social care services who feel safe remains above the national average	> 69.9%	Feb-21	72%	G	72%	G	72%	G	National social care user survey February 2020.3%pts increase in year
3.6 Maintain the number of home care hours purchased per week	21,779	Q2 2021/22	25,282	G	26,333	G	25,643	G	
3.7 Reduce the rate of Emergency Admissions (65+) per 100,000 of the 65+ population	24,550 or fewer	Q2 2021/22	23,858	G	21,822	G	22,949	G	22949 in year to September
3.8 90th percentile of length of stay for emergency admissions (65+)	18 or below	Q2 2021/22	13	G	13	G	14	G	14 days in year to September; 16 days in September
3.19 (New measure): unplanned hospitalisation for chronic ambulatory care sensitive conditions per 100,000 population	705	Q4 2020/21	622.3	G					New measure in Better Care fund. In year monitoring being put in place
3.20a (New measure) % of patients who have been an inpatient for 14 days or more	7.4%								New measure in Better Care fund. In year monitoring being put in place. Current local measurement is % of beds. Target for position at March 2022
3.20b (New measure) % of patients who have been an inpatient for 21 days or more	3.4%								New measure in Better Care fund. In year monitoring being put in place. Current local measurement is % of beds. Target for position at March 2022
3.21 (New measure) % of people discharged to their normal place of residence	93.0%	Q2 2021/22					91.0%		New measure in Better Care fund. In year monitoring being put in place.
3.12 Reduce unnecessary care home admissions such that the number of older people placed in a care home each week (BCF measure)	11	Q2 2021/22	11	G	9.4	G	8.1	G	Target amended to 11 per week as per Better Care Fund plan
3.13 Increase the Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services (BCF measure)	77%	Oct - Dec 2020	67.2	R	62	R	62	R	Figure fell in year, possibly as people with higher needs were supported. Targeted amended in line with BCF
3.14 Increase the Proportion of older people (65+) who are discharged from hospital who receive reablement / rehabilitation services	3.3% or more	Oct - Dec 2020	1.75%	A	2.85%	A	2.85%	A	Figure now at national average
3.15 Increase the estimated diagnosis rate for people with dementia	67.8%	Jul-20	61.2%	R	63.0%	R	63.0%	R	61% for year to date to September and 61% in September
3.16 Maintain the level of flu immunisations for the over 65s	75%	Sep 20 to Feb 21	84.4%	G	84.4%	G	84.4%	G	Notable increase in uptake among this cohort. Efforts ongoing aiming for a high uptake for the 21/22 season.
3.17 Increase the percentage of those sent bowel screening packs who will complete and return them (aged 60-74 years)	60% (Acceptable 52%)	Q3 2020/21	71.4%	G	70.3%	G	70.3%	G	Notable increase in uptake among this cohort. Efforts ongoing aiming for a high uptake for the 21/22 season.
3.18 increase the level of Breast screening - Percentage of eligible population (women aged 50-70) screened in the last three years (coverage)	80% (Acceptable 70%)	Q4 2019/20	55.4%	R	55.4%	R	55.4%	R	Notable increase in uptake among this cohort. Efforts ongoing aiming for a high uptake for the 21/22 season.

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Measure (frequency)	National Target (21/22)	Reporting date	Oxon value	RAG*
Flu vaccine uptake for all 2-year-olds	70%	Up to 26th Nov	51.5%	**R**
Flu vaccine uptake for all 3-year-olds	70%	Up to 26th Nov	55.9%	**R**
Flu vaccine uptake for Reception	70%	Up to 26th Nov	22.9%	**R**
Flu vaccine uptake for Year 1	70%	Up to 26th Nov	23.7%	**R**
Flu vaccine uptake for Year 2	70%	Up to 26th Nov	23.8%	**R**
Flu vaccine uptake for Year 3	70%	Up to 26th Nov	22.1%	**R**
Flu vaccine uptake for Year 4	70%	Up to 26th Nov	22.8%	**R**
Flu vaccine uptake for Year 5	70%	Up to 26th Nov	22.1%	**R**
Flu vaccine uptake for Year 6	70%	Up to 26th Nov	23.2%	**R**
Flu vaccine uptake for Year 7	70%	Up to 26th Nov	44.9%	**R**
Flu vaccine uptake for Year 8	70%	Up to 26th Nov	43.9%	**R**
Flu vaccine uptake for Year 9	70%	Up to 26th Nov	41.5%	**R**
Flu vaccine uptake for Year 10	70%	Up to 26th Nov	44.6%	**R**
Flu vaccine uptake for Year 11	70%	Up to 26th Nov	42.5%	**R**

*Target of 70% is a cumulative target over course of flu season (Sept 21 until Jan 22). Therefore in November it is not expected to have reached 70%

Higher uptake in secondary school age reflects vaccination offer earlier in season to align with delivery of COVID vaccine

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Report to the Health and Wellbeing Board, 16th November 2021

Report from	Health Improvement Partnership Board
Report Date	29th November 2021
Dates of meetings held since the last report:	18 November 2021
HWB Priorities addressed in this report	☐ Improving mental wellbeing. ☐ Improving rates of Physical Activity ✓ A Healthy Start in Life ✓ Living Well ✓ Ageing Well ✓ Tackling Wider Issues that determine health
Link to any published notes or reports:	Papers for the November 2021 meetings were published and can be found here: Health Improvement Partnership Board - Thursday, 18 November 2021 2.00 pm
Priorities for 2021-22	In the light of the Coronavirus Pandemic the Board undertook a review of its key priorities within its overarching objectives to promote prevention and address inequalities. It was agreed that its focus for 2021/22 will be: • Healthy Weight and Physical Activity • Smoking • Mental Well-being. These priorities are all supported by recent strategies endorsed by the Board and will have significant impact on inequalities.

1. **Progress reports on priority work to deliver the Joint HWB Strategy (priority, aim, deliverable, progress report)**

A. Mental Health & Wellbeing: Update from Suicide Prevention Multi Agency Group

Priority	✓ Improving mental wellbeing and Tackling Wider Issues that determine health. Across whole life course
Aim or Focus	To understand current trend in suicide rates, changes in risk factors for suicide and development of initiatives across the partnership to address these risk factors.
Deliverable	To see a stable and then reducing rate of suicide and self-harm in Oxfordshire
Progress report	There has not been an observable impact in national and local suicide rates and self-harm presentations during the COVID-19 pandemic. However, there has been an increase in associated risk factors related to suicide and self-harm such as unemployment, financial difficulties, self-reported wellbeing, domestic abuse, depression, anxiety, social isolation, relationship strain, bereavement, and loneliness. The board received an update on some training initiatives being delivered to DWP workforce to support action on financial risk factors and an updated on the safe haven initiative on Cowley Road in Oxford as an alternative to A&E for those in mental health crisis

B. Active Travel Programme

Priority	✓ Improving physical activity and Tackling Wider Issues that determine health. Across whole life course
Aim or Focus	To understand initial evaluation findings of the Cycling and Walking Activation Programme
Deliverable	To see an increase in participation in physical activity rates within Oxfordshire via a range of active travel initiatives.
Progress report	The work covers 5 distinct initiatives. These are as follows; 1. School Streets (completed) 2. Street Tag (completed) 3. Community Activation (in progress) 4. Schools Park and Stride (in progress) 5. Kidlington 'Zoo Trails' (in progress) The board received an update on progress of achieving the following 6 aims

	• To increase the proportion of people who regularly walk or cycle in Oxfordshire by promoting modal shift to active travel (**Delivered)** • To increase the proportion of people who feel safe when walking or cycling, including on journeys to school **(Delivered)** • To reduce inequalities in active travel (including geographical inequalities and those by age, gender, ethnicity, and socio-economic status) **(In progress)** • To identify and understand the barriers to walking and cycling, including hyperlocal barriers **(More work needed)** • To build local capacity to address these barriers **(In progress)** • To reduce carbon and air pollution emissions across the network **(More work needed)**

C. Domestic Abuse Support- Safer Accommodation

Priority	Tackling Wider Issues that determine health. Live well
Aim or Focus	As per the report to the HIB in September- The Domestic Abuse Act 2021 ("the Act") was introduced in April 2021, and statutory duties came into force on 1st October 2021. A safe accommodation strategy is required under the Act. An overarching needs assessment and strategy is currently being worked on in Oxfordshire. However, to ensure compliance with the Act requirements, Oxfordshire Domestic Abuse Strategic Board published a separate draft Safe Accommodation Strategy, which is currently out for consultation.
Deliverable	They key deliverable targets of this work will be defined by the data included in the needs assessment and the subsequent strategy review. The specific deliverable related to this paper is the delivery of a safer accommodation strategy
Progress report	The Domestic Abuse Safe Accommodation Strategy was produced in draft on 26th October 2021, and is currently under consultation The consultation dates are 27th October to 24th November 2021. The delivery plan for the safe accommodation strategy will developed by the Safe Accommodation Working Group' (SAWG) and approved by the Oxfordshire Domestic Abuse Strategic Board in 2021/22. This will include developing and agreeing baseline measures and targets to monitor the impact of the Oxfordshire Domestic. This will also work to address the gaps in data which have been highlighted in the needs assessment.

2. Note on what is being done in areas rated Red or Amber in the Performance Framework

Of the 21 indicators reported to the HIB: Five indicators are green, four indicators are amber, six indicators are red. The red ones are as follows:

- 2.16 Reduce the percentage of the population aged 16+ who are inactive (less than 30 mins/week moderate intensity activity)
- 2.17 Increase the number of smoking quitters per 100,000 smokers in the adult population
- 2.18 Increase the level of flu immunisation for at risk groups under 65 years
- 2.21i Increase the level of Cervical Screening (Percentage of the eligible population women aged 25-49) screened in the last 3.5 years)
- 2.21ii Increase the level of Cervical Screening (Percentage of the eligible population women aged 50-64) screened in the last 5.5 years)
- 3.18 Increase the level of Breast Screening - Percentage of eligible population (women aged 50-70) screened in the last three years (coverage)

The board noted that these indicators did not have new data reported against them from what was seen at the last HIB meeting in September. Therefore, a review of the progress of plans to improve performance was not undertaken.

As per discussion at the September board meeting, the HIB received an additional section to the performance report at this meeting- at deep dive into one of the priority areas. This time the deep dive showed performance against metrics specific to mental wellbeing. At future meetings, this will rotate to other subject areas. This deep dive showed that Oxfordshire performs fairly well in this area but three indicators showed as Red;

- School Readiness: percentage of children with free school meal status achieving a good level of development at the end of Reception
- Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate
- Loneliness: Percentage of adults who feel lonely often / always or some of the time

David Munday, December 2021