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OXFORDSHIRE COUNTY COUNCIL

Notice of a Meeting

People Overview & Scrutiny Committee

Thursday, 11 November 2021 at 10.00 am

Council Chamber - County Hall, New Road, Oxford OX1 1ND

These proceedings are open to the public

Please note that Council meetings are currently taking place in-person (not virtually). Meetings will continue to be live-streamed and those who wish to view them are strongly encouraged to do so online to minimise the risk of Covid 19 infection.

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

Places at the meeting are very limited. If you still wish to attend this meeting in person, you must contact the Committee Officer by 9am four working days before the meeting and they will advise if you can be accommodated at this meeting and of the detailed Covid-19 safety requirements for all attendees.

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

Membership

Chair - Councillor Ian Corkin
Deputy Chair - Councillor Kate Gregory

Councillors:	Juliette Ash	Andy Graham	Michael Waine
	Hannah Banfield	Nigel Simpson	
	Imade Edosomwan	Bethia Thomas	

Co-optees:

Notes: ***Date of next meeting:*** *17 February 2022*

For more information about this Committee please contact:	
Chair	Councillor Ian Corkin Email: ian.corkin@oxfordshire.gov.uk
Committee Officer	*Colm Ó Caomhánaigh, Tel: 07393 001096* *E-Mail: colm.ocaomhanaigh@oxfordshire.gov.uk*

Yvonne Rees
Chief Executive

November 2021

What does this Committee review or scrutinise?

- All services and preventative activities/initiatives relating to children, young people, education, families and older people.
- Enables the council to scrutinise it statutory functions relation to children, adult social care and safeguarding. Includes public health matters where they are not covered by the Joint Health Overview and Scrutiny Committee.
- This committee will also consider matters relating to care leavers and the transition between children's and adult services

How can I have my say?

We welcome the views of the community on any issues in relation to the responsibilities of this Committee. Members of the public may ask to speak on any item on the agenda or may suggest matters which they would like the Committee to look at. **Requests to speak must be submitted to the Committee Officer below no later than 9 am 4 working day before the date of the meeting.**

About the County Council

The Oxfordshire County Council is made up of 63 councillors who are democratically elected every four years. The Council provides a range of services to Oxfordshire's 678,000 residents. These include:

schools	social & health care	libraries and museums
the fire service	roads	trading standards
land use	transport planning	waste management

Each year the Council manages £0.9 billion of public money in providing these services. Most decisions are taken by a Cabinet of 9 Councillors, which makes decisions about service priorities and spending. Some decisions will now be delegated to individual members of the Cabinet.

About Scrutiny

Scrutiny is about:

- Providing a challenge to the Cabinet
- Examining how well the Cabinet and the Authority are performing
- Influencing the Cabinet on decisions that affect local people
- Helping the Cabinet to develop Council policies
- Representing the community in Council decision making
- Promoting joined up working across the authority's work and with partners

Scrutiny is NOT about:

- Making day to day service decisions
- Investigating individual complaints.

What does this Committee do?

The Committee meets up to 4 times a year or more. It develops a work programme, which lists the issues it plans to investigate. These investigations can include whole committee investigations undertaken during the meeting, or reviews by a panel of members doing research and talking to lots of people outside of the meeting. Once an investigation is completed the Committee provides its advice to the Cabinet, the full Council or other scrutiny committees. Meetings are open to the public and all reports are available to the public unless exempt or confidential, when the items would be considered in closed session.

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, giving as much notice as possible before the meeting

A hearing loop is available at County Hall.

AGENDA

1. Introduction and Welcome

2. Apologies for Absence and Temporary Appointments

3. Declaration of Interests - see guidance note on the back page

4. Minutes (Pages 1 - 6)

To approve the minutes of the meeting held on 30 September 2021 (**POSC4**) and to receive information arising from them.

5. 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 5 November 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.

6. Health Inequalities (Pages 7 - 28)

Report by the Corporate Director of Public Health and Wellbeing.

The purpose of this briefing (POSC6) is to provide the People Overview and Scrutiny Committee with requested information on health inequalities in Oxfordshire to provide an opportunity to review current approach to tackling inequalities, the context for future agenda items and inform the development of the scrutiny work programme.

The Committee is RECOMMENDED to

a) note the background information provided on health inequality in Oxfordshire;

b) note activity currently underway and consider implications for the Committee's future programme of work.

7. **Family Solutions Plus** (Pages 29 - 42)

Report by Corporate Director of Children's Services

The report (**POSC7**) discusses the progress to date and what has been achieved, both quantitatively and qualitatively, a year into the implementation.

The Committee is RECOMMENDED to:

a) consider the contents of the report and put relevant questions to the Cabinet Lead member, Director of Children's Services and supporting officers.

b) decide if any further action is required.

c) consider recommending to the Oxfordshire Place Board consideration of the Family Solutions Plus (FSP) business case to agree the future funding approach.

Close of meeting

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.

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PEOPLE OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 30 September 2021 commencing at 10.00 am and finishing at 12.30 pm

Present:

Voting Members:

Councillor Juliette Ash
Councillor Hannah Banfield
Councillor Ian Corkin
Councillor Imade Edosomwan
Councillor Andy Graham
Councillor Bethia Thomas
Councillor Nigel Simpson
Councillor Michael Waine
Councillor Andrew Gant (In place of Councillor Kate Gregory)

Other Members in Attendance: Councillor Liz Leffman, Leader of the Council; Councillor Liz Brighouse, Deputy Leader of the Council and Cabinet Member for Children, Education and Young People's Services; Councillor Jenny Hannaby, Cabinet Member for Adult Social Care; Councillor Mark Lygo, Cabinet Member for Public Health and Equalities; Councillor Glynis Phillips, Cabinet Member for Corporate Services; Councillor Pete Sudbury, Cabinet Member for Climate Change Delivery and Environment; Councillor Eddie Reeves, Leader of the Opposition; Councillor Jane Murphy, Deputy Leader of the Opposition.

Officers:

Whole of meeting: Ansaf Azhar, Corporate Director for Public Health; Stephen Chandler, Corporate Director for Adult and Housing Services; Kevin Gordon, Corporate Director for Children's Services; Anita Bradley, Director for Law & Governance and Monitoring Officer; Jodie Townsend and Colm Ó Caomhánaigh, Democratic Services.

The Scrutiny Committee considered the matters, reports and recommendations contained or referred to in the agenda for the meeting and agreed as set out below. Copies of the agenda and reports are attached to the signed Minutes.

1/21 ELECTION OF A CHAIR FOR THE COUNCIL YEAR 2021/22

(Agenda No. 1)

Councillor Ian Corkin was nominated for Chair by Councillor Nigel Simpson and seconded by Councillor Andy Graham. Councillor Ian Corkin was elected Chair nem con.

2/21 ELECTION OF A DEPUTY CHAIR FOR THE COUNCIL YEAR 2021/22
(Agenda No. 2)

Councillor Kate Gregory was nominated for Deputy Chair by Councillor Andy Graham and seconded by Councillor Imade Edosomwan. Councillor Kate Gregory was elected Deputy Chair nem con.

3/21 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS
(Agenda No. 3)

Apologies had been received from Councillor Kate Gregory (substituted by Councillor Andrew Gant).

4/21 DECLARATION OF INTERESTS - SEE GUIDANCE NOTE ON THE BACK PAGE
(Agenda No. 4)

There were no declarations of interest.

5/21 DEVELOPING THE OVERVIEW AND SCRUTINY FUNCTION
(Agenda No. 6)

The Committee considered a report setting out proposals and initial ideas to develop the Overview and Scrutiny function.

The Chair opened the discussion by noting the diversity of elected members on the Committee and how he believed that would lead to better decision making. There was an opportunity with the current review of scrutiny to design a system to better serve the public and other councillors who are not on scrutiny committees.

His experience as a councillor was that the opportunity for other Members to impact policy making at a time when it made a difference were limited in the Leader and Cabinet model. He believed that the Committee would be most effective if it spoke with one voice and was able to win the trust of Cabinet and officers.

Members introduced themselves and described their own background and divisions. Those Cabinet Members and senior officers participating also introduced themselves and their roles.

Anita Bradley, Director of Law & Governance and Monitoring Officer, stated that she wanted to ensure that the Committee had the support that it needed to do its work.

Councillor Liz Leffman, Leader of the Council, welcomed the formation of this important committee and the enthusiasm of its Members. She stated that she was particularly interested in hearing suggestions as to where the Council could do more for its residents.

Jodie Townsend, Democratic Services, introduced himself and the report. The development plan had already been presented to the Health and Place overview and

scrutiny committees. It was important that scrutiny be Member-led. He noted that at the scrutiny training sessions there had been support for prioritising issues in order to have a more thorough scrutiny on a shorter list of issues rather than trying to cover everything.

There was a strong commitment from officers and Cabinet to facilitate more effective scrutiny. Training and development had started and would be a continuous process to look at best practice.

Members made the following comments on the report:

- It was a good start which they could refine as the committee progressed.
- There should be a review process – perhaps after 6 months.
- There should be a greater role for the public than the current opportunities for petitions and public address.
- Joint scrutiny with city and district councils should be considered.
- Having data is important and knowing what data is already in the system.
- Does the Committee want to focus on outcomes rather than outputs?
- The Joint Strategic Needs Assessment (JSNA) was an impartial source of data across the Council and partners and it informed the Health and Wellbeing Strategy.
- It was sometimes important to look back at the history of an issue for context and the decision-making process that took place.
- Reports should be circulated with the agenda in good time and most of the time in the meeting should be made available for questions.
- There was a need to consider the involvement of the following:
    - co-opted members of the former Education Scrutiny Committee
    - faith groups
    - those working with Looked After Children
    - service users
    - external expertise
    - people beyond those who are already engaged
    - public representatives at other levels and locality meetings

The Chair concluded with a summary of the discussion:

The Committee was looking to promote greater public participation. There was a desire to engage with stakeholders and a paper would be needed to discuss options around that. The Committee needed to be flexible in its work programme. In the Public Health area there was a need to focus on preventative, upstream measures. Cabinet Members should front the responses from the administration, supported by officers as appropriate. There should be an item on the agenda for Full Council meetings to discuss scrutiny.

This was agreed as a summary.

Actions: provide a report on how the Committee could engage with stakeholders.

6/21 WORK PROGRAMME 2021/22

(Agenda No. 7)

The Committee had before it a report to support and advise Committee members on determining their work programme for the 2021/22 municipal year.

Councillor Michael Waine noted that the agenda pack did not include the items from the former Education Scrutiny Committee. He had circulated those to Members before the meeting. He believed that the most important items to include were the annual opportunities to scrutinise the work of the Regional Schools Commissioner, Ofsted and the Education Funding Agency.

Jodie Townsend, Democratic Services, emphasised that the Committee did not have to agree the whole work programme for the rest of the municipal year at this meeting. A limited process had been conducted to get an initial list of ideas. However, a more complete process was to be developed for prioritising items for work programmes going forward.

The Committee could also consider activities outside the meetings such as Task and Finish Groups, deep-dives, briefings and public engagement days for example.

The Chair suggested that the Committee could work best by taking a strategic overview rather than discussing operational issues. He suggested considering the list of items in the appendix under Children and Young People first:

- Home to School Transport – perhaps needing a Task and Finish Group
- Engagement with Young People
- Family Solutions Plus – possibly an external evaluation
- New strategy for neurodiversity, CAMHS (Child and Adolescent Mental Health Service), EHCPs (Education Health and Care Plans) and SEND (Special Educational Needs and Disability) - especially since the pandemic
- Looked After Children – a national review is expected in the new year
- Safeguarding annual reports
- Care providers, including out-of-county
- Lessons learned from Covid
- Identifying gaps in provision for Young People
- Community and voluntary infrastructure will be coming to Cabinet for decision

The following issues were suggested under Adults:

- Workforce challenge – there was a new government initiative to examine
- Preparing for the new inspectorate for health and social care from 2023
- Impact of transformation
- Costs of care in Oxfordshire
- Front door, first contact
- Transition from young people's to adult services

Under Public Health:

- Community and voluntary sector
- Physical fitness

- Health inequalities - most deprived areas
- Smoke-free Oxfordshire
- Domestic abuse
- Preventive approach

Under Education:

- Regional Schools Commissioner
- SEND funding
- Workforce including wellbeing
- Lessons learned from lockdown
- Access to broadband
- Early Years and 0-5 Reform
- School Management
- Parental choice
- Inclusion

The Chair suggested that the following summary of priorities –

- Children & Young People
    - Engagement with Young People
    - Family Solutions Plus external evaluation
    - Safeguarding
    - Workforce
    - Mental Health
    - Community and Voluntary Sector
- Adults
    - Transition
    - Front door
    - Workforce
- Public Health
    - Preventative mental health
    - Physical fitness
    - Smoking
    - Most deprived wards
- Education
    - Regional Schools Commissioner
    - Ofsted
    - Stakeholders
    - Early Years provision
    - Recruitment/retention
    - Home to School Transport
    - Inclusion

Jodie Townsend suggested that in the longer term work programme the Committee could consider bringing partners together on wider issues such as cost of rail travel, County Lines, post-Covid recovery.

Action:

The Chair proposed that the list be further prioritised at a meeting between the Chair, Deputy Chair and Officers to produce a list for circulation to the Members of the Committee. This was agreed.

…….. in the Chair

Date of signing …….

Divisions Affected - All

PEOPLE OVERVIEW AND SCRUTINY COMMITTEE
11 November 2021

Health Inequalities

Report by Corporate Director of Public Health & Wellbeing

RECOMMENDATION

1. **The Committee is RECOMMENDED to**

   (a) note the background information provided on health inequality in Oxfordshire

   (b) note activity currently underway and consider implications for the Committee's future programme of work

Executive Summary

2. The purpose of this briefing is to provide the People Overview and Scrutiny Committee with background information on health inequality to provide context for future agenda items and inform the development of the scrutiny work programme.

Scrutiny Guidance

3. In order to assist the People OSC, key background data and information about local health inequalities is available for review via the following links;
   - Director of Public Health Annual Report – This is the key underpinning document regarding local inequalities in health
   - Oxfordshire Joint Strategic Needs Assessment (JSNA) – Provides a very detailed look at a broad range of data to understand health status and need locally
   - Interactive Inequalities Dashboard - Is an interactive tool that shows some key data from the JSNA specific to health inequalities
   - Banbury Ruscote ward profile- Is provided as an example of ward profiles in development that are referenced in this paper.

4. This agenda is intended to operate as follows at the People OSC Meeting:
   i. Background to the issue of health inequalities
   ii. Outlining the tiered approach to addressing inequalities that is used locally

iii. The data on current health inequalities in Oxfordshire
iv. A summary of how COVID-19 has impacted on health inequalities
v. Priority areas for action by partners
vi. Proposed next steps
vii. Question and answer session with Cabinet Member for Public Health and Equality and relevant Officers

Oxfordshire Health Inequalities

Background

5. Health inequalities are best defined as "unfair and avoidable differences in health across the population, and between different groups within society". The causes of health inequality are complex, and a range of factors can be involved. These include;

i. Age, sex, race DNA and other personal biological features
ii. Individual lifestyle factors
iii. Social and community networks
iv. Living and working conditions across the life-course
v. Availability and access to relevant health and care services

6. It is important partners within Oxfordshire seek to address health inequalities. This is not only because of the rationale from a social justice perspective but because of the impact on families, community and the cost to the local economy and public services of such inequalities. Initiatives that effectively address health inequalities will reduce demand on services as more people live in good health for longer.

7. Due to the broad range of determinants of health that exist, action to improve health and wellbeing requires a very broad approach. This is spread across the functions of the Council, our partners and the wider community. The determinant of health range from the built environment, to community resilience, from clean air to access to medical services, from good education and housing in childhood to access to care support in older age. In our areas that experience the greatest health inequality we often see several of these determinants being less favourable and clustering together causing the health inequality. Effective action therefore requires holistic and coordinated action across the Council and with many other partner organisations. As well as commissioning specific preventative services, the Council's role is to provide system's leadership and to convene partners and the community to address inequality.

8. Some activity needs to be delivered at very local, place based, level while others must be at scale, some actions produce more immediate results, while others will only demonstrate benefit in several years or even decades time. All actions fit into one of three tiers and this tiered approach is fundamental in bringing cohesion to our approach to talking inequalities in Oxfordshire.

A tiered approach to tackling Health Inequalities

9. The tiered approach to addressing health inequalities is a continuum from quite "downstream" actions that aim to minimise the impact of established diseases or needs (tier 1) to "upstream" interventions that seek to address the underlying causes of ill health and health inequalities. Action from a range of partners is need at all tiers to make a positive impact. A fuller explanation of each tier is as follows:

10. Tier 1- or tertiary prevention- addresses inequalities where disease or care needs are already established and seeks to optimise treatment and self-management to minimise the impact. For example, Adult Social Care teams taking a strength-based/community asset-based approach when someone needs support to maintain their independence at home or Primary Care teams proactively supporting good blood pressure management. In both examples, the need for this is typically greater in some of our ethnic minority or more deprived communities. A lot of the actions within this tier sit with colleagues in the NHS and in collaboration with OCC's adult social care services.

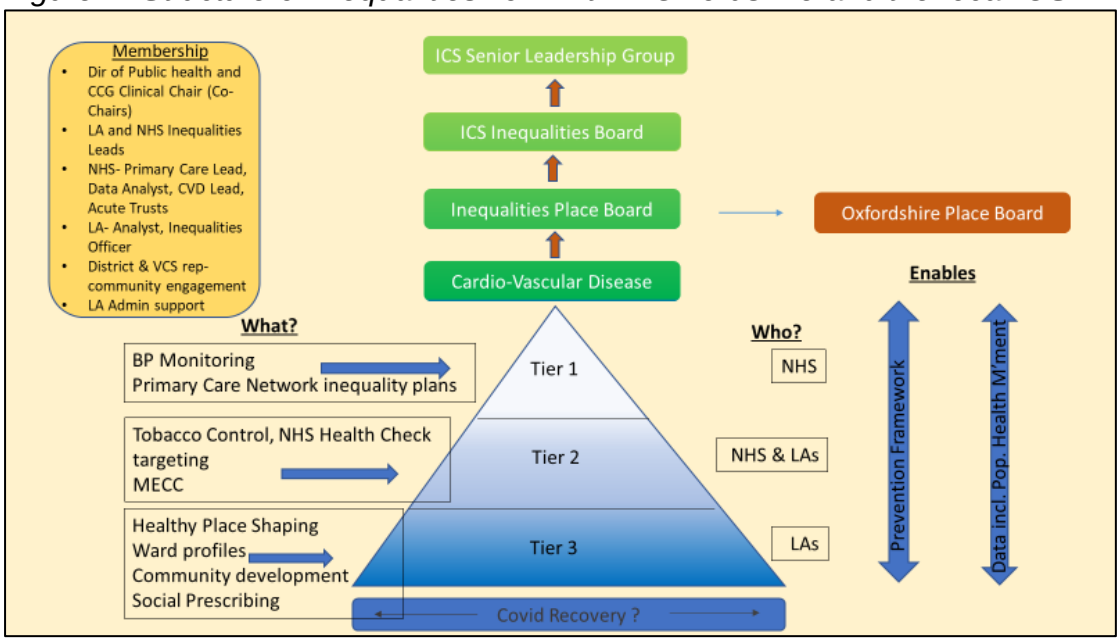
11. Tier 2- or secondary prevention- addresses inequalities where a disease is in earliest stages or a disease risk factor can be addressed before it causes problems. For example, social care colleagues signposting to physical activity support for someone who has started to lose mobility at home and is at risk of falls. Or within the NHS, screening people for undiagnosed or early-stage Cardio-Vascular Disease (CVD) via the NHS Health Check Programme or supporting people with nicotine addiction to be tobacco free. In these areas we know residents from the most deprived communities in Oxfordshire are most likely to smoke or have CVD undiagnosed or diagnosed late. Many of the actions in this tier are led by OCC's public health team and includes a mixture of commissioning and partnership working.

12. Tier 3 or primary prevention- addresses inequalities by tackling the causes of unequal disease prevalence or care needs and the drivers of less healthy behaviours. For example, providing access to green space, supporting active travel and building community resilience are important initiatives because they are strong determinants of health and across the county they vary quite considerably. Place-shaping, community building and supporting the most vulnerable is core to the work of local authorities, both at County and City and District levels, and so teams across councils are engaged in work which ultimately contributes to primary prevention.

    Within these tiers of action, OCC's connection with the community and voluntary sector (VCS) is of great importance. This includes the grant funding the council makes to VCS groups, the VCS infrastructure contract and the partnership working we are engaged with alongside City and District partners through community forums such as Health and Wellbeing Partnerships in Oxford City and the Brighter Futures initiative in Banbury. Adult social care teams also work closely with the VCS in delivering some of the Oxfordshire Way work programme including the empowering communities initiatives.

13. The emerging overarching structure of the health inequalities work within the Oxfordshire "place" within the Buckinghamshire Oxfordshire and Berkshire West Integrated Care System (BOB ICS) is summarised below, using Cardio-Vascular Disease as an example of how the tiered approach described approve fits within it. This aims to bring closer working with NHS colleagues to take forward initiatives that require a joined-up approach with the NHS.

Figure 1- Structure of Inequalities work within Oxfordshire and the local ICS



10 Wards with greatest health inequality

14. Despite being an affluent and healthy county overall, Oxfordshire comprises of 10 wards which are within the 20% most socio-economically deprived in the country. This is detailed in the Director of Public Health Annual Report and the Oxfordshire Joint Strategic Needs Assessment. The details around such inequalities are described more fully in these documents, but in summary the difference in life expectancy between the most and least deprived neighbourhoods is 11 years, whilst the difference in healthy life expectancy (how long you can expect to live without an impactful long-term condition or disability) is often even greater. There is more than a 5-fold difference in preventable mortality between the same areas.

15. The 10 wards which are among the 20% most deprived in the country and experience the greatest health inequalities are as follows;

i. Abingdon Caldecott
ii. Banbury Cross and Neithrop
iii. Banbury Grimsbury and Hightown
iv. Banbury Ruscote
v. Barton and Sandhills
vi. Blackbird Leys
vii. Carfax
viii. Littlemore
ix. Northfield Brook

x. Rose Hill and Iffley

16. The data pack in Appendix 2 presents the latest information available on the inequalities in Oxfordshire. It shows that whilst there may be little variation from Oxfordshire and England averages (red and black lines) at a District or City level, there is significant variation at a ward level. The data also highlights, for a range of different measures of health inequality, how commonly these "top 10" wards appear as those with the worst outcome in the county. The cumulative impact of these poor outcomes across the life-course is what leads to the reduced life expectancy and healthy life expectancy noted above. While focus on the most deprived geographical inequality is important, significant inequality exists between different groups within the community, within and beyond the most deprived areas.

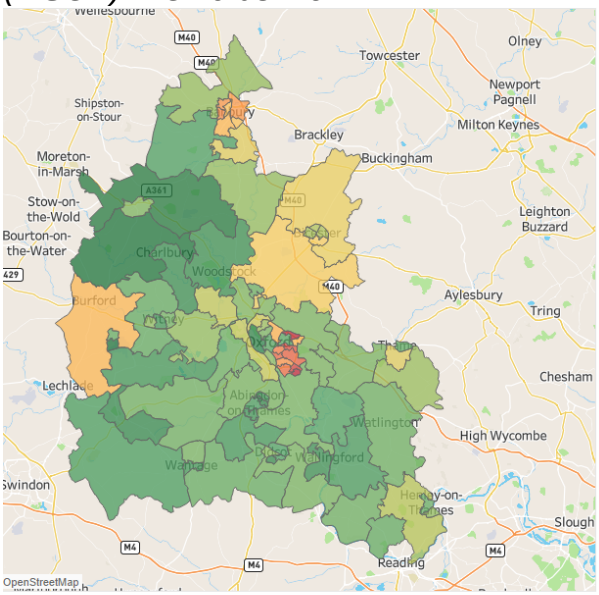
Covid impacts and lessons learned

17. It is clear that the COVID-19 pandemic has had a major impact on all residents of Oxfordshire in some form. To understand the impact and organise our response, we can categorise this impact as:

- Direct COVID related through COVID infection, illness and in some cases death – this is the impact we have clearest data on
- The indirect health impact of COVID, for example through increased prevalence of mental ill-health, periods of inactivity or limitations on access to health care delaying diagnosis and treatment – data is emerging about these impacts locally and nationally
- The wider impacts of COVID which will have long term health consequences, for example educational outcomes and loss of employment - these are the longest-term impacts for which data is limited

18. By the end of October 2021, more than 75,000 people have tested positive within the county showing that the direct impact has been seen across the County. However, we know that the direct impact of the pandemic has not been felt equally. The map below in figure 2 shows that cases have been more prevalent within the urban parts of Oxfordshire and in the areas with the highest level of socio-economic deprivation.

Figure 2- Cumulative case rate of COVID-19 per Medium Super Output Area (MSOA) in Oxfordshire



MSOA long name	Cases	Rate per 1000..
Barton	1,188	17,140
Greater Leys	1,063	17,101
Blackbird Leys	929	16,236
Churchill	1,133	15,855
Cowley North	2,052	15,278
Iffley Fields	757	15,170
Littlemore & Rose Hill	1,467	14,995
East Central Oxford	1,533	14,458
Banbury Ruscote	1,176	13,914
Cowley South & Iffley	1,263	13,787
Banbury Hardwick	1,126	13,663
Banbury Grimsbury	1,611	13,580
Marston	796	12,960
Risinghurst & Sandhills	958	12,857
Banbury Easington	1,080	12,857
Burford & Brize Norton	782	12,818
Banbury Neithrop	746	12,685
Banbury Calthorpe	641	12,618
Islip, Arncott & Chesterton	1,469	12,400
Bicester South	979	12,391
Kidlington South	680	12,257
Caversfield, Ambrosden & Fringford	1,240	12,207
Bodicote, Adderbury & Bloxham	1,175	12,080
Thame South	872	12,066
Wolvercote & Cutteslowe	664	11,847
Botley & Kennington	1,187	11,726
Hanborough & Cassington	732	11,636
Shiplake & Binfield Heath	710	11,446

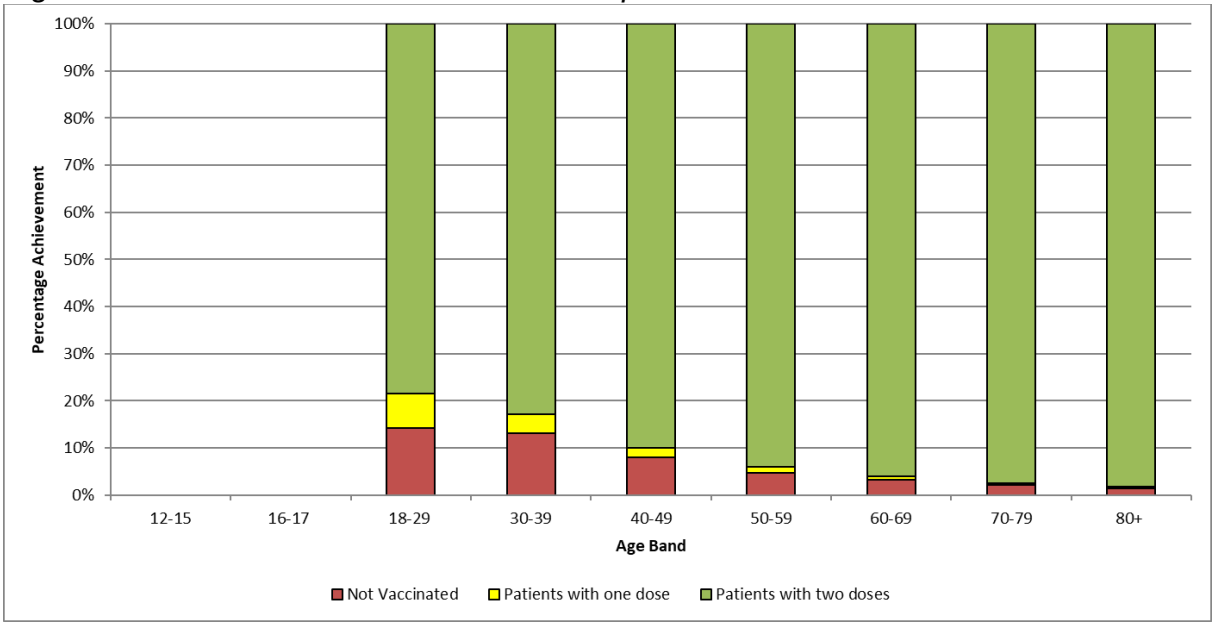
NB- only MSOAs with highest prevalence listed in table on right

19. The data pack in Appendix 2 shows the same cumulative case rate over the course of the pandemic but segmented by age, gender, ethnicity and deprivation. It is clear from page 1 that younger populations have had greater infection rates, although the more serious outcome of hospitalisation and death is more common in older age. More females than males have tested positive, although this may reflect patterns of access to testing than true prevalence. Overall mortality has been higher in men than women.

20. There has been a clear difference in the impact of COVID-19 between different ethnic groups. Although the local data on page 2 shows the greatest count of cases is within British residents this is because they are the largest ethnic group in the county. The mortality rate at different points in the pandemic has shown up to a 4-fold increase in mortality between Black African and some Asian ethnicities when compared to white British. The graph on table 3 shows that at a small neighbourhood level (referred to as a Lower Super Output Area or LSOA) the case rate has been 1.5 times greater in more socio-economically deprived communities compare to the least deprived.

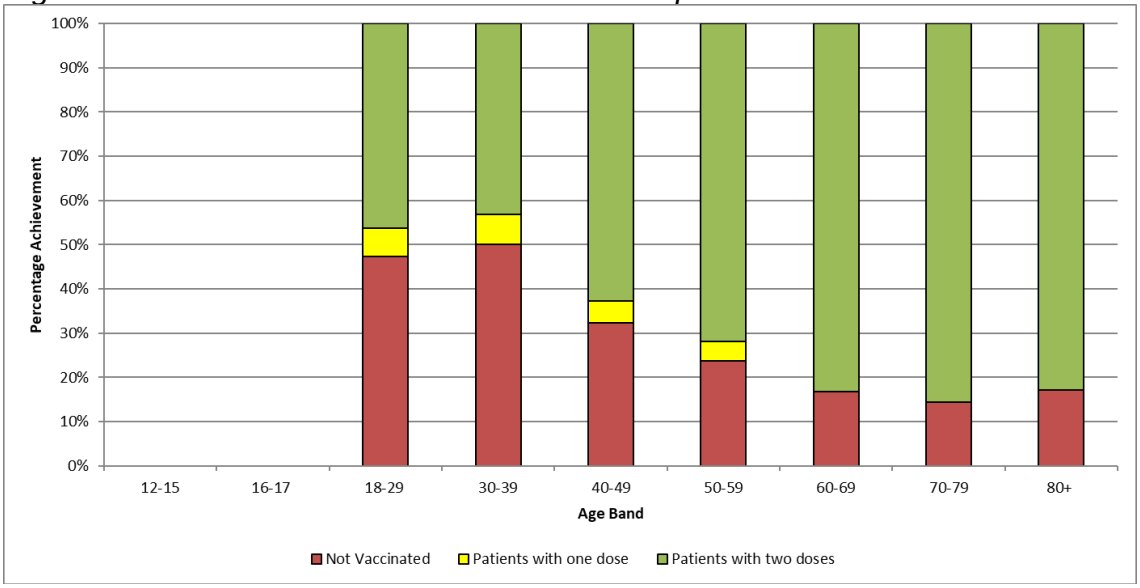
21. Vaccination inequalities have been present before the national vaccination programme had started, with some Black ethnic groups reporting 2-3 times the level of vaccine hesitancy than other ethnic groups. This hesitancy is present within vaccination uptake data in figure 3a and 3b below that shows difference in uptake between White British and African Caribbean residents as an example of the difference seen locally.

Figure 3a- White British residents vaccine uptake in Oxfordshire



NB- single dose vaccination data for 12-17 year olds omitted from this data set as roll-out not complete at the time of reporting

Figure 3b- Black Caribbean residents vaccine uptake in Oxfordshire



22. Ultimately, the greatest impacts of COVID-19 at the population level are not likely to be the direct impacts of COVID-19 but rather caused by the impacts of lockdowns and COVID restrictions on people's health and wellbeing. For example, the impact on there being less access to health services for non-infectious diseases (such as cancer or heart disease), or the wider impact of missed education, financial impacts, job losses, social isolation and reduced mental wellbeing.

23. While data and insight into the longest-term impacts on COVID remain in development, it is clear that those who were already likely to be suffering the most health inequality are also likely to suffer the greatest consequences of

the pandemic. Directly and indirectly, the impact of COVID will have exasperated existing inequalities and must therefore be a significant factor in our long-term planning.

24. While partnership working has always been at the core of public health work in the widest sense, Oxfordshire's COVID response has accelerated and expanded planning and activity at the systems level, focussing on the needs of communities and individuals rather than the specific services of individual organisations. A significant element of the learning from the COVID-19 period will be on how these ways of working can continue to develop and grow to tackle cross-community issues such as health inequality.

Priority areas for action

25. In partnership with key stakeholders, the Public Health team is currently focussing our action on inequalities on the priority areas of; Tobacco Control, Physical Activity and Healthy Weight, and Mental Wellbeing. These three areas have been selected because of the significant contribution they make to premature mortality and morbidity, because there are significant inequalities present within each one and because they are issues that have become all the more important in light of the COVID-19 pandemic.

26. Smoking tobacco is the leading modifiable risk factor for premature mortality and it accounts for over half of the difference in risk of premature death between the most and least deprived social groups.

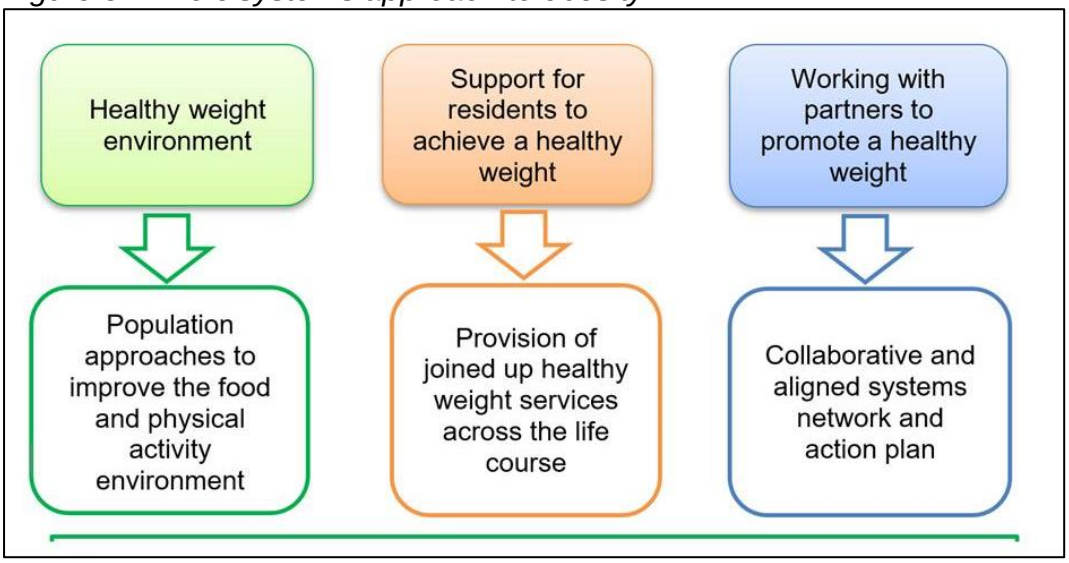
27. In May 2020, County and District Councils across Oxfordshire, as well as local NHS organisations, signed up to a County-wide Tobacco Control Strategy with an ambition for Oxfordshire to be smoke free by 2025 (defined as an overall smoking prevalence of <5%). This is five years earlier than the national target, as outlined in the Government National Tobacco Control Plan for England 2017-22. The Oxfordshire Tobacco Control Strategy has four key pillars for a whole systems approach to local tobacco use: prevention, creating smokefree environments, enforcement, and supporting smokers to quit. The Oxfordshire Tobacco Control Alliance is responsible for delivering the action plan that sits under this strategy. It is an officer-led alliance of organisations signed up to the strategy and regularly reports on its progress to the Oxfordshire Health Improvement Board.

28. Data on childhood obesity clearly shows a social gradient which increased with age meaning that children from more deprived areas are more likely to be of unhealthy weight by age 4 when compared to more affluent peers, a difference which then increases 2-3 fold by age 11. Physical inactivity and unhealthy weight levels have worsened during the pandemic in children and adults. Both lower physical activity levels and higher obesity levels are most pronounced in the more deprived communities in Oxfordshire.

29. Obesity is a complex problem with multiple causes. Most interventions to date have focussed on individual behaviour change like improving diet or reducing sedentary behaviour. While these remain important, a system wide

approach, tailored to local need across the life course is required, in line with the national Whole Systems Approach/Obesity Framework. Consequently, in Oxfordshire a similar approach to that utilised for tobacco control, is underway. This involves developing work that addresses 3 inter-related areas of; promoting a healthy weight and preventing obesity, addressing the physical and social environment and providing support to residents to achieve a healthy weight.

Figure 3- Whole systems approach to obesity



30. The importance of mental wellbeing has become increasingly apparent as we have moved through the COVID-19 pandemic and we know that certain population groups have been at a greater risk of experiencing mental ill-health. For the majority of residents of Oxfordshire this does not mean they need specialist mental health services from the NHS, but rather to be supported individually and in their social or community context to care for their mental wellbeing. A Mental Wellbeing Health Needs Assessment has recently been completed and presented to the Health and Wellbeing Board

31. The actions to support this are coordinated by the Prevention Concordat for Better Mental Health. This concordat aims to facilitate local action around preventing mental health problems and promoting good mental health. The concordat is underpinned by an understanding that taking a prevention focused approach to improving the public's mental health is shown to make a valuable contribution to achieving a fairer and more equitable society. The concordat promotes evidence-based planning and commissioning to increase the impact on reducing health inequalities.

32. As noted, health inequality must be tackled across the organisation. As well as consideration being developed with the overall council strategic plan under development, a number of corporate and partnership strategies are in development to address issues that have come to additional prominance during the pandemic, including digital exclusion and access to food. The Digital Inclusion and Food Strategies are being developed in partnership with public sector and VCS partners to collectively address inequalities in day-to-

day life, which can indirectly impact on health, which include access to healthy food and access to training and devices to get online safely and confidently.

33. Revised consideration of the priority of health inequalities will also inform system-level planning for COVID-19 recovery and renewal planning. One part of that is a review of the Health and Wellbeing Strategy for Oxfordshire undertaken by the Health and Wellbeing Board in September 2021. That review concluded that the strategy, although written pre- COVID-19, remains relevant for the county and the priority it gives to health inequalities is an increasingly important focus. Overall system planning also presents an opportunity to influence the wider determinants of health – for example through the development of long-term place-based plans including Oxfordshire 2050 and through the delivery of sector specific recovery programmes such as the Oxfordshire Economic Recovery plan.

Next Steps

34. To take forward effective action to address health inequalities Officers are in the process of taking forward a range of actions. These do not sit with any one team, service or organisation, but rather require partnership working to ensure they are effective. Initiatives being developed include the following list.

35. Establishing a health inequalities board for Oxfordshire. This board will be co-chaired by the Director of Public Health and the NHS Clinical Commissioning Group's Clinical Chair. It will report into the Integrated Care Partnership for our area and initially focus on taking a tiered approach to addressing inequalities in CVD.

36. Tackling inequalities and providing opportunities for everyone in Oxfordshire to achieve their full potential is one of the 9 priorities of the Fair Deal Alliance. Work has commenced to develop the County Council's Strategic Plan to take these priorities forward and Officers will seek to include actions which tackle inequalities in health that sit across the organisation.

37. Our partnership with the Voluntary and Community Sector (VCS) plays a significant role in addressing health inequalities. Cross-organisational work is already underway to develop a VCS Strategy which will underpin our collective commitment to the sector and enable us to work more closely to address the needs of our communities. This work will also support the longer-term vision for the infrastructure provision that supports VCS organisations and volunteers across the county, and will seek to strengthen our commitment to equality, diversity and inclusion through prioritising the needs of our under-represented groups across Oxfordshire

38. To improve inequalities in physical activity levels and un-healthy weight Officers are developing a whole systems approach to obesity. There already is consensus across County and District Councils plan to expand the Families Active and Sporting Together (FAST) initiative which has run successfully in the 3 most deprived wards in Banbury. This will be made available to residents

in the other most deprived wards in the county and to all children in Oxfordshire in receipt of Pupil Premium support. This work will report into the Oxfordshire Health Improvement Board

39. With oversight from the Oxfordshire Health Improvement Board and the new health inequalities board for Oxfordshire, work is now progressing to expand the reach of the Tobacco Control strategy. Officers are working with colleagues in the NHS to galvanise action to support smoking cessation with residents who are in contact with NHS Secondary Care services, especially aiming to reduce smoking prevalence among pregnant women and acute mental health service users.

40. The 2021 Mental Wellbeing Health Needs Assessment has provided a comprehensive picture of mental wellbeing in Oxfordshire and the impacts of COVID-19. This has been presented to the Health and Wellbeing Board and Officers will be taking forward the recommendations within the report to reduce inequalities in this area. This work will be overseen by the Oxfordshire Mental Health Prevention Concordat Partnership Group reporting into the Oxfordshire Health Improvement Board

41. After the publication of the Director of Public Health Annual Report (link above), Officers intended to undertake more detailed ward profiles of the 10 wards with the greatest health inequalities to more fully understand the need in these communities. This involves the collection of further quantitative data but crucially also involves asset mapping with the community and gathering qualitative insight from residents in these areas. This work has been delayed because of the COVID-19 pandemic response work and one profile has been completed so far (Banbury Ruscote). Officers are now moving forward with undertaking more of these profiles to ensure this work is completed.

42. The overall impact of COVID-19 on different communities in Oxfordshire has been described briefly above but is not yet fully understood. As has been highlighted, some ethnic minority groups have borne a greater burden, but we need greater insight into this. We therefore intend, alongside the ward profile insight work, to undertake further impact analysis in this area.

Financial Implications

43. There are no direct financial implications to this report. All projects or services referred to in the report have established and various funding streams. As work is developed and any changes to funding levels is required this is decided via the usual governance process within the relevant service area.

44. The Public Health team hold a small Health Inequalities Fund which has a value of £600k per annum. This is being used to seed fund specific initiatives such as FAST expansion or other cross-cutting work areas such as the ward profile work, which enable a more informed insightful approach to be taken to address health inequalities.

45. The bulk of resources available to tackle health inequalities are of course within service and partner budgets and work programmes. Good intelligence and joined up planning will maximise the impact that existing funding can have to tackle health inequalities from a whole-system perspective.

Legal Implications

46. There are no direct legal implications of this report. The Council's duty under the Equality Act 2010 is supported by the range of work described above and individual projects are required to have Equality Impact Assessments undertaken in the usual way.

Ansaf Azhar
Corporate Director of Public Health and Wellbeing

Annexes:
Appendix 1 Data Pack on latest Health Inequalities Data in Oxfordshire
Appendix 2 Data Pack on Cumulative Cases of COVID-19 in Oxfordshire

Background papers:
Nil

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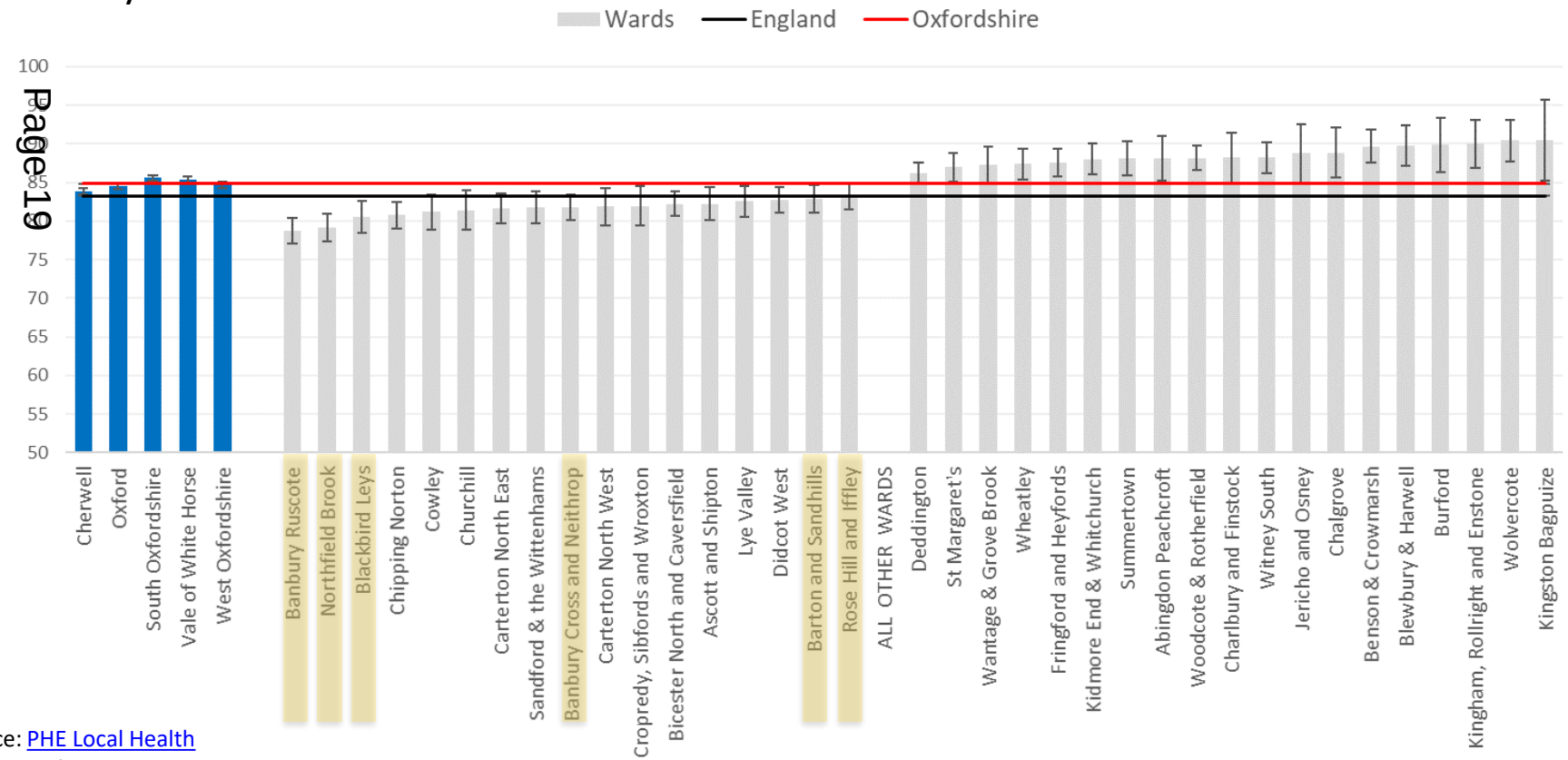
David.munday@oxfordshire.gov.uk, 07922 849652

November 2021

Life expectancy at birth for females, wards significantly better and worse than Oxfordshire, 2015-19

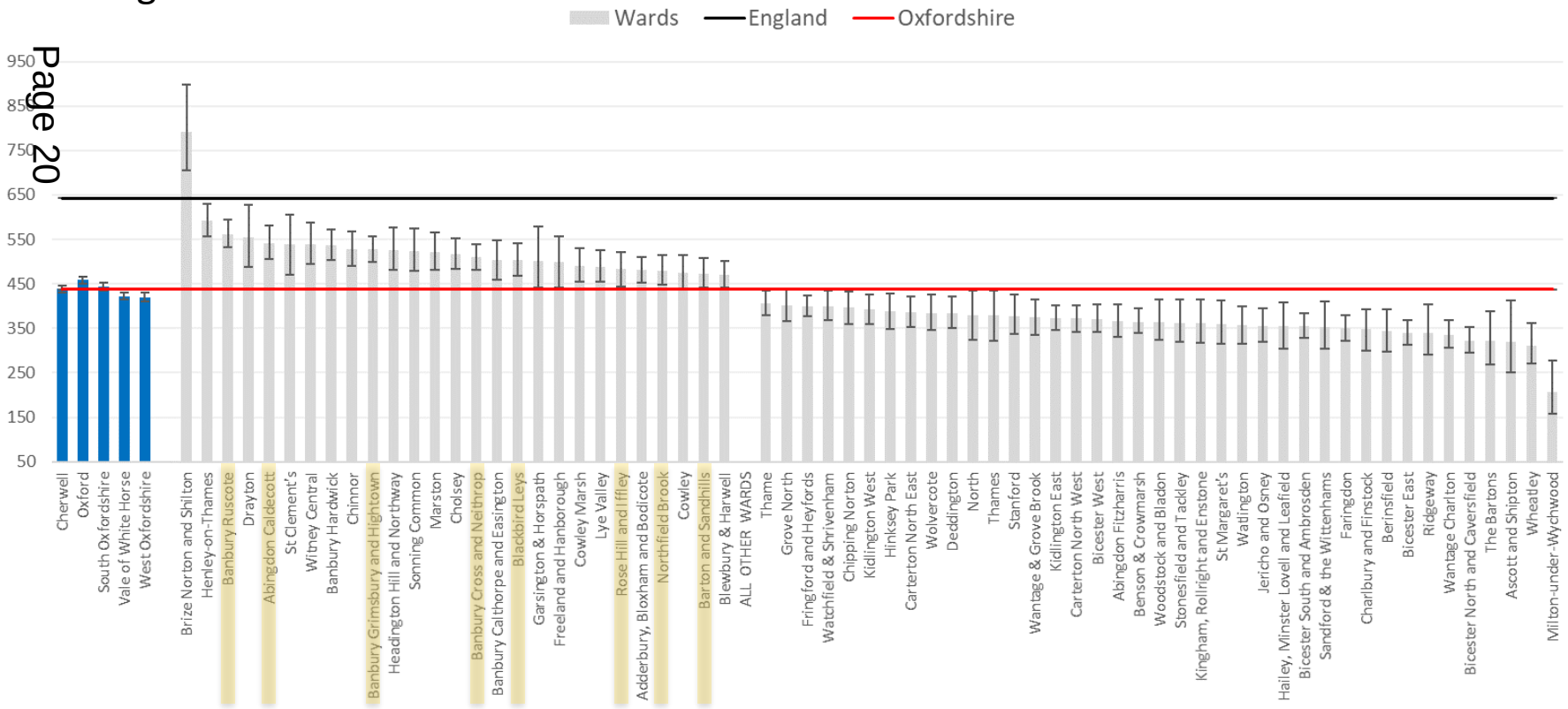
There are clear inequalities in life expectancy across Oxfordshire, with people in the more deprived areas having significantly lower life expectancy compared with the less deprived. The gap in female life expectancy between the highest and lowest wards is 11.8 years.



Source: PHE Local Health
Note: axis does not start at zero

A&E attendances aged under 5 years old, crude rate per 1,000 population, wards significantly better and worse than Oxfordshire, 2017/18 - 19/20

Although the rate in Oxfordshire is significantly lower than the national average, one ward, Brize Norton and Shilton, has a significantly higher rate than the national average. Eight of the 10 most deprived wards* have a higher rate than the county average.

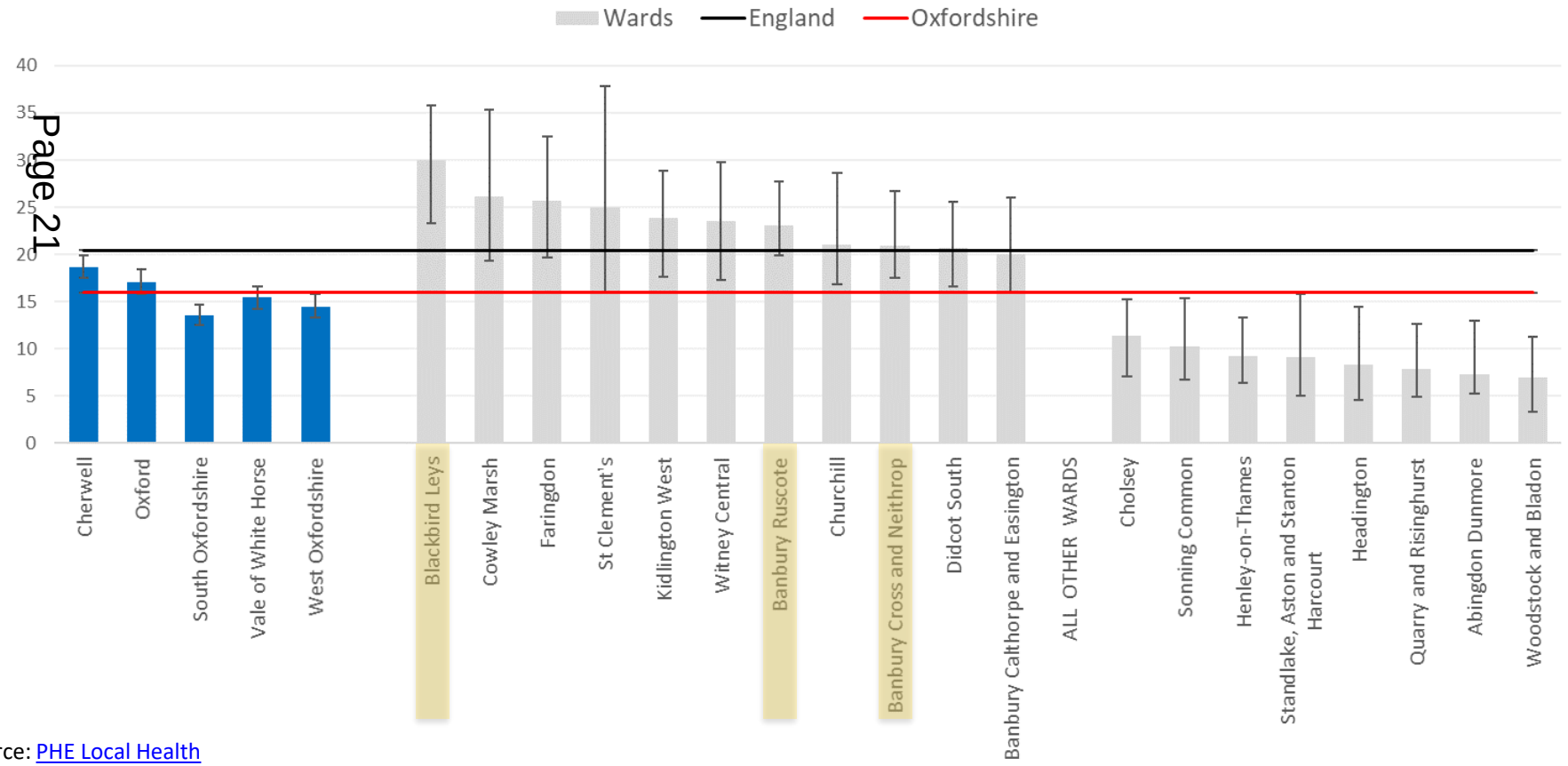


Source: PHE Local Health

* "Most deprived wards" include wards containing LSOAs in the 20% most deprived nationally, using 2019 English Indices of Multiple Deprivation (IMD)

Year 6 Prevalence of obesity (including severe obesity), wards significantly better and worse than Oxfordshire, 2017/18 - 19/20

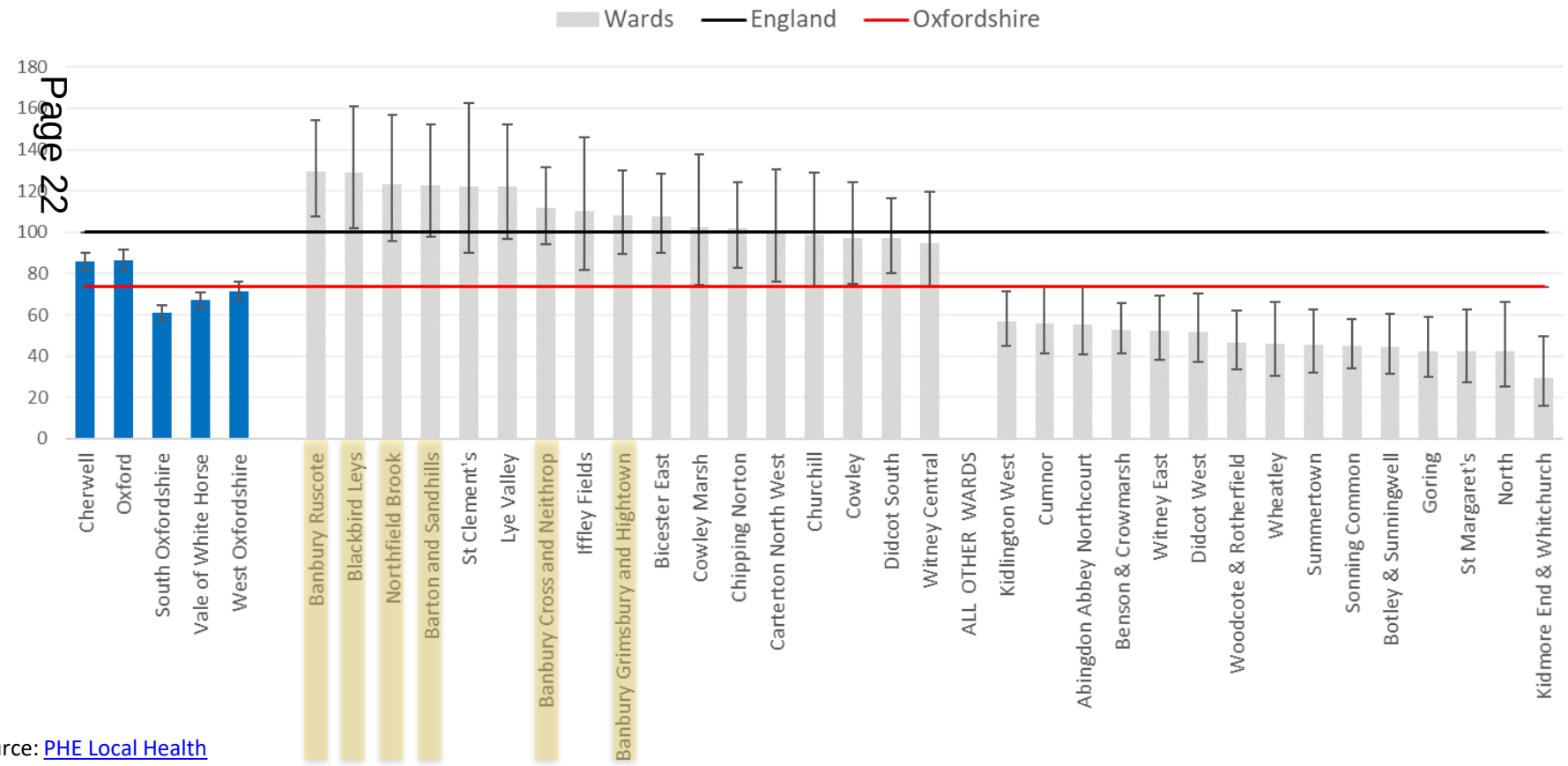
Prevalence of healthy weight decreases as deprivation increases. National data also show that ethnicity has an effect on obesity prevalence, with children from Black, Pakistani, and Bangladeshi ethnic groups experiencing the highest prevalence.



Source: PHE Local Health

Emergency hospital admissions for coronary heart disease, SAR, wards significantly better and worse than Oxfordshire, 2015/16 - 19/20

Although the rate in Oxfordshire is better than the national average, two wards, Banbury Ruscote and Blackbird Leys, are significantly worse than England.

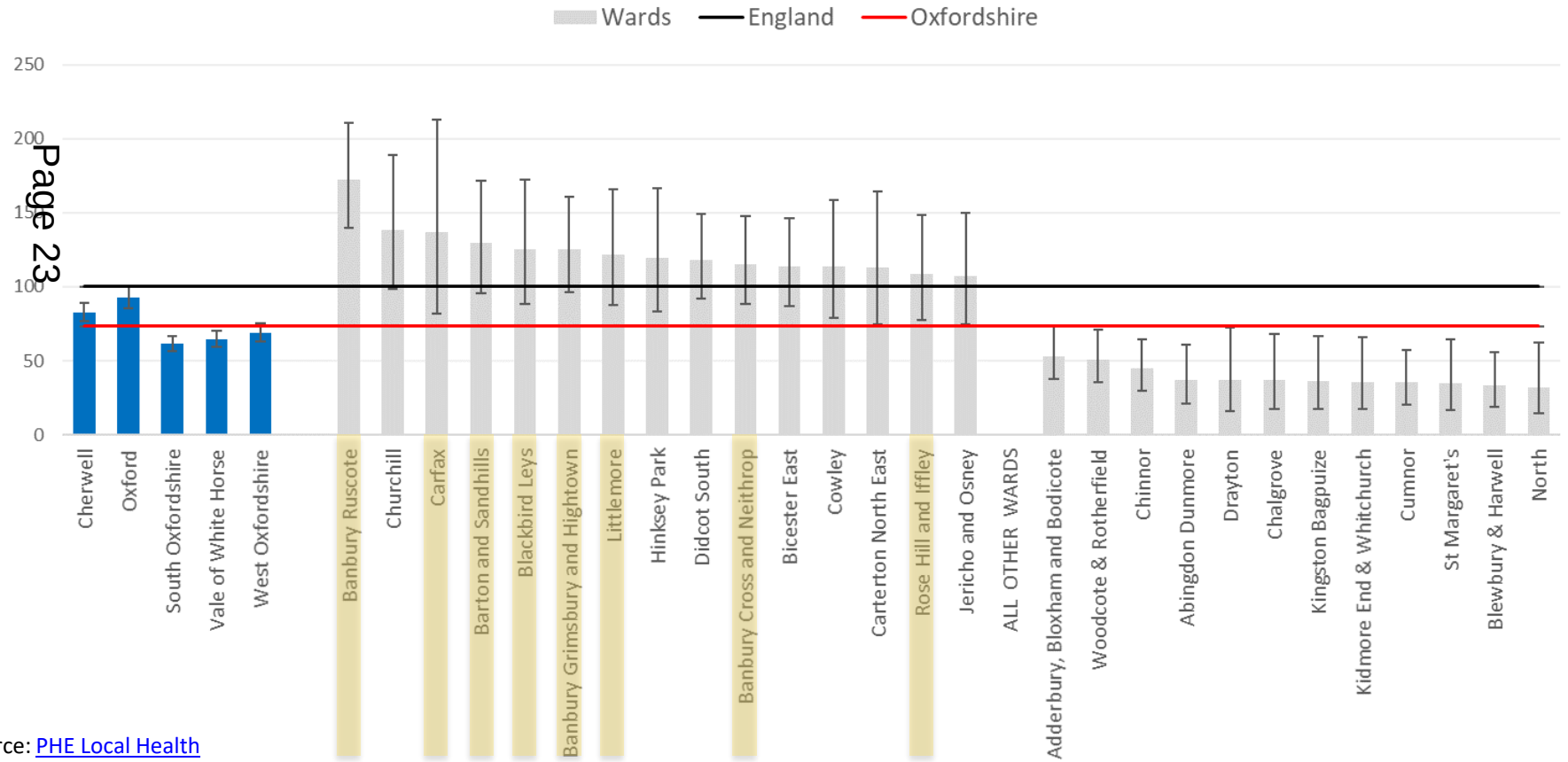


Source: PHE Local Health

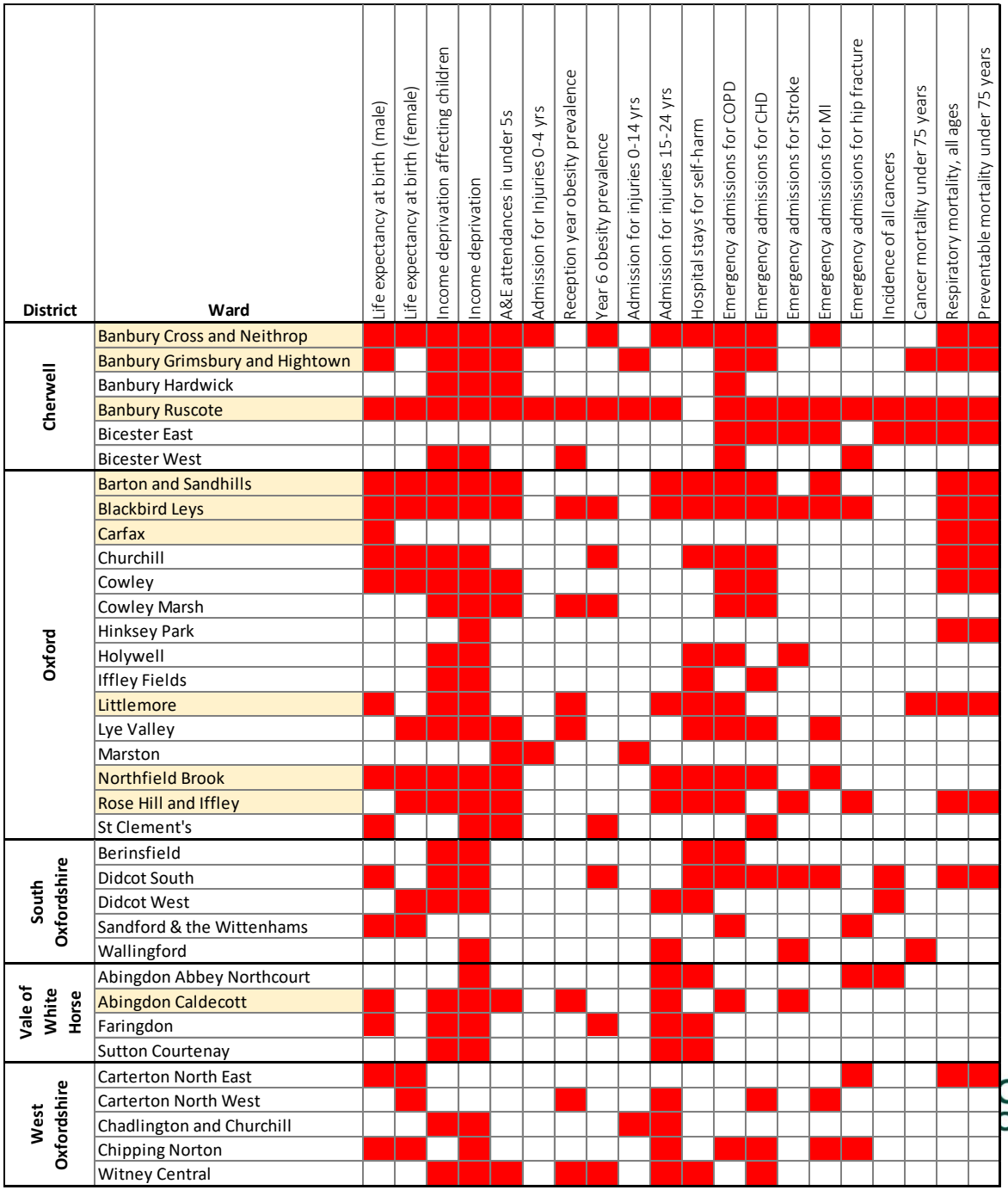
Note: SAR = Standardised Admission Ratio

Deaths from causes considered preventable under 75 years, SMR, wards significantly better and worse than Oxfordshire, 2015/16 - 19/20

Nine of Oxfordshire's 10 most deprived wards* have a higher rate than the county average. Banbury Ruscote is also worse than England overall.



Source: PHE Local Health
Note: SMR = Standardised Mortality Ratio
* "Most deprived wards" include wards containing LSOAs in the 20% most deprived nationally, using 2019 English Indices of Multiple Deprivation (IMD)



Source: PHE Local Health

OXFORDSHIRE COUNTY COUNCIL

Oxfordshire Cumulative covid cases

Data up to 28 October 2021

All cases by 5y age band

Age band	Count	Rate per 100,000 population
0-4	1,664	4,243
05-9	3,631	8,418
10-14	7,900	18,696
15-19	8,577	21,073
20-24	8,065	16,213
25-29	6,451	14,228
30-34	5,725	13,822
35-39	5,102	11,347
40-44	5,381	12,662
45-49	5,266	11,720
50-54	4,952	10,365
55-59	3,829	8,278
60-64	2,490	6,475
65-69	1,649	4,974
70-74	1,283	3,745
75-79	956	3,730
80-84	875	4,721
85+	1,579	8,480
Grand Total	**75,375**	**10,816**

All cases by Gender

Age band	Count
Female	38,508
Male	35,930
Unknown	937
Total	**75,375**

All cases by Ethnicity

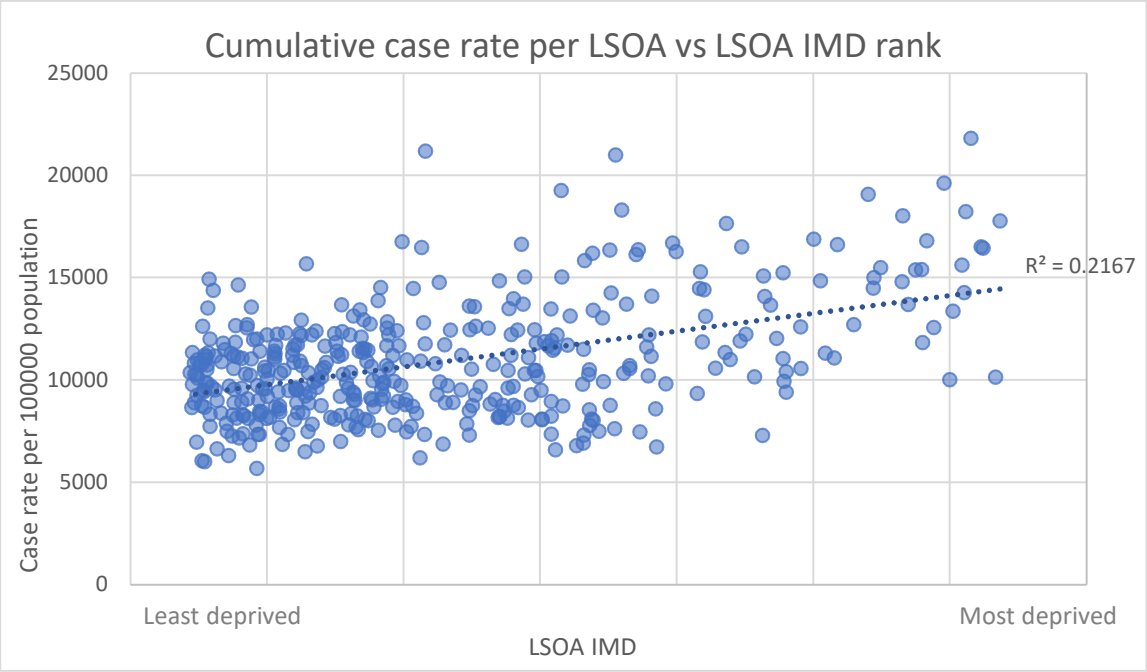
Excluding 19559 cases with no ethnicity information

Ethnicity	Count
African	738
Any other Asian background	897
Any other Black / African / Caribbean background	232
Any other ethnic group	676
Any other Mixed / Multiple ethnic background	534
Any other White background	4,759
Bangladeshi	240
British	44,052
Caribbean	262
Chinese	231
Indian	906
Irish	280
Pakistani	1,091
White and Asian	420
White and Black African	185
White and Black Caribbean	313
Total	**55,816**

All cases by Deprivation decile

Excluding 91 cases

Deprivation decile	Count
1	244
2	3,841
3	2,673
4	3,816
5	4,308
6	7,797
7	9,801
8	10,326
9	15,112
10	17,366
Total	**75,284**


Cumulative case rate per LSOA vs LSOA IMD rank
25000
20000
15000
10000
5000
0
Case rate per 100000 population
R² = 0.2167
Least deprived
Most deprived
LSOA IMD

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Divisions Affected - All

PEOPLE OVERVIEW AND SCRUTINY COMMITTEE
11 November 2021

FAMILY SOLUTIONS PLUS

Report by Corporate Director of Children's Services

RECOMMENDATION

1. The Committee is RECOMMENDED to:

   a) consider the contents of the report and put relevant questions to the Cabinet Lead member, Director of Children Services and supporting Officers.
   b) decide if any further action is required.
   c) consider recommending to the Oxfordshire Place Board consideration of the Family Solutions Plus (FSP) business case to agree the future funding approach.

Executive Summary

2. The purpose of this report is to provide the People Overview and Scrutiny Committee with requested background information to inform the review and discussion of the Family Solutions Plus service.

3. The report discusses the progress to date and what has been achieved, both quantitatively and qualitatively, a year into the implementation.

4. The report also highlights the challenges of sustainability, particularly the long-term funding of the Substance Misuse, Domestic Abuse and Mental Health Workers after 2023.

Scrutiny Guidance

5. In order to assist the People Overview and Scrutiny Committee, a briefing on Family Solutions Plus was provided to Committee Members on 20 October 2021, followed by drop-in information sessions on 8 and 9 November 2021.

6. This agenda is intended to operate as follows at the People Overview and Scrutiny Committee meeting:

   a) Short presentation from Officers on the key themes.
   b) View from the independent external review of FSP undertaken by Oxford University, followed by question and answer session
   c) Two live case examples covering Domestic Abuse, Mental Health and Alcohol and Substance Abuse.

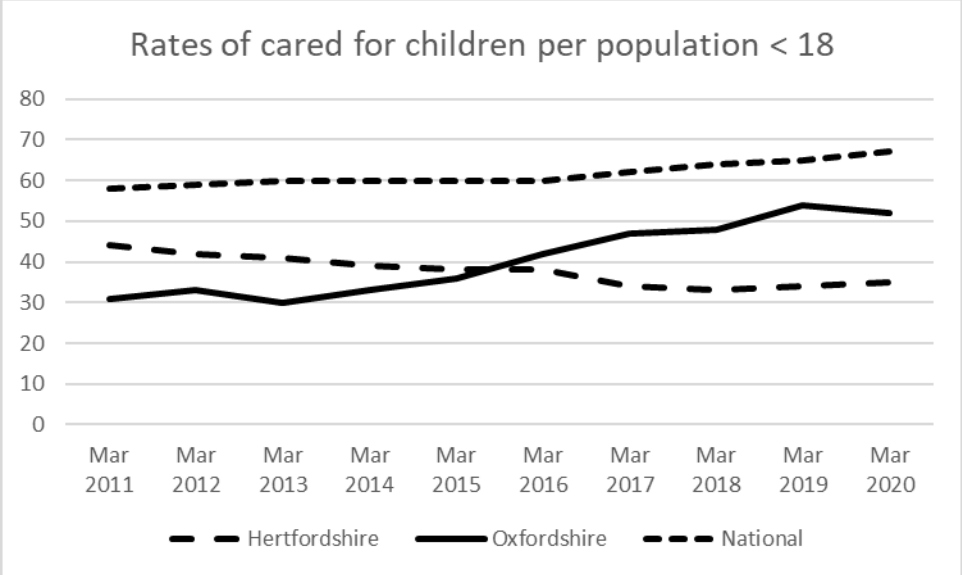
d) Committee questions and answers with Cabinet Portfolio Holder and key Officers.

Family Solutions Plus

7. Family Solutions Plus (FSP) is the title of the Children's Social Care Service in Oxfordshire in which the Family Safeguarding Model has been implemented within a local context. FSP is designed to provide rapid, proactive support to children and their families. It is delivered by small multi-agency teams who are trained in a range of highly effective interventions.

8. Hertfordshire County Council developed the Family Safeguarding Model in 2015 and it has helped them to deliver more preventative social care services to children, notably significantly reducing the number of children who become subject to child protection plans and the number who enter care. The project has been independently evaluated by the Department for Education and is one of three proven national social care models attracting government funding for local authorities judged by Ofsted to 'require improvement'. Oxfordshire was unable to access this fund due to being judged as 'good'. There is a growing number of councils adopting the model across the country.

9. For a number of years, both locally and nationally, the number of children cared for by local authorities has been growing. In Oxfordshire, the number has risen from 413 in 2013 to 776 at the end of March 2021. However, in Hertfordshire, the implementation of the Family Safeguarding model (FSM) has seen numbers fall. The model is seen as a key means of safely reducing the numbers of children that a local authority needs to care for and positively impacting on spending levels.



10. Oxfordshire agreed its approach to a Family Safeguarding model in July 2019, investing £4.8m on the basis that, as in Hertfordshire, over time, children's social care savings would be made on placements and reduced demand for casework. Also partner agencies would be successfully approached to contribute financially as improved adult health and community safety

outcomes were realised. Arguably FSP represents the most significant opportunity to stabilise increased service demand and meet MTFS targets. A link to the Cabinet Paper from July 2019 is below:

https://mycouncil.oxfordshire.gov.uk/documents/s47880/CA_JUL1619R19%20FSP%20-%20TJ%20Finance%20Section%20002.pdf

Key Interventions

11. In 2019/20, over 7000 children in Oxfordshire received a children's social care assessment. In 31% of these assessments, issues with a parent's mental health led to risks for the child; 28% of assessments identified parental violence as a risk factor and 28% identified parental drug and alcohol abuse as a risk factor. 707 children in the year became the subject of a child protection plan; in over 60% of these, parental mental health and domestic violence was a risk factor.

	No. assessments identifying risk factor (7022 assessments)		**No. children starting child protection plans where this risk factor was identified (747 plans)**	
Child neglect	879	13%	437	59%
Child emotional abuse	1010	14%	429	57%
Child physical abuse	813	12%	229	31%
Parental drug misuse	837	12%	250	33%
Parental alcohol misuse	1121	16%	286	38%
Parental domestic abuse	1992	28%	467	63%
Parental mental health	2170	31%	464	62%
Child sexual abuse	282	4%	51	7%
Child socially unacceptable behaviour	760	11%	129	17%

12. The Family Solutions Plus Model was developed to address the issues outlined in the table. The service went live on 2 November 2020 after a five month delay due to the initial impact of the first Covid lockdown, and has been implemented over the last year, whilst the service has been severely impacted by the on-going pandemic. Although that has been challenging, it is arguable that children and families would have suffered more, and the service would be under greater stress, if no changes had been made and new interventions had not been introduced.

13. Prior to 'go live', teams and service structures were completely remodelled. With all social care front line teams impacted (apart from the Multi-Agency Safeguarding Hub (MASH), Disabled Children's Teams and Children We Care For Teams). There are now 17 multi-disciplinary Family Solutions Plus Teams, based in localities throughout the county, co-located with our 8 Early Help Teams.

14. Each team has 7 or 8 social workers, an assistant team manager and a team manager. 30 FTE adult-facing practitioners employed by Turning Point, Oxfordshire MIND and Elmore Community Services are based within the 17 teams. The teams work with children and families who meet the social care threshold for help and protection, including those on the edge of, and entering, care.

15. All components of the original Hertfordshire Family Safeguarding model were implemented. In addition, the Oxfordshire model has added continuity of worker undertaking both assessment and intervention; and a joint approach with local housing workers from the District Councils targeted at preventing homelessness.

16. The key elements outlined in the original business case have been implemented:

- FSP teams take a 'relationship-based' approach, prioritising a consistent worker for the family and driving down changes of worker.
- All practitioners have a core skill set with Motivational Interviewing (MI) at its heart. Training and a MI app to support practice have been embedded.
- Evidence-based interventions are provided by specialist adult mental health, substance misuse and domestic abuse practitioners.
- A single structured electronic 'workbook' to assess parents'/carers' capacity for change and their progress, in which the different disciplines record.
- Family group supervision: adult and children-facing practitioners are supervised together by the social care team manager.
- A partnership outcomes-based performance framework. Children's Social Care and adult organisations' measures are in place. Performance is managed monthly and reports to the multi-agency FSP Steering Group (comprised managers of all constituent organisations and chaired by the Deputy Director).
- The FSP Board is attended by senior representatives of the wider children's system (Health, Police, Probation, Voluntary Sector, Children's Social Care, District Councils) in order to support the sustainability of FSP and align other organisations with its objectives.

Targets

17. Modelling undertaken in 2019 as part of the FSP business case identified a bleak trajectory, with increased volume and associated costs. The table below highlights the likely demand if no changes were made. This would result in a significant requirement to invest in additional social work staff and uplift of other associated costs (e.g. children's placements).

	March 2020	**March 2021**	**March 2023**	**March 2025**	**March 2030**
Children in care	810	846	919	990	1143
Child protection plans	658	723	854	1008	1459

18. Oxfordshire's FSP adopted targets of a 5% reduction, year on year, capped at the top of the lowest quartile of statistical neighbours, in both children in care and child protection. The table shows the target reductions over time:

	March 2020	March 2021	March 2023	March 2025	March 2030
Children in care	756	736	697	682	727
Child protection plans	587	585	581	606	654

Performance and Outcomes

Activity

19. At any time, FSP teams are undertaking approximately 700 assessments; working with 1200 children in need; 500+ children subject to child protection plans and 200 children who have entered care.

20. The adult-facing interventions have become established. The table below shows a month's snapshot of their activity in June 2021:

Organisation	Open Cases	Completed Programmes	Comments
Turning Point: drugs and alcohol	188	22	1178 interventions, including 326 drug tests, 214 breathalysers, 229 1:1 sessions.
Elmore Community Service: domestic abuse (victims and perpetrators)	105	7	76% of all requests have received interventions. Three perpetrator groups running.
Oxfordshire MIND: adult mental health	96	15	42 mental wellbeing tests completed: 90.24% meaningful improvement.

Covid impact

21. The targets assumed that the service would go live in June 2020. However, due to Covid 19, the actual 'go live' was November 2020 and, therefore, has just completed its first year of full operations.

22. In 2019, the projected overall target caseload for FSP in 2021/22 was 1905. There are currently 2628 open cases to FSP. This is 38% above target; and 13% increase on last year. This is accounted for by higher than anticipated social care assessments, children in need plans and care proceedings.

23. In the five years to March 2020, on average, 46% of the children cared for at the start of the year left the cared for system. In 2020/21, during Covid, just 35% of children left the system. 82 more children would need to have left to

reach the normal rate (46%). If the proportion of children leaving had reduced to 42% (the national average), 52 more children would have left the system.

24. The factors causing children to remain in care longer are:

- Increased complexity of need: children in/edge of care are presenting with high levels of emotional and mental health needs.
- Excessive delays in court timescales (the 26 week target is frequently extended to >40 weeks) leading to a 65% increase in the number of children in proceedings between March 2020 and March 2021.
- A national shortage of placements that are able to meet children's needs and prepare them for permanence/return home.

25. The combination of high casework demand (linked to Covid) and the increasing problems presented by a national shortage of experienced social workers has led to recruitment, retention and sickness absence problems, which in turn has increased workloads to very high levels.

26. Across FSP, social workers are supporting 38% higher numbers of children than planned. Over one-third of staff are agency workers and, in a small proportion of teams, there is 50+% agency staffing. This trend is common to authorities across the country, where the teams working in children's acute safeguarding are the hardest to recruit to. It is emotionally demanding work that does not fit neatly into office hours. In Oxfordshire, as in many local authorities, we are seeing staff leaving the profession, or seeking posts in teams that are perceived as less stressful, after two to three years post-qualification.

27. The Council has responded positively with additional Covid-funding for extra temporary staff; however, sourcing suitably qualified staff is as much a problem for agencies as it is for local authorities. As a consequence, staff vacancies are not fully covered and workloads remain stubbornly high.

28. FSP has invested in a special internal NQSW professional development unit which provides bespoke induction and support to social workers, with a view to 'growing our own' resilient and experienced staff who have benefitted from tailored professional development programmes. We currently have an enthusiastic group of 15 NQSWs in the unit, and 15 more starting in January 2022, who are being gradually introduced into teams to fill vacancies and reduce agency staff. This is not an immediate 'fix', but will impact positively in the medium and long-term.

29. The pressures experienced by staff are reflected in the staff feedback below. The workload has undoubtedly made FSP more challenging to implement, as quality work with families requires staff with time to think, plan and deliver face-to-face interventions. However, the managers report high levels of staff commitment to delivering the new model and achieving good outcomes for children and families, which is reflected in the performance and the qualitative feedback from parents.

Current Performance

30. A Covid-adjusted target for children in care, to take account of the bottlenecks in the pandemic, has been created by adding 50 children per annum to the target. The service is meeting the Covid-adjusted target. See below:

	March 2020	March 2021	June 2021
2019 projection of cared for numbers	810	846	855
Projection based on FSP reducing the numbers by 5% per year	756	736	729
Actual cared for figure	767	784	786
Variation from the target	1%	7%	8%
Covid adjusted FSP target	756	788	797
Variation from adjusted target	1%	-1%	-1%

31. In 2020/21, 288 children entered care. This was 14% lower than the average across the previous five years and the lowest annual figure for over six years. Since the implementation of FSP there has been 12% reduction in children entering care. This indicates promising preventative impact of the new model.

32. The impact of FSP on child protection plans is also promising: much good family safeguarding practice development and management oversight was introduced during the run-up to and since go-live. The impact of Covid is harder to determine, but many local authorities saw an increase in child protection in 2020/21 that Oxfordshire did not, in spite of a 35% increase in the number of contacts coming into the MASH.

33. The 5% reduction in child protection has been achieved and exceeded. The number of children starting a child protection plan in 2020/21 was 8% lower than the average of the previous 5 years (60 fewer children). The time that children spend on a plan has also reduced, so that now 85% are on a plan for less than 12 months, due to families achieving their plans more quickly. Both reductions have had a good impact on bringing down the size of the child protection cohort.

	March 2020	March 2021	June 2021
2019 projection of child protection numbers	658	723	763
Projection based on FSP reducing the numbers by 5% per year	587	585	585
Actual child protection	541	451	510
Variation from target	-8%	-23%	-13%

Service User Experience

34. The following examples have been received in recent weeks:

*" **** is like no other social worker I have had, instead of demanding things are done to their standard, with the expectations that are, when you have kids,*

*near impossible. **** works with you in a way that is not patronising, also she is willing to help out instead of just dictating that certain things are done. My impression of **** is that she is a kind but firm social worker that if needed will do the job that is required. **** has an empathy for the position that the parent is facing and for the best possible solution. If necessary, she will get tough if she feels you are not pulling your weight in a situation. I would like to take this opportunity to thank **** for all the work she has done with me and the boys to get us to a position that will hopefully sort things out in the long term."*

*"Hi (mental health practitioner), it's ***** just wanted to check in and let you know how things are going. First off we miss you and I hope you are well. ***** will be 8 this month and is loving year 3. ***** has started nursery and loves it, and we are potty training. We saw the health visitor last week and he is way above average height. The child protection plan has been reduced to a child in need plan. I am 77 days clean from cocaine, 50 days clean of alcohol and cannabis and 35 days since I gave up cigarettes."*

"We had a dad that came to Family Links (parenting programme) for the first time yesterday. He was voicing his upset about why he had to attend, and that he only had contact with his child for a couple of hours a week. He felt he was doing his best. Another parent who only had weekly contact with her child reassured him that he is not alone and explained that the group was not about saying he is a bad parent, it's about learning new ideas that might help. This was quite touching. The dad listened, accepted and respected what she said. He was more relaxed thereafter and apologised. We told him there was no need to apologise and thanked him for his input."

*"From myself and ****, thank you for helping our family to become the best version of itself, for supporting us through a tricky time and giving us advice on how to help our children reach their best!"*

"Thank you again for always being so kind and supportive towards me. You've helped me massively over the last few months, I really can't thank you enough. You've been amazing. I've also been thinking that if the worst does happen, I will still stick to my plan to complete detox and rehab, for myself. All I can do is not give up."

*"I would like to say thank you so much for helping me during my difficult time, I really appreciate of what you do. Now I and my child are in the safe place (women's refuge) and relieved finally. Also, I would like to thank **** and **** for supporting me as well. I hope you all have a good rest of the day."*

Staff Feedback

35. All the feedback below was derived from six staff focus groups hosted between May and August 2021 by Ruta, the independent research assistant from the University of Oxford:

36. "The new Family Safeguarding model in Oxfordshire County Children Services has been broadly welcomed by staff. All staff interviewed broadly supported

the increased emphasis on strengthening relationships within families and between families and professionals. There was also strong support for the move to one consistent staff member working with families in both the assessment and longer-term support, even though many found it challenging to acquire the new skills they needed to work throughout the intervention period. Staff especially valued motivational interviewing as providing skills and underpinning for a more therapeutic and supportive relationship with families. The introduction of adult-facing practitioners to address domestic abuse, substance misuse and mental health problems, was seen in a very positive light as a potential support to social workers rather than a diminution of their role. They also valued the support of management that helped them deal with the challenges."

37. "Senior staff in OCC had devoted considerable time to explaining the model and preparing staff for the new roles. The importance of having time to introduce the model and get buy-in from the staff made them believe in the model. In addition, substantial training allowed them to learn different parts of the model and prepare for the implementation of the services. However, some things could have been improved. For example, more time was required for transition between teams as well as adjusting to new roles."

38. "The staff interviewed were also clear that the implementation of the model had posed considerable challenges and that current pressures had delayed full implementation. Implementation was, of course, considerably affected by the Covid-19 pandemic, the shift to home working, increased workload and the pressures on both staff and the families they were supporting. At the time of the interviews, the new service was not fully staffed, which increased pressures on the remaining staff. Adjusting to managing assessments within each team, although thought desirable, led to large short-term fluctuations in workload."

39. Staff comments:

"The most rewarding thing is seeing the changes parents/carers make so that their child/children have a loving and positive life. Knowing I have had a role in helping this happen is a privilege, especially when parents thank you."

"I think for families and for children, having the same social worker right from the start is much better for them. I think they feel they can build a relationship."

"I feel we are really able to offer a better, more holistic service to families, and that certainly makes my job satisfaction higher."

"The work that I'm doing feels more meaningful than it has been."

On Motivational Interviewing: "It's not just based on gut or doing something, but actually … working within like a system, and the framework, and the theory. For me that makes me feel a bit more grounded in what I'm doing, and as a worker I like having that basis, and knowing that, that sort of being pulled from."

"There is a lovely thread through where you can see how you know, from the initially coming into the team that workers gonna be the one worker for that family consistently supporting them going forward, and that, and plans are more focused because of that definitely."

"I've noticed that because of the support of our adult-facing practitioners, our social workers and children's practitioners have more time and more capacity to just focus on the direct work with our young people."

"I'd also say in terms of the group supervision everyone, all these practitioners contributing during the group supervision has helped to create better outcomes for the children….When we come up with actions, as to what needs to be done, at least everyone is coming from different perspectives, depending on their area of specialisation. Then we come up with good plans, I would say."

Challenges for Staff

40. As described above, the most challenging aspects of the implementation have been the high workload and turnover of staff:

"But reality of the workload is overwhelming, when have low staff… there are a lot of tears now- I feel like I am not doing anything meaningful, so it is very difficult…but if we have the full staff this would be better."

"I believe in the model and think it could be good… I have seen where it has worked with families and think collaboration is great but not having the staff has been hard… in a couple of weeks, all staff gone again - don't know who I'm working with on a weekly basis…"

41. It has also been challenging for staff to adjust to the aspects of the work they had not experienced in their careers, prior to the restructuring, or for some time; and to balance the competing demands of short and long-term work.

"Managing court work alongside fast paced parts of the assessment is hard."

42. To address this, managers continue to offer regular training and development workshops to staff and keep close communication with teams to improve systems and support mechanisms. Skills and confidence are improving.

External Independent Review

43. An independent evaluation by the University of Oxford, has been funded by the National Institute for Health Research through the Thames Valley Applied Research Collaboration. It is sponsored by Professor Charles Vincent and Professor Ray Fitzpatrick. Ruta Buivydaite, the research assistant, is supported by an evaluation sub-group of FSP staff and managers.

44. The first report is based on staff feedback, see above.

45. Interviews with families to assess their experiences of the model; and interrogation of data to evaluate the impact on services, are also part of the first year studies, to come.

Developing Family Solution Plus

46. The priorities for the service are:

- Continue to embed the model, grow the motivational skills of all practitioners and realise the preventative and therapeutic impact on families.
- Continue to deliver the reductions in new entrants to the care system.
- Continue to deliver the reductions in children subject to a child protection plan.
- To manage demand so that workloads are lower and the practitioners can further increase face to face time with families.
- For the service to be financially sustainable post-2023.

Cabinet Perspective

47. Councillor Brighouse, Cabinet member for Children & Families, would like to highlight the commitment and effort of all the children and adult practitioners and managers in delivering FSP throughout its first year. She also draws attention to the significance of the 'whole family' approach embodied by this way of working, seeing it as a major step forward in the Council's delivery of children's social care.

Financial Implications

48. Due to the overall size of the caseload being 38% higher than the target, the original social care savings schedule approved in 2019 is being revised and addressed through the budget-setting process.

49. FSP is a partnership endeavour and the original business case included a laudable aspiration to align partner service priorities and secure funding for the adult-facing practitioner roles. Significant engagement has taken place with partner agencies and they are active members of the Board. However, experiences from other Family Safeguarding implementors across the country indicate challenges in obtaining continued investment funding from partners.

50. The investment made by the council in 2019 included funding for the adult-facing organisations of £1.5m per annum for the first 1.5 years of the service. The contracts were due to expire on 31st March 2022. In order to extend for a further year, Public Health and Children's Services have built into their budget-planning for 2022/23 £1.0m (£0.5m from each directorate). The remaining £0.5m will be funded from Supporting Families grant funding from central government.

51. The permanent funding for the adult-facing practitioners beyond 2023 will be part of the future strategy for FSP. Discussions will continue with partners

about the impact FSP has in reducing cost pressures across the wider system. This business case for continued investment will sit alongside any savings that are realised by the avoidance of the costs of children coming into the care system.

Legal Implications

52. There are no legal implications in the report.

Annexes: Annex 1 – Family Solution Plus Guide

Kevin Gordon
Corporate Director of Children's Services

Contact Officer: Hannah Farncombe, Deputy Director, Children's Social Care.

1 November 2021

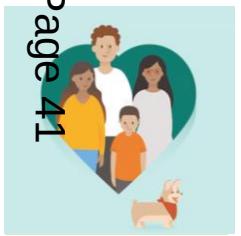
Family Solutions Plus Model:

Multi-disciplinary Teams:

Our multi-disciplinary teams work with families to get to the heart of their difficulties - our adult-facing practitioners work with parents/carers to support them with addressing unmet needs to increase their parenting abilities .

Strengths-based practiced model

Our workers are trained in working with families to understand why we are involved, and build on family strengths using motivational interviewing to build rapport and promote change .



Reducing Bureaucracy:.

The family Workbook enables holistic and purposeful work with families based on a modular approach to assessing parenting capability whilst reducing social workers' recording.

Relationship-based.

Every family will be assigned one social worker who will work with them throughout assessment and intervention; one worker; one assessment; one meaningful intervention to ensure sustainable change.

OXFORDSHIRE COUNTY COUNCIL

Multi-disciplinary

Strengths-based

Reducing bureaucracy

Relationship-based

Founded on and overseen by a strong multi-agency partnership including District Councils, Public Health, key statutory partners and local voluntary sector partners.
Our domestic abuse, mental health, and substance misuse adult –facing practitioners are embedded in our social work teams and have been directly commissioned by the local authority from voluntary partners.

We have **created 17 locality-based multi-disciplinary teams across Oxfordshire** delivering support and intervention to families where they live.

Teams are comprised of social workers, adult-facing practitioners and children's practitioners, who work directly with children and their parents, delivering evidence-based interventions and programmes in response to assessed need.

We are changing our focus to working **with**, not at or to, in line with our restorative practice principles. We engage families and promote change through **motivational interviewing**.

Our work with every family is reviewed, considered and evaluated in **family group supervisions** to allow all practitioners involved an opportunity to review progress, define outcomes achieved, and collectively agree current risks and needs, so that risk is shared.

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