NHS
Oxfordshire
Clinical Commissioning Group

Oxfordshire Clinical Commissioning Group
Board Meeting

Date of Meeting: 26 May 2016	**Paper No: 16/39**

Title of Presentation: Safeguarding Activity Report

Is this paper for	**Discussion**		**Decision**		**Information**	✓

Purpose and Executive Summary (if paper longer than 3 pages):

To provide an overview of safeguarding activity within the OCCG and to inform the board of the findings and requirements of relevant reviews and reports

Financial Implications of Paper:

Action Required:

Include details of the actions for the OCCG Board

NHS Outcomes Framework Domains Supported (please delete tick as appropriate)	
	Preventing People from Dying Prematurely
	Enhancing Quality of Life for People with Long Term Conditions
	Helping People to Recover from Episodes of Ill Health or Following Injury
✓	Ensuring that People have a Positive Experience of Care
✓	Treating and Caring for People in a Safe Environment and Protecting them from Avoidable harm

Equality Analysis completed (please delete tick and attach as appropriate)	Yes	No	Not applicable ✓
Outcome of Equality Analysis			

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Safeguarding Activity Report

Assurance and governance in safeguarding is closely linked to the work of the safeguarding adults and safeguarding children's boards.

As commissioners we seek assurance from the providers that their statutory and contractual obligations are being met. In the absence of specific outcome measures there are process measures which can be applied to safeguarding activity.

Serious case reviews for children (SCRs), safeguarding adults reviews (SARs), domestic homicide reviews (DHRs) and mental health homicide reviews MHRs) all produce recommendations and action plans. Assurance that the plans are being implemented is sought through the structure of the safeguarding boards.

Adult safeguarding update

Adult case reviews

One of the two South Oxfordshire and Vale domestic homicide reviews (DHRs) that have been ongoing has been completed and the report is due to be signed off by the Community Safety Partnership at their next meeting in May, before submission to the Home Office for approval and publication.

The draft findings were that the homicide was neither predictable nor preventable.

There is one Mental Health Homicide (MHR) review currently in progress. A further MHR is likely to be commissioned for another Oxfordshire case.

There is one serious case review currently underway.

Safeguarding children update

Children's case reviews

Two serious case reviews continue with all providers contributing internal management reports and chronologies. These are both due to be completed in July and will be published later in the year.

Multi-Agency Inspection

There has been a multi-agency inspection by Ofsted, CQC, Her Majesty's Inspectorate of Constabulary (HMIC) and Her Majesty's Inspectorate of Probation (HMIP) to look at Oxfordshire's response to Child Sexual Exploitation and missing children.

Inspectors looked at records and processes in a number of settings. This included assessing partnership working within the MASH, the Kingfisher team, and the partnership quality assurance committee. All cases audited met expectation with some areas identified as excellent.

Initial feedback has been positive about health services provided to children at risk of CSE. There are concerns about the functioning of the MASH, particularly around timeliness and about strategy meetings. The draft report has been received by the OSCB.

The report is available at **www.gov.uk/government/publications/joint-inspections-of-child-sexual-exploitation-and-missing-children-february-to-august-2016**

Published reports with implications for commissioning and assurance requirements.

1.1 **Goddard Inquiry**

The Independent Inquiry into Child Sexual Abuse was established by the Home Secretary in March 2015, and was officially opened by Chair, Justice Lowell Goddard DNZM, on 9 July 2015. The investigation is due to report in 2020 following information gathering, inspections and interviews across England and Wales. All chief executives have been written to and asked to ensure that services are prepared for the investigation and that they do not destroy any information that may be requested for the enquiry.

To assist in preparations within Oxfordshire a proactive records review has been proposed for all key health providers.

3.2 **The Bradbury Inquiry**

An independent review has been published into case of Myles Bradbury, a paediatric haematologist who sexually abused children in his care over a number of years. The report looked at how Bradbury was able to carry out abuse undetected.

This report has been shared with our providers, including primary care, who have been requested to review the learning and recommendations, and to report back on how they are assured a similar situation could not arise locally.

Conclusion and recommendations

Safeguarding remains a core aspect of all health care delivery and commissioning. Activity is increasing at a time when all services are under increasing resource pressures. There is a range of scrutiny processes that provide assurance and increase understanding of the effectiveness or services.