NHS
Oxfordshire
Clinical Commissioning Group

Oxfordshire Clinical Commissioning Group
Board Meeting

Date of Meeting: 26 January 2017	**Paper No: 17/11**

Title of Presentation: Safeguarding update report

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

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

Update of safeguarding to inform the board.

Financial Implications of Paper:

None

Action Required:

To note

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	Yes	No	Not applicable ✓
Outcome of Equality Analysis			

Author: Helen Ward, Senior Quality Manager and Alison Chapman, Designated Nurse-Safeguarding Lead.	**Clinical Lead:** Sula Wiltshire

Safeguarding Activity

1. Annual safeguarding self-assessment

Oxfordshire Clinical Commissioning Group (OCCG) has submitted its safeguarding self-assessment to the Oxfordshire Safeguarding Boards.
OCCG has provided evidence of compliance for all the standards within the assessment. Demonstration of good practice was seen in the regular updates provided to Quality Committee and the Board, the development of a data set and the coordination of health care teams in safeguarding practice across providers.

2. Provider contracts 2017-19

Safeguarding reporting requirements for providers have been standardised. The dataset established with providers during 2016 is included in the updated contract for 2017-19. The smaller independent providers will submit a safeguarding audit annually ensuring all providers will continue to be assessed against national standards.

3. Adult Safeguarding

OCCG has reflected on the findings of the CQC report 'Learning, Candour and Accountability', published in December 2016 (link to full report). The review looked at NHS trusts in England providing acute, community and mental health service, how they report and investigate incidents and how families are involved in the investigation process. There was a particular focus on people with mental health conditions and learning disabilities. The report found inconsistency and some very poor practice, and made recommendations for improvement.

The CCG has a well-established Serious Incident Investigation process. Reporting and investigation of incidents is closely managed by the CCG and incidents are only closed when we are confident appropriate action has been taken to address identified deficits. Health care providers commissioned by the Clinical Commissioning Group have all reviewed and updated their process for reviewing deaths within their services. All undertake mortality reviews.

3.1. Vulnerable Adults Mortality Group

OCCG has led on the establishment of a subgroup of the Oxfordshire Adult Safeguarding Board to review the deaths of people with learning disabilities and other vulnerable adults. The group has agreed a process similar to the Child Death Overview Process. The process will be managed by OCCG.

4. Safeguarding Children

4.1 Oxford Refugee Health Initiative

OCCG, in partnership with providers, has been awarded some funding by NHS England South (South Central) from its safeguarding development programme fund to develop a solution to better support unaccompanied asylum seeking children.

4.2 Child Death Review Processes

OCCG has authority, delegated from the OSCB to manage the child death overview process (CDOP). The CCG is procuring an on-line system that maximises opportunities to identify themes and learn lessons. This system is also being adopted by neighbouring authorities,

including Buckinghamshire and Gloucestershire. This will improve the consistency of processes for professionals in our large provider organisations.

5. Conclusion and recommendations

This report provides assurance that OCCG is meeting its safeguarding requirements. We have an established system of rigorous SI management and have managed the CDOP process since 2013. More recently, the CCG has run a project reviewing the deaths of people with learning disabilities and has taken a leading role in establishing the vulnerable adult's mortality.