OXFORDSHIRE COUNTY COUNCIL

NHS

Oxfordshire
Clinical Commissioning Group

PLANNING TO MEET THE HEALTH & SOCIAL CARE NEEDS OF CHILDREN & YOUNG PEOPLE IN OXFORDSHIRE

OXFORDSHIRE (CHILDREN & YOUNG PEOPLE'S) JOINT COMMISSIONING STRATEGY

2013/14 – 2015/16

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1. INTRODUCTION

1.1 This joint strategy sets out the areas where Oxfordshire Clinical Commissioning Group (OCCG) and Oxfordshire County Council commission services.

1.2 Oxfordshire County Council is responsible for the social care and support of children, young people, parents and carers. Oxfordshire Clinical Commissioning Group is the body that commissions most health services. Together we believe that a joint approach will work better for people in Oxfordshire. The Oxfordshire Joint Commissioning Strategy for Children and Young People's is designed to meet the needs of:

- Children and young people aged 0-18
- Children and young people with a disability aged 0-25
- Parents and carers of children and young people 0- 25)

1.3 The aim of this strategy is threefold:

- To ensure that externally commissioned services are based on need and on the evidence of what works.
- To communicate with the market across Oxfordshire and more widely to show what we plan to commission and de-commission in the future.
- To enable the Oxfordshire Health and Wellbeing Board to hold the commissioners to account for their part in delivery of improved outcomes for children and young people.

1.4 Some services for children, young people and their parents and carers in Oxfordshire are provided directly by the County Council, including children's social care. These are not included within this strategy as they are not externally commissioned.

1.5 Schools are outside the scope of this strategy. However, they have a key role in providing services and may also be users of services provided as a result of this strategy. They are therefore important stakeholders in the development of this strategy.

1.6 Other commissioning agencies for Oxfordshire are the District Councils and Oxford City Council who have statutory responsibilities for families in relation to housing and leisure services, and Thames Valley Police with responsibilities relating to Youth Justice and Safeguarding.

1.7 The local voluntary and community services across Oxfordshire attract significant new investment into Oxfordshire every year through grants and fundraising and they form an important part of the landscape in terms of

resources available for children and young people. They also provide services under contracts with the public sector (not just OCC).

1.8 However, for the purposes of this strategy the focus will be on OCCG and County Council commissioning activities. For the County Council this means services that are purchased by providers external to the Local Authority. For the CCG this relates primarily to services that are purchased from NHS provider Trusts.

2. COMMISSIONING CONTEXT

2.1 Oxfordshire's Joint Health and Wellbeing Strategy 2012-2016 sets the vision and strategic direction for improving the health and wellbeing of children, young people, families and carers. In particular, it sets the following priorities for children and young people that this Joint Commissioning Strategy will help to deliver:

2.2 **PRIORITY 1**: All children have a healthy start in life and stay healthy into adulthood

2.3 **PRIORITY 2**: Narrowing the gap for our most disadvantaged and vulnerable groups

2.4 **PRIORITY 3**: Keeping all children and young people safer

2.5 **PRIORITY 4**: Raising achievement for all children and young people

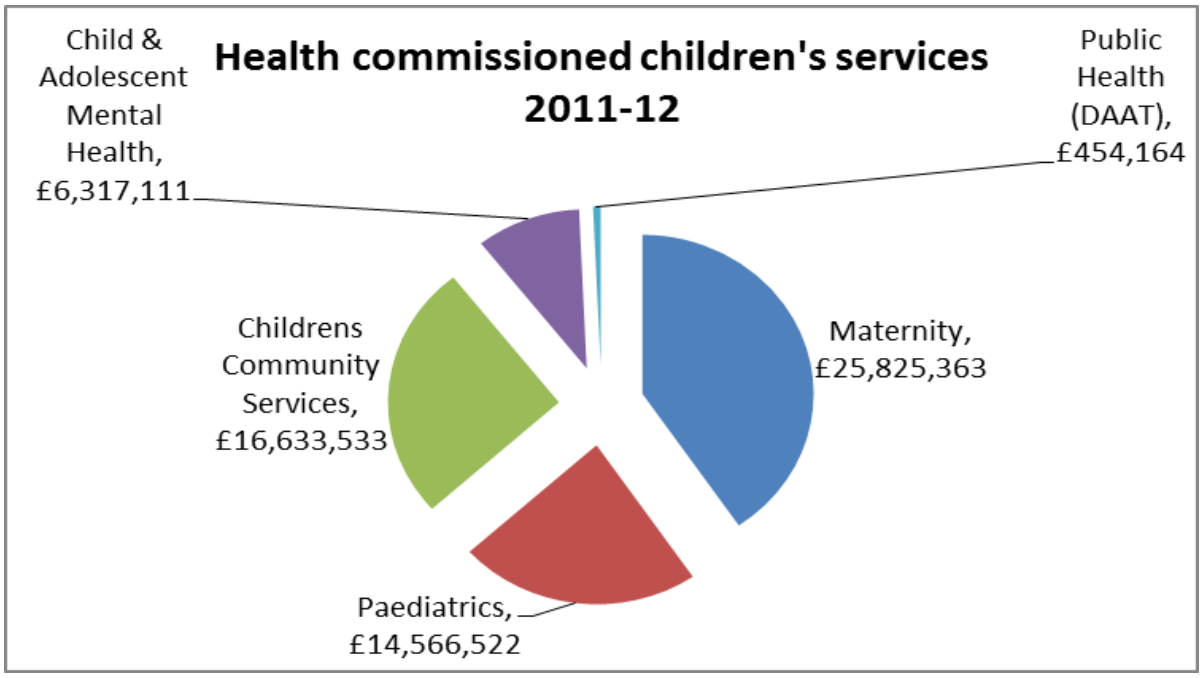
2.6 Over the past few years, there has been a steady development of jointly commissioned services (PCT and County Council) through a system of pooled budgets which operate under Section 75 of the NHS Health and Social Care Act (2001); they now have a combined annual value of over £30m. There is not currently a Section 75 pooled budget for children's services, although nearly £7m of specialist and targeted Child and Adolescent Mental Health Services are part of the Section 75 Mental Health pooled budget.

2.7 The Ofsted inspection of Oxfordshire's Looked after Children and Safeguarding Services (May 2011) judged the commissioning of services as good, in particular multi-agency commissioning. The current jointly commissioned services are included in appendix 3.

2.8 From 1 April 2013 the OCCG became responsible for commissioning children's health services for Oxfordshire, worth in the region of £64 million (2011-12 figures). The main part of this £64m is invested in services commissioned as part of the PCT's major multi-million pound contracts with local NHS Trusts.

2.9 Figure 1 shows how this £64m is invested across services. This does not account for the services that the PCT commissions from 'independent contractors' – specifically General Practitioners, Pharmacists, Dentists and Optometrists.

Figure 1



2.10 The County Council is responsible for children's social care, education and learning, information to parents and carers, and working with children and young people. The Children, Education and Families Directorate (CEF) aim to deliver good outcomes for all children and young people, whilst targeting resources to those most in need.

2.11 In 2011-12 the gross budget of the CEF Directorate was £540.4m of which £381m was schools budget. A significant proportion of the non-schools budget of £159.4m was invested into County Council in-house provision including an early intervention service, social care assessment, child protection, youth offending services and school support services. However some £12m of services was commissioned from external providers through contracts and grant funding arrangements and just over another £10m used to purchase specialist placements for children and young people with high levels of need. This £22m of external spend includes the investment in jointly commissioned services with health

2.12 Figure 1.1 shows the proportions in which the whole CEF budget was invested in 2011-12.

Figure 1.1

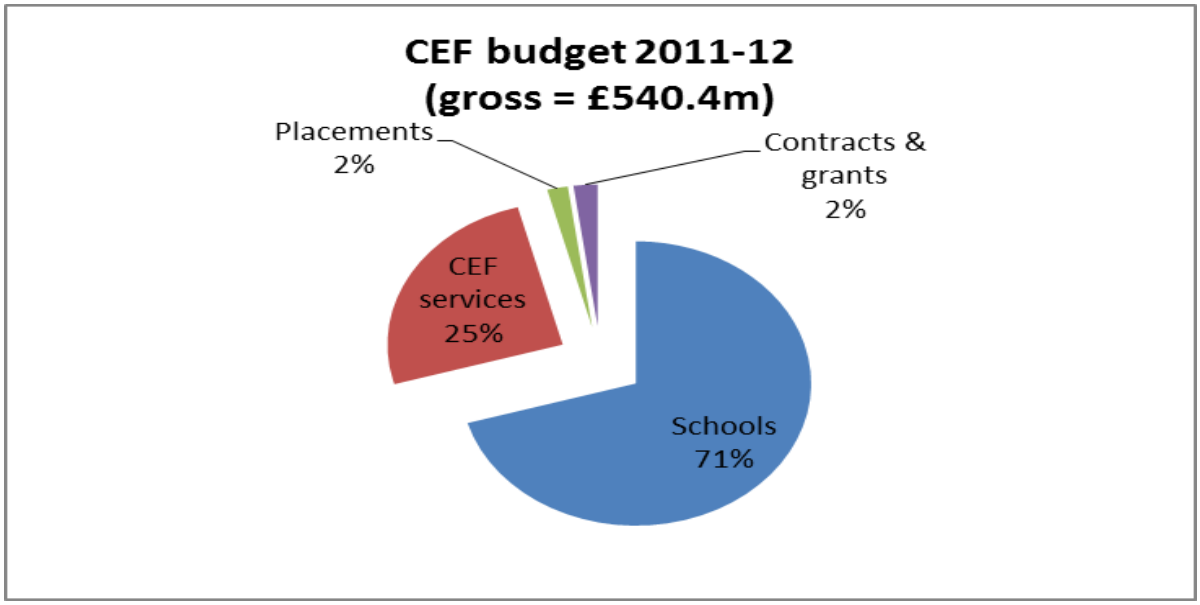
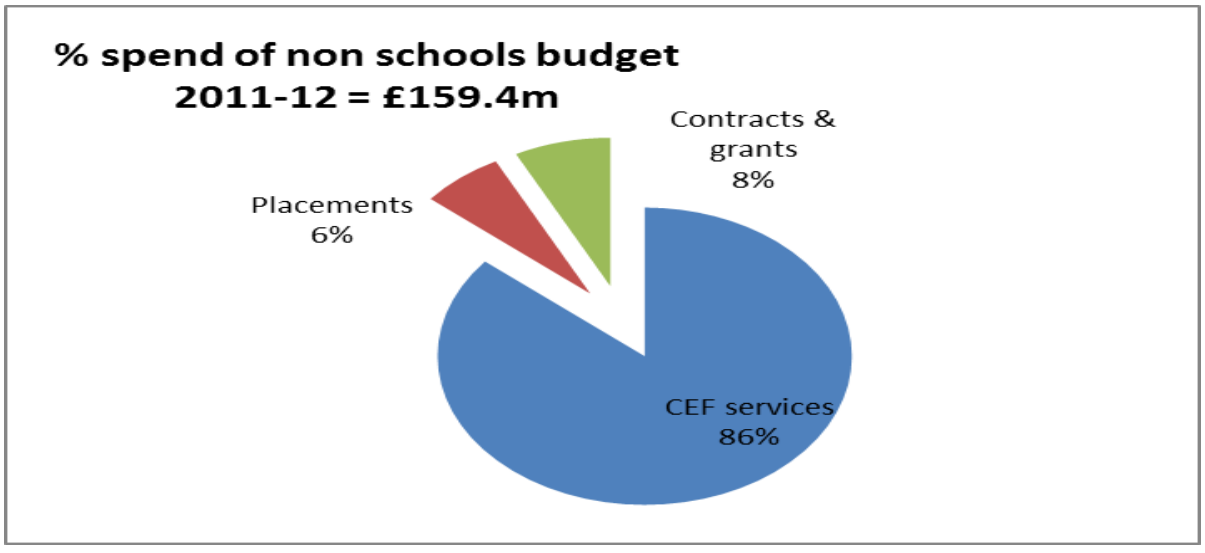


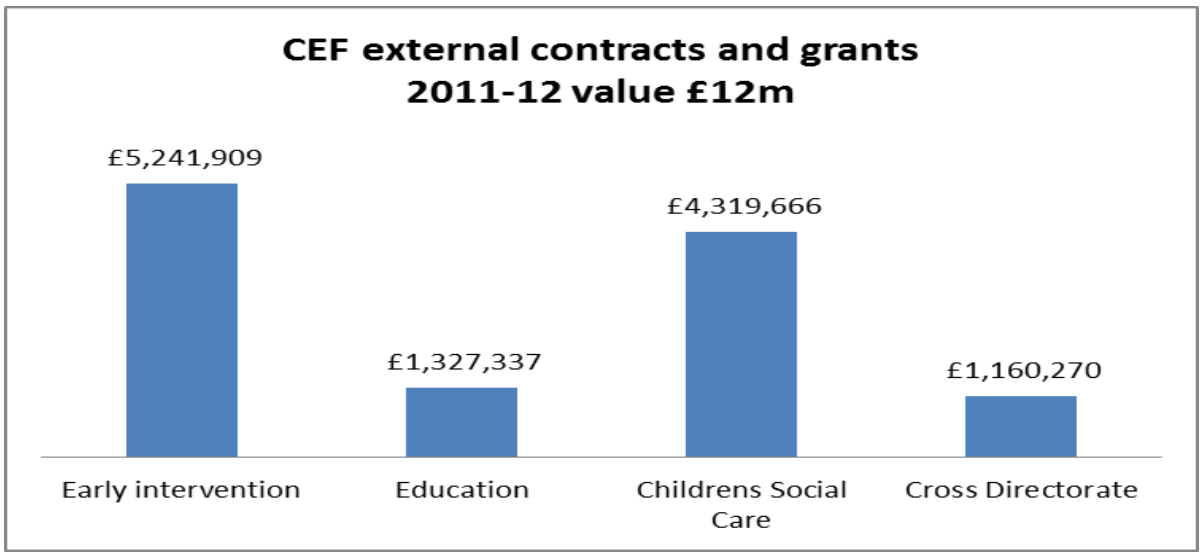
Figure 1.2 shows the proportions in which the non-schools budget was invested in 2011-12.

Figure 1.2



2.13 Contracts and grants were awarded to a range of organisations from small local voluntary sector groups to large national organisations. Figure 1.3 shows this £12m broken down by service area (excluding residential placements).

Figure 1.3


CEF external contracts and grants
2011-12 value £12m
£5,241,909
£1,327,337
£4,319,666
£1,160,270
Early intervention
Education
Childrens Social Care
Cross Directorate

3. INVOLVING CHILDREN, YOUNG PEOPLE, PARENTS AND CARERS

3.1 There is a clear commitment and a number of routes for engaging families in the decisions that are made about what services to commission, what works for families and what needs to change in order for services to become more responsive to the needs of individuals and families. The subjects covered and topics discussed have been wide-ranging – from provision of specialist continence services to issues of intergenerational poverty. An issue young people are always keen to discuss is their mental health and the help that is available for young people with mental health problems.

3.2 Children and young people with experience of being in care are consulted through the Children in Care Council (CICC). They meet to talk about ways of improving how children and young people are cared for in Oxfordshire.

3.3 Over time some young people have gone beyond being involved in discussions and have become involved in a practical way in designing the solutions including peer support schemes. Parents of children with additional needs have been able to be involved with a range of discussions too; about the diagnosis of children with autism, access to appropriate childcare and short breaks and the way residential respite care is provided.

3.4 The Health and Wellbeing Board for Oxfordshire remains a clearly committed to involving children and young people in the discussions about services and commissioning including the Public Involvement Network and a wide range of other forums such as Oxfordshire Young Enablers (OYE!), the Oxfordshire Youth Parliament (OYP), the Children in Care Council (CICC) and Healthwatch.

4. MARKET DEVELOPMENT

4.1 Children's services traditionally have a poorly developed market locally and indeed nationally. The Council and OCCGs relationship with that market is at an early stage. It is important to recognise that the Council remains a significant provider of children's services.

4.2 NHS contracts in Oxfordshire tend to be few and large (£80 – 160m). The contracts are for all care groups although over the past five years work has been undertaken to specify children's services separately, especially in community and mental health services. Most services for children are contracted for on a block contract basis using a standard NHS contract.

4.3 The OCCG is committed to a programme of outcome based commissioning for certain services. Outcome Based Commissioning relies on alignment between agreed clinical (user) outcomes and the commercial aspects of the contract. One of the objectives is to move towards more contractual incentive mechanisms and Maternity Services is currently under consideration.

4.4 There is a diverse but under-developed voluntary sector market in children's services. This ranges from the national organisations that operate on more commercial basis, to very local voluntary sector organisations with little infrastructure and no capacity to engage with regulated procurement processes.

4.5 Most of the high-cost, low volume commissioning of individual placements for children is in the private or voluntary sector and there is a very strong imperative to improve quality whilst reducing costs and making savings. More and more Councils are developing consortium arrangements to reduce costs and manage risk across these placements and Oxfordshire is actively involved in three such consortiums.

5. COMMISSIONING PRIORITIES

Given what we know about the performance of our current commissioned services, learning from experience and feedback on what has worked well, and based on the needs assessment, the following six areas are proposed as commissioning priorities over the next three years. There are also a number of additional themes that weave through the 6 priorities and will be vital in successfully achieving our vision:

THEME 1 - PROMOTING, PROTECTING AND IMPROVING HEALTH

THEME 2 - MATERNITY AND OTHER HOSPITAL SERVICES

THEME 3 - EARLY INTERVENTION

THEME 3 - MENTAL HEALTH

THEME 4 - SPECIAL EDUCATIONAL NEEDS (SEN) AND DISABILITIES

THEME 5 - SAFEGUARDING AND LOOKED AFTER CHILDREN

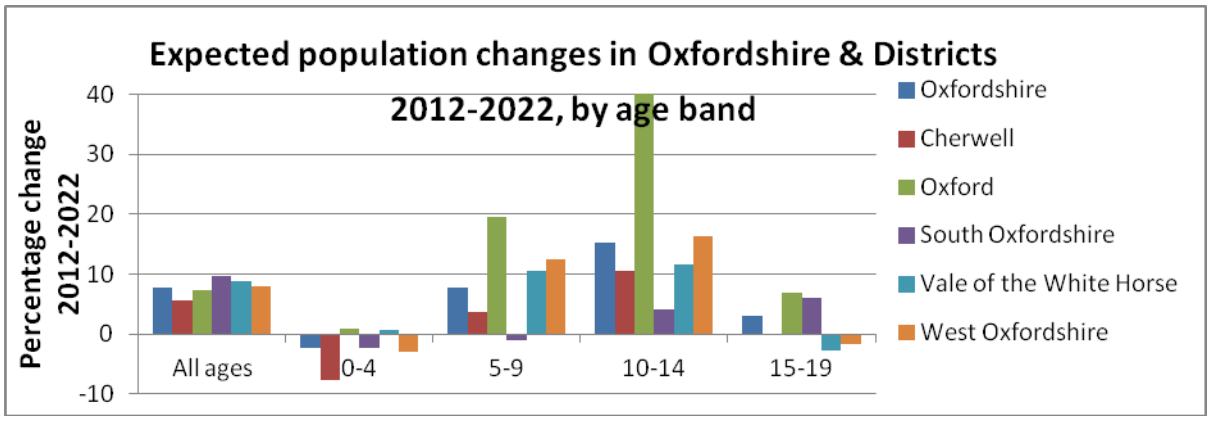
6. THEME 1 - PROMOTING, PROTECTING AND IMPROVING HEALTH

Where are we now?

6.1 From the 2011 Census, the overall population of Oxfordshire is estimated to be 653,800 people. Of these 157,000 (24%) are aged under 0-19 and 41,000 (6%) are aged 0-4.

6.2 Over the next ten years, the number of younger people in Oxfordshire is expected to increase, but at a slower rate than the overall population. The increase is not expected to be uniform across the County: some areas will see a drop in numbers of younger people (for example the under 4's in Cherwell District), whilst Oxford City is expected to see a particularly big increase in the number of 10-14 year olds. This in turn will place differing demands on services across the county, and commissioning approaches will need to reflect this.(See Figure 1.4)

Figure 1.4



6.3 Oxfordshire is overall a relatively wealthy and healthy county. It is in the top 10% of authorities for both healthiness and low level of deprivation (2010 Index of Multiple Deprivation). This means that compared with the national average, children in Oxfordshire can overall look forward to a longer life (Figure 1.5), and better than average levels of mental and physical health.

6.4 However, there are several areas of significant deprivation, particularly in Oxford City and Banbury. In these areas children and young people experience greater levels of ill health, are less successful at school, are more likely to become involved in or experience crime, face unemployment, lower earning capacity. There are eight urban areas across the county which are in the worst 10% of areas in the UK for child poverty and a further 12 wards (out of a total of 136) are in the top 25% nationally.

6.5 Additionally there are small pockets of poverty in some of our rural areas which can be masked by the general affluence of the population. Transport difficulties and lack of affordable childcare can compound the problem of deprivation in rural areas, making access to employment difficult.

6.6 There have been improvements in inspection outcomes and in the performance of some schools however GCSE results fell below national averages in 2011/12. Although. However, there are some signs of improvement, such as early years reading and progress in maths between KS2 and KS4. In particular there has been significant improvement in achievement at KS2.

6.7 Overall children born in Oxfordshire have a very healthy start to life. The percentage of mothers who start breastfeeding is high (79%). The overall level of childhood obesity is low (below national average). The uptake of immunisations is good compared to national levels. Children under 5 are admitted to hospital for viral infections, respiratory tract infections and gastroenteritis, less often than their peers nationally.

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Figure 1.5

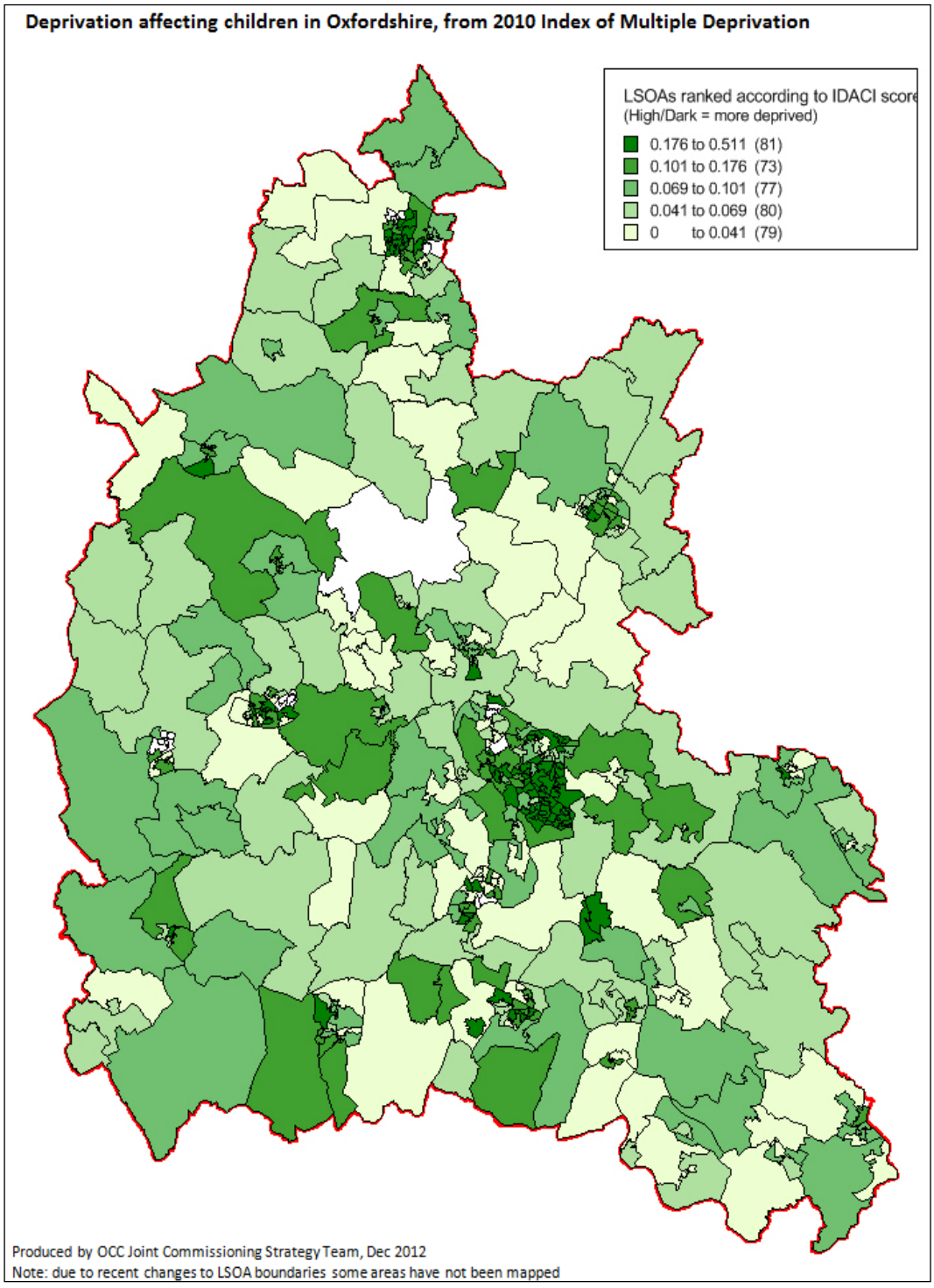
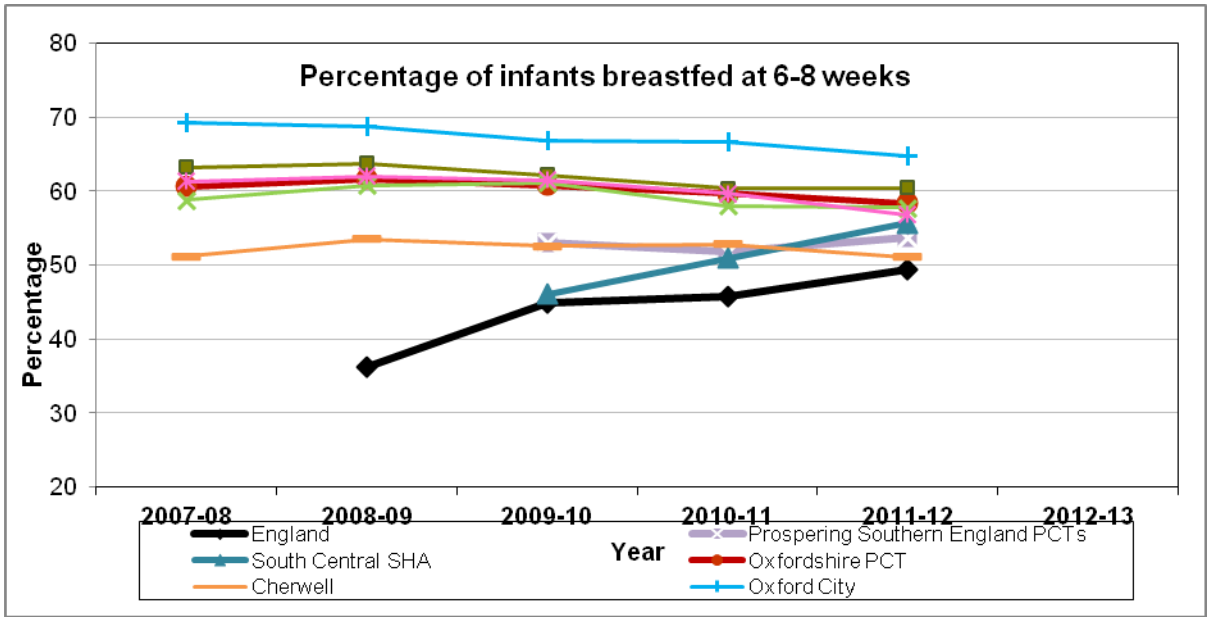

Deprivation affecting children in Oxfordshire, from 2010 Index of Multiple Deprivation
LSOAs ranked according to IDACI score
(High/Dark = more deprived)
0.176 to 0.511 (81)
0.101 to 0.176 (73)
0.069 to 0.101 (77)
0.041 to 0.069 (80)
0 to 0.041 (79)
Produced by OCC Joint Commissioning Strategy Team, Dec 2012
Note: due to recent changes to LSOA boundaries some areas have not been mapped

Figure 1.6



6.9 Death rates in socially deprived wards are higher than in affluent areas. Admission rates to hospital are higher for young children living in wards with high levels of deprivation and breastfeeding rates in Oxford and Banbury remain significantly lower than the rest of Oxfordshire. By Year 6, obesity levels in children living in Oxford City are significantly higher than the national average. We need to tackle these differences.

6.10 There is a significant military presence in the county which means some of our children and young people in military families experience unsettled lives and live with anxieties that sometimes impact upon their well-being. However they also bring rich diversity and experience to the local community and it is important that we commission services that meet their needs.

6.11 Sexual Health: community-based Contraception and Sexual Health services (CASH) are commissioned from Oxford Health NHS Trust with a contract value in 2011-12 of £1.4m, including services targeted at young people.

6.12 A number of preventative services including chlamydia screening for young people aged 15-24 years and genitourinary medicine (GUM) are commissioned from Oxford University Hospitals NHS Trust.

6.13 Drug and Alcohol abuse; prevention and treatment, Oxfordshire DAAT (Drug and Alcohol Action Team) as part of Public Health is the lead commissioner of substance misuse treatment services for all ages. The DAAT also leads on

the recreational drugs and ‘legal highs’ agenda and is the main commissioner of education programmes and awareness campaigns targeted at the 11–25 age range. In 2011-12 it commissioned £454 of services for children and young people covering specialist treatment, drugs education, a substance misuse website, and social marketing campaigns. The Council provides substance misuse early intervention and prevention services through the Hubs and the Healthy Oxfordshire Schools Team.

6.14 Public Health will also be responsible for the commissioning of School Nursing. Currently about £1.2m is spent on school nursing with the most recent investment focused on increasing capacity in schools in areas of highest deprivation (Oxford and Banbury). The service is traditionally term-time only although the recent investment has been used to make school nurses available via a text service out of school hours. A specialist school nursing service, funded by the Council is provided in special schools to enable children with complex conditions to access education.

What needs to be different?

6.15 A Healthy Start in life**:** All children and young people deserve the best start in life. This is achieved by the provision of high quality maternity services including early uptake of antenatal care, access to screening programmes, safe quality care during labour and postnatal care of the mother and baby. Promotion of maternal and infant mental health leads to secure mother/baby attachments.

6.16 Increasing the number of babies who are breastfed, access to immunisation programmes advice and support for parents on weaning and healthy eating, child development reviews and parenting support are all evidence based ways of ensuring a healthy start for all young babies. The same is true for reducing the number of babies and young children who are exposed to tobacco smoke.

6.17 Children need to have access to high quality and comprehensive screening pre-school, through the national Health Child Programme (HCP). This will include good uptake of the childhood immunisation programme. Breastfeeding offers babies the best start and has benefits that will endure through adulthood and into old age.

6.18 Health Inequalities, the gap in health outcomes between those who live in the most affluent areas and the least affluent areas continues to rise. There is no quick fix and no one agency alone can address this challenge. Reducing child poverty is just one strand of this challenge which can only be addressed

by focusing on the broader determinants of health including attainment, skills, employment, housing and community safety.

6.19 Obesity, being obese in childhood gives a child a very poor start in life and will predispose them to a range of conditions including high blood pressure, heart disease, diabetes, stroke, cancer and early death. After smoking, obesity is the biggest underlying cause of ill health in adults. Halting the increase in childhood obesity is a challenge, especially as obesity is linked to social deprivation, with more deprived parts of the county having higher rates of childhood obesity. The national Child Measurement Programme ensures that we can monitor trends in the numbers of children who are overweight and obese and the data can be used for planning prevention and responsive services.

6.20 Lifestyles and behaviours, taking risks is fairly common in adolescence and in many ways is a normal part of growing up. However, some lifestyles and behaviours can be associated with serious, long term consequences both for an individual's health and future life chances. Risky behaviours include substance misuse (smoking, alcohol and drugs), risky sexual behaviour, self-harm, violence and bullying, youth offending and other behaviour that is harmful to health and overall wellbeing.

6.21 Teenage Pregnancy, although Oxfordshire has seen a steady decrease in teenage pregnancy over the last three years it is important not to become complacent. There is clear evidence that babies born to teenage mothers have worse outcomes across all domains; health, education, employment and mental wellbeing. Similarly teenage parents in Oxfordshire often find themselves not engaged in education, unable to get paid employment, living on benefits, in poor housing with a steep ladder to climb if they are to get out of this cycle.

6.22 There needs to be a clear universal offer to all families and parents-to-be that outlines what services are available to enable them to give their children the best start in life.

6.23 There will be good coverage and high quality services for evidence based screening programmes.

6.24 This will need to be communicated using new media including online service directories and social media campaigns. This will build on the work already being undertaken through the Health Visiting Programme and with the Oxfordshire Services Directory.

6.25 There needs to be targeted access to evidence based, structured programmes to address issues such as obesity, smoking and parenting skills. There will be a culture of promoting positive activities and raising children and young people's aspirations to inspire and divert children away from harmful behaviours such as substance misuse.

6.26 It is important to ensure that children and young people and their parents and carers are able to access the right information easily and in a way that makes finding the right support straightforward. This also allows them to take control of their own care and support needs and exercise choice where appropriate carers.

What we will do to achieve this:

Ambition	**What we will do to achieve this**?
Promoting Health	• Prepare for re-tendering of 0 – 5s services (Health Visiting) by the Local Authority in 2015 by joint working with the National Commissioning Board Local Area Team. • Increase the number of babies who are exclusively breastfed by commissioning breastfeeding support in the 6 – 8 weeks of life, targeted on areas of deprivation. • Commission smoking cessation services in order to reduce smoking in pregnant women. • Review and re-tender the School Health Nursing Service so that the new service is in place by April 2014.
Improving Health	• Ensure access to evidence based, structured programmes are commissioned to reduce childhood obesity. • Re-tender the services for brief interventions in alcohol misuse and young people's substance misuse services by September 2014.

Lifestyle and Behaviours	• Implement the recommendations for future commissioning from the recent Lifestyles and behaviours needs assessment for Oxfordshire: • Focus on building social and emotional competence among children and young people through PSHE in Oxfordshire schools • Promote positive activities and aspirations to inspire and divert children and young people away from risky behaviours • Review the Risky Behaviours multi-agency training programme with a view to re-tendering from 2014.
Protecting Health	• Increase uptake of flu vaccination in pregnant women through maternity services commissioning. • Monitor the contracts for evidence based screening programmes in maternity services to ensure good coverage and uptake. • Prevent infectious diseases of childhood by increasing uptake of the childhood immunisation programme, especially the MMR vaccine through commissioning.

7. THEME 2 - MATERNITY AND HOSPITAL SERVICES

Maternity services

7.1 Maternity outcomes in Oxfordshire are among the best in the country, although testing of the maternity pathway in Oxfordshire with providers and users illustrates that there are differences in practice in both community and hospital settings and also between hospital settings. For example, a woman is more likely to have a caesarean section if she has her baby at the Horton General Hospital than if she has the baby at the John Radcliffe Hospital. There are three stand-alone Midwifery Led Units (MLUs) across Oxfordshire. In Oxford City and surrounding areas, women with normal pregnancies can chose to give birth in an integrated MLU (based at the JR). Overall women have a good range of choices as to where to have their babies, either in the hospital or in an MLU.

7.2 The Needs Analysis shows that the number of live births has increased from 7,665 in 2006 to 8,156 in 2011 but Office of National Statistics (ONS) projections show that births have probably reached their peak now and the number of births will decline steadily over the next five years. The population for females of childbearing age from ONS is projected to decrease to approximately 7,000 by 2021.92% of births to Oxfordshire women took place at the OUHT. The breakdown of maternal age on giving birth (2010) indicates that Oxfordshire women are having children at a later age than compared to averages for England. This is particularly evident in the 35-39 age band. At the other end of the spectrum we know that the number of young women having their first babies under 20 years of age is also decreasing.

What needs to be different in maternity services?

7.3 When women and their partners are asked what they want they want from maternity services there are some clear and consistent message. Most women want a normal birth in the place of their choice; they want continuity of care in terms of who cares for them. Many want their partners involved throughout their care, including at antenatal education classes. Many women want more consistent advice and support in breastfeeding. The following outcomes have been agreed with women and their partners as the most important outcomes to achieve:

- *Healthy baby, healthy mother*
- *Fit and capable to be the parent you want to be*

- *Comfortable and confident in the transition from being pregnant to being a new mother and father*
- *Experiencing continuous and seamless care throughout pregnancy, birth and the postnatal period*

7.4 Work is underway in the OCCG to look at options for re-commissioning maternity services in order to deliver these 'outcomes' rather than the traditional input and activity based contract more typical in the NHS.

Urgent care for sick children

7.5 There will always be times when some children need admission to hospital. At this point the focus is on ensuring they get admitted quickly and are treated in age appropriate environments. Early discharge planning will ensure that they can get home as soon as possible.

7.6 Paediatric inpatient beds are provided at two sites of the Oxford University Hospital Trust, at the Horton General Hospital and the Children's Hospital at the John Radcliffe Hospital. Both sites offer a 24/7 emergency service.

7.7 Emergency paediatric admissions into secondary care have continued to rise over recent years; this is partly due to a significant change in demographics within the 0-4 year age group. The general increase in admissions has put substantial pressure on paediatric inpatient beds. As a result the paediatric urgent care pathway has been reviewed and re-designed to improve the patient experience and, where appropriate deliver more acute care in the community.

What needs to be different?

7.8 A recent audit looking at the admissions into the John Radcliffe Hospital has shown that 48% of children referred to the emergency department, (ED) by GP's were not admitted and of these 30% may have benefited from an alternative route. There needs to be clear alternatives to admission including review clinics in Out of Hours services and Children's Community Nurse follow-up.

7.9 A key priority will be to look at a children's targeted "Choose Well" campaign in order to keep children with minor illnesses, cared for safely at home.

End of life care for children and young people

7.10 Unlike adult palliative care, which tends to focus on end of life, children's palliative care has a different definition with palliative care extending over

many years. For this reason health resources have been directed into providing specialist palliative care in the community, to enable the child, young person and family to stay in their own home for as long as possible. The specialist palliative care service, managed by the Children's Community Nursing Team, Oxford Health not only provides care, but also acts as a single point of access for palliative care needs by working in close association with other voluntary sector palliative care providers and Helen and Douglas House Hospice.

7.11 Each year 40-50 children and young people die in Oxfordshire with less than half of these deaths planned or expected. The majority of children and young people with life threatening/life limiting conditions still die in hospital. Oxfordshire does not have a systematic commissioning process for palliative care provided to children and young people.

What needs to be different?

7.12 All healthcare delivered to local populations must be fair and transparent with integrated pathways of care improving the patient and family experience. Wherever possible, care should be delivered in the community and closer to home. Following the Palliative Care Funding Review, a national tariff is in the process of being developed.

7.13 From a commissioning perspective, this presents a moderate financial risk. It also means that there will need to be clear specifications and quality standards that all providers will be expected to deliver. Given the small number of children and young people who need this type of care and the specialist nature of children's hospices, it is expected that CCGs nationally will work together to develop standard or consistent service specifications.

7.14 In order to do this there is a need for:

- A Specialist Palliative Care Pathway
- Transparent Referral Criteria
- Assessment Process for integrated packages of palliative care
- A service specification with clear quality standards for all inpatient end of life care.

What we will do to achieve this:

Ambition	What we will do to achieve this?
Re-commission maternity services using an outcome based commissioning approach	• Work with Clinical Commissioning Group to implement Outcome Based Contracts in maternity services.
Complete redesign of the paediatric urgent care pathway and evaluate impact of changes	• Work with providers to complete redesign of pathway for children in hospital. • Monitor activity and costing from Trust activity data in order to inform commissioning plans from 2014 / 2015. • Identify options for strengthening alternatives to admission for children working with Oxford Health and Primary Care. • Agree a pathway, specification and tariff for specialist palliative care wherever it is provided.

8. THEME 3 - EARLY INTERVENTION

Where are we now?

8.1 There are a number of children and young people who experience poor outcomes across a range of measures including health outcomes, social outcomes, employment and educational outcomes. There is also clear evidence that these outcomes are further impacted on by where a child lives and from a public health perspective the environment that any child grows up in.

8.2 Early intervention is well-established and widely accepted as a key way to improve outcomes for children and young people, in terms of both chronological age and in terms of the presenting problem. There is already a strong emphasis on early intervention and support across Oxfordshire, including through the four biggest services provided by the County Council and Oxford Health NHS Foundation Trust; Health Visiting, Family Nurse Partnership (FNP), School Nursing and the Early Intervention Service, including Children's Centres. Together these services represent about £30m of expenditure.

8.3 The Council's Early Intervention Service is a countywide service, working closely with key partners to address the needs of children; young people and their families from 0 -19 years and up to age 25 for young people with special educational needs and care leavers. The service, which is currently largely provided "in house", is targeted at vulnerable children, young people and families with additional and complex needs, where there is a risk that without additional targeted services the child or young person may not reach their full potential and their life chances are likely to be impaired. The service operates mainly on a referral basis from 7 hubs across Oxfordshire, although some services to young people are open access.

8.4 Supporting Carers and Young Carers, carers perform a vital role in supporting children and young people, and it is estimated that the overall value of carers to Oxfordshire is in excess of £70m. It is also estimated that there are more than 11,000 young carers in Oxfordshire (Oxfordshire Young Carers Strategy 2008-2013).

8.5 Young carers experience a range of significant negative impacts of caring, on health, wellbeing and educational attainment. Young carers and parent carers highlight ensuring successful transition to adult services as a key need. It is therefore important to identify those with caring responsibilities and offer appropriate support.

8.6 The 44 children's centres across Oxfordshire are part of the Early Intervention Service, providing access to a range of services in partnership with health and others, for families with babies and young children from pre-birth up to age 5. Services are universally available to all families, but centres have a strong focus on targeting support to children and families in greatest need. 15 centres are externally commissioned, with the remaining 29 provided by OCC, often in partnership with schools.

8.7 The Health Visiting service is commissioned now by the Thames Valley Area Team (TVLAT) and provided by Oxford Health. More than 100 health visitors deliver the Healthy Child Programme (HCP) in Oxfordshire to all children from birth to 5 years old. It is the universal public health programme for children and families. The HCP, led by health visitors and their teams, offers every child a schedule of health and development reviews, screening tests, immunisations, health promotion guidance and support for parents tailored to their needs, with additional support when needed and at key times. The current Health Visitor Development Programme will see the number of health visitors in Oxfordshire, rise from 96.5 FTE in 2010 to 126.5 FTE in 2015.

8.8 The Family Nurse Partnership is a targeted service provided by Oxford Health and commissioned by the Thames Valley Area Team. In Oxfordshire up to 200 first time mothers aged under 20 years are offered the programme at any one time. It consists of a set of evidence based interventions, delivered by specially trained nurses, from 28 weeks of pregnancy until the child's second birthday. Young women who are Looked After or who are leaving care are prioritised for referral by the FNP team.

8.9 The School Nursing Service is also provided by Oxford Health and commissioned by Public Health (Local Authority). The service provides the Healthy Child Programme for young people aged 5-16 years, as well as individual support to children and families with additional needs including Looked After children. The service provides 'drop-in' services to young people living in Oxford and Banbury during and outside of school term times.

What needs to be different?

8.10 There are also a number of other smaller but important areas of provision such as reading support in schools, child bereavement services, infant attachment support and early learning support in Early Years settings. However, arguably the area in which we can make the biggest impact and bring about the greatest change is in the four areas outlined above.

- The four main services that offer early interventions to families and children need to be more integrated at the frontline.
- Families need to be clearer about how to access services and what they can expect from services.
- There need to be clear multi-agency pathways for common problems such as parenting problems, attachment issues, developmental delay and behaviour problems.

What we will do to achieve this:

Ambition	What will we do to achieve this?
Best possible outcomes (and value for money) for children and young people	• Re-commission early attachment and therapeutic intervention services by April 2014. • Continue to develop joint strategies with OCCG to achieve integrated commissioned services with NHS, including working with the National Commissioning Board to ensure the on-going effectiveness of Health Visiting and Family Nurse Partnership services • Review and evaluate evidence based programmes currently commissioned to support targeted early interventions, to inform future outcomes based commissioning. • Implement the outcomes of the County Councils review of Children's Centres (including rural centres) and re-tendering of existing contracts by 2015.
Optimal configuration of high quality early intervention services	• Look at options for integrated pathways, common systems and processes and an integrated front door for families. • Develop joint commissioning arrangements to ensure provision of co-ordinated information and advice services to children, young people and their families. • Look at options to re-tender Child Bereavement Services in schools by March 2015.

9. THEME 4 – CHILD AND ADOLESCENT MENTAL HEALTH

Where are we now?

9.1 Mental ill health represents up to 23% of the total cost of ill health in the UK – the largest single cause of disability. People with severe mental illnesses die on average 20 years earlier than the general population. Half of those with lifetime mental health problems first experience symptoms by the age of 14 and three-quarters by their mid-20s, and 20% of children have a mental health issue in any given year according to some estimates.

9.2 1 in 10 children and young people aged 5-16 suffer from a diagnosable mental health disorder – that is around three in every class at school. About half of these (5.8%) have a conduct disorder, whilst others have an emotional disorder (anxiety, depression) and Attention Deficit Hyperactivity Disorder (ADHD).

9.3 The most deprived communities have the poorest mental and physical health and wellbeing. Children from the poorest 20% of households have a three-fold greater risk of mental health problems than children from the wealthiest 20%. Parental unemployment is also associated with a two- to three-fold greater risk of emotional or conduct disorder in childhood – in the UK one in six children now lives in a workless household, the highest proportion of any country in Europe.

9.4 Looked After Children (LAC) experience significantly worse mental health than their peers, and a high proportion experience poor health, educational and social outcomes after leaving care. An estimated that between 45 and 60% of Looked After Children aged 5 to 17 have mental health difficulties: over four times higher than all children. Young carers are also more likely to have mental health problems than their non-carer peers.

9.5 1% of children are thought to have Autistic Spectrum Disorder (ASD) (including Asperger's Syndrome). This equates to 1500 children and young people in Oxfordshire. Recent studies have shown that approximately 70% of people with ASD also meet diagnostic criteria for at least one other (often unrecognised) psychiatric disorder that is further impairing their psychosocial functioning.

9.6 95% of imprisoned young offenders have a mental health disorder, and young people in prison are 18 times more likely to take their own lives than others of the same age.

9.7 Self-harming in young people is not uncommon (10–13% of 15–16-year-olds have self-harmed) but only a fraction of cases are seen in hospital settings. There are about 150 admissions to hospital for self-harm each year – but this is only the tip of the iceberg with many more engaging in self-harm but never being admitted.

9.8 Applying some national prevalence figures to the Oxfordshire population it is evident that:

- 14,000 children experience a mental health problem at some time in childhood
- 2600 14-17 year olds self-harm to some degree
- 1500 children and young people with autistic spectrum condition.

9.9 OCCG and the Council currently manage all mental health commissioning through a Section 75 partnership agreement and a single pooled budget. This budget is used to commission all specialist and targeted mental health services for Oxfordshire children. Oxford Health NHS Foundation Trust is the main provider of these services and have contracted services over £6m.

What needs to be different?

9.10 There is a need to improve timely access to mental health support through PCAMHS in line with National Mental Health strategy (including 16-17 year olds). This will include targeted support for children and young people at particular risk of developing mental health problems. This will need to focus on Looked After Children.

9.11 The Oxfordshire Health and Wellbeing Strategy has identified mental health transitions for young people aged 16-24 years as an area for improvement. The aim will be to enable young people to stay in CAMHS based provision until they are ready to be discharged from care.

9.12 There needs to be a focus on delivering the key priorities of the new Oxfordshire Autism Strategy including streamlining the diagnostic pathway between Community Paediatrics and the CAMHS Teams and local schools.

9.13 Current health services for young people with a severe to moderate Learning Disability and mental health problems need to be strengthened to ensure that community based services support young people in their home, school and where appropriate hospital setting. There needs to be early and effective transition planning to adult services.

What we will do to achieve this:

Ambition	What will we do to achieve this?
Improve transitions from children's to adult mental health services	• Finalise commissioning of a new service and operationalise by September 2013 and be evaluated by April 2014. • Complete Mental Health Transitions project so that the new service is operational by September 2013 and evaluated by April 2014. • Continue review of gaps in provision for young people aged 16-24 years resulting from eligibility thresholds and transition from CAMHS to adult services, particularly young people with ADHD, ASD or with conduct disorders
Better outcomes for children with Autism	• Co-ordinate the review the ASD diagnostic pathway for 5-18 year olds across all relevant providers including schools. • Prioritise actions coming out of Oxfordshire Autism Strategy • Continue to implement Improving Access to Psychological Therapies (IAPT) for children and young people.
Ensure support is available to children and young people with mental health issues	• Development of mental health support in community settings such as schools, clubs, hubs (Youth counselling and joint working with Public Health) • Continue to implement IAPT for children and young people.
Improve existing mental health services for children and young people	• Review of PCAMHS/CAMHS against overall strategy direction and in preparation for end of Oxford Health NHS contract (2014 / 2015) • Roll out of Performance By Results for CAMHS (2014/15)
Improve targeted support for children and young people at particular risk of developing mental health problems	• Commission effective support for young carers.

10. THEME 5 – SPECIAL EDUCATIONAL NEEDS (SEN) AND DISABILITIES

Where are we now?

10.1 The national picture indicates that the number of children and young people with disabilities and complex conditions is increasing, and in Oxfordshire the number of children with Special Educational Needs (SEN) has risen steadily (from 18,434 in 2009 to 19,055 in 2012). However, the proportion of children with SEN has remained constant at around 18.3%.

10.2 The term Disability covers an enormous range of conditions, such as sensory impairment (sight and hearing), physical disability, behavioural difficulties, learning disability, autistic spectrum conditions, and problems with speech and communication.

10.3 It is not known exactly how many children aged 0-16 in Oxfordshire have a disability, but it could be up to about 7,000 Oxfordshire children.

- About 100 of these are severely disabled.
- Many hundreds more are affected by a long-standing illness and associated co-morbidities
- Just over 500 children are supported by the Disability Social Care Teams
- Around 19,000 have special educational needs and of these just over 2,000 have a statement of needs.

10.4 We need to respond to children and young people's and parents' aspirations to live 'an ordinary life', and to have opportunities and services to enable them to learn, play and develop like their peers. As they get older they should be supported to fulfil aspirations such as accessing further education and training, getting a job, having a career, finding a place to live near family and friends, and making a contribution to their community. They should have access to universal services like any other child.

10.5 This means giving choice and control to children, young people and their families about the services and support they access, treating people as individuals, working with them to develop tailor-made plans and interventions that will meet their needs and enable them to progress towards their goals.

10.6 The new Children and Families Bill 2013 means that both the services provided and the way they are commissioned will need to be very different by September 2014: The Bill requires local authorities to publish a clear and transparent 'local offer' detailing services to support children and young

people with SEN and their families. It introduces a more streamlined assessment process for those with severe and complex needs, integrating education, health and care services and involving children, young people and their parents. It replaces statements and learning difficulties assessments with Education, Health and Care (EHC) Plans. These plans cover a child and young person from birth to age 25 and can give children, young people and their families the option of a personal budget, extending their choice and control over their support.

10.7 The Bill also introduces a new requirement for local authorities and health services to commission education, health and social care services jointly. This includes arrangements for considering and agreeing what advice and information is to be provided about education, health and care provision.

What needs to be different?

10.8 Currently children and young people with SEN and disability have a low level of educational achievement compared to their peers and similar areas elsewhere in the country. They are also less likely to be in employment, education or training when they leave school.

10.9 National and local data indicates that disabled children are more likely to live in poverty. This is likely to compound the stresses and strains that families caring for a disabled child may experience. Working parents of disabled children face the additional challenge that suitable childcare, both day care and 'wraparound care' at either end of the school day, is typically very hard to find. There are also a higher proportion of SEN children receiving free school meals than in other groups.

10.10 Support for parents and carers to help them maintain their caring role is vital. One of the ways in which this is currently provided is through 'Short Breaks' services which provide opportunities for children and young people to access social and leisure activities, while also giving their parents a break. The popularity of these services means that demand cannot always be met, especially for children with high staff support needs, for example around challenging behaviour. Limited care options increase the strains on these families and the risk of family breakdown and children coming into care.

What we will do to achieve this:

Ambition	What will we do to achieve this?

Developing residential and educational provision that is closer to home	• Look at options for new cross regional arrangements with neighbouring authorities, in order to increase availability and cost effectiveness of residential SEN placements for Looked After Children. • Ensure that the residential academy project for children and young people with autism and learning difficulties keeps on track.
Ensuring children and young people have an opportunity to access a range of activities that support their learning and development, and that parents and carers providing high intensity support for their children benefit from respite provision	• Review Short Breaks services involving children, young people and their parents and providers; re-commission so new services in place from April 2014
Improving the quality of services that are commissioned out	• Develop strategy for commissioning around individual child placement for children with SEN and Disability in partnership with the NHS.
Ensure children are supported across their range of clinical needs in special schools	• Review and re-commission the Children's Specialist Nursing Service; under a Section 76 Agreement and strengthen the partnership in view of Special Educational Needs and Disability reforms in the Children and Families Bill by April 2015.
Develop the Children's Communities Therapies Service	• Continue to work with the provider to embed and develop the service, manage increasing demand and explore join ups with adult services e.g. around equipment. • Re-commission the service for 2015.
Improve pathways into work for disabled young people / young adults.	• Review options for improving support systems and growing the market, including working with providers. • Commission an increased range of local post 16 education, training and employment options for young people with SEN and disabilities.

Prepare for implementation of new SEN legislation in 2014	• Develop joint commissioning arrangements that will deliver the education, health and care provision (assessments, services, personal budgets, mediation etc.) that will be required. • Develop joint commissioning arrangements to ensure provision of coordinated advice and information services by the local authority and clinical commissioning group. • Work with providers to increase personal budgets for children with SEN and disabilities. • Work with providers to ensure delivery of high quality 'core offer' of provision. • Ensure existing providers are able to deliver the integrated Education, Health and Social Care Plan by 2015.

11. THEME 6 – SAFEGUARDING AND LOOKED AFTER CHILDREN (LAC)

Where are we now?

11.1 Safeguarding or keeping children and young people safe is one of the key priorities highlighted in Oxfordshire's Joint Health and Wellbeing Strategy 2012-2016. Safeguarding is 'everyone's business' and therefore cuts across all the themes in this strategy. All providers are expected to comply with Section 11 requirements of the Children's Act (2004).

11.2 Child Sexual Exploitation (CSE) is emerging as an important issue both nationally and locally. A detailed Strategy and multi-agency action plan has been put in place and is overseen by the Oxfordshire Safeguarding Children's Board (OSCB), covering prevention, disruption, protection and support and prosecution a number of new projects and initiatives will be commissioned to strengthen our approach to prevention. These may include residential provision as well as awareness raising and education to build resilience and resistance to CSE amongst children and young people, parents and carers, communities and professionals.

11.3 At the end of October 2012 there were 3364 children and young people with an on-going involvement (an 'open case') with the County Council's social services. These involvements can be categorised as: child protection cases, looked after children, leaving care, and other children in need (children who have had an Initial Assessment to assess need and whose cases are still open to the Children's Social Care, but who do not have a child protection plan, and are not a looked after child or care leaver).

11.4 The majority of cases are the lower level 'in need' ones, with the number of child protection and looked after children averaging about 400 and 450 respectively each month. The number of children looked after rose by 6% in Oxfordshire in 2011/12, and many are presenting with increasing difficulties. This may be in part due to an increased awareness of safeguarding and earlier action being taken. There are also 378 care leavers, including 88 Unaccompanied Asylum Seeking Children (UASCs).

11.5 The number of LAC is expected to increase. From December 2012 all young people receiving a secure remand or custodial sentence are treated as being looked after children while they are in custody. From 1 April 2013, Oxfordshire County Council under the new 2012 LASPO Act will have to fund the cost of those remanded into the care of the local authority. Eighteen additional young people are likely to become looked after each year as a result of these changes. Ten additional young people will become care

leavers each year, and Oxfordshire will have a responsibility to support them until they are at least 21 years old.

11.6 Educational achievement of LAC remains low when compared with peers in other authorities. We also know that Looked After Children experience more mental health problems and therefore there is another overlap with Theme 4 (pages 29 – 32). There are also concerns that Looked After Children and care leavers are between four and five times more likely to attempt suicide in adulthood than their peers.

11.7 37% of LAC have a Statement of Special Educational Needs, and 79% have a special educational need (SEN). It is often more difficult to find adopters for these children, they are more likely to remain in care for long periods, often in residential homes out of county.

11.8 One third of all children and young people in contact with the youth justice system have been looked after. It is also important to note that a substantial majority of children and young people in care who commit offences had already started to offend before becoming looked after.

11.9 There is a strategic and operational overlap between LAC and those children with SEN/Disabilities (pages 33 – 37). There is also an important link to supporting children and their families on the edge of care to stop them becoming looked after, including the Oxfordshire Thriving Families Programme to build resilience in families and to stop children coming into care.

11.10 There are a range of options for LAC including being supported in the family home, being placed with foster carers (including relatives and friends), being placed in children's homes, being placed in secure accommodation or living with prospective adopters.

11.11 Currently 51 children are placed by the Council in residential children's homes. Of these, 12 are in Oxfordshire County Council's in-house residential care homes and 39 are in homes run by others, mainly out of county.

11.12 Most services for LAC are provided in-house by the County Council. The Council has also worked with cross-regional partners to commission residential children's homes. In 2009, the Council began working with Buckinghamshire, Milton Keynes, Reading, Bracknell Forest and Hertfordshire to commission a residential children's care service for 20 young people with complex needs aged 11-18. The Council currently has nomination rights to six of the 20 beds.

11.13 Although fewer young people from Oxfordshire are placed out of county than other authorities, when they are placed we have a tendency to place them further away. This means children are a long way from family and social networks, and in many cases the costs of individual placements is high.

11.14 The Children in Care Council was asked recently for their views and they said that being placed out of county would make them feel more "unsafe", could lead to them mixing with the wrong crowd, and would make them much more likely to run away.

Housing

11.15 There are an increasing number of 16 and 17 year olds in supported housing, and demand for supported housing exceeds supply. There is also an increasing number of homeless young people of all ages, and demand for appropriate emergency accommodation for homeless young people either becoming homeless for first time or because they have exhausted all of the existing housing options.

11.16 There are already strong joint working arrangements between the County and District councils in Oxfordshire on responses to youth homelessness, although there is a need to review and further develop pathways from care placements and corporate parenting into independence (for example supported housing) and from children's to adults services. There is also a need to continue and strengthen focus on education, employment and training outcomes for homeless young people as this underpins future successful lives.

What needs to be different?

11.17 A Corporate Parenting Review is currently in progress and due to report in October 2013. The new *Placement Strategy For Children In and On the Edge of Care* is currently being finalised and is due to be issued in July 2013; it highlights a number of areas where there is a commissioning role in bringing about the necessary changes.

11.18

- More local solutions are required to meet the needs of LAC and to prevent them having to travel and live away from their communities (where possible and appropriate). This will include victims of child sexual exploitation.
- The cross-regional work with other authorities needs to continue in order to increase the supply of good quality cost-effective fostering and residential provision for LAC.
- The quality of care from external providers needs to be improved.

- The young people's Supported Housing Pathway needs to be reviewed and re-commissioned starting in June 2013.

What will we do to achieve this

Ambition	What will we do to achieve this?
Strengthen prevention of child sexual exploitation (CSE)	• Commission new initiatives and projects to raise awareness and build resilience and resistance amongst children and young people, parents and carers, communities and professionals. Projects to include theatre education and one to one mentoring.
Increase local residential solutions for the needs of LAC and victims of CSE to prevent them having to travel and live away from their communities (where possible and appropriate)	• Help develop the business case and define the pathway. • Evaluate options for residential provision in county including the use of the Council's land and premises.
Increase the supply of good quality cost-effective fostering and residential provision for LAC in neighbouring authorities	Continue to work with cross regional groups to procure high quality and value for money placements in neighbouring authorities.
Review need and re-commission the young people's Supported Housing Pathway	A review of the Young People's Supported Housing Pathway will be carried out starting in June 2013 with a view to re-commissioning the pathway by April 2015.
Contract management and procurement of existing external contracts	Review and retender the Birth and Adoption Records Counselling contract.

12. MAKING IT HAPPEN - COMMISSIONING INTENTIONS:

Over the next three years there will be a programme of work to deliver these priorities and the table below outlines the key areas where external services will be commissioned or re-tendered. It is recognised that this list is subject to change at any time.

	Commissioning intention	What will we do to achieve this?
Promoting, Protecting and Improving Health	Promoting health	Prepare for re-tendering of 0 – 5s services (Health Visiting) by the Local Authority in 2015 by joint working with the National Commissioning Board Local Area Team. Increase the number of babies who are exclusively breastfed by commissioning breastfeeding support in the 6-8 weeks of life, targeted on areas of deprivation. Commission smoking cessation services in order to reduce smoking in pregnant women. Review and re-tender the School Health Nursing Service so that the new service is in place by April 2014.
	Improving health	Ensure evidence based, structured programmes are commissioned to reduce childhood obesity by April 2015. Re-tender the services for brief interventions in alcohol misuse and young people's substance misuse services by September 2014.

Pr	Commissioning intention	What will we do to achieve this?
	Lifestyle and behaviours	Review the Risky Behaviours multi-agency training programme with a view to re-tendering from 2014.
Promoting, Protecting and Improving Health	Re-commission maternity services using an outcome based commissioning approach (Working with provider to redesign and if required re-commission policy by 2014).	Work with Clinical Commissioning Group to implement Outcome Based Contracts in maternity services
	Complete redesign of the paediatric urgent care pathway and evaluate impact of changes	Work with providers to complete redesign of pathway for children in hospital. Monitor activity and costing from Trust activity data in order to inform commissioning plans from 2014 / 2015. Identify options for strengthening alternatives to admission for children working with Oxford Health and Primary Care. Agree a pathway, specification and tariff for specialist palliative care wherever it is provided. Propose activity and tariff for implementation from April 2014.

Pr	Commissioning intention	What will we do to achieve this?
Early Intervention	Best possible outcomes (and value for money) for children and young people	Re-commission early attachment and therapeutic intervention services by April 2014. Review and evaluate evidence based programmes currently commissioned to support targeted early interventions, to inform future outcomes based commissioning. Implement the outcomes of the County Councils review of the Children's Centres and re-tendering of existing contracts by 2015.
	Optimal configuration of high quality early intervention services	Review the provision of information and advice services to children, young people and families. Look at options to re-tender Child Bereavement Services in schools by March 2015.

Pr	Commissioning intention	What will we do to achieve this?
Child and Adolescent Mental Health	Improve transitions from children's to adult mental health services	Finalise commissioning of a new service operationalise by September 2013 and evaluated by April 2014.
	Better outcomes for children with Autism	Co-ordinate the review of the Autistic Spectrum Diagnostic pathway for 5-18 year olds across all relevant providers including schools.
	Improve existing mental health services for children and young people	Re-commission (Primary) Child and Adolescent Mental Health Service (PCAMHS/CAMHS) against overall strategy direction and in preparation for end of Oxford Health NHS Trust contract (2014/15). Roll out of Performance By Results for CAMHS (2014/15).
	Improve targeted support for children and young people at particular risk of developing mental health problems	Commission effective support for young carers.
Education Needs	Developing residential and educational provision that is closer to home	Look at options for new cross regional arrangements with neighbouring authorities, in order to increase availability and cost effectiveness of residential SEN placements for Looked After Children.

Pr	Commissioning intention	What will we do to achieve this?
	Ensuring children and young people have an opportunity to access a range of activities that support their learning and development, and that parents and carers providing high intensity support for their children benefit from respite provision	Commission Short Breaks services involving children, young people and their parents and providers; re-commission so new services in place from April 2014.
	Improving the quality of services that are commissioned out	Develop strategy for commissioning around individual child placement for children with SEN and Disability in partnership with the NHS.
	Ensure children are supported across their range of clinical needs in special schools	Review and re-commission the Children's Specialist Nursing Service; under a Section 76 Agreement and strengthen the partnership in view of Special Educational Needs and Disability (SEND) reforms in the Children and Families Bill by April 2015.
	Develop the Children's Communities Therapies Service	Re-commission the service for 2015.
	Improve pathways into work for disabled young people / young adults.	Commission an increased range of local post 16 education, training and employment options for young people with SEN and disabilities.

Pr	Commissioning intention	What will we do to achieve this?
	Prepare for implementation of new SEN legislation in 2014	Work with providers to increase personal budgets for children with SEN and disabilities. Work with providers to ensure delivery of high quality 'core offer' of provision. Ensure existing providers are able to deliver the integrated Education, Health and Social Care Plan by 2015.
Safeguarding and Looked After Children	Strengthen prevention of child sexual exploitation (CSE)	Commission new initiatives and projects such as awareness raising and education to build resilience and resistance amongst children and young people, parents and carers, communities and professionals.
	Increase local residential provision for the needs of LAC and victims of CSE to prevent them having to travel and live away from their communities (where possible and appropriate)	Evaluate options for residential provision in county including the use of the Council's land and premises.
	Increase the supply of good quality cost-effective fostering and residential provision for LAC	Continue to work in cross regional collaboration to procure high quality and value for money placements in neighbouring authorities.
	Review need and re-commission the young people's Supported Housing Pathway	Re-commission the Young People's Supported Housing Pathway by April 2015.

Pr	Commissioning intention	What will we do to achieve this?
	Contract management and procurement of existing external contracts	Re-tender the Birth and Adoption Records Counselling contract.

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