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Brent Clinical Commissioning Group

Health and Wellbeing Board

Wednesday 3 July 2013 at 7.00 pm
Boardroom - Civic Centre, Engineers Way, Wembley, HA9 0FJ

Membership:

Voting Members	**Non Voting Members**
Councillor R Moher (chair)	Ann O' Neill Health Watch representative
Councillor Crane	Phil Porter Director Adult Social Care
Councillor Hirani	Krutika Pau Director Children Services
Councillor Pavey	TBC Director of Public Health
Councillor HB Patel	Sue Harper Director Environment and Neighbourhood Services
TBC CCG Representative	Christine Gilbert Interim Chief Executive
TBC CCG Representative	
TBC CCG Representative	

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The press and public are welcome to attend this meeting

Agenda

Introductions, if appropriate.

Apologies for absence and clarification of alternate members.

Item Page

1 Election of Chair and Vice Chair

2 Declarations of interests

Members are invited to declare at this stage of the meeting, any relevant financial or other interest in the items on this agenda.

3 Minutes of the previous meeting 1 - 4

4 Matters arising

5 Health and Wellbeing Board Governance 5 - 10

This report provides details of the decisions taken by Full Council and invites the Health and Wellbeing Board to consider its membership and voting options.

6 Future plans for health and social care integration - the Pioneer Bid 11 - 16

This paper sets out the:

- The national context for the health and social care integration, including the Pioneer programme
- A summary of what is already happening in terms of integration in North West London and, more importantly, in Brent
- An overview of the Expression of Interest, prior to the final document being circulated on 28 June.

7 Winterbourne View Stocktake 17 - 26

The Health and Wellbeing Board is recommended to consider the Winterbourne View stocktake return and question officers from the council and CCG on the progress Brent is making in delivering the commitments in the Winterbourne View Concordat.

8 Adult Safeguarding Service Update 27 - 38

The Board is asked to comment on the contents and provide a steer on the Board's role in Safeguarding Adults, in particular driving improvements in the health and social care sector to reduce abuse.

9 Shaping a Healthier Future - Implementation Update 39 - 48

Brent's Health and Wellbeing Board has been provided with an update on Shaping a Healthier Future by Brent Clinical Commissioning Group. The update is attached as an appendix to this covering report.

10 Health and Wellbeing Board - Future Work Programme

A verbal discussion will take place regarding the future work programme of the Health and Wellbeing Board.

11 Any other urgent business

Notice of items to be raised under this heading must be given in writing to the Democratic Services Manager or his representative before the meeting in accordance with Standing Order 64.

Date of the next meeting: Wednesday 11 September 2013

Please remember to ***SWITCH OFF*** your mobile phone during the meeting.

- The meeting room is accessible by lift and seats will be provided for members of the public.

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Health and Wellbeing Board – 27th February 2013

Meeting Notes

Present – Councillors Ruth Moher (chair), Krupesh Hirani, Mary Arnold and Sandra Kabir, Phil Newby, Alison Elliott, Krutika Pau, Graham Genoni, Ethie Kong, Sarah Basham, Jo Ohlson, Penny Toft, Phil Sealy, Chris Spencer, Margaret Chirgwin, Anna Janes, and Andrew Davies

1. Minutes of the previous meeting

The minutes of the previous meeting held on the 19th December 2012 were approved.

2. Matters Arising

(i). Public Health Contracts – Phil Newby explained to the Board that the Department of Health's guidance on the transfer of public health contracts had changed and that potentially the council was going to have to agree new contracts with providers for 2013/14. This was different to the advice that had been issued previously, which was clear that contracts could be extended and transferred. At this stage the council was waiting for clarity on the new guidance before starting to work up new contracts.

On GUM services, contracts for 2013/14 hadn't been agreed and it was likely that Brent would have to lead negotiations with NWL Hospitals as negotiations weren't progressing through the CSU as planned. GUM remains the biggest risk area to the council as it is a demand led, open access service.

(ii). Public Health Budget – Work has taken place to finalise the public health budget. Staffing and contract obligations can be met, as well as funding for programmes in Children and Families, smoking cessation, sexual health and DAAT. A contingency sum has been set aside for GUM and to ensure any unforeseen costs are covered. Details will be set out in a report for the Executive in March 2013.

3. Children and Families Plan

Anna Janes, Head of Children and Families Policy, presented the Children and Families Plan to the Health and Wellbeing Board. The plan has been developed by the Children's Trust Board and contains three overarching priorities - Ensure that children and young people in our borough are healthy and safe; narrow the gap between those children who do well and those who need extra support to thrive, so the aspirations of every Brent child are realised; and to fully integrate services to develop resilient families. There is a clear link to the Health and

Wellbeing Strategy in the Children and Families Plan to emphasise the link between the two Boards.

The Health and Wellbeing Board discussed the plan, and in particular how services should respond to changes in policy at a local and national level. Of particular concern was the impact that changes in benefit rules could have on child protection and safeguarding, particularly if vulnerable children are moved out of the borough. This has been picked up by the Safeguarding Board as an issue.

Looking at what can be done by schools to help children from chaotic or vulnerable backgrounds, the value of breakfast clubs was questioned. This was because they were generally used by those children who needed them least, children of working parents who take their children to school earlier to enable them to get to work, rather than those children who aren't given breakfast at home.

The Board agreed that a partnership response to changes in Government policy was required to help negate the impact of changes on the most vulnerable children as cuts to services and welfare become more challenging. Reconfiguring services to meet the strategic needs identified by the Health and Wellbeing Board and the Children's Trust Board was a significant challenge, but one that needs to be taken up by both groups.

The Board agreed that there should be a regular update on its agenda on the Children and Families Plan to provide a challenge back to the Children's Trust Board that the plan is being delivered.

4. Action Plan in response to the Ofsted Inspection of local authority arrangements for the protection of children

Graham Genoni presented to the Board the action plan developed in response to the Ofsted inspection of the council's child protection arrangements. Brent was one of 90 local authorities that was rated adequate or inadequate at their initial Ofsted inspection and as a result was subject to a follow up inspection to assess progress. The inspection regime is getting tougher and more challenging which makes it harder to move up from one grade to the next.

The follow up inspection praised some areas of the service and it was acknowledged that a lot of good work was happening to improve safeguarding arrangements. For example, the safeguarding board has been re-established. The inspection itself was very focussed on children's social care, looking at case files and interviewing a relatively small number of people. However, the service will need to work with partners to ensure that all parts of the system are working well. Future ratings will be as strong as the weakest score within the assessment – if one element of the service is judged inadequate, the whole service is considered inadequate.

The challenges of tracking children in Brent were discussed and included populations churn, overcrowding, and GP registrations, where families are registered but questions aren't asked as to whether the family has any dealings with social services. Some children live in very complex circumstances that make solutions to safeguarding problems difficult to implement.

Chris Spencer, the chair of the Brent Local Children's Safeguarding Board explained that the bar has been raised in the safeguarding inspection regime, but that safeguarding board arrangements are now in place but the narrative on outcomes is not there, yet. The pace of

change and improvement across all facets of the service needs to pick up if Brent is to receive a better inspection outcome in the future.

Regarding the action plan, the Board noted that none of the actions were red rated, but some are yet to be completed reflecting the complexity of some of the recommendations. It was agreed to bring the inspection action plan back to the Board in six months time for an update on progress.

5. Outer North West London Integrated Care Business Plan 2013/14

Alison Elliott presented to the Board an update on the Integrated Care Pilot and business plan. It was noted that councils and NHS organisations in NWL, including Brent and NHS Brent support the principle of the ICP, but that funding for the scheme is scheduled to come to an end on 31st March. It is an expensive model, but Brent CCG will continue to fund it for an additional 12 months whilst work takes place to develop a less bureaucratic and more sustainable model that can be implemented in the future. In the next 12 months commissioners will be looking for value for money and outcome improvements because it is unaffordable in the long term in its current form.

The integrated care service was said to be delivering "soft" outcomes, such as better working relationships between practitioners, but the value for money measures are not clear at present, such as fewer acute admissions. Although the outcomes can't yet be proved, it was felt that the principle behind the project was correct and that it should continue locally for 12 months whilst changes are made to improve it.

It was agreed that details on the new model for integrated care would be brought to the Board for consideration once it had been developed, including financial modelling.

6. Brent Clinical Commissioning Group Draft Operating Plan

The Health and Wellbeing Board was updated on the Brent CCG operating plan for 13/14. The plan sets out the CCGs local priorities:

- To increase the number of people receiving a health check, in particular to find people with heart disease
- To provide more health checks for people with learning disabilities
- To improve access to GP services. A six month pilot in parts of Brent will see GP practices stay open until 9pm and open on Saturdays for additional or urgent appointments to try to improve access.

Targets for these priorities are still being negotiated with the Department of Health and the NHS Commissioning Board.

There was some debate around how the priorities were chosen and which ones were not, such as combating TB, or taking action to reduce domestic violence. Whilst the Health and Wellbeing Board was supportive of the plan and priorities, it would have liked to have understood how they were arrived at the reasons for rejecting other areas.

It was acknowledged that the CCG will have to work with public health to be successful on health checks, as this is a service commissioned by the council but delivered by GPs. Regarding domestic violence, the Board was informed that the CCG would be working with the Working with Families project to pick this up. The Aligned Services Strategy will bring partners together to give this work some cohesion. The Health and Wellbeing Board agreed it should look at this issue in the future.

It was suggested that the CCG publicises its plan using the Brent Magazine so that members of the public understand its priorities. The plan would be finalised and submitted to the Commissioning Board by 3rd April 2013.

7. Diabetes Task Group Report

The Health and Wellbeing Board considered the report from the Diabetes Task Group. The Board supported the recommendations in the report, as did the CCG representatives. It was agreed that the CCG would provide a response to the recommendations that related to their services.

8. Health and Wellbeing Board Regulations

The Health and Wellbeing Board considered and noted a report setting out the main points from the health and wellbeing board regulations that had been published in February 2013. The Board will not be able to meet in shadow form any longer, and Full Council now needs to properly constitute the Board before it is able to meet again formally. This should happen in May 2013.

9. The future of local suicide prevention plans in England – circulated for information.

Alison Elliott agreed to raise this issue with the Interim Director of Public Health, Imran Choudhury.

10. Any other business

The Board suggested a number of issues for inclusion in the work programme:

- Mental health services report – suggested by Alison Elliott
- Reablement service peer review
- Aligned services strategy

Krutika Pau raised two issues. Firstly, that she was concerned with health reviews for looked after children and that she wanted the Board to investigate this issue to see how they could be improved. Secondly, there is funding available from the Family Nurse Partnership to set up a scheme in Brent, to work with young mothers under the age of 20. Additional support is provided until the child is two years old. It was suggested that this is looked at to see whether Brent could implement a service such as this.

11. Date of Next Meeting

The next meeting is currently scheduled for 5th June 2013.

Brent	**Health and Wellbeing Board** **3rd July 2013** **Report from the Assistant Director of Strategy, Partnerships and Improvement**
For Action	Wards Affected: ALL

Establishment of the Brent Health and Wellbeing Board

1. Summary

1.1 On 24th June Full Council formally established the Brent Health and Wellbeing Board. The purpose of the Board is to assess the health needs of the Brent population and produce a strategy to address those needs and to encourage the provision integrated health and social care services.

1.2 This report provides details of the decisions taken by Full Council and invites the Health and Wellbeing Board to consider its membership and voting options.

2. Recommendations

2.1 The Health and Wellbeing Board is recommended to:

(i) Note that the Health and Wellbeing Board has been established as a Committee of the Council with the Terms of Reference and Membership set out in Paragraphs 3.7.1 and 3.5.2 below.

(ii) Consider whether it wishes to appoint any additional members to the Board.

(iii) Respond to the proposed voting arrangements for the Board set out in paragraph 3.3.5.

3. Details

3.1 Policy Context

3.1.1 Section 194 of the Health and Social Care Act 2012 requires that every upper-tier local authority establish a Health and Wellbeing Board ('HWB'). Collaboration is at the heart of Health and Wellbeing Boards; they provide new opportunities for local government to work in partnership with the NHS and communities to understand local need and develop a shared strategy to address the issues that matter most to local people.

3.1.2 Brent's shadow Health and Wellbeing Board has been meeting since February 2011. In developing the Board, the Council has followed the spirit of the original NHS White Paper, "Liberating the NHS" and subsequent Health and Social Care Act 2012. The terms of reference reflect the Government's ideas around the roles of Health and Wellbeing Boards, that they should be forums of collaboration and partnership working. Brent's approach has been informal, focussing on building relationships between councillors and GPs. However, it has overseen the development of a new Joint Strategic Needs Assessment for Brent and a Joint Health and Wellbeing Strategy, two of the board's statutory functions.

3.1.3 The main functions of Health and Wellbeing Boards are to:

- Assess the needs of the population through the Joint Strategic Needs Assessment (JSNA)
- Agree and produce a Health and Wellbeing Strategy to address needs, which commissioners will need to have due regard to in developing commissioning plans for health care, social care and public health. Commissioning plans can be referred to the CCG, local authority executive or NHS Commissioning Board if they do not reflect the JSNA and Health and Wellbeing Strategy
- Promote joint commissioning between health and social care
- Promote integrated provision, joining up social care, public health and NHS services with wider local authority services
- Participate in the development of CCG commissioning plans including commenting on the CCGs readiness to take on commissioning responsibilities and become authorised.
- Provide advice to the NHS Commissioning Board in authorising and assuring CCGs

3.1.4 Health and Wellbeing Boards needed to move out of their "shadow" form and become properly constituted by following the passing of the Health and Social Care Act in April 2013. Regulations on the operation of Health and Wellbeing Boards were published in February 2013. As a result it was only possible to take a report to Full Council in June 2013 because there wasn't a Council meeting (apart from Mayor Making) following the publication of the regulations. The relevant regulations are The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

3.2 Legal Context

3.2.1 In order to fit Health and Wellbeing Boards within local authority structures, the Government has used section 102 of the Local Government Act 1972 as their legislative framework which governs the Council's ordinary Committee arrangements. By using this established legislation there are consequences that have become apparent regarding the operation of this Board and the recent Regulations seek to address the various issues which arise. For example, under normal circumstances a section 102 committee only permits elected members of the council to vote on decisions. It has always been the explicit policy intention that Health and Wellbeing Boards will, as a forum for collaborative local leadership, be very different to a normal local authority committee. The regulations permit a move away from these ordinary rules in relation to Health and Wellbeing Boards.

3.2.2 As a section 102 committee, Full Council has taken the decision to formally establish the Health and Wellbeing Board. There are some membership requirements that are statutory. The statutory members of the health and wellbeing board are:

- At least one elected member (appointed by the Leader)
- Director of Adult Social Care
- Director of Children's Services
- Director of Public Health
- A representative of the local Clinical Commissioning Group
- A representative of Health Watch

3.2.3 Section 194(2) (g) of the Health and Social Care Act 2012 allows additional members beyond the statutory minimum to be appointed to the Board by the Local Authority and Section 194 (8) enables the board itself to appoint additional members. The Board should consider whether it wishes to appoint any additional members.

3.2.4 It is worth reinforcing the key underlying issue facing councils that are establishing Health and Wellbeing Boards - the need to strike a delicate policy balance between utilising the local accountability that is expected by establishing a Health and Wellbeing Board as a statutory committee, with the objective of providing the flexibility and support needed to empower local authorities to shape boards that are focused and effective, which work for them and really make a difference. The Health and Wellbeing Board may be delegated other functions but it cannot be responsible for overview and scrutiny functions.

3.3 Health and Wellbeing Board Regulations and choices for the Council

Establishment of Sub Committees and Delegations

3.3.1 Current legislation enables the council to arrange for the discharge of functions by a committee, sub committee, officer or another local authority. The Department of Health is clear that Health and Wellbeing Boards are being established to bring together key health and social care commissioners and they want the core functions of the boards to remain within the collective ownership of the whole board The regulations allow the Health and Wellbeing Board, unless the Council directs otherwise, to establish a sub committee and delegate functions to a sub committee, if it wishes to do so. Council has not prohibited the Health and Wellbeing Board from setting up sub-committees.

Delegation of powers to the Health and Wellbeing Board

3.3.2 Councils are able to delegate executive functions to Health and Wellbeing Boards and the Boards will have their own statutory responsibilities such as developing the borough's health and wellbeing strategy. Apart from its statutory functions, the Health and Wellbeing Board has not had any further powers delegated to it.

Voting restrictions

3.3.3 Ordinarily S102 of the Local Government Act 1972 prevents non members of the Council from voting at section 102 committees except in relation to a specified set of committees. However, regulation 6 of Regulations provides that unless the Council chooses to restrict voting rights to certain members of the Health and Wellbeing Board, all members of the Health and Wellbeing Board will have voting rights.

3.3.4 Although Health and Wellbeing Boards have a unique role and membership requirement, the voting regulation presents a problem to local authorities. It is highly

unusual to have officers of the council and external partners voting on a council committee since this goes against the principles of local democracy and decision making by elected representatives.

3.3.5 That said, Health and Wellbeing Boards are supposed to act as the leaders of health and social care services in their area. Health and Wellbeing Boards were intended to be collaborative groups that work to implement a shared agenda for health and social care in each council area. If a collaborative board is to be established, setting up a board where only elected members can vote would seem to go against the original intention. It is recommended that representatives of the council and the Clinical Commissioning Group should be at the table as equals if the Board is to work and genuinely improve health and wellbeing through its strategic influence and powers. For this reason, Council proposes to give the three CCG representatives voting rights on the Board. However, other members of the Board, including officers of the council, Health Watch representatives, and any others appointed to the Board (including any additional CCG members), should not be given voting rights.

3.3.6 The regulations require councils to consult with Health and Wellbeing Boards before making any decision on voting rights at the board. The Brent Health and Wellbeing Board should consider the proposals for voting arrangements and report back its views to Council in order that a final decision on Health and Wellbeing Board voting arrangements can be taken.

3.4 Disqualification for membership

3.4.1 Currently persons who are disqualified from being councillors are disqualified from being a member of the local authority or committee or joint committee. The grounds of disqualification include being an employee of the Council. The regulations have amended these restrictions to allow officers to become members of the board.

Application of a code of conduct and declaration of interest

3.4.2 Part 1, Chapter 7 of the Localism Act 2011 sets out provisions on the new standards regime for local authorities. This includes provisions in relation to the Code of Conduct and the disclosure of pecuniary interests The Act requires co-opted members of committees to disclose pecuniary interests. A co-opted member is a person who is not a member of the authority but who is a member of any committee or sub-committee and who is entitled to vote on any question that falls to be decided at any meeting of that committee or sub-committee. These provisions will therefore apply to all voting members of the Health and Wellbeing Board. Accordingly arrangements will need to be made for the disclosure of pecuniary interests and training and guidance will be provided to members regarding the Code.

Application of transparency provisions

3.4.3 The Health and Wellbeing Board is subject to the same access to information rules as other council committees.

3.5 Membership of the Board

3.5.1 Given the points made above about membership (both statutory and non-statutory), Full Council has agreed the membership of the Board as set out below in order to ensure it is able to properly fulfil its functions as a leader of the health and social care system in the borough.

3.5.2 The appointments made by Full Council are:

Statutory members

- Five elected councillors, with voting rights, to be nominated by the Leader of the Council. Four councillors will be Executive members from the majority party. The fifth member will be from an opposition party. An elected councillor will chair the Health and Wellbeing Board
- Director of Adult Social Care
- Director of Children's Services
- Director of Public Health
- A representative of Brent CCG, with voting rights
- A representative of Health Watch

Non-statutory members

- Director of Environment and Neighbourhood Services
- Two additional representatives from Brent Clinical Commissioning Group with voting rights
- Brent Clinical Commissioning Group Borough Director

At least one of the Brent CCG members shall be a GP

3.5.3 No further members will be added to the Board, unless the Board explicitly agrees to appoint additional members.

3.6 Quorum

3.6.1 Although the membership of the Board is wider than just councillors and CCG representatives, as it is proposed they be the only voting members, the Health and Wellbeing Board will only be quorate if three elected members and one CCG representative from the Brent Clinical Commissioning Group is present.

3.7 Terms of Reference

3.7.1 The terms of reference for the Health and Wellbeing Board are set out below. These have been approved by Full Council. They recognise that operational activities sit with the individual organisations represented on the Health and Wellbeing Board. The Board's role is to set the strategic direction and influence commissioning processes prior to operational decisions being taken.

Brent's Health and Wellbeing Board will:

- Lead the improvement of health and wellbeing in Brent, undertaking duties required by the Health and Social Care Act 2012.
- Lead the needs assessment of the local population and subsequent preparation of the borough's Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy and ensure that both are updated at regular intervals
- Oversee the implementation of the priorities in the borough's health and wellbeing strategy and other work to reduce health inequalities in Brent
- Develop initiatives between the council and health service partners to improve health and wellbeing, focussing on tackling Brent's health inequalities.
- Promote integration and partnership working between health, social care and public health by developing joined up commissioning plans

- Provide steer and oversight to CCG and social care commissioning plans to ensure they meet the borough's health needs and the wider strategic plans for health and social care.
- Consider the wider determinants of health including (but not limited to) housing, education, and the environment to ensure that there is an integrated response to tackling health and wellbeing priorities and health inequalities in Brent.
- To oversee the borough's plans to respond to a health related emergency.
- Oversee the development of the borough's pharmaceutical needs assessment, which requires updating every three years.
- Agree an annual work programme for the Board.

4. Legal Implications

4.1 The legal implications are included in the body of the report.

5. Finance Implications

5.1 None

6. Diversity Implications

6.1 None

7. Staffing/Accommodation Implications

7.1 There are no specific staffing implications. The Shadow Board has been provided with administrative support including that from Democratic Services and the policy unit and this will continue.

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Cathy Tyson
Assistant Director of Strategy, Partnerships and Improvement

Brent	**Health and Well Being Board** 3 July 2013 **Report from Acting Director of Adult Social Care**

North West London Health and Social Care Pioneer Expression of Interest

1. Introduction

1.1 This paper sets out the:

- The national context for the health and social care integration, including the Pioneer programme
- A summary of what is already happening in terms of integration in North West London and, more importantly, in Brent
- An overview of the Expression of Interest, prior to the final document being circulated on 28 June.

1.2 The aim of the paper is to give the Health and Well Being Board an opportunity to:

- Discuss health and social care integration in Brent, particularly in light of the Pioneer bid
- Start the process of developing a shared vision for health and social care in Brent
- Agreeing what the role of the Board will be in leading this and its role in overseeing implementation.

2. National Context: Health and Social care Integration

2.1 In May 2013, 'Integrated Care and Support – Our Shared Commitment' was published. This is a document which was agreed and signed by Department of Health, NHS England, Monitor, LGA, ADASS and Public Health England. The document set out a shared vision for health and social care integration which was co-developed by National Voices engaging with patients, service users and carers. The focal point of this vision was building care and support around the individual:

> *"I can plan my care with people who work together to understand me and my carer(s), allowing me control, and bringing together services to achieve the outcomes important to me."*

2.2 The document also clearly sets out the shared expectation of all signatories that localities will adopt the shared vision for integrated care and support, working to make it the norm within the next five years. However, it is less explicit about how this will be delivered and instead focuses on examples of good practice, recognising that there is no single answer to integration. It proposes a variable geometry approach to implementation: the government's role is to create a sustained national collaborative programme to seek solutions that local areas will develop to implement local solutions.

2.3 One key way in which government is seeking to energise this renewed focus on integration is the Pioneer programme. (Overview of Pioneer selection criteria attached at Appendix 1).

2.4 Pioneer sites will be provided with additional expertise, support and constructive challenge to help them realise their aspirations on integrated care. This opportunity to be selected as a national pioneer site would be a natural continuation and enhancement of local borough based initiatives on integrated health and social care but could also bring some additional benefits. Expressions of Interest need to be submitted to the Department of Health by 28 June.

3. Health and Social Care Integration in North West London and Brent

3.1 There is already a strong track record of integrated ways of working across the health and social care localities of NWL. Councils and CCG's across North West London have been leading the way nationally in relation to integration of health and social care ranging from the development of fully integrated to the tri-Borough's work with their health partners on Community Budgets Pilot sites to the key project that underpins the development of the North West London Pioneer expression of interest: Integrated Care Pathway (ICP) pilots.

3.2 Brent has not implemented the ICP as quickly as other Boroughs in North West London. The Council and the CCG share concerns about whether or not it will deliver the savings targets and change it is supposed to. However, there is also a significant opportunity to refocus and speed up implementation to ensure that the Multi-Disciplinary Group meetings (MDGs) are more closely linked to the key issues in the health and social care system, particularly the need to reduce delays in A&E and reduce demand for non-elective secondary care admissions.

3.3 However, there are also a number of specific projects and services in Brent that are focused on delivering improved outcomes for the people of Brent, but require health and social care providers to work together, including:

- *Single Point of Access project.* This is a health led project to reduce unnecessary admissions and to improve the quality of discharges. At the moment the focus is on A&E and reducing unnecessary admissions by putting a GP and social worker into A&E. In the future it will build on the current joint working for discharge (e.g. Hospital Occupational therapists

doing the social care reablement goal setting) to develop an integrated discharge health and social care pathway with a single discharge plan

- *Enhanced Reablement Service (ERS)* – this service was implemented to bridge the gap between Social Care Reablement and Health funded Community Rehabilitation. Currently, these services are aligned, but not integrated, reducing the quality of outcomes. Based on the success of the ERS pilot, the CCG and the Council are looking to jointly commission across the full spectrum of these services
- *Short Term Assessment, Reablement and Rehabilitation Services (STARRS).* This is a long standing health service, which has a priority referral mechanism into social care. The STARRS team is made up of Occupational Therapists, Nurses and Physiotherapists who take referrals primarily from GPs to see people in the community at short notice to avoid hospital admissions. There is a need to fully integrate this service with social care.

3.4 In other words, there is a strong platform of joint working on which to build through a more strategic and shared local vision for health and social care integration.

4. Overview of the Expression of Interest (prior to the final document being circulated on 28 June)

4.1 Feedback suggests that most localities in England are considering or actively pursuing an Expression of Interest (EoI), which means that any EoI needs to be genuinely innovative, and also replicable – so that Department of Health can see the benefits for the rest of the country.

4.2 This, along with the work already done in North West London, means that an EoI for North West London makes sense. There are concerns about this approach (concerns about being swallowed up into either a health dominated bid, or a north west London dominated bid), which have been identified and stressed throughout the process of developing the EoI, but there are also clear benefits if it fully reflects the two levels:

i. North West London to tackle regional, systemic issues, and
ii. Brent, to develop genuinely local care and support that reflects the population and the current service position.

4.3 The key benefits are set out below:

- A whole system approach with an explicit agreement to sharing the benefits for the good for the people of Brent
- A whole system bid across a number of boroughs and CCG's with differing models of integrated care will enable learning about what works to be shared

- It will allow stakeholders to leverage Central Government support in co-designing the Whole System approach across North West London
- It will provide additional expertise, support and constructive challenge
- As a whole systems bid it will also include the acute hospital trusts across the sector. Patient flows across North West London mean that patients attend hospitals across borough boundaries thus strengthening the case to look at integration across the sector
- There is a potential for freeing up NHS acute hospital budgets to reinvest in local community services.

4.4 The EOI will be very high level. It will be no more than 10 pages long and yet it will need to describe the complete transformation of the North West London health and social care economy. However, a number of key elements frame the bid, these elements are a direct response to the barriers to integration that have been experienced in previous integration projects in NWL:

- Population based approach – focusing on the population as a whole, rather than on health patients and social care customers, responding to their needs on a risk stratification model, for example, 20% of people use 75% of health and social care budget, how do we design integrated services to manage this
- GP network development – developing options for establishing GP as centre of care network, developing organisational models and contractual arrangements between practices and applying technology to facilitate this
- Provider network development - aligning and/or integrating a range of services with GP networks, ensuring their organisational forms are fit for purpose
- Information governance and infrastructure – identifying and implementing models that can enable integrated commissioning and service delivery and overcome some of the challenges identified, particularly data sharing
- Commissioner governance - developing and establishing the necessary governance arrangements, and the contractual and legal agreements between commissioners to enable pooled funding or capitated budgets.

5. Conclusions

5.1 The Pioneer process came at short notice with a tight deadline. However, it has created an opportunity for health and social care partners, and the Health and Well Being Board in particular. The key role of the Health and Well Being Board in driving health and social care integration is reflected in the EoI.

5.2 Therefore, the Board is asked to comment on the contents of the paper and Pioneer bid (when it is circulated on 28 June) to outline its view on:

- the importance of health and social care integration to Brent, and the Pioneer bid in particular
- how it will lead the development of a shared vision in Brent to ensure we can clearly articulate this in the development of the Pioneer project
- agree what the role of the Board will be in leading this and its role in overseeing implementation.

Appendix 1: Pioneer site expression of interest – Criteria for selection

1. Articulate a clear vision of its own innovative approach to integrated care and support
    - Adopting the narrative of National Voices aligned with Making it Real
    - Delivery focused on better outcomes and experiences
    - Potential financial efficiencies for reinvestment have been identified and potential measures of success

2. Plan for Whole System integration
    - Involvement of other public services such as education, housing, the community and voluntary sectors
    - Focus on greater prevention of ill health and deterioration of health, and personalisation
    - A model for how unpaid contributions of families and communities are part of coordinated services

3. Demonstrate commitment to integrate care and support across the breadth of relevant stakeholders
    - The involvement and support of Health and Well Being Boards is an essential prerequisite
    - Local executive and political, staff groups including clinicians, patients groups, people who use services and carers/families must support our approach

4. Demonstrate capability and expertise to delivery public sector transformation at scale and pace
    - Proven track record in this area
    - Robust plans to tackle barriers to integration

5. Commit to sharing lessons on integrated care and support across the system
    - Involvement in peer to-peer (including clinicians) promotion, dissemination and learning networks

6. A vision and approach that are based on robust understanding of the evidence
    - Plans that take account of latest evidence and a commitment to test and co-produce new measurements of experience of care and support

Brent	**Health and Wellbeing Board** **3 July 2013** **Report from the Acting Director of Adult Social Services**
For Action	Wards Affected: ALL

Winterbourne View Joint Improvement Programme – Local Stocktake

1. Introduction

1.1 All Health and Wellbeing Boards have been contacted by the Winterbourne View Joint Improvement Board in relation to a stocktake of progress against the commitments made in the Winterbourne View Concordat which was signed by a broad range of agencies and organisations.

1.2 The Concordat was the joint response of agencies including the LGA and the NHS to the Department of Health Transforming Care report arising from the significant failings at Winterbourne View. The Concordat sets out the commitment to transform health and care services and improve the quality of the care offered to children, young people and adults with learning disabilities or autism who have mental health conditions or behaviour that challenges.

1.3 The purpose of the stocktake is to enable councils and CCGs to assess their progress against commitments in the Concordat and to allow for good practice and progress from local areas to be shared nationally. It is expected that Health and Wellbeing Boards should play a significant leadership role to ensure that the Concordat commitments are achieved.

1.4 Details of the stocktake questions and a letter to all council's from Chris Bull, Chair of the Winterbourne View Joint Improvement Board are attached as appendices to this report. A completed stocktake return will be circulated to the Health and Wellbeing Board members once it is available.

2. Recommendations

2.1 The Health and Wellbeing Board is recommended to consider the Winterbourne View stocktake return and question officers from the council and CCG on the progress Brent is making in delivering the commitments in the Winterbourne View Concordat.

Contact Officer:

Andrew Davies
Policy and Performance Officer
Tel – 020 8937 1609
Email – Andrew.davies@brent.gov.uk

Phil Porter
Acting Director of Adult Social Care

31 May 2013

Dear Chief Executive,

Winterbourne View Joint Improvement Programme – Local Stocktake

I am writing to you to ask for your assistance in completing a stocktake of progress against the commitments made in the Winterbourne View Concordat which was signed by a broad range of agencies and organisations.

The Concordat was the joint response of agencies including the LGA and the NHS to the Department of Health Transforming Care report arising from the significant failings at Winterbourne View. The Concordat sets out the commitment to transform health and care services and improve the quality of the care offered to children, young people and adults with learning disabilities or autism who have mental health conditions or behaviour that challenges.

You will recall that the Concordat contains a number of specific commitments that will lead to all individuals receiving personalised care and support in community settings no later than 1st June 2014.

The purpose of the stocktake therefore is to enable local areas to assess their progress against commitments in the Concordat and to allow for good practice and progress from local areas to be shared nationally.

Given his personal interest in the programme, Norman Lamb, Minister of State for Care Services, has recently written to Chairs of Health and Wellbeing Boards (HWBs) explaining the significant leadership role that HWBs should play in ensuring that the Concordat commitments are achieved. We are therefore sending this stocktake to local authorities given your leadership role in Health and Wellbeing Boards.

However, this stocktake is not simply about data collection but is to assist in your discussions locally with Clinical Commissioning Groups (CCGs) and other key partners including people who use services, family carers and advocacy organisations, as well as providers. The stocktake can only successfully be delivered through local partnerships. We would specifically ask that the responses are developed with local partners and shared with your Health and Wellbeing Board. We would also ask that CCG's sign off the completed stocktake.

The stocktake is also intended to enable local areas to identify what support and assistance they require from the Joint Improvement Programme. The core purpose of the programme is to work alongside local commissioners to enable you to deliver your local plans. Further information on the Winterbourne View Joint Improvement Programme is available on the Local Government Association Website

The deadline for the completed stocktake is Friday 5th July 2013. The stocktake should be returned to Sarah.Brown@local.gov.uk if you require any further information or have any questions please send these to Sarah Brown in the first instance.

I am fully aware that there will be other requests for information over the next few months relating to progress with Learning Disabilities and Autism. The Winterbourne View Programme will work to ensure that we do not ask for information that is duplicated elsewhere, as the purpose of this stocktake is to ensure support is provided to local areas and that we work together to deliver commitments in the Concordat.

Yours sincerely

Chris Bull

Chair of the Winterbourne View Joint Improvement Board

Cc
Chairs of Health and Wellbeing Boards
CCG Accountable Officers
CCG Clinical Leaders
Directors of Adult Social Service
Directors of Children's Services
NHS England Regional and Area Directors

Winterbourne View Joint Improvement Programme

Initial Stocktake of Progress against key Winterbourne View Concordat Commitment

The Winterbourne View Joint Improvement Programme is asking local areas to complete a stocktake of progress against the commitments made nationally that should lead to all individuals receiving personalised care and support in appropriate community settings no later than 1 June 2014.

The purpose of the stocktake is to enable local areas to assess their progress and for that to be shared nationally. The stocktake is also intended to enable local areas to identify what help and assistance they require from the Joint Improvement Programme and to help identify where resources can best be targeted.

The sharing of good practice is also an expected outcome. Please mark on your return if you have good practice examples and attach further details.

This document follows the recent letter from Norman Lamb, Minister of State regarding the role of HWBB and the stocktake will provide a local assurance tool for your HWBB.

While this stocktake is specific to Winterbourne View, it will feed directly into the CCG Assurance requirements and the soon to be published joint Strategic Assessment Framework (SAF). Information compiled here will support that process.

This stocktake can only successfully be delivered through local partnerships. The programme is asking local authorities to lead this process given their leadership role through Health and Well Being Boards but responses need to be developed with local partners, including CCGs, and shared with Health and Wellbeing Boards.

The deadline for this completed stocktake is Friday 5 July. Any queries or final responses should be sent to Sarah.Brown@local.gov.uk

An easy read version is available on the LGA website

May 2013

Winterbourne View Local Stocktake June 2013			
1. Models of partnership 1.1 Are you establishing local arrangements for joint delivery of this programme between the Local Authority and the CCG(s). 1.2 Are other key partners working with you to support this; if so, who. (Please comment on housing, specialist commissioning & providers). 1.3 Have you established a planning function that will support the development of the kind of services needed for those people that have been reviewed and for other people with complex needs. 1.4 Is the Learning Disability Partnership Board (or alternate arrangement) monitoring and reporting on progress. 1.5 Is the Health and Wellbeing Board engaged with local arrangements for delivery and receiving reports on progress. 1.6 Does the partnership have arrangements in place to resolve differences should they arise. 1.7 Are accountabilities to local, regional and national bodies clear and understood across the partnership – e.g. HWB Board, NHSE Local Area Teams / CCG fora, clinical partnerships & Safeguarding Boards. 1.8 Do you have any current issues regarding Ordinary Residence and the potential financial risks associated with this. 1.9 Has consideration been given to key areas where you might be able to use further support to develop and deliver your plan.	**Assessment of current position evidence of work and issues arising**	**Good practice example (please tick and attach)**	**Support required**
2. Understanding the money 2.1 Are the costs of current services understood across the partnership. 2.2 Is there clarity about source(s) of funds to meet current costs, including funding from specialist commissioning bodies, continuing Health Care and NHS and Social Care. 2.3 Do you currently use S75 arrangements that are sufficient & robust.			

2.4 Is there a pooled budget and / or clear arrangements to share financial risk. 2.5 Have you agreed individual contributions to any pool. 2.6 Does it include potential costs of young people in transition and of children's services. 2.7 Between the partners is there an emerging financial strategy in the medium term that is built on current cost, future investment and potential for savings.			
3. Case management for individuals 3.1 Do you have a joint, integrated community team. 3.2 Is there clarity about the role and function of the local community team. 3.3 Does it have capacity to deliver the review and re-provision programme. 3.4 Is there clarity about overall professional leadership of the review programme. 3.5 Are the interests of people who are being reviewed, and of family carers, supported by named workers and / or advocates.			
4. Current Review Programme 4.1 Is there agreement about the numbers of people who will be affected by the programme and are arrangements being put in place to support them and their families through the process. 4.2 Are arrangements for review of people funded through specialist commissioning clear. 4.3 Are the necessary joint arrangements (including people with learning disability, carers, advocacy organisations, Local Healthwatch) agreed and in place. 4.4 Is there confidence that comprehensive local registers of people with behaviour that challenges have been developed and are being used. 4.5 Is there clarity about ownership, maintenance and monitoring of local registers following transition to CCG, including identifying who should be the first point of contact for each individual 4.6 Is advocacy routinely available to people (and family) to support assessment, care planning and review processes 4.7 How do you know about the quality of the reviews and how good practice in this area is being developed. 4.8 Do completed reviews give a good understanding of behaviour support being offered in individual situations.			
4.9 Have all the required reviews been completed. Are you satisfied that there are clear plans for any outstanding reviews to be completed.			

5. Safeguarding 5.1 Where people are placed out of your area, are you engaged with local safeguarding arrangements – e.g. in line with the ADASS protocol.			
5.2 How are you working with care providers (including housing) to ensure sharing of information & develop risk assessments. 5.3 Have you been fully briefed on whether inspection of units in your locality have taken place, and if so are issues that may have been identified being worked on. 5.4 Are you satisfied that your Children and Adults Safeguarding Boards are in touch with your Winterbourne View review and development programme. 5.5 Have they agreed a clear role to ensure that all current placements take account of existing concerns/alerts, the requirements of DoLS and the monitoring of restraint. 5.6 Are there agreed multi-agency programmes that support staff in all settings to share information and good practice regarding people with learning disability and behaviour that challenges who are currently placed in hospital settings. 5.7 Is your Community Safety Partnership considering any of the issues that might impact on people with learning disability living in less restrictive environments. 5.8 Has your Safeguarding Board got working links between CQC, contracts management, safeguarding staff and care/case managers to maintain alertness to concerns.			
6. Commissioning arrangements 6.1 Are you completing an initial assessment of commissioning requirements to support peoples' move from assessment and treatment/in-patient settings. 6.2 Are these being jointly reviewed, developed and delivered. 6.3 Is there a shared understanding of how many people are placed out of area and of the proportion of this to total numbers of people fully funded by NHS CHC and those jointly supported by health and care services. 6.4 Do commissioning intentions reflect both the need deliver a re-provision programme for existing people and the need to substantially reduce future hospital placements for new people. 6.5 Have joint reviewing and (de)commissioning arrangements been agreed with specialist commissioning teams. 6.6 Have the potential costs and source(s) of funds of future commissioning arrangements been assessed.			

6.7 Are local arrangements for the commissioning of advocacy support sufficient, if not, are changes being developed. 6.8 Is your local delivery plan in the process of being developed, resourced and agreed. 6.9 Are you confident that the 1 June 2014 target will be achieved (the commitment is for all people currently in in-patient settings to be placed nearer home and in a less restrictive environment). 6.10 If no, what are the obstacles, to delivery (e.g. organisational, financial, legal).			
7. Developing local teams and services 7.1 Are you completing an initial assessment of commissioning requirements to support peoples' move from assessment and treatment/in-patient settings. 7.2 Do you have ways of knowing about the quality and effectiveness of advocacy arrangements. 7.3 Do you have plans to ensure that there is capacity to ensure that Best Interests assessors are involved in care planning.			
8. Prevention and crisis response capacity - Local/shared capacity to manage emergencies 8.1 Do commissioning intentions include an assessment of capacity that will be required to deliver crisis response services locally. 8.2 Do you have / are you working on developing emergency responses that would avoid hospital admission (including under section of MHA.) 8.3 Do commissioning intentions include a workforce and skills assessment development.			
9. Understanding the population who need/receive services 9.1 Do your local planning functions and market assessments support the development of support for all people with complex needs, including people with behaviour that challenges. 9.2 From the current people who need to be reviewed, are you taking account of ethnicity, age profile and gender issues in planning and understanding future care services.			

10. Children and adults – transition planning 10.1Do commissioning arrangements take account of the needs of children and young people in transition as well as of adults. 10.2 Have you developed ways of understanding future demand in terms of numbers of people and likely services.			
11. Current and future market requirements and capacity 11.1 Is an assessment of local market capacity in progress. 11.2 Does this include an updated gap analysis. 11.3 Are there local examples of innovative practice that can be shared more widely, e.g. the development of local fora to share/learn and develop best practice.			

Please send questions, queries or completed stocktake to Sarah.brown@local.gov.uk by 5th July 2013

This document has been completed by

Name……

Organisation……..

Contact……

Signed by:

Chair HWB ……

LA Chief Executive ……..

CCG rep……

Brent	**Health and Well Being Board** **3 July 2013** **Report from Acting Director of Adult Social Services**

Safeguarding Adults in Brent

Introduction

1. This is the first Safeguarding Adults report to be presented to the Health and Well Being Board, therefore, it provides:
   - An overview of Safeguarding Adults
   - A summary of operational arrangements in Brent
   - An overview of the Brent Safeguarding Adults Board (BSAB) and its work, and
   - High level activity analysis for 2013/14.

2. The Board is asked to comment on the contents and provide a steer on the Board's role in Safeguarding Adults, in particular driving improvements in the health and social care sector to reduce abuse.

Overview of Safeguarding Adults

3. There are 4 terms that define Safeguarding Adults:
   i. *Adult at risk / Vulnerable adult* – an adult (18 years or older) who needs community care services because of mental or other disability, age or illness and who are, or may be unable, to take care of themselves against significant harm or exploitation.
   ii. *Abuse* - includes physical, sexual, emotional, psychological, financial, material, neglect, acts of omission, discriminatory and institutional abuse.
   iii. *Significant harm* - is not only ill treatment (including sexual abuse and forms of ill treatment which are not physical), but also the impairment of, or an avoidable deterioration in, physical or mental health, and the impairment of physical, intellectual, emotional, social or behavioural development
   iv. *Mental Capacity* - If you have mental capacity, it means that you are able to make your own decisions – that you are able to understand and think through information and make a choice based on that information. The Safeguarding Adults process assumes Mental Capacity, ensures that adults are supported to make their own decisions (even if they are unwise) and makes sure that anything done for or on behalf of people without capacity should be an option that is less restrictive of their basic

4. In 2000 the Government published 'No Secrets', which prioritised the need to safeguard vulnerable adults from abuse. It also set out a framework for action within which local agencies work together to prevent and reduce the risk of harm to vulnerable adults and respond to abuse of vulnerable adults. The focal point for this action is local multi-agency Safeguarding Adults board and the local codes of practice which underpin multi-agency practice.

5. 'No Secrets' remains the defining document for Safeguarding Adults, but it is only statutory guidance. The Care and Support Bill, which is going through Parliament at the moment, recognises the need for a clear legal framework for Safeguarding Adults, similar to Children's Safeguarding. These changes are likely to be implemented in April 2015 and will reinforce the work already happening in Brent. The Local Authority will be required to:
   - establish and run a Safeguarding Adults Board and require key organisations to take an active role - Brent already has a Board, details set out below, and representation and engagement from partner organisations is good
   - publish a Safeguarding Annual report – Brent has written, but not published annual reports over the last 3 years. A summary of the Annual Report was included in last year's Local Account, but there are already have plans to publish the 2012/13 report at a conference in October
   - investigate when allegations of abuse are raised - Brent has a dedicated Safeguarding Adults team (SGA team) which responds to all allegations of abuse and an overview of the team and an analysis of their work is set out below
   - to carry out Safeguarding Adults Reviews (Serious Case Reviews) when there are serious concerns about operational practice – the Brent Safeguarding Adults Board already has a process for escalating serious concerns and an Independent Management Review (IMR) was undertaken, in line with this policy, in 2012 in relation to a number of sexual assaults where the perpetrator lacked Mental Capacity.

Operational arrangements in Brent

6. The core of the Safeguarding Adults process in Brent is the Adult Social Care Safeguarding Adults (SGA) team. The SGA team receives and screens all Safeguarding Alerts. It signposts where the alert does not require a full investigation and co-ordinates the response when a full investigation is required.

7. The SGA team works to the Pan London Safeguarding procedures, an overview of these procedures is attached at Appendix 1. The Safeguarding Adults Manager (SAM) is the key accountable role when responding. Their first priority is to ensure the victim and any other victims are safe, and then to co-ordinate a multi-agency response to ensure that the incident is robustly investigated and the relevant actions are agreed and implemented.

8. The fact that there is a single team with responsibility for this work has facilitated strong working relationships with police and health and other partners. However, there is on-going work to ensure that all partners understand the range of

Safeguarding Adults activity they should be undertaking, including improving core practice to prevent abuse, raising good quality SGA alerts on time, delivering actions in the SGA protection plan to ensure people are safe, undertaking investigative actions within Pan London timescales and challenging the SGA team when they do not think things are being done correctly.

9. The SGA team was reviewed and restructured at the start of this year. The review and restructure was driven by:
   - the findings of the multi-agency audits and the Independent Management Review, which highlighted the need for SAMs to be focused on decision making and challenging partner agencies to deliver, rather than chasing actions and other detailed operational activity
   - activity data that highlighted the different types of investigations that need to be undertaken and how by closer working with partners, the team could reduce its investigative capacity and focus resources on chasing actions and detailed operational activity. For example, approximately 20% of all investigations relate to Serious Incidents in health (e.g. Grade 3 and 4 pressure sores). There is a robust and independent process for investigating these incidents in health, therefore, these investigation reports now contribute to the SGA process, rather than the SGA team duplicating the investigation.

10. The team's new structure is set out at Appendix 2. The recruitment campaign has been relatively successful, but there will still be 3 vacancies in a team of 11 staff. These vacancies will be offered as secondments, through the Safeguarding Board, as it is important that the team gains health experience and knowledge. The key transition period, from old to new structure, will be July and August this year and a transition plan is in place. The Board has contributed to and signed off the transition plan and there will be updates at upcoming Boards on the implementation of the new structure.

Brent Safeguarding Adults Board

11. Brent Safeguarding Adults Board meets every two months and is made up of the key statutory agencies and a range of other key partners – the full membership is set out at Appendix 3. BSAB's primary objective is to ensure that Safeguarding Adults is everyone's responsibility and ensure the protection of adults at risk of significant harm. They do this by:
    - working together to promote safer communities to prevent harm and abuse, and
    - identifying, investigating and responding effectively to allegations of abuse.

12. The BSAB has maintained a close focus on improving performance and practice in relation to identifying, investigating and responding effectively to allegations over the last 2 years after the implementation of the Safeguarding Adults team in April 2011. Therefore, the Board's agenda has been driven by two core items: performance reports (an overview of core data is set out in the High Level Analysis section), and multi-agency audits.

13. The multi-agency audits are carried out every two months. The aim is to audit 10% of all the alerts that go on to a full Safeguarding Adults investigation. The

Board chooses the focus for each Audit and the conclusions are presented to the next Board. There have been 8 audits (40 cases) and these audits have involved 32 people from 12 organisations. The focus for the audits is listed below:

- Financial Abuse, where the outcome of the investigation was inconclusive - high numbers reported
- Learning Disability, where the outcome of the investigation was inconclusive – high numbers reports
- Repeat Referrals – issues raised about the impact of the wider impact of SGA process from the Learning Disability audit
- Investigations – quality of investigations was questioned in previous audits, so more detailed analysis carried out
- Mental Health alerts – identified to assure the Board after the transfer of Mental health Safeguarding Adults work to the Adult Social Care SGA team
- Screened alerts – percentage of alerts being screened out of the process had increased significantly in 2012/13 and the Board wanted assurance that this process was safe
- Nursing Home alerts – SGA team identified the high number of pressure care alerts coming from nursing homes and so requested further analysis
- Alerts where the Home Carer was the alleged perpetrator – following on nursing home SGA alerts, home care alerts are the second biggest sectoral source of alerts.

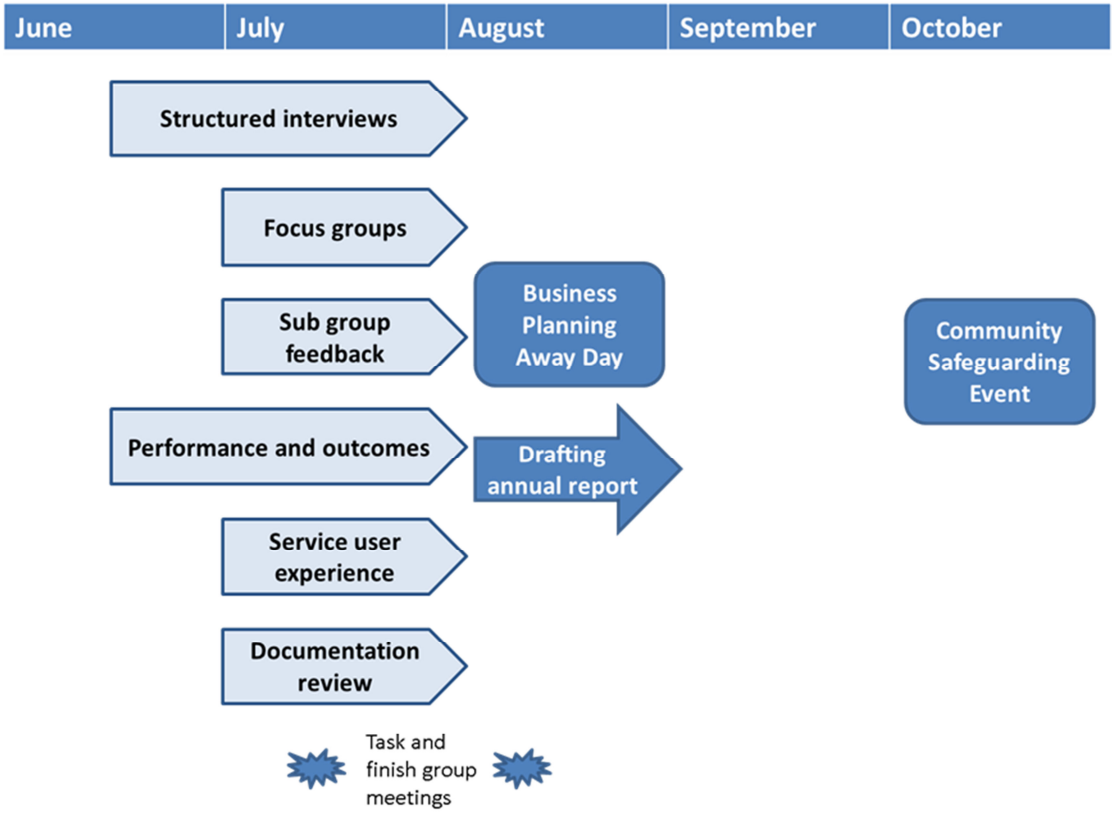
14. The multi-agency audits service a number of purposes. They:
    - provide the Board with assurance about the quality of practice in Brent
    - create a clear focus on outcomes for people. The audit tool is set up to look at: the person, the nature of the alert, the SGA process and the outcomes for the individual – how did the SGA process improve the person's life
    - are an excellent tool for engaging and promoting Safeguarding Adults across all agencies
    - drive operational change. In addition to the review of the SGA team, the following improvements have all been delivered as a result of the multi-agency audit process: the secondment of an Investigator from Audit and Investigation into the SGA team to lead on improving practice in relation to financial abuse cases; implementation of a new screening process for all alerts, roll out of investigation training (led by Audit and Investigation); alignment of Serious Incident and SGA processes to remove duplication; formal mechanisms for recording provider issues and communicating them to commissioners; operational guidance on suspension of home carers when there is an SGA alert.

15. The Board is creating a stronger focus on prevention and communication though as well. For example, over the last six months:
    - GP training has been rolled out across Brent – all GPs and their staff have been invited to attend
    - There is an on-going awareness raising campaign running across Brent. The new SGA leaflets have been designed and distributed, a bill board poster campaign has been run (attracting attention from national media outlets such as the Guardian and community Care) and this will be followed by a bus campaign and a Safeguarding Adults event in October

- Health partners have been working to improve pressure care although there is still more to do to see the impact of this work through a co-ordinated dataset
- Health and social care commissioners continue to work closely with the Care Quality Commission, providers and the Safeguarding Adults team to identify institutional problems and tackle them, but again there is more to do to ensure that all of this work is robustly evidenced and the impact is shown.

16. As the last section suggests, while the SGA team and the Board continue to deliver a range of improvements, there is still more to achieve. Therefore, the Board agreed, at its most recent meeting, to:
    - Review the work undertaken over the last 12 months
    - Review and confirm the Board's priorities
    - Ensure the governance and resources of the Board are set up to deliver those priorities.

17. The diagram below provides an overview of this work and the proposed timetable:



High level activity analysis for 2013/14

18. The approach to performance and activity analysis has been to focus on a core set of data (alerts, referrals, outcomes of investigations and types of abuse) and then to analyse specific issues in line with multi-agency audit topic (for example, there was a detailed analysis of data relating to home care alerts at the last Board).

19. The core dataset is only added to where the specific analysis highlights the need for on-going monitoring, for example, at its last meeting the Board agreed to include Pressure Care data (number, source (hospital, care home etc.)) from now.

20. Additional work is also required on setting the baseline for Safeguarding Adults (the context, how many vulnerable adults are there in Brent), so that the Board can better understand how the level of activity relates to the population of vulnerable adults in Brent. This will be undertaken as part of the 'Performance and Ouctomes' work stream as illustrated in the diagram above.

21. The table below sets out the alerts, referrals and completions of investigations, and in particular highlights a number of key trends:
    - The number of alerts has doubled in 2012/13
    - The number of alerts progressing to a referral (full investigation) has significantly reduced as a result of the new screening process
    - The percentage of referrals being completed in year has grown significantly, highlighting that the team is dealing with referrals in a more timely manner

	2011/12	2012/13 Q1	2012/13 Q2	2012/13 Q3	2012/13 Q4	2012/13
Alerts	435	211	229	223	216	879
Referrals	387 (89%)	55 (26%)	73 (32%)	88 (42%)	97 (45%)	313 (36%)
Completed referrals	210	53	67	69	66	255
% (CR to R)	54%	96%	92%	78%	68%	81%

22. The next table (overleaf) sets out the type of referral and the outcome of the investigations. This highlights that:
    - Financial, neglect and physical abuse are the 3 most common types of abuse (they make up 85% of referrals). This has not changed over the last 3 years
    - Fewer cases are ending in an inconclusive outcome (down from 30% in 2011/12) to 13% in 2012/13, this suggests that the investigations and the SGA process is now more robust, which is backed up by the multi-agency audits
    - Financial abuse no longer has the highest level of inconclusive outcomes, which reflects the focus on improving investigative activity and closer working with the police.

	Referrals	Substantiated	Not substantiated	Inconclusive	Not complete
Financial	95	32	41	10	12
Neglect	92	22	32	10	28
Physical	111	28	32	19	32
Emotional	31	9	9	4	9
Sexual	16	3	7	0	6
Discriminatory	1	0	0	1	0
Institutional	6	0	1	3	2
Total	352	94 (27%)	122 (35%)	47 (13%)	89 (25%)

Conclusions.

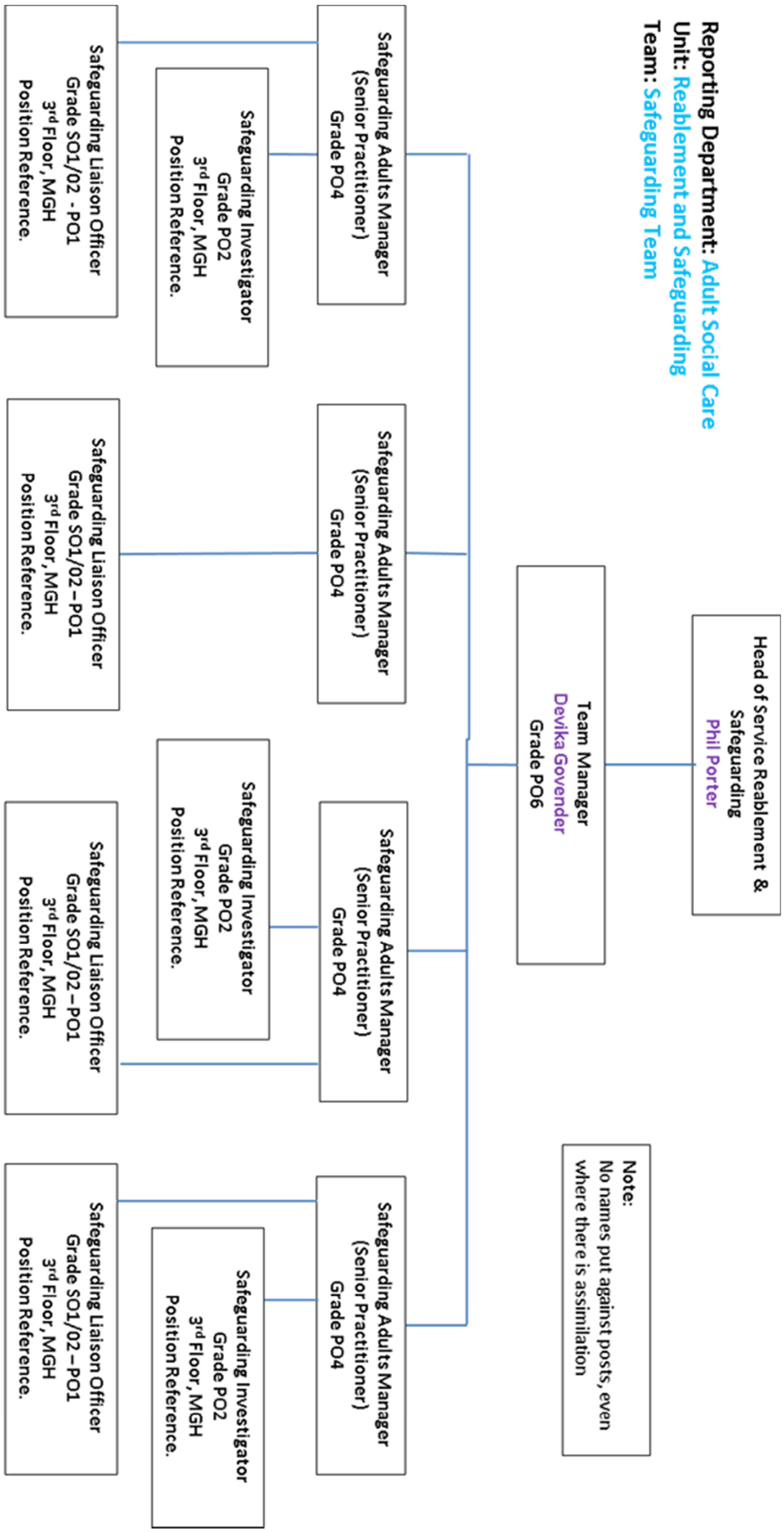
23. The Health and Well Being Board is asked to comment on the:

- contents of the report
- the Board's role in terms of Safeguarding Adults, and how it can support the preventative agenda through its leadership of the health and social care economy
- Governance arrangements: the Director of Adult Social Services currently chairs the BSAB and sits on the Health and Well Being Board, so there is a clear connection
- Future reports: the proposal is that the Board receives two reports a year, the Brent Safeguarding Annual Report to sign off and a 6 monthly update focused on performance, outcomes of the multi-agency audits and progress against actions.

Phil Porter
Acting Director of Adult Social Care

Appendix 1
Pan London Safeguarding Procedure

Appendix 2
Safeguarding Adults Team Structure



Membership of the Brent Safeguarding Adults Board

Phil Porter	Chair, Acting Director of Adult Social Care, Brent
Yolanda Dennehy	Acting Head of Reablement and Safeguarding, Brent Council
Steven Forbes	Head of Adult Social Care Commissioning, Brent Council
Anna Dias	Learning and Organisational Development Manager, Brent Council
Fiona Bateman	Senior Lawyer, Brent Council
David Murray	Acting Head of Community Safety, Brent Council
Laurence Coaker	Head of Housing Solutions, Brent Council
Sue Matthews	Safeguarding Children Co-ordinator
Ann O'Neill	Mencap
John Sclocco	Brent Carers Centre
Fiona Hill	Brent Mental Health User Group
Amanda Craig	Brent Clinical Commissioning Group (CCG) Director
Sarah Mansuralli	Deputy Borough Director, Brent CCG
Kim Rhymer	Operational Safeguarding Lead, CCG
Yvonne Leese	Director of Community Service, Ealing Hospital Trust
Bridget Jansen	Deputy Director of Nursing, North West London Hospital Trust
Natalie Fox	Borough Director, Central and North West London Trust
Mike West	Detective Inspector, Metropolitan police
Terry Harrington	Borough Commander, London Fire Brigade
Judith Brindle	Care Quality Commission
Hannah Storer	Brent Safeguarding Lead, London Ambulance Service
Deirdre Bryant	Probation Service

Appendix 4

Brent Safeguarding Adults Board Priorities

1. ***Effective Implementation of the Pan London Procedures*** - improving practice at each stage of the Pan London process itself. It is primarily focused on the ASC Safeguarding Team and how they manage each stage of the process, Strategy Meetings, Investigations, etc.

2. ***Excellent case recording and case communication*** - the Independent Management Review (IMR) was clear that all agencies should have recorded and communicated information more effectively. Therefore, this priority is to improve case specific recording and communication across all agencies in core practice and all stages of the Pan London procedure

3. ***Improved multi agency working*** – like the second theme, this theme is focused on individual cases and improving practice across all stages of the Pan London procedure, with a particular focus on key multi-agency interfaces

4. ***Core practice standards that prevent safeguarding*** – if core assessments (social care and clinical) are done well (and in particular mental capacity is clearly evidenced and support plans reflect this evidence), it will reduce abuse, therefore, this was agreed as a priority for prevention

5. ***Commissioning for quality*** – the IMR highlighted the need for the Board to ensure that the relationship between local authorities and providers is structured in such a way as to reduce abuse, so this becomes another key element of prevention

6. ***Cultural change*** - this is a broad and strategic theme, which looks beyond individual cases to how organisations and the public can think differently about safeguarding, for example, promoting dignity and respect for all including those with dementia

7. ***Board effectiveness*** – in this theme the Board is to be clear about its role and what it will take direct responsibility for and how its success will be measured.

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Brent	**Health and Wellbeing Board** **3 July 2013** **Report from the Acting Director of Adult Social Services**
For Action	Wards Affected: ALL

Shaping a Healthier Future – Implementation Update

1. Introduction

1.1 Brent's Health and Wellbeing Board has been provided with an update on Shaping a Healthier Future by Brent Clinical Commissioning Group. The update is attached as an appendix to this covering report.

2. Recommendations

2.1 The Health and Wellbeing Board is recommended to consider the update on Shaping a Healthier Future and question representatives from the Brent CCG on the progress of its implementation.

Contact Officer:

Andrew Davies
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North West London Collaboration of Clinical Commissioning Groups

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Introduction

Since the JCPCT made its decisions in February there has been significant activity and changes in the *Shaping a healthier future* programme and in the health economy generally. The transition to new organisations occurred on 1 April and Clinical Commissioning Groups which had been driving the direction of the programme are now also responsible for ensuring delivery of the changes needed to meet the challenges ahead.
This update is provided to ensure you are kept informed of the progress being made. Please let the programme know if there is more information you require at consultation@nw.london.nhs.uk

Background

The JCPCT agreed at its meeting on 19 Feb 2012 to:

- adopt the NW London acute and out of hospital standards in order to improve the safety and quality of care
- adopt a model of care based on five major hospitals to achieve these standards. Major hospitals to be at Chelsea and Westminster, Hillingdon, Northwick Park, St Mary's and West Middlesex
- create a local and specialist hospital at Hammersmith and a local and elective hospital at Central Middlesex
- recommend CCGs work with stakeholders to develop an enhanced range of services at Charing Cross and Ealing
- move the Hyper Acute Stroke Unit from Charing Cross to St Mary's and move the Western Eye to St Mary's
- implement and coordinate £190m investment in 'out of hospital' services in conjunction with the above changes
- implement these changes over five years

Independent Reconfiguration Panel and Judicial Review

Ealing Council has begun the process of requesting a judicial review of *Shaping a Healthier Future*. The Council has also referred the decisions of the JCPCT to the Secretary of State and requested an investigation by the Independent Reconfiguration Panel. Given that all stakeholders are clear that improvements in out of hospital services are vital, work will continue on development and implementation of these schemes whilst the two challenges run their course. We will also continue developing plans for the reconfiguration of hospitals and working with Ealing Council to seek a resolution to their concerns. We will be unable to implement hospital reconfigurations, however members will recall that the plan is to improve out of hospital services and then reconfigure hospital services in three to five years.

We are confident of successfully defending both challenges to the decisions made by the JCPCT given the robustness of the work we have done and the importance of moving forward with the reconfiguration of services to improve the health and health care of residents.

The *Shaping a healthier future* team has written to Ealing Council regarding their proposed judicial review. We are clear that:

- the Council's case has no merit
- the Council is fighting for retention of an A&E that makes no clinical sense. The hospital trust's own board recognise that the services are not capable of being sustained safely
- the cost of the judicial review is likely to be well over £1 million of taxpayers' money
- the local NHS has offered to provide services that are fit for purpose and directly meet the needs of Ealing residents by providing better out of hospital care and new state of the art facilities at Ealing Hospital.

We believe the actions will be costly in terms of taxpayers' money, administrative burden and lives lost.

Organisational changes at the acute trusts

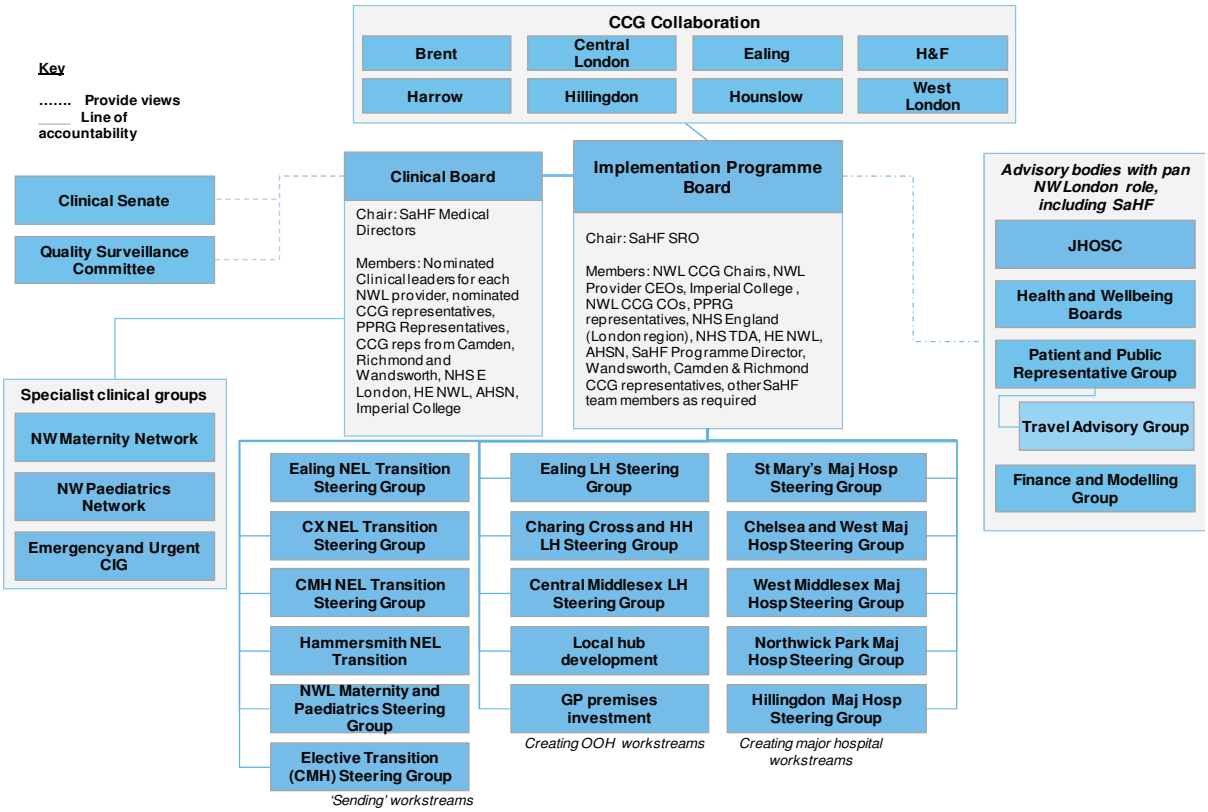
In April West Middlesex University Hospital NHS Trust (WMUH) announced that, following an options appraisal process, Chelsea and Westminster Hospital NHS Foundation Trust had been selected as the preferred bidder to explore a potential partnership which would enable WMUH achieve Foundation Trust status. The two trusts are now working together to further investigate the benefits and opportunities of such a partnership. Later in the year the two trusts and the NHS Trust Development Authority will review the work done and decide whether to proceed. If all goes to plan, the formal partnership would commence on 1 April 2014.

Ealing Hospital NHS Trust and North West London Hospitals NHS Trust are both committed to a merger. The current plan is to develop a full business case by the Autumn of 2013 with a merger occurring in Spring 2014.

Programme update on progress since 19 February

1. Governance

The eight CCGs in NWL have formed a Collaboration Board to oversee implementation and assurance of *Shaping a healthier future* via a number of networks, groups and committees



The programme will be subject to quality assurance and scrutiny from:

- Clinical Board to advise on clinical safety and manage clinical risk during transition
- Patients, carers and the public through involvement at all levels including a patient group and a travel group
- A robust governance structure (see below)
- Monitoring of progress and reviewing of key deliverables
- Regular risk management workshops and meetings with workstream leads.

2. Improvements in out of hospital (OOH) services

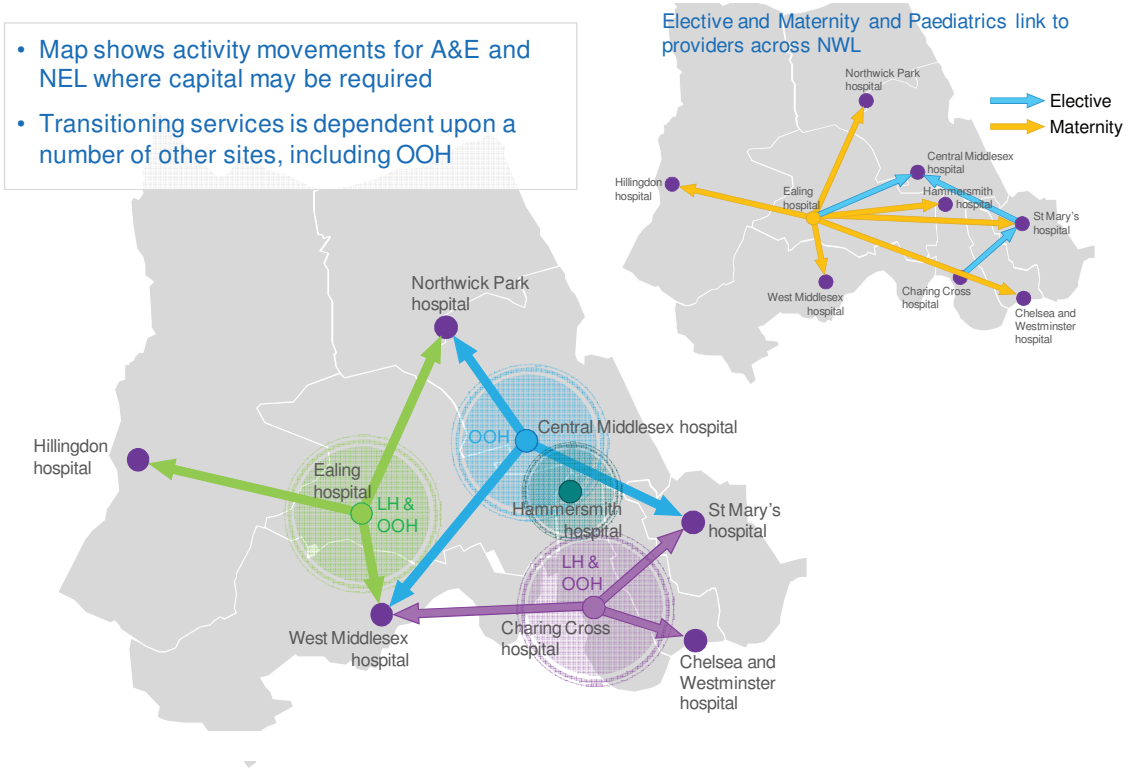
CCGs continue to develop and implement their OOH strategies as part of their usual business. The *Shaping a healthier future* team is ensuring that all OOH strategies are coordinated, safe and flexible and will monitor investment to ensure they deliver the changes required before we can move forward with full implementation of *Shaping a healthier future*. We continue to work with CCGs, to coordinate the process for Primary Care Business Case Development.

3. Implementation and monitoring/assessment of progress

In order to provide public and clinical reassurance throughout the service changes we have developed a set of key principles of implementation that will guide the process:

- Maintain safety throughout transition
- All changes will be clinically led
- Any changes must be able show that they will deliver the anticipated benefits including clinical quality and patient experience
- Clear points of accountability
- Allow for different parts of the programme to progress at different speeds
- Light touch where possible, with additional support where necessary
- Support integration across acute, OOH, social and mental health services
- Economy of effort – using assumptions agreed by the board throughout the programme, reducing duplication of project activity and reporting
- Transparent and open to scrutiny
- We must monitor and mitigate impact on protected groups, disadvantaged groups and carers
- Enable providers to take responsibility for their own changes within a system wide approach.

Because many of the proposed changes affect more than one borough and/or more than one hospital, the programme has developed a 'zone' approach (see diagram below) to ensure the changes are thoroughly considered and monitored. Each zone will have a manager and small team to co-ordinate the changes. So, for instance, reconfiguration of acute services at Charing Cross Hospital would mean that patients currently using these facilities would tend to go to St Mary's, Chelsea and Westminster or West Middlesex. The 'zone' team will ensure that services at St Mary's, Chelsea and Westminster and West Middlesex are all fit for purpose prior to changes being made at Charing Cross.



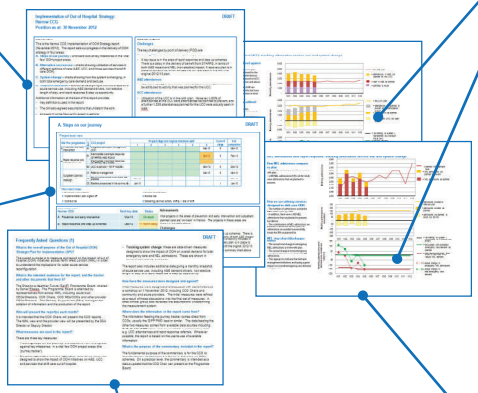
As agreed with the Joint Overview and Scrutiny Committee, we have developed a series of reports to allow us monitor the implementation of out of hospital (OOH) strategies and show the impact of each CCG's OOH initiatives on acute activity in four areas:

- Steps on our journey – a forward look at key milestones in the 'vital few' OOH project areas.
- Service use – charts showing utilisation of services in different settings of care (A&E, UCC, and those services that shift care OOH)
- System change – charts showing how the system is changing, in both total emergency care demand and bed use.
- Snapshot data table – additional data giving a monthly snapshot of acute service use, including A&E demand drivers, non-elective length of stay, and rapid response & step up opportunity.

Report summary: providing a guide to the content of the report and a summary of key issues and challenges. This format is consistent across the three types of report.

Progress against milestones: a summary of where the system is 'on-track' or 'delayed' in developing OOH capacity.

- *CCG level reports* include detail at project level ('vital few').
- *NWL report* contains high level summary.
- *Provider* monitoring is not currently included.



Data presentation: all three report types include charts showing both service utilisation and system change.

- *CCG level reports* include data relating to all their providers, presented by month.
- The *NWL report* is an aggregate presentation of all providers presented by CCG for the most recent month.
- *Provider reports* are at individual trust level and show changes by month.

Supporting information: including FAQs, glossary of key terms and clinically-agreed assumptions.

Data interpretation: reports are supplied with a narrative describing the key messages from the data.

This will allow us to make informed decisions on the progress of service change and whether we can move forward to the next stage.

4. Hospital reconfigurations

Whilst hospital trusts relentlessly make improvements to standards of care, the team continues to develop the detailed plans regarding hospital reconfigurations. The proposed judicial review means that we will not be able to implement reconfiguration plans until the challenge is decided, but the programme is allowed (and the Independent Reconfiguration Panel require us) to develop our plans in order to show how the reconfiguration could be delivered, to test all the assumptions and ensure finances and other requirements are in place.
During 2013/14 the focus for improvements for hospitals will be to develop business cases for capital funding required for the changes. A financial strategy has been set out by the eight CCGs, and providers (hospital trusts) are developing their business cases to improve and expand current facilities where necessary. Outline business cases are expected towards the end of 2013 and full business cases by early 2014.

5. Workforce

We are planning radical and far reaching changes to the way services are provided in NW London and there are some workforce related activities where it makes sense to do the work once, rather than it being done multiple times by different Clinical Commissioning Groups/providers. It is also helpful to have a view across local workforce plans to make sure that any collective issues are identified and addressed. To address these issues a workforce workstream will:

- Undertake pan-NWL work to support out of hospital and acute workforce development in NWL, taking into account local workforce strategies and work already completed
- Co-ordinate pan-NWL workforce-related activities required to implement *Shaping a healthier future*
- Provide a view of workforce planning across NWL to make sure any collective workforce issues are being identified and addressed
- Engage with key stakeholders (e.g. Local Education & Training Board (LETB)) where it makes sense to do so on a pan-NWL basis
- Identify and manage pan-NWL risks associated with workforce (excluding the risk around clinical services 'falling over' during transition which is being managed directly by the Clinical Board)

6. Whole systems integration

Systems integration is the co-ordination of care between multiple health, social care and voluntary agencies to ensure people receive joined-up, personalised care that addresses their full range of physical, social and psychological needs. It is a core pillar of CCGs' strategies to support *Shaping a healthier future*. Significant progress has been made in all eight NWL boroughs of NWL with systems integration. All boroughs have implemented the Integrated Care Programme or Wellwatch, aimed at pro-active care in the community of the frail elderly and diabetic patients and are developing further programs for children and those with respiratory or cardiac disease or mental illness. In addition, many boroughs have developed integrated services for patients whose condition is rapidly deteriorating. NWL is now pushing forward on the 'Whole Systems' Integration Programme, which is a way of working that will provide integrated services for people with the greatest need, not only those with specific medical conditions. All eight CCGs are part of this programme which will undertake a design phase over the next six months, followed by and expected implementation from early 2014.

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