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Community and Wellbeing Scrutiny Committee

Tuesday 19 September 2017 at 7.00 pm
Boardrooms 3-5 - Brent Civic Centre

Membership:

Members
Councillors:

Ketan Sheth (Chair)
Kansagra (Vice-Chair)
Conneely
Colacicco (substituting for Hector)
Hoda-Benn
Jones
Nerva
Shahzad

Substitute Members
Councillors:

Aden, Crane, Ezeajughi, Kelcher, Mashari and Stopp

Councillors:

Colwill and Davidson

Co-opted Members
Alloysius Frederick, Roman Catholic Diocese schools
Helen Askwith, Church of England
Iram Yaqub, Parent Governor Representative (Primary)
Sayed Jaffar Milani, Muslim Faith

Observers
Ms Sotira Michael, Brent Teachers' Association
Lesley Gouldbourne, Brent Teachers' Association
Jean Roberts, Brent Teachers' Association
Jai Patel, Brent Youth Parliament
Siofra Healy, Brent Youth Parliament
Priya Bharadia, Brent Youth Parliament
Samira Monteleone, Brent Youth Parliament
Aleena Majeed, Brent Youth Parliament
Najib Rahman, Brent Youth Parliament

For further information contact: Nikolay Manov, Governance Officer
Tel: 020 8937 1348; Email: nikolay.manov@brent.gov.uk

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The press and public are welcome to attend this meeting.

Notes for Members - Declarations of Interest:

If a Member is aware they have a Disclosable Pecuniary Interest* in an item of business, they must declare its existence and nature at the start of the meeting or when it becomes apparent and must leave the room without participating in discussion of the item.

If a Member is aware they have a Personal Interest** in an item of business, they must declare its existence and nature at the start of the meeting or when it becomes apparent.

If the Personal Interest is also a Prejudicial Interest (i.e. it affects a financial position or relates to determining of any approval, consent, licence, permission, or registration) then (unless an exception at 14(2) of the Members Code applies), after disclosing the interest to the meeting the Member must leave the room without participating in discussion of the item, except that they may first make representations, answer questions or give evidence relating to the matter, provided that the public are allowed to attend the meeting for those purposes.

***Disclosable Pecuniary Interests:**

(a) **Employment, etc. -** Any employment, office, trade, profession or vocation carried on for profit gain.
(b) **Sponsorship -** Any payment or other financial benefit in respect expenses in carrying out duties as a member, or of election; including from a trade union.
(c) **Contracts -** Any current contract for goods, services or works, between the Councillors or their partner (or a body in which one has a beneficial interest) and the council.
(d) **Land -** Any beneficial interest in land which is within the council's area.
(e) **Licences-** Any licence to occupy land in the council's area for a month or longer.
(f) **Corporate tenancies -** Any tenancy between the council and a body in which the Councillor or their partner have a beneficial interest.
(g) **Securities -** Any beneficial interest in securities of a body which has a place of business or land in the council's area, if the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body or of any one class of its issued share capital.

****Personal Interests:**

The business relates to or affects:

(a) Anybody of which you are a member or in a position of general control or management, and:
- To which you are appointed by the council;
- which exercises functions of a public nature;
- which is directed is to charitable purposes;
- whose principal purposes include the influence of public opinion or policy (including a political party of trade union).

(b) The interests a of a person from whom you have received gifts or hospitality of at least £50 as a member in the municipal year;

or

A decision in relation to that business might reasonably be regarded as affecting, to a greater extent than the majority of other council tax payers, ratepayers or inhabitants of the electoral ward affected by the decision, the well-being or financial position of:
- You yourself;
- a member of your family or your friend or any person with whom you have a close association or any person or body who employs or has appointed any of these or in whom they have a beneficial interest in a class of securities exceeding the nominal value of £25,000, or any firm in which they are a partner, or any company of which they are a director
- any body of a type described in (a) above

Agenda

Introductions, if appropriate.

Item Page

1 Apologies for absence and clarification of alternate members

2 Declarations of interests

Members are invited to declare at this stage of the meeting, any relevant disclosable pecuniary, personal or prejudicial interests in the items on this agenda.

3 Deputations (if any)

To hear any deputations received from members of the public in accordance with Standing Order 69.

4 Minutes of the previous meeting 1 - 10

To approve the minutes of the previous meeting as a correct record.

5 Matters arising (if any)

6 Scoping paper for Home Care Scrutiny Task Group 11 - 24

Members of the Community and Wellbeing Scrutiny Committee agreed that during 2016/17 they would set up a task group in order for scrutiny to review home care in the Borough. The task group scoping document in Appendix A sets out the task group's remit, methodology, research methods and its objectives.

Ward Affected: All Wards

Contact Officer: Peter Gadsdon, Director Performance, Policy and Partnerships
Tel: 020 8937 1400
Email: peter.gadsdon@brent.gov.uk

7 Local Safeguarding Children's Board Annual Report 25 - 26

Section 13 of the Children Act 2004 requires each local authority to establish a Local Safeguarding Children Board (LSCB) for their area and specifies the organisations and individuals (other than the local authority) that should be represented on LSCBs. The Brent LSCB annual report summarises the work of Brent LSCB during 2016/17.

(report to follow)

Ward Affected: **Contact Officer**: Wendy Proctor, Strategic

All Wards

Partnership Officer
Tel: 020 8937 4237
Email: wendy.proctor@brent.gov.uk

8 Safeguarding Adults Board Annual Report 2016-17 27 - 54

The report provides a summary of safeguarding activity carried out by Brent Safeguarding Adults Board (SAB) partners across social care, health and criminal justice sectors in Brent in 2016-2017.

Ward Affected:
All Wards

Contact Officer: James Pearce, Strategic Partnership Officer
Tel: 020 8937 4271
Email: james.pearce@brent.gov.uk

9 Identification of Female Genital Mutilation (FGM) in Brent 55 - 82

Female Genital Mutilation (FGM) is illegal in the UK. This report outlines Brent Clinical Commissioning Group's in identifying cases of FGM in Brent and seeks the support of the Committee for the work done locally to address this.

Ward Affected:
All Wards

Contact Officer: Gilly Attree, Designated Nurse Safeguarding Children - NHS Brent Clinical Commissioning Group
Tel: 020 8900 5383
Email: g.attree@nhs.net

10 Update on scrutiny work programme (If any) 83 - 96

This report updates members on the Committee's Work Programme for 2017/18 and captures scrutiny activity which has taken place outside of its meetings.

Ward Affected:
All Wards

Contact Officer: Peter Gadsdon, Director Performance, Policy and Partnerships
Tel: 020 8937 1400
Email: peter.gadsdon@brent.gov.uk

11 Any other urgent business

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

Date of the next meeting: Wednesday 22 November 2017

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.

Brent

MINUTES OF THE COMMUNITY AND WELLBEING SCRUTINY COMMITTEE
Wednesday 19 July 2017 at 7.00 pm

PRESENT: Councillor Ketan Sheth (Chair), Councillors Colwill, Conneely, Hector, Hoda-Benn, Jones, Nerva and Shahzad, Co-opted Member Mr Frederick, and appointed observers Mrs Roberts and Mr Patel

Also Present: Councillors Hirani, M Patel, and Perrin

1. **Apologies for absence and clarification of alternate members**

Apologies for absence were received from Councillor Kansagra (Councillor Colwill substituting) and appointed observer Ms Gouldbourne.

Councillor Sheth informed the Committee that Councillor Conneely was running late.

2. **Declarations of interests**

Councillor Colwill declared that he was a member of the Health and Wellbeing Board and that his wife was a governor at Brent River College.

Councillor Sheth declared that he was Lead Governor at Central and North West London NHS Foundation Trust.

Councillor Jones declared that she was part of the Patients' Panel at the Willesden Centre for Health and Care.

3. **Deputations (if any)**

There were no deputations received.

4. **Minutes of the previous meeting**

RESOLVED that the minutes of the previous meeting, held on 29 March 2017, be approved as an accurate record of the meeting.

5. **Matters arising (if any)**

There were no matters arising.

6. **Sustainability and Transformation Plan - Update**

At the invitation of the Chair, Councillor Hirani (Cabinet Member for Community and Wellbeing), provided an update on actions undertaken related to the Sustainability and Transformation Plan (STP) since the previous update in September 2016 and reminded Members that decisions about what happened in local areas had been

delegated to Clinical Commissioning Groups (CCGs) and local hospitals. Members heard that, Cabinet had considered the STP in October 2016. As part of wider engagement and consultation, six areas had been identified to be included in the Brent Health and Care Plan, with each item being led by officers working at Brent-based organisation:

- Prevention - improve outcomes by developing and targeting services that prevented identified ill-health issues in Brent such as smoking and childhood obesity.
- New Models of Care - greater access to more effective services, including care planning and integrated care.
- Joining up Older People's services proving support to residents aged 65 and over to prevent them being admitted to hospital and to reduce their length of stay.
- Improve outcomes for people with mental health illness - develop a recovery-focused pathway. Councillor Hirani said this area built on existing work taking place across North West London and that it had been considered to link it with single homelessness pathway.
- Transforming Care – supporting people with learning disabilities and developing a holistic integrated service.
- Central Middlesex Hospital (CMH) – developing the CMH as a centre of excellence and utilising its capacity to respond to the increasing population in the area.

In response to questions that related to the services to be delivered at the CMH and recent developments related to the STP, including cross-borough collaboration, Councillor Hirani said that building primary care capacity at the CMH was one of the priorities as it had been decided that the hospital would become a centre for elective admissions, with day surgeries and minor surgeries complementing the existing services. In addition, he noted that the STP had changed since it was announced as extra money had been allocated for social care and additional STP funds had been provided. Councillor Hirani said that these were big changes that required cross-borough working which would also help influence what had been happening on a local level.

The Chair thanked Councillor Hirani for the comprehensive update.

RESOLVED that the verbal update provided by the Cabinet Member for Community and Wellbeing on the Sustainability and Transformation Plan be noted.

Councillor Conneely entered the meeting at 7:12 pm.
Mr Jai Patel entered the meeting at 7:20 pm.

7. **Order of Business**

RESOLVED that the order of business be amended as set out below.

8. **Report by the Child and Adolescent Mental Health Services Scrutiny Task Group**

Councillor Shahzad introduced the report which evaluated Child and Adolescent Mental Health Services (CAMHS) in Brent and explored options on how the model

could be adapted to better meet future needs. He informed the Committee that the paper had been informed by quantitative data and interviews with National Health Service and health providers, Brent Clinical Commissioning Group (CCG), school and education representatives and community representatives. The Committee heard that the Task Group had agreed five recommendations – four for the Brent CCG and one jointly for the CCG and Brent Council (page 50 to the Agenda pack). Hamza King (former member of Brent Youth Parliament) spoke about his role in the Task Group and highlighted the importance of including the perspective of young people in the Borough in the work of the Group. He said that he was pleased progress had been made towards clarity and tackling issues effectively. Duncan Ambrose (Assistant Director at Brent CCG) commented that the process had been in-depth and fair and he said that Brent CCG endorsed the recommendations of the report and an event related to the fifth recommendation might be held in October 2017. Gail Tolley (the Council's Strategic Director of Children and Young People) acknowledged that such an event (modelled on It's Time to Talk) was helpful, but warned the Committee that half term needed to be avoided to ensure the involvement of schools and other partners. In relation to the other recommendations, Ms Tolley said that there was not a direct role for the Council as it used to have as the majority of schools were self-governing so a direct contact between the schools and Brent CCG had to be established. Moreover, Councillor Mili Patel (Cabinet Member for Children and Young People) thanked the Group for their work and suggested that the fourth recommendation related to establishing a network of community champions) could be integrated to the fifth one and Sarah Basham (Vice Chair and Co-Clinical Director at Brent CCG) added that ideas from a recent event held in North West London could be implemented in the It's Time to Talk-modelled event.

Members asked questions that related to taking steps to ensure that the recommendations presented in the report were adhered to, using the proposed additional funding to create capacity and CAMHS' ability to take on additional referrals. Mr Ambrose said that waiting times had been reduced and the number of people on waiting lists had been halved. He noted that changes were about to be implemented and results would be visible soon. In addition, Ms Basham said that the Anna Freud model would be adopted and more prevention work would be undertaken to reduce the need for children to access CAMHS.

RESOLVED that:

(i) The contents of the Child and Adolescent Mental Health Services in Brent Scrutiny Task Group Report be noted;

(ii) The following recommendations be endorsed:

a. Brent Clinical Commissioning Group

1. Increase investment in mental health support with Brent's schools to ensure all schools can access Targeted Mental Health in Schools (TaMHS), Place2Be or an equivalent mental health support programme for schoolchildren.

2. Improve pathways to young people receiving CAMHS support by emphasising to head teachers that they can refer directly to

CAMHS and increasing the CCG's information and communication to schools about what support is available.

3. Offer a programme of peer and staff support in schools and further education to strengthen awareness of emotional health and wellbeing and signpost them to effective support.

4. Organise a network of community champions to promote good mental health and wellbeing among children and young people in their community and signpost young people to effective support.

b. Brent Clinical Commissioning Group and Brent Council

5. Organise a one-off event for parents modelled on It's Time to Talk to develop community-led solutions to improving children and young people's emotional wellbeing and mental health in Brent, and strengthen partnership working between the CCG, local authority, schools, voluntary sector, faith and community groups, youth organisations, and further education colleges on this issue.

(iii) An update on CAMHS provision in Brent be provided at a future meeting of the Committee.

9. **Children's Oral Health in Brent**

Dr Melanie Smith (the Council's Director of Public Health) introduced the report, outlining that Brent children had some of the worst oral health outcomes in England, with dental extractions remaining the top cause for elective hospital admissions in children. She stressed that although there had been some improvement, levels of tooth decay remained unacceptable bearing in mind that it was almost entirely preventable. Dr Smith said that National Health Service England (NHSE) had awarded a new five-year Community Dental services (CDS) contract to Whittington Health from 1 April 2017, with funding for oral health promotion staff remaining with NHSE with a section 75 agreement being put in place meaning that Brent Public Health would provide £20,000 for resources. Jeremy Wallman (Head of Acute and Specialised Dental Commissioning at NHSE) commented that this had made Brent the first borough council that fully recognised that oral health promotion resource sat within the contract (section 75 agreement). Claire Robertson (Public Health England) said that failures of prevention had contributed to high levels of disease and noted that the contract would enable the delivery of an integrated service by several partners. Ian Niven (Healthwatch Brent) said that Healthwatch Brent recognised this problem and it would prioritise it for the year ahead.

Members asked questions that related to the overall picture of children's oral health, uptake of dental care, investment in dental services and public health prevention, and lessons that could be learned from other boroughs, such as Enfield, where tooth decay rated had been lowered. Dr Smith said that there was a strong correlation between tooth decay and deprivation, with decay being a universal problem in Brent, which meant that there was not an area where oral health was satisfactory. As far as funding was concerned, she informed the Committee that the right level of funding was available, however, oral health promotion needed to be targeted at young children as there was a common misconception that problems

with milk teeth did not transfer to permanent teeth. Moreover, there was a generational issue as often parents who did not visit the dentist would not take their children to regular check-ups. Therefore, behavioural change would take time and it might be a good idea to encourage registration with a dentist (free of charge) when people register with a General Practitioner (GP) or when a new Council Tax account was set up. Mr Wallman commented that this would improve uptake of dental care as at present obligation ceased when a patient finished their treatment at a dental surgery. Kelly Nizzer (Regional Lead London Dental, Pharmacy and Ophthalmic Services at NHSE) said that NHSE had run similar campaigns and that leaflets had been distributed to pharmacies about nine months ago, with an electronic version sent to them so they could print additional copies. In relation to measures taken in Enfield, Dr Smith said she would see more information from the Director of Public Health at Enfield and Ms Robertson added that a fluoride varnish programme and other sustained programmes had been implemented in the borough. As far as capacity was concerned, Ms Nizzer informed the committee that NHS practices underperformed due to the lack of patients registering and various campaigns had been run to address this, with performance being measured by how many children visited dentists. It was noted that data presented in the report had been provided by the NHS and information from private practices had not been included.

In relation to questions about dental checks in schools and children centres, Ms Robertson explained that there was no evidence demonstrating that screening at school would necessarily transfer to an appointment as letters often did not reach parents. Moreover, there was not information about a correlation between the withdrawal of dental checks in schools and children's oral health. Dr Smith said that all children centres were part of the Healthy Early Years award scheme and Gail Tolley (the Council's Strategic Director for Children and Young People) added that dental checks and immunisations were part of the expectations from foster carers, with children in care being monitored by a Looked After Children (LAC) nurse. She emphasised that oral health was linked to attainment as it had impact on speech and language development and attendance at school.

A Member of the committee asked what outreach work had been done to promote sugar reduction and better tooth brushing. In response, Councillor Hirani (Cabinet Member for Community Wellbeing) said that work had been undertaken with children centres to address not only oral health, but also obesity as there was a close correlation between the two. He said that prevention could help combat both issues and he talked about the Slash Sugar campaign. In addition, Ms Tolley said that the under five group was a concern as by the time they reached school age, took decay might have started. Dr Smith commented that there had been a strong partnership between Public Health, NHSE and Brent's dental practices, which had demonstrated that efforts to improve children's oral health had been coordinated. In terms of work with community groups, Dr Smith referred to the Making Every Contact Count and Making Oral Health Everybody's Business programmes which had to be promoted and training had been provided to the school nursing service and would be offered to all front line staff in the Community and Wellbeing Department.

As far as future priorities were concerned, Dr Smith noted that it would take time for the outcomes from the 2017-2018 oral health promotion programme to become visible, but options for intervention prior to birth had been explored as pregnant

women could be encouraged access dentists during pregnancy (the service was provided free of charge). This statement was echoed by Ms Robertson who said that a programme had to be in place for a number of years so a whole cohort could go through it in a sustainable way.

RESOLVED that:

(i) The contents of the Children's Oral Health in Brent report, be noted;

(ii) The following potential recommendations be identified by the Committee for further consideration:

1. Promote fluoride varnish as part of the Make Every Contact Count programme
2. Consider ways to encourage residents to register with a dentist as part of the Brent Landlord Registration Scheme – this could be incorporated into new Council Tax registrations.
3. CCG and Public Health England could make better use of Brent's website to promote campaigns.
4. Re-examine the notion of school visits by dentists, with a pilot on a smaller scale.
5. Collect data about visits at dental practices on a wider scale
6. Consider a Harlesden-specific recommendation to address the issue of high number of dental admissions in hospital and events taking place between tooth decay and dental update.
7. Address the issue of publicity not reaching parents, adhering to national policy guidelines.

The meeting was adjourned for a comfort break between 8:51 pm and 8:56 pm. Councillor Mili Patel left the meeting at 8:51 pm

10. **Primary Care Transformation**

Sheik Auladin (Chief Operating Officer at Brent Clinical Commissioning Group (CCG)) and Sarah McDonnell (Deputy Chief Operating Officer at Brent CCG) presented the report which covered some of the main drivers around primary care transformation. They informed the Committee that some of the challenges faced by Brent CCG were a growing number of people aged 85 and over; demand on services was outstripping Brent CCG's ability to deliver care; variation in care quality and outcomes; financial pressures; aging infrastructure; and issues related to recruitment and retention of General Practitioners (GPs). The Committee heard that the four key areas on which Brent CCG would focus were access, resilience, commissioning of primary care, and delegation. In addition, Dr Ethie Kong (Chair of Brent CCG) said that two videos had been shown around the Borough with the aim to increase residents' awareness of the role of care navigators and to inform them how to utilise the services of GP access hubs. Councillor Hirani (Cabinet Member for Community Wellbeing) commented that the present situation required items (services) to be added to existing contracts to ensure the needs of the local community were met.

A Member of the Committee enquired whether the growth in the registered population for primary care was concentrated in particular parts of the Borough or among certain groups of the population. In response, Ms McDonnell said that growth had been uniform across Brent, with a main factor contributing to the increased number of people registered for primary services being the housing developments. She highlighted that while the number of primary care contacts had doubled, there was a marginal decrease in patient satisfaction levels and ability to access appointments. She noted that one of Brent CCGs key aims was to manage these two factors, while exploring potential ways of delivering extended opening hours. In relation to a question that related to the regeneration areas in Wembley and South Kilburn, Ms McDonnell stated that Brent CCG had strategic estates updates and worked closely with developers to try to identify hot spots and provide input into what a primary care facility might look like. She gave Park Royal as an example of an area where undersupply of GPs had led to the procurement of a practice at Central Middlesex Hospital (CMH) - a joint venture with the London Borough of Ealing, opened to patients from both boroughs. She made it clear that according to the current provisions, practices were commissioned by National Health Service England (NHSE) so what Brent CCG could do was to maximise the services delivered by the existing 62 practices. In terms of challenges, Ms McDonnell said that the biggest issues were related to small practices (located in houses), shortage of workforce and cost of locating practices in new developments (spaces available might not be affordable). Therefore, Brent CCG was looking into developing long-term plans for practices and handover protocols.

In response to a question that related to measures being taken to ensure that vulnerable residents were not adversely affected by changes to primary care delivery, Ms McDonnell said that one of the groups disproportionately affected by transformation were new residents as they might not have a GP and might have found it difficult to register. Therefore, she stressed the importance of informing residents what they could do if a practice refused to register them. Dr Kong added that all practices had defined catchment areas and maintained open register so if a practice refused a new registration, this could result in a complaint.

As far as what a vision for primary care should look like, Ms McDonnell informed that committee that the primary care strategy had to be refreshed which would happen in the autumn of 2017. She went on to explain that the structure of three GP networks and a Federation contributed to improving primary care by providing out of hospital services. She commented that patient satisfaction with the integrated model and the hub was high and more could be done to ensure providers would sign up for it. In relation to the Personal Medical Services contract review, Ms McDonnell said that Brent CCG had started an informal consultation and that there were significant differences between the 11 practices so the next step would be to have one-to-one discussions to consider how these could be addressed. She noted that many decisions and functions were still led by NHSE, with Brent CCG focusing on management of contracts with practices – for example, all practices had to cover core access (core hours) and extended hours were subject to negotiation.
In relation to Brent CCG's priorities in 2017-18 and improving the quality of frontline primary care, the Committee heard that Brent had one of the highest rates of uptake of annual health checks. Sarah Basham (Vice Chair and Co-Clinical Director at Brent CCG) said that Brent CCG's programme focused on people who were frail, had long-term conditions or were part of a vulnerable family. Dr Kong added that

there had been a ten-year difference in life expectancy between males in Kenton and Harlesden, which had been tackled down and reduced to seven and a half years. Ms Auladin spoke about care management and the provision of services in nursing homes to prevent patients being admitted to hospitals. He said that KPIs would be regularly examined to assess the impact of transformation on patients. Dr Kong suggested that this approach could be supplemented by encouraging Brent CCG's partners to carry out independent surveys to assess the commissioned services.

Members questioned how patients had been chosen for the trial of the Babylon application (paragraphs 3.33-3.36 on pages 35 and 36 to the Agenda pack). Ms McDonnell explained that the application had not been rolled out across Brent and, in fact, no practice in North West London had implemented it. She said that a detailed risk assessment had been undertaken as it was a clinical tool and it had been certified safe. In relation to selecting patients, Ms Donnell clarified that users had not been chosen as the tool had been promoted to residents, meaning that sign up was voluntary. Ms Donnell said that she did not have information if the application was available in other languages to address Brent's diversity.

RESOLVED that:

(i) The contents of the Primary Care Transformation report, be noted;

(ii) The following potential recommendations be identified by the Committee for further consideration:

1. Brent CCG considers the implementation of one public sector communication strategy (including links to the Brent website) that not only gives residents information, but also provides answers to common questions.
2. General Practitioners are strongly advised to display information about new developments.
3. Brent CCG works together with Brent Council's Planning Service to ensure that provision of health services is included in discussions about what developers have to provide when (re)developing a site.
4. Brent CCG is encouraged to provide a clear guidance what good looks like in terms of primary care and how Brent Council could assist delivery.
5. Brent CCG is advised to inform residents about their rights in case a practice refuses to register them.

Councillor Hoda-Benn left the meeting at 9:50 pm.
Councillor Perrin entered the meeting at 9:50 pm.

11. **Overview and Scrutiny 2016-17 Annual Scrutiny Report**

RESOLVED that the contents of the Overview and Scrutiny 2016-2017 Annual Report, be noted.

12. **Scrutiny Committee's Work Programme 2017-18**

RESOLVED that:

(i) The contents of the Community and Wellbeing Scrutiny Work Programme 2017-18 report, be noted; and

(ii) The Community and Wellbeing Scrutiny Work Programme for 2017-18 be agreed as set out in Appendix A to the report.

13. **Any other urgent business**

None.

14. **Date of next meeting**

The committee noted that the next meeting was scheduled for Tuesday 19 September 2017.

The meeting closed at 9.54 pm

COUNCILLOR KETAN SHETH
Chair

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Brent	**Community and Wellbeing Scrutiny Committee** 19 September 2017 **Report from the Director of Policy, Performance and Partnerships**
For information	Wards affected: ALL

Scoping paper for Home Care Scrutiny Task Group

1.0 Summary

1.1 The Community and Wellbeing Committee agreed in its work plan for 2017/18 to set up a number of task groups to review important matters of council policy. Members agreed that during 2016/17 they would set up a task group in order for scrutiny to review home care in the Borough.

1.2 Home care as a subject for a scrutiny task group was judged by members to have met the IMPACT criteria which scrutiny has developed to evaluate and filter whether or not a subject is appropriate to be included in its annual work programme for 2017/18. The task group scoping document in Appendix A sets out the task group's remit, methodology, research methods and its objectives.

2.0 Recommendations

2.1 Members of the Community and Wellbeing Scrutiny Committee to discuss and agree the contents of the report and scoping paper in Appendix A.

2.2 The committee to agree to set up a task group to review home care which will produce a report with recommendations to committee.

3.0 Background

3.1 Home care, also known as domiciliary care, is a key way of improving a person's quality of life. Domiciliary support is practical, including help to get out of bed and dressed in the morning, assistance in preparing meals and taking medication. This care enables people to live safely and autonomously in their own homes, whilst also receiving the support they need to complete activities of daily living such as getting washed and dressed.

3.2 Home care is an important part of Brent's health and social care system. However, the provision of the service is facing significant challenges. The majority of home care delivered at present is a traditional service. However, the local authority also offer some reablement provision. During 2016 – 2017 home

care was provided to a total of 2,578 Brent residents, with a further 904 receiving reablement home care in the same year.

3.3 The local authority's existing arrangement with the West London Alliance for purchasing home care ends in September 2018. As a result, Brent Council will organise its own commissioning arrangements to come into effect from 1 October 2018, which is an important priority for the Community Wellbeing Department and the Cabinet Member for Community Wellbeing.

4.0 Detail

4.1 The task group will focus on four areas: resources, health and wellbeing outcomes, partnerships and relationships, and the quality of home care. Members of the task group will engage with a number of stakeholders as part of their review.

4.2 The scope of the enquiry by the scrutiny task group is limited to its terms of reference as set out in the scoping paper. In essence, the purpose of the scrutiny task group will be to develop recommendations for the Cabinet based on what the task group thinks are the important priorities for a future home care commissioning model, how the challenges can be addressed, and how the local authority's existing policies and strategies might need to be updated.

4.3 The chair of task group is Cllr Ketan Sheth, and the other members will be Cllr Pat Harrison and Cllr Jean Hossain.

5.0 Financial Implications

5.1 There are no immediate financial implications arising from this report.

6.0 Legal Implications

There are no legal implications arising from this report.

7.0 Diversity Implications

7.1 There are no diversity implications immediately arising from this report.

Contact Officers

Pascoe Sawyers
Head of Policy and Partnerships
Chief Executive's Department

Mark Cairns
Policy and Scrutiny Manager
Chief Executive's Department

PETER GADSDON
Director Performance, Policy and Partnerships

Scrutiny Task Group Scoping Paper

Community and Wellbeing Scrutiny Committee

Home Care Commissioning

Brent's Context

1. Home care is a statutory service provided by the council's Adult Social Care service. Home care, also known as domiciliary care, is a key way of improving a person's quality of life and it is an important part of Brent's health and social care system. However, the provision of the service is facing significant challenges.

2. Domiciliary support is practical, including help to get out of bed and dressed in the morning, assistance in preparing meals and taking medication. This care enables people to live safely and autonomously in their own homes, whilst also receiving the support they need to complete activities of daily living such as getting washed and dressed, being supported to go to the toilet, getting support with food preparation and taking medication.

3. The majority of home care delivered at present is a traditional service, in which an individual is 'cared for' by one or more care worker. However, the local authority also offer some reablement provision. This is a different type of home care, which focuses on supporting individual to recover some or all of their independence. Goals are set at the beginning of the process, and specialist agencies work with Occupational Therapists to support individuals to achieve those goals. For example, rather than a home care agency making lunch for an individual, a reablement package might focus on supporting an individual to regain the skills to make their own lunch. Goals are individual and tailored to the person in question. This timely provision of intensive support, therapy and care for short periods of time is usually provided for people who have just been discharged from hospital or are otherwise entering the care system following a crisis.

4. Reablement can be provided for anyone, at any stage of their interaction with the council, and not just for those people being discharged from hospital. The aim of home care is to allow an individual to stay at home for as long as is safely possible. This means that the needs of people receiving home care is now much higher than they were in the past. People who would have been admitted to residential or nursing care even five years ago are now being supported at home.

5. Home care is not a directly provided local authority service. There is a range of providers in the private, not-for-profit and voluntary sectors from whom the local authority purchases packages procured through the West London Alliance framework (WLA). [1] However, the local authority is still able to 'spot purchase' outside the framework. During 2016 – 2017 home care was provided cumulatively to a total of 2,578 Brent residents, with a further 904 receiving reablement home care in the same year. The final outturn expenditure figure for the provision of home care and reablement home care for 2016 – 2017 was about £15million. As of May 2017, there were 1,780 people receiving home care in the borough.

6. Brent Council usually only purchases home care on behalf of an individual when he or she doesn't have the money to purchase care privately, and the person's needs are significant enough to meet criteria set out in the Care Act 2014. However, there are an increasing number of 'self-funders' who require the council to arrange their care, often after a stay in hospital, both to ensure that they can be discharged from hospital in a timely manner, and because many older people do not have family or friends who are willing or able to do this for them. Some residents may meet the eligibility criteria but opt to organise their own support separately from the local authority with a Direct Payment, or may wish to use a Direct Payment to purchase support directly from the same care providers that the council commission with rather than asking the council to arrange this care for them.

7. In addition to local authority purchased home care, care is provided informally by family, friends and wider community or social networks. There are estimated to be around 27,000 carers in the borough. [2] It is important to note that under the Care Act 2014, the council are only require to provide services if a need is unmet. This means that where an unpaid carer is providing care for an individual, we would not classify the need as unmet and would not fund or provide care. However, the local authority has a duty to take into account the welfare of unpaid carers, and will often provide respite or support to ensure that care arrangement do not breakdown.

8. Complaints about home care packages are low at just 1% of statutory and corporate complaints. But the majority of complaints are reported directly to the home care provider and resolved by them. [3] The Burstow Commission highlighted nationally that too often, care plans under commissioning arrangements are fixated on 'time and task'. They struggle to integrate people's 'sociability' needs and the willingness of friends, family and neighbours to help, and the end goal of a person's independence is too often lost. [4]

[1] 'West London Collaborative Framework, Report from the Director of Housing and Community Care, Brent Council, 11 August 2010, p8

[2] Brent Adult Social Care Local Account 2014/15, p5

[3] Brent Council Annual Complaints Report 2015-16, Appendix A, Adult Social Care Complaints, p2

[4] *Key to Care: Report of the Burstow Commission*, LGIU (2014) p24

9. Nationally, there are growing concerns about the sustainability of the domiciliary care market, and the viability of some businesses. [5] At present, Brent has numerous providers who are part of the WLA framework. Other local authorities have opted to create a sustainable market by having a stronger relationship with fewer providers.

10. Nationally, Unison has consistently highlighted widespread problems for its members including the use of zero-hour contracts. Unison's view is that in many areas, home care is stuck in an equilibrium of low-skill, low-status, and low-pay. [6]

Demographic trends

11. The main recipients of home care are older people and adults with physical disabilities. The majority of people who receive home care in Brent are aged 65 or older. While resources to provide home care have decreased overall client numbers have rose last year by about 13% as the size of the population who are aged 65 or older has risen. [7] As chart 1 shows, the number of people aged 85 and over is also expected to rise by 2020. Those aged 65 and over is expected to increase by 26.4% to 41,500 people by 2020, and those aged 85 and over will rise by 54.5% by 2020, according to Greater London Authority population projections.

12. Research has shown that late-life dependency is increasing, as the years lived for men and women with low and high-dependency care needs rises. [8] However, living in poverty contributes to poorer health, wellbeing and social isolation, and while the overall life expectancy in Brent is in line with the rest of London, there are significant health inequalities within the borough. For example, the gap in life expectancy for men between the most affluent and most deprived parts of the borough is 8.8 years. Another feature, as important as total life expectancy, is healthy life expectancy, and males (born in 2010-12) can expect to have a healthy life expectancy of 62 years, compared to an overall life expectancy of 79.9 years. Females (born 2010-12) can also expect 62 years of healthy life compared to a total life expectancy of 84.5 years. [9]

13. People who are eligible for home care have increasingly more complex needs. This has occurred as the number of young disabled adults with physical or learning disabilities has risen, but also as the incidence of dementia in the population increases, and as described above, as the acuity of people being supported at home as opposed to in an institutional care setting also increases. As chart 1 shows, the number of people aged 85 and over, who are more likely to have complex needs, is expected to increase significantly.

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[5] Jonathan Holmes, *An Overview of the Domiciliary Care Market in the United Kingdom*, UKHCA, May 2016, p8

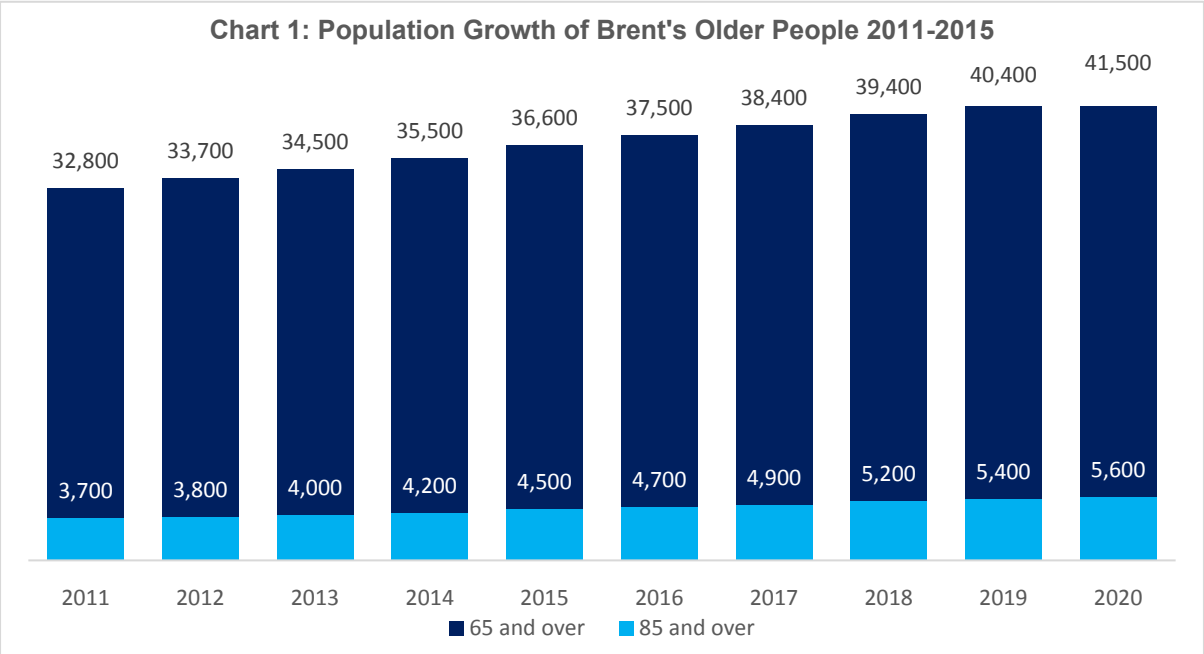
[6] 'Authority to Award a Framework Agreement for Home Support Services', Brent Council, 16 June 2014, p7; '

[7] Brent Local Account, p13

[8] Andrew Kingston et al, 'Is late-life dependency increasing or not? A comparison of the Cognitive Function and Ageing Studies', The Lancet, 15 August 2017

[9] Brent Joint Strategic Needs Assessment 2014/15

14. These projections have profound implications for the delivery of adult social care and between 2009/10 and 2014/15 spending on adult social care fell by 17% in real terms, as councils' overall budgets were reduced, according to the King's Fund. This occurred at a time when the number of people looking for support increased by 14%.



Source: GLA Short-Term Population Projections, 2015 based **© Greater London Authority, 2017**

15. The profile of Brent's older population is changing. At present, Black and Minority Ethnic (BAME) groups make up fewer than 40% of the population aged over 75. However, by 2020 the Asian population will make up 39% of the population aged 65 or over. It's estimated that around 27% of people over the age of 65 live alone, and this will increase as the number of single households in the wider population rises. [10]

Finance

16. Brent Council's expenditure on domiciliary care is a substantial part of the Adult Social Care budget, which has fallen significantly since 2009/10. [11] Full Council last municipal year agreed a two-year budget up to 2018/19 with a precept for Adult Social Care of a 2% council tax as well as a 1.99% general rise. In the budget, £1.5million was factored in for home care each year as the additional cost of providing the same level of services to an increasing rising population. [12]

17. From March 2014 to March 2016 there was a consistent increase in the number of people needing home care across a range of hours per week, with a total increase of over 30% in that period. The current hourly rate for external home care packages in

[10] Brent Local Account, p4
[11] Brent Adult Social Care Local Account 2014/15, p13
[12] Brent Council Budget, Cost Pressures - 2017/18 - 2019/20' Appendix B

2014/15 is £13.82 per hour, with annual average costs of between £10,060 and £35,932 per person per year, and the average package of care is 17.75 hours per week at an annual cost of £12,740. A further pressure is the increasing number of people who require more than one carer to support them. 'Double up' care packages present significant challenges to both the council and the market and are increasing significantly year on year. [13] Work is currently being done to evidence the need for dual-handed packages of care with an expectation that greater use of equipment and assistive technology will reduce the numbers and free up care worker time for other key activities.

18. Brent's 2016/17 Scrutiny Budget Panel highlighted that the Community Wellbeing Department is facing increasing challenges as a result of a changing demography as Brent's residents live longer and develop more complex needs. As a result, the last three years has seen the department deliver care to an increasing number of users and also fund more complex and expensive care packages. [14]

19. A rising cost for providers is the London Living Wage (LLW). Brent Council is an accredited LLW employer, and the Cabinet is strongly committed to LLW. Brent Council even offers a one-off discount in business rates to companies based in Brent which pay LLW. [15]

Policy and Legal

20. Brent's Borough Plan 2015-19, has committed the local authority to a number of priorities related to home care commissioning, including improving life chances and building partnerships with communities and providers. [16] Within the Brent 2020 strategy, the local authority has stipulated managing demand for services as a key priority. Brent also has a Social Value Policy and Procurement Strategy 2016-18, which commit the local authority to meet certain objectives when commissioning.

21. Under the Care Act 2014, local authorities have an explicit duty to shape their local care markets by working with a variety of care providers to make care services available whether they are paid for by the local authority or not. A significant number of residents purchase home care from providers separately to the council. The council additionally has a duty to ensure that the market is sustainable.

22. All home care providers in the borough are regulated by under the Health and Social Care Act 2008 by the Care Quality Commission (CQC). The 2014 Care Act sets out the local authority's legal duties.

[13] Brent Local Account, p15

[14] Budget Scrutiny Panel Report, Resources and Public Realm Scrutiny Committee, 10 January 2017, pp.8-9

[15] NNDR Discretionary Discount Scheme for Businesses Accredited to Living Wage Foundation, Brent Council Cabinet, 26 January 2015

[16] Brent Borough Plan 2015-19, p4

Task Group Rationale

23. The local authority's existing arrangement with the WLA for purchasing home care ends in September 2018. As a result, Brent Council will organise its own commissioning arrangements to come into effect from 1 October 2018, which is an important priority for the Community Wellbeing Department and the Cabinet Member for Community Wellbeing. A review is underway and options are being developed, working with providers and engagement with people receiving services, their families and other stakeholders. The new commissioning model will be from 2018-2023.

24. As members we want the best possible health and wellbeing for residents. Home care is only provided to a small proportion of Brent's population, but it is fundamental to their health and wellbeing. We want to understand home care at present and how it could be further improved to maximise people's independence and quality of life. Also, we want to understand how a new commissioning model could work.

25. As an Overview and Scrutiny task group we are interested in taking a broader perspective and understanding how home care fits within the 'bigger picture' of a local authority and its services rather than just viewing it as a commissioning exercise by a single department. The task group's terms of reference and membership are set out in Appendix A and B.

Task Group Objectives

26. Overall, the task group's objective is to develop recommendations which are clear and directive and supported by detailed evidence. They will be based on what the task group thinks are the important priorities for a future home care commissioning model, how the challenges can be addressed, and how the local authority's existing policies and strategies might need to be updated. These recommendations will help to inform the Cabinet when it takes a decision next year on the different policy options for commissioning home care. As set out the task group will take a broader perspective to understand how home care fits within the 'bigger picture' of local authority services and other public services.

27. The task group will focus on four areas: resources, health and wellbeing outcomes, partnerships and relationships, and the quality of home care. The task group's work will be guided by a number of themes, including:

Resources

- long-term demographic trends
- workforce status, skills and pay
- adult social care budgets
- 'time and task'

Health and Wellbeing Outcomes

- promoting independence
- health and wellbeing
- prevention

Partnerships and Relationships

- partnership working
- health and social care integration
- wider community and social networks

Home Care Quality

- priorities for people using home care and their families
- understanding complaints
- how quality can be improved.

Methodology

28. The focus of the task group's work will be on understanding the issues and gathering information across the four themes using qualitative and quantitative evidence.

29. The final report and its recommendations will be presented to Community and Wellbeing Scrutiny Committee on 31 January 2018, and agreed recommendations will then be presented to Brent Council's Cabinet.

30. The task group will meet with various stakeholders who have an interest in home care in Brent, to better understand the issues. Task group activities and meetings will be set out in a project plan once the Community and Wellbeing Scrutiny Committee has agreed the scoping paper.

APPENDIX A

Terms of reference

The terms of reference for the task group will be to:

a) Understand the commissioning model and how effective the services provided are in supporting independence and improving a person's quality of life.

b) Understand the options for a new model of home care.

c) Evaluate how home care sits within wider local authority services.

d) Review the local authority's partnership working and relationships with people receiving home care and their families.

e) Evaluate how home care can improve health and wellbeing outcomes.

f) Review how home care fits within existing social networks and communities.

g) Evaluate the quality of home care and how quality can be improved.

APPENDIX B

Task group membership:

Cllr Ketan Sheth, task group chair

Cllr Pat Harrison

Cllr Jean Hossain

Dr Laura Cole, a researcher at the Social Care Workforce Research Unit at King's College London will act in an advisory capacity to the task group.

James Diamond, Scrutiny Officer, will provide support to the members' task group.

Brent	**Community and Wellbeing Scrutiny Committee** 19 September 2017 **Report from the Independent Chair of Brent Local Safeguarding Children Board**
For Information	Wards Affected: ALL

Brent Local Safeguarding Children Board (LSCB) Annual Report 2016-17

1.0 Summary

1.1 Section 13 of the Children Act 2004 requires each local authority to establish a Local Safeguarding Children Board (LSCB) for their area and specifies the organisations and individuals (other than the local authority) that should be represented on LSCBs.

1.2 Chapter 3 of Working together to Safeguard Children 2015 outlines the statutory objectives and functions of LSCBs.

1.3 In order to provide effective scrutiny, the LSCB must be independent and every LSCB must have an independent chair who can hold all agencies to account.

1.4 It is important to note that LSCBs do not commission or deliver direct frontline services though Brent LSCB does provide training. While LSCBs do not have the power to direct other organisations they do have a role in making clear where improvement is needed. Each Board partner retains its own existing line of accountability for safeguarding.

1.5 The Chair must publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area. The annual report should be published in relation to the preceding financial year.

1.6 The Brent LSCB annual report summarises the work of Brent LSCB during 2016/17.

2.0 Recommendations

2.1 The Community and Wellbeing Scrutiny Committee is asked to note this report and it's content.

3.0 Detail

3.1 The achievements of LSCB business is detailed in the report including the challenges and proposed areas of work for 2017-18.

4.0 Financial Implications

4.1 All LSCB member organisations have an obligation to provide the Board with resources to enable it to carry out its functions. These contributions can include money, staff time (representation at the Board and sub-groups) or 'in kind'. Queens Park Rangers Football Club, the FA, the College of North West London and Ark Elvin Academy provided meetings rooms and refreshments for the Board in 2016/17.

4.2 In 2016/17 the Board had a budget made up of contributions from our partners. The main contributor to the LSCB budget continues to be Brent Council, with Brent CCG being the next highest contributor.

4.3 All LSCBs, regardless of size, continue to receive the same level of contribution from the Metropolitan Police, CAFCASS and Probation Services.

5.0 Legal Implications

5.1 Currently all local authority areas have a statutory responsibility to have a LSCB.

6.0 Equality Implications

6.1 The role of Brent LSCB is to co-ordinate and measure the effectiveness of the services provided to safeguard and promote the welfare of children and young people in Brent. In exercising its statutory functions Brent LSCB must be assured that the multi-agency services are accessible, inclusive and responsive to the diverse needs of Brent's children and young people, including those with additional needs and/or vulnerabilities. It also aims to ensure that services are culturally aware and skilled in identifying, assessing and meeting the individual needs of children and their families.

Contact Officers

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MIKE HOWARD
Independent Chair Brent Local Safeguarding Children Board

Brent	**Community and Wellbeing Scrutiny Committee** 19 September 2017 **Report from the Independent Chair of Brent Safeguarding Adults Board**
For information	Wards Affected: ALL

Safeguarding Adults Board Annual Report 2016-17

1.0 Summary

1.1 The purpose of this report is for the Independent Chair to present the Safeguarding Adults Board's Annual Report for 2016-17

2.0 Recommendations

2.1 That the Scrutiny Committee reviews and notes the contents of the Brent SAB Annual Report.

3.0 Detail

3.1 2015/16 saw the implementation of the Care Act 2014. This placed Safeguarding Adults Boards on a statutory footing, specified the circumstances where Safeguarding Adult Reviews must and may be commissioned, required Boards to produce annual reports and business plans, and itemised the roles in particular of three statutory partners, namely the local authority, the police and the clinical commissioning group. The types of abuse and neglect with which Safeguarding Adults Boards must have policies and procedures, have been extended to cover, for example, self-neglect and modern slavery, alongside physical and institutional abuse, discriminatory abuse and domestic violence. The Care Act 2014 requires all agencies with roles in the protection of adults from abuse and neglect to co-operate both in strategic planning and in the operational delivery of services. It also emphasises that services should be acutely tuned into the needs and aspirations of people needing care and services, with a particular focus on the outcomes they desire through an approach known as making safeguarding personal.

3.2 The report provides a summary of safeguarding activity carried out by Brent Safeguarding Adults Board (SAB) partners across social care, health and criminal justice sectors in Brent and is broadly divided into 3 sections. In the first part context and purpose of the Board is defined with reference to the SAB

2017-19 strategic plan. In the second part there is analysis of the statutory authority's response to reported concerns with year on year comparison (2015-16) incorporating trends in occurrence and the statutory authority's performance. The final section of the report contains contributions from the subgroups and Partner organisations of the SAB. This year in the SAB annual report we aimed to achieve a greater degree of accessibility in comparison to the 2015/16 report. To support this approach, acronyms were in the main either removed or explained. In some instances text box explanations were added where it was felt there would be added value to understanding the subject referenced. Photograph and graphic content were used to link text and subject. We are currently looking to create an easy read/accessible version of this report.

3.3 In 2016-17 the Safeguarding Adults Team (SAT) received 1,712 concerns, compared with 1,678 concerns in 2015-16. 628 of the Concerns were investigated and completed as S42 enquiries.

3.4 The safeguarding activity is displayed in simple graphic format and in this year's report a greater emphasis has been placed on Making Safeguarding Personal (MSP) data.

3.5 MSP data is set against that of reducing risk and in this aspect SAT have achieved improved results compared to 2015-16 and present a percentage significantly above that of London average.

3.6 Four core types of harm (Neglect or Acts of Omission, Psychological and or Emotional Abuse, Financial Abuse, Physical Abuse) present in the majority of reported concerns in 2016-17. There is an acknowledgment within the report and the partner contributions that further work is required regarding awareness and understanding of all forms of harm and abuse, in particular some of the more recently recognised categories such as self-neglect. The case studies selected for this report provide further examples across the range of categories.

3.7 In Summary, there has been a slight increase in the level of enquires and in the level of enquiries progressed to concerns. In terms of category type there has been an increase in incidences of neglect. 2016-17 marked a reduction in the number of enquiries involving pressure ulcers. Risk was removed or reduced in a higher number of cases compared to 2015-16. An increase in the Adult at Risk preferred outcomes was achieved compared to 2015-16.

3.8 Deprivation of Liberties Safeguards. The figures for 2016-17 are presented and display a consistent level of performance across the four quarters. Context is provided by reference to Cheshire West Judgement and more recently review carried out by The Law Society.

3.9 Case Studies are included in this report and provide a range of examples to illustrate categories of harm and the response and outcome of the concern. There is a recognition here of the evidence that real life experiences are

extremely helpful in conveying a greater understanding of the safeguarding process for all stakeholders.

3.10 Subgroup and Partner contributions. In this report contributions have been included from the 5 subgroups of the Board. They follow a format providing examples of work completed and to be undertaken in line with priority actions taken from the 2017-19 SAB Strategic Plan. The Chair of each subgroup is the author of the corresponding contribution and this is a positive development, indicative of the development of The SAB and Partners' increased involvement towards a common aim. The contributions from Partners vary to some extent in detail and content. Whilst there was significant challenge in the edit process (principally due to time constraint) the contributions included provide valuable evidence of safeguarding work carried out across the borough in 2016-17

3.11 Safeguarding Adult Review: The Case Review Subgroup contribution details the learning from case reviews to improve practice which were commissioned and completed in 2016/17. The completion of the Safeguarding Adult Review (SAR) for Adult A resulted in changes to Adult Social Care processes regarding management of client financial affairs, additionally resulted in an external agency (the Department for Work and Pensions) reviewing its policy regarding Appointee applications. The CRG contribution also provides details of SAR commissioned regarding Adult B. Subsequent annual reports will provide the outcome and learning.

4.0 Financial Implications

4.1 There are no specific financial implications to note

5.0 Legal Implications

5.1 The Care Act 2014 requires Brent Council to establish a SAB and provides for accountability of the Independent Chair to the Chief Executive of the Local Authority. The Act also requires that the Board publish an annual report detailing what the SAB has done during the year to achieve its main objective and implement its strategic plan, and what each member has done to implement the strategy as well as detailing the findings of any safeguarding adults reviews and subsequent action. Annual Report must be circulated to Healthwatch, the Borough Police Commander, the Chair of the Health and Wellbeing Board and the Clinical Commissioning Group. This has been done.

5.2 The public sector equality duty, as set out in section 149 of the 2010 Act, requires the Council, when exercising its functions, to have "due regard" to the need to eliminate discrimination, harassment and victimisation and other conduct prohibited under the Act, and to advance equality of opportunity and foster good relations between those who have a "protected characteristic" and those who do not share that protected characteristic.

5.3 The "protected characteristics" are: age, disability, race (including ethnic or national origins, colour or nationality), religion or belief, sex, sexual orientation, pregnancy and maternity, and gender reassignment. Marriage and civil

partnership are also a protected characteristic for the purposes of the duty to eliminate discrimination.

5.4 Having “due regard” to the need to “advance equality of opportunity” between those who share a protected characteristic and those who do not includes having due regard to the need to remove or minimise disadvantages suffered by them. Due regard must also be had to the need to take steps to meet the needs of such persons where those needs are different from persons who do not have that characteristic, and to encourage those who have a protected characteristic to participate in public life. The steps involved in meeting the needs of disabled persons include steps to take account of the persons’ disabilities. Having due regard to “fostering good relations” involves having due regard to the need to tackle prejudice and promote understanding.

6.0 Equality and Diversity Implications

6.1 Brent Safeguarding Adults Board works closely with the Brent Adult Social Care Safeguarding Team to deliver its statutory functions, in compliance with the Equality Act 2010 and in conjunction with Brent Equality Strategy 2015-19.

Data on gender, age, ethnicity and disability is regularly collected and monitored, as this is the primary support need of anyone who is the subject of a safeguarding enquiry. As with previous years, the data demonstrates that the diversity profile of individuals’ subject of safeguarding enquiries broadly reflects the demographic makeup of Brent.

The Board recognises that there are still gaps that need to be addressed in terms of its engagement with service users, carers, faith groups and LGBT communities, for example, and is currently developing its plans to narrow these gaps and examples can be referenced within the Subgroup and Partner contributions in the SAB 2016-17 Annual Report.

This year in the SAB annual report we aimed to achieve a greater degree of accessibility and inclusivity. To support this approach, acronyms were in the main either removed or explained. In some instances text box explanations were added where it was felt there would be added value to understanding the subject referenced. Photograph and graphic content were used to link text and subject. We are currently looking to create an easy read/accessible version of this report.

Background Papers

Amended list from Brent SAB Constitution below e.g. National Probation Service not Trust, Healthwatch Brent. Carer's Forum added.

Membership of the SAB will consist of representatives from the following:-

- Brent Council
  - Director of Adults Social Care
  - Director of Children and Families
  - Director of Housing Services
  - Director of Regulatory Services
- Metropolitan Police: Brent
- National Probation Service
- Community Rehabilitation Company
- Brent Clinical Commissioning Group
- NHS England (London)
- London North West Healthcare NHS Trust
- Central and North West London NHS Foundation Trust
- London Ambulance Service
- Healthwatch Brent
- London Fire Brigade
- Care Quality Commission
- Brent Community Voluntary Services
- Brent Carers Forum
- Department for Work and Pensions
- Crown Prosecution Service

Other membership of the SAB who will act in an advisory/observer role and will include:-

- The Lead Cabinet Member for Health and Adult Social Care
- The Director of Public Health
- Designated Health Professionals
- Principal Social Worker
- Brent Mencap
- Legal Advisor to the Board

Contact Officers

James Pearce
Strategic Partnerships Officer
Brent Safeguarding Adults Board

Michael Preston-Shoot
Independent Chair
Brent Safeguarding Adult Board

MICHAEL PRESTON-SHOOT
Independent Chair, Brent Safeguarding Adult Board

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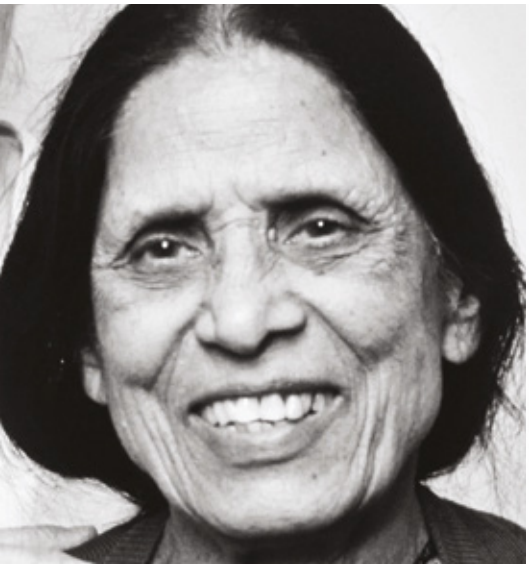
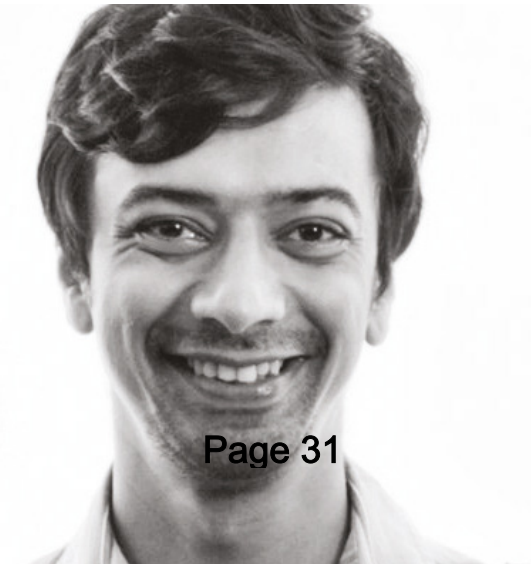
Brent Safeguarding Adult Board

ANNUAL REPORT 2016-2017

Brent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How do I Report abuse in Brent?

If you wish to raise a safeguarding concern complete this safeguarding form (.docx, 111.3kB) and email it to safeguardingadults@brent.gov.uk. If you have any trouble completing the form, please contact the Duty Team at safeguardingadults@brent.gov.uk or call 020 8937 4300 and they will help you

PHYSICAL ABUSE
Including assault, hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions.

DOMESTIC VIOLENCE
Including psychological, physical, sexual, financial, emotional abuse; so called 'honour' based violence.

ORGANISATIONAL ABUSE
Including neglect and poor care practice within and institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one's own home.

MODERN SLAVERY
Encompasses slavery, human trafficking, and forced labour and domestic servitude.

DISCRIMINATORY ABUSE
Including forms of harassment, slurs or similar treatment because of race, gender and gender identity, age, disability, sexual orientation or religion.

PHYSICAL ABUSE
Including assault, hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions.

PSYCHOLOGICAL ABUSE
Including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation or blaming.

SELF-NEGLECT
This covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding.

SEXUAL ABUSE
Including rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography.

NEGLECT AND ACTS OF OMISSION
Including ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating.

FINANCIAL OR MATERIAL
abuse Including theft, fraud, internet scamming, coercion in relation to an adult's financial affairs or arrangements.

Brent

NHS Brent

local mencap Brent

METROPOLITAN POLICE
Working together for a safer London

healthwatch Brent

National Probation Service

NHS Brent Clinical Commissioning Group

Brent lscb local safeguarding children board

CareQuality Commission

LFB LONDON FIRE BRIGADE

Who is an Adult at risk and when would we consider a Section 42 Enquiry?

1	2	3
AN ADULT AGED 18 YEARS OR OVER	WHO IS OR MAY BE IN NEED OF COMMUNITY CARESERVICES BY REASON OF MENTAL OR OTHER DISABILITY, AGE OR ILLNESS	UNABLE TO TAKE CARE OF HIM OR HERSELF, OR UNABLE TO PROTECT HIM OR HERSELF AGAINST SIGNIFICANT HARM OR EXPLOITATION

Introduction to the 2016/2017 Annual report

Brent Safeguarding Adults Board (SAB or 'Board') is a multi-agency partnership of statutory and voluntary agencies working together to review and improve local safeguarding arrangements.

The Board is required by law, under the Care Act 2014, to produce and publish an annual report each year. In the report we must tell you what we have done during the last year to support adults at risk of abuse and neglect in our Borough. The Care Act came in to force on 1st April 2015.

Our Responsibilities are:

- To ensure people are safe and able to protect themselves from abuse and neglect.
- To intervene and ensure people are protected when they need to be.
- To ensure people are treated with dignity and respect.
- To make sure each person affected can get the support and services they need to protect themselves without difficulty.
- To contribute and when required lead in strategic decision making for safeguarding arrangements.
- To provide guidance on operational best practice.

In this report we will tell you:

- What the Board has done to provide, protect and promote safeguarding in Brent
- What the sub groups and our partner agencies have done in the last year and about their future plans
- About the Safeguarding Adult Reviews (SARs) investigations we have carried out
- How we will we use this evidence to provide better outcomes for our residents
- The case studies in this report are taken from real safeguarding concerns but we have changed names in all cases to protect people's identities. We have included these to demonstrate how we are working to make safeguarding personal, tackle abuse, promote well-being and support adults to be safer in our community.

CASE STUDY – RAY

CONCERN

Trafficked from the UK to another nation for "therapy"

The "therapy" consisted of physical and emotional abuse

RESPONSE

Emergency accommodation and assistance with benefits was provided

Multi-agency working between police, housing and Adult Social Care

OUTCOME

Ray was protected from further abuse

Human slavery protocol being developed as a result

Foreword from the Independent Chair

This annual report covers the year April 2016 to March 2017. I took over as Independent Chair in June 2016. It is a statutory requirement (Care Act 2014) that the Brent Safeguarding Adults Board (SAB) publishes an annual report.

Our work in the first half of the year focused on:

- Ensuring that the terms of reference for the SAB and its sub-groups were clear, realistic and linked to the Board's strategic plan;
- Establishing an Executive, with membership drawn from the SAB's three statutory partners (local authority, clinical commissioning group and police) and the chairpersons of the sub-groups, with the remit to monitor the work of the sub-groups and the achievement of the objectives contained within the strategic plan;
- Appointing staff to manage the day-to-day business of the Board and its sub-groups.

This work came together in the Board's first development day. Such days will become annual events, enabling SAB members to reflect on the performance of the Board and to hear directly from practitioners and managers, and from organisations of service users and carers, what is working well and where improvements are needed to keep adults safe from abuse and neglect.

At this first development day, Board members agreed the terms of reference for the SAB and its sub-groups, and refined the strategic plan. This was helped by contributions from practitioners and managers across all the agencies in Brent that work with adults at risk of abuse and harm, or in need of care and support. The strategic plan has been published and is available on the Board's web pages.

Our work in the second half of the year focused on:

- Completing one Safeguarding Adult Review (SAR) and ensuring that the recommendations for practice improvement and service development were fully implemented;
- Commissioning a second SAR, which will be completed early in the 2017/2018 year;
- Completing an audit of adult safeguarding policy and practice across agencies in Brent;
- Ensuring that the sub-groups have an action plan to take forward their part of the SAB strategic plan;
- Agreeing a system of performance reporting with all the agencies in Brent whose roles and responsibilities include adult safeguarding so that the SAB can be reassured about the effectiveness of single and multi-agency systems in keeping people safe, and can take action to improve services where necessary;
- Updating the SAB's web pages;
- Making productive links with the Safer Brent Partnership and with the Local Safeguarding Children Board.

All this work is reported upon in the pages that follow in this annual report. Our objective this year has been to make the annual report fully accessible. Thus, partner agencies and the sub-groups have been asked to report succinctly on their objectives and achievements for the year in question and to outline their plans for the future. Our hope is that this gives readers an easy insight into how the SAB is overseeing the work of the different agencies in keeping adults in need of care and support safe from abuse and neglect.

I would like to thank everyone involved for their commitment to adult safeguarding in Brent. I hope that you find the annual report useful in understanding the work of the Board and its partner agencies.

Professor Michael Preston-Shoot
Independent Chair
July 2017

The SAB plan for 2017-19

You can find details of this plan on our website (LINK) All the agencies and organisations are working together to contribute to this plan.

There are 7 Areas of Priority:

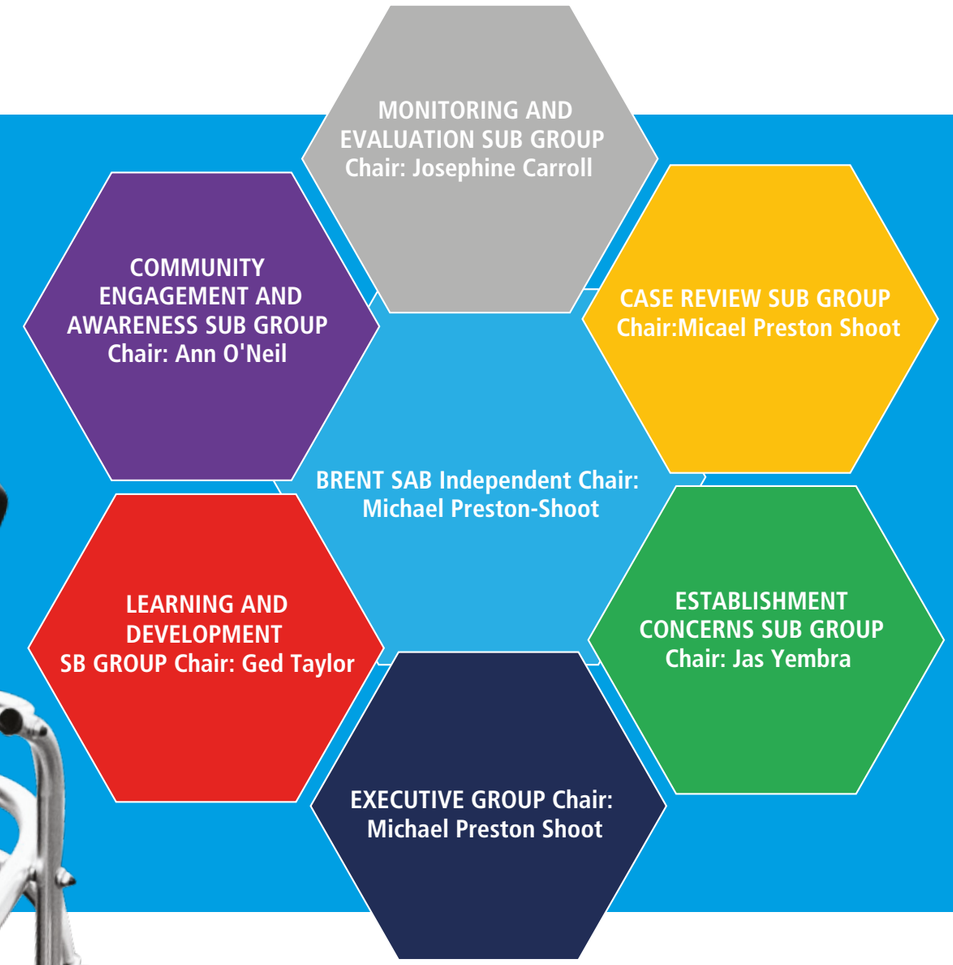
- To raise awareness and understanding of safeguarding adults within the Brent Safeguarding Adults Board (BSAB) workforce and wider community
- Continuing to work together to understand and meet the challenges of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS)
- To increase the voice of service users and carers, and their representatives in the work of the SAB
- Continue to work to progress the making safeguarding personal agenda
- Training and Workforce Development is used to support the delivery of SAB priorities and to add value
- Better Quality Data – to work with partners to develop a multi-agency data set to monitor key safeguarding activity within the SAB partnership and to hold partners to account
- An effective Board is established through good Governance, Leadership, Responsibility, Partnership and Accountability

The Board

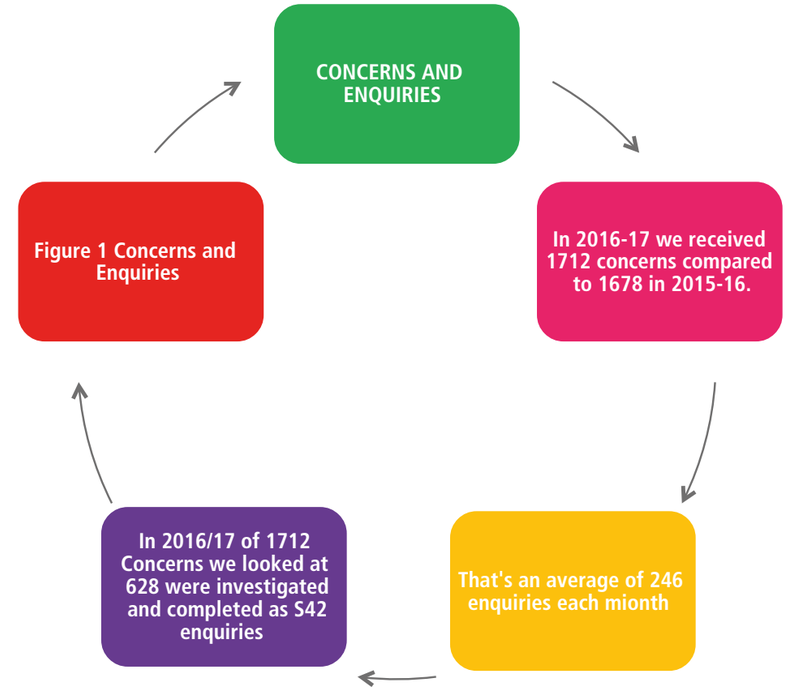
The Brent Safeguarding Adults Board is made up of The Safeguarding Adults Board, the Safeguarding Adults Board Executive and five Sub Groups. The Chairs of each Sub Group will tell you about their contributions in section 8.

The Board meets quarterly and in future the minutes of its meetings will be posted on the SAB's web pages. It is responsible for agreeing the contents of the annual report and the strategic plan. It must accept the findings and recommendations of safeguarding adult reviews, and ensure that the recommendations are fully implemented through action planning, staff training, policy development and changes to how services are organised. It ensures that regional and national adult safeguarding developments and issues are fully reflected in local discussions, procedures and practice.

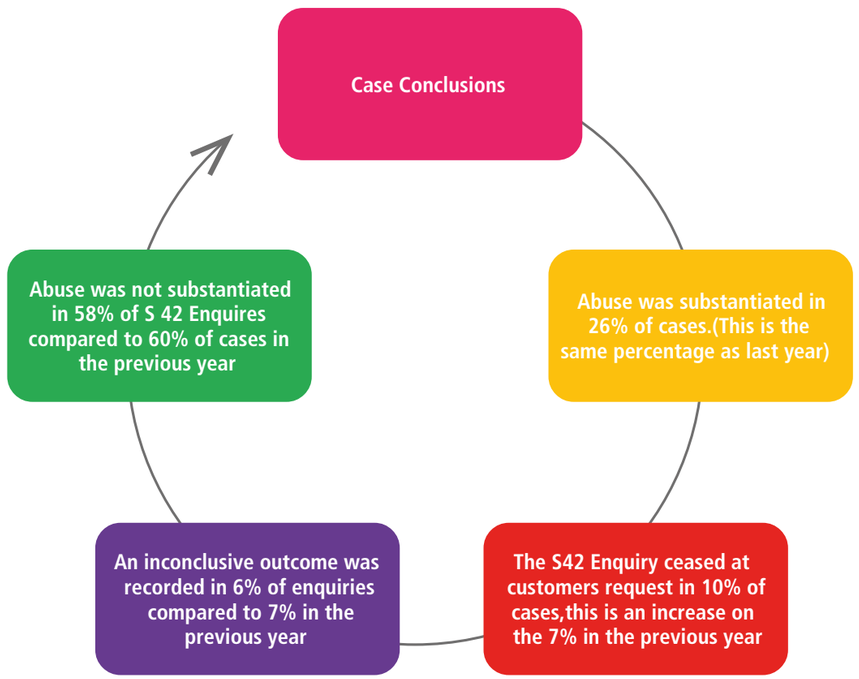
The Safeguarding Adults Executive Board meets every six weeks. It receives reports from the sub-groups and ensures that they are making an active contribution to the achievement of the priorities in the strategic plan. It also scrutinises the performance of local agencies in safeguarding adults and escalates any concerns to the SAB. Future priorities for the Executive include building on established links with housing providers, domiciliary care providers and care home providers, and developing or reviewing policies and procedures to address those types of abuse and neglect newly included in adult safeguarding by the Care Act 2014, especially modern slavery and self-neglect.



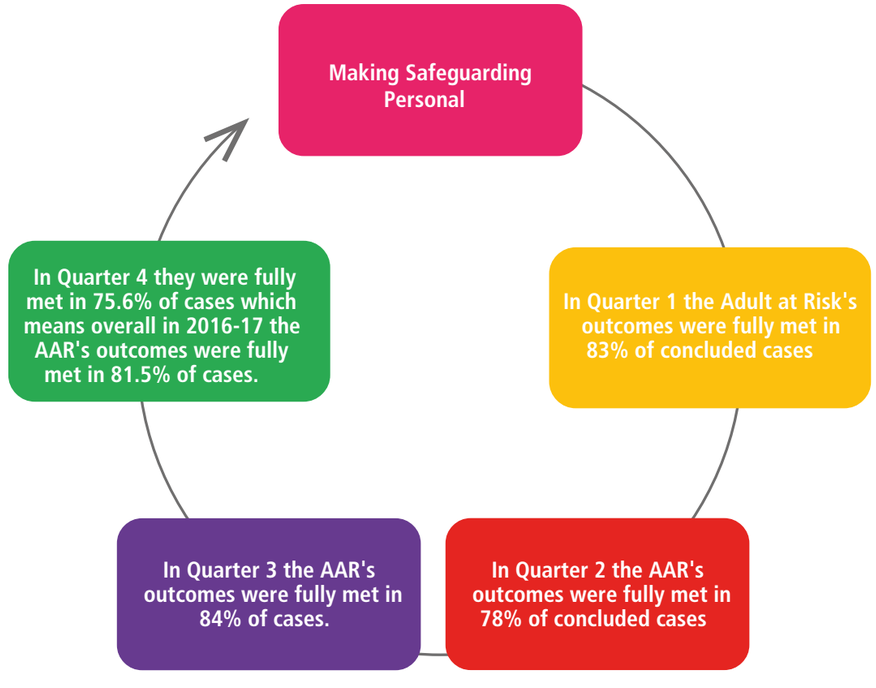
Brent Safeguarding Adult Team Activity 2016-17



Case conclusions



Making Safeguarding Personal for the Adult at Risk

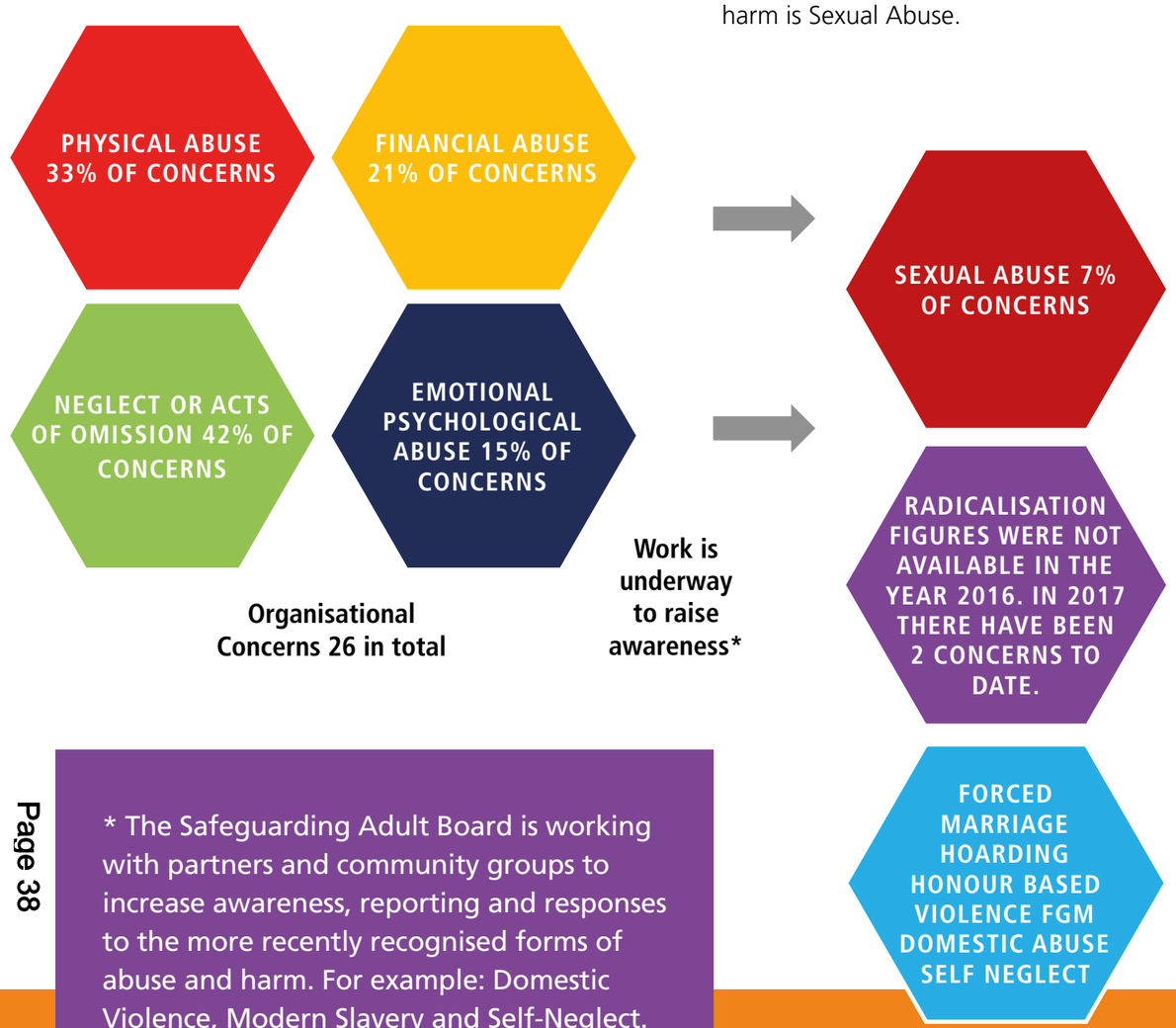


Reducing Risk

Types of Harm

The Core 4 Highest Categories in 1720 Concerns. In these 4 types of harm more than 1 category is often indicated in the Concern.

Concerns about neglect or acts of omission increased in comparison to last year. There was a decrease in other core categories. The next highest category of harm is Sexual Abuse.



* The Safeguarding Adult Board is working with partners and community groups to increase awareness, reporting and responses to the more recently recognised forms of abuse and harm. For example: Domestic Violence, Modern Slavery and Self-Neglect. One of the ways we plan to do this in 2017-18 is by bringing all Partner safeguarding data together for the first time. We will then use this information to better identify where we need to focus our resources to tackle abuse and harm and prevent or reduce risks for residents of Brent.

Deprivation of Liberties

227 ASSESSMENTS WERE COMMISSIONED IN QUARTER 1

221 ASSESSMENTS WERE COMMISSIONED IN QUARTER 2

206 ASSESSMENTS WERE COMMISSIONED IN QUARTER 3

226 ASSESSMENTS WERE COMMISSIONED IN QUARTER 4

880 ASSESSMENTS WERE COMMISSIONED IN 2016/17

TIMELINESS OF ASSESSMENTS IS THE MAIN ISSUE WITH A HIGH PROPORTION OF ASSESSMENTS BEING COMPLETED OUTSIDE STATUTORY TIME SCALES

TIMELINESS OF ASSESSMENTS IS AN ISSUE LOCALLY, REGIONALLY AND NATIONALLY. THESE FIGURES SHOULD BE VIEWED IN THE CONTEXT OF THE CURRENT NATIONAL CONCERN ABOUT THE QUALITY OF COMPARATIVE DATA FOR DOLS

THE CHESHIRE WEST JUDGEMENT

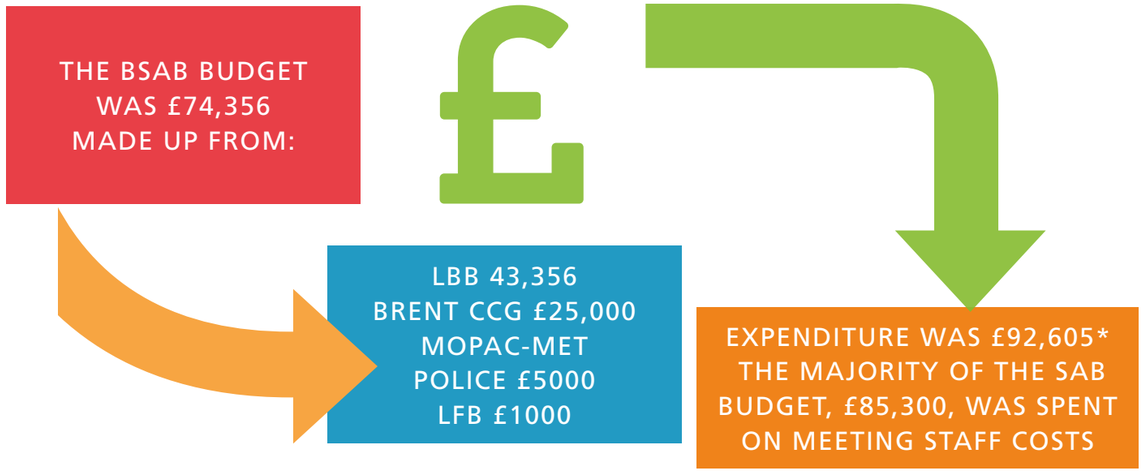
The Cheshire West judgement continues to present real challenge for local authorities due to the huge number of applications being requested where it is assessed that individuals are being deprived of their liberties under article 5 of the Human Rights Act. Since this ruling government has asked the law society to review the DoLS legislation, based on the concern that councils are unable to cope. Their finding was that the DoLS should be replaced with a new system as the 'current system is in crisis' (Mc Nicoll (2017). The Law Society has proposed that Liberty Protection Safeguards (LPS) replace the DoLS saying that this system will be less onerous than the DoLS while still offering human rights protections.

Summary of brent safeguarding trends

Increases	Decreases	Outcomes
THE NUMBER OF ENQUIRIES HAS INCREASED SLIGHTLY AND THE NUMBER OF CONCERNS HAS ALSO INCREASED THERE HAS BEEN AN INCREASE IN CONCERN ABOUT NEGLECT	A REDUCTION IN THE NUMBER OF ENQUIRIES INVOLVING PRESSURE ULCERS HAS BEEN RECORDED RISK CONTINUES TO BE REMOVED OR REDUCED IN A HIGHER NUMBER OF CASES	MAKING SAFEGUARDING PERSONAL FULLY MET OUTCOMES IMPROVED FROM 75% TO 81% THERE WAS AN INCREASE IN THE NUMBER OF CASES CLOSED AT THE REQUEST OF THE ADULT AT RISK

Brent Safeguarding Adults Board Budget

Income and Expenditure 2016-2017



*An overspend of 18,249 was met by LBB

THE SUBGROUPS OF THE SAB

THE LEARNING AND DEVELOPMENT SUBGROUP

THE CHAIR IS GED TAYLOR

What the L&D subgoup did in 2016-17:

- Contributed fully to all board meetings and subgroups and the executive group
- Reviewed relevant structures and policy documents through the Executive Group
- Collected information from service users who indicated that their outcomes were fully met in 81% of cases
- A single point of contact for modern slavery has been established and played a key role in a multi-agency conference about modern slavery which was attended by neighboring Boroughs
- Played a key role in the development of the workforce survey and also of the Training Matrix and Learning and Development Toolkit. Plans developed to use existing care providers' events/forums to disseminate learning and information to improve safeguarding practice
- Key role in the development of a Multi -Agency Shared Data Set for gathering safeguarding activity
- Reviewed and improved website content

How we contributed to 2016-17 SAB Priorities:

Following the SARs (Safeguarding Adult Review) for Adult A and Adult B we played a key role in the development of strategic plans in the following areas:

- Developing new Policies, Protocols and Procedures
- Implementing further training in 'Making Safeguarding Personal' approaches within Brent

Working with one of our service providers we played a key role in the development of strategic plans in the following areas:

- Governance, Leadership, Responsibility, Partnership and Accountability
- Policies, Protocols and Procedures
- Training and Workforce Development
- Auditing and Competency Framework

COMMUNITY ENGAGEMENT AND AWARENESS SUBGROUP

THE CHAIR IS: ANNE O'NEIL

What the CE&A subgoup did in 2016-17:

In July 2016 the Community Engagement and Awareness Sub Group held a Safeguarding Awareness Conference for Community Leaders; this was a one-day event to bring together influential community leaders who can reach out to all areas of Brent; to increase their knowledge of abuse, how to talk about it, and how to raise concerns.

The Subgroup and conference focused on Financial Abuse because local research had indicated there was a low level of awareness in our community. Presentations looked at different types of financial abuse and how to prevent such abuse and take protective action when it occurs.

The Conference we held was part of a long term strategy to engage community leaders so that messages can reach all areas of Brent's diverse community.

The sub-group is working with trading standards officers to help raise awareness about financial abuse, including from postal and email scams and rogue traders.

The sub-group is working with groups of service users and carers, and also with faith groups, to establish regular two-way dialogue with Brent Safeguarding Adults Board, ensuring that some meetings take place in community settings.

THE CASE REVIEW SUBGROUP

THE CHAIR IS MICHAEL PRESTON-SHOOT

What the CR subgoup did in 2016-17:

The case review group receives referrals for consideration for safeguarding adult reviews and, when a safeguarding adult review is commissioned, the group ensures its timely completion.

During 2016/2017, the group has reviewed and refreshed its terms of reference and strengthened its membership from across partner agencies. The group has also reviewed the documentation that is available to partner agencies when they are considering making a referral for a safeguarding adult review.

Learning and service development seminars will now be held quarterly to ensure dissemination of the lessons learned from safeguarding adult reviews, both those commissioned and completed by the Brent Safeguarding Adults Board, and those that have been published by other Safeguarding Adults Boards.

Within 2016/2017, two safeguarding adult reviews have been commissioned.

Case – Adult A

During 2016/2017, the group agreed to a safeguarding adult review for Adult A. This case was referred by the Court of Protection on behalf of Adult A's parents who were concerned that the Department of Work and Pensions and the Local Authority had not managed his financial affairs appropriately. The terms of reference for the review focused on how the Local Authority and the Department of Work and Pensions had managed this case. The review found that staff in both agencies had not understood the legal rules regarding the management of someone's financial affairs when they do not have the capacity to do so themselves. Staff had not appreciated the parents' longstanding involvement in managing their son's financial affairs. Consequently, they and their son had been significantly affected and their complaints had not been appropriately handled.

The safeguarding adult review's recommendations required the Safeguarding Adult Board to seek assurance that all relevant staff in the local authority have sufficient knowledge and understanding of welfare rights and benefits, mental capacity legislation and best interest decision-making, and the role of the Department of Work and Pensions and of Appointees. Recommendations were also made that the Safeguarding Adults Board should ensure that all staff in the local authority know how to escalate concerns to senior management for investigation, and that the management of complaints is improved so that the response is timely, appropriate and at the right level within the organisation.

The report also recommended that copies of staff supervision files are retained for future reference, even after staff have left the organisation, and that all agencies have access to up to date information on changing legislation regarding safeguarding adults. The Safeguarding Adult Board will also seek assurance that all agencies are listening to and involving family carers as appropriate in care planning.

How we contributed to 2016-17 SAB Priorities:

As a result of the case, changes have been made in the Local Authority and the Department of Work and Pensions regarding the recording of family involvement in the management of a family member's financial affairs, how the Local Authority responds to complaints has been (IDEA- Action bubble with what we

changed?) changed, and training offered to Adult Social Care on the legal rules surrounding Appointeeships and Deputyships, the system for managing the financial affairs of an individual who does not possess mental capacity themselves. The Department of Work and Pensions has also reviewed its handling of Appointee applications received from the Local Authority.

Case – Adult B

This case focuses on the probable sexual abuse of a learning disabled adult living in a care home. The case was referred by the Safeguarding Adults Team in Adult Social Care following a section 42 (Care Act 2014) enquiry. The terms of reference focus on the standards and quality of care and support services provided to Adult B. Adult B's family are contributing to the review which is on-going.

Specifically, the terms of reference require that the review considers the health and care and support provision for Adult B from January 2007 to March 2016. In so doing, to look specifically at the outcome of the police investigation, the determination of mental capacity in relation to all aspects of Adult B's health and wellbeing, and service provision for adults with learning disabilities.

ow we contributed to 2016-17 SAB Priorities:

Arrangements have already been made to ensure the on-going safety and appropriate care and support for Adult B. Subsequent annual reports will give details of the recommendations made by this review and the outcome of subsequent actions.

THE MONITORING AND EVALUATION SUBGROUP

THE CHAIR IS JOSEPHINE CARROLL

The M&E subgroup met on 6 occasions in 2016-17:

- The membership was reviewed and the member organisations have committed to ensure attendance at the subgroup for 2017/18. The dates are arranged in advance and meetings have been held monthly since the group was relaunched in January 2017. New Terms of Reference were agreed and a Vice Chair appointed.
- The group have agreed their work plan for 2017/18 and this has been signed off by the Board.

Achievements so far:

The group have developed a multi-agency sub group to address Monitoring and Evaluation terms of reference.

Developed the Monitoring and Evaluation Action plan for April 2017 to September 2019.

Established consistent membership, support and attendance from the member organisations of the Brent Safeguarding Adults Board

Developed and conducted a safeguarding adults awareness survey for all SAB member organisations as well as partner agencies in the Private and Voluntary sector.

Liaised with the Safeguarding Children's Board to ensure shared learning from their workforce survey.

The subgroup have had active involvement in both the Executive Group and the BSAB and involvement in the development day on 10th January 2017 and facilitated discussion groups on the day.

Plans to use existing structured forums and organised events to disseminate learning and information to improve safeguarding practice.

The group developed a safeguarding workforce survey to ascertain the level of awareness of the safeguarding process, the satisfaction with feedback from the safeguarding adults team and the level of training attended in the past 2 years

Issues were noted that not all partner organisations disseminated the survey to all their staff. This will be addressed with the next survey in January 2018, on the workshop days and the Board to address with member organisation.

The group are advising and briefing the Learning and Development subgroup to develop a series of 3 events to improve understanding of Safeguarding principles, Mental Capacity Act and Making Safeguarding Personal.

The M&E subgroup advised the Learning and Development subgroup on training requirements for the coming year for partner organisations.

These priorities will contribute to the following areas of the Strategic Plan:

The SAB is assured that Brent safeguarding adults procedures are effective.

Compliance with Mental Capacity Act (MCA) 2005 means service users are supported to make decisions in their best interest.

The SAB is assured that Deprivation of Liberty Safeguards (DoLs) practice is in line with national requirements.

Measures and processes effectively capture the outcomes of safeguarding adults work in Brent.

ESTABLISHMENT CONCERN SUBGROUP

THE CHAIR IS JAS YEMBRA

The subgroup has a dual purpose; the first part of the meeting is to provide an arena for statutory partners to share knowledge and intelligence about local care services, identify collective concerns or issues and agree an appropriate multi agency response. Partners ensure a robust multi-agency approach to all quality concerns raised beyond the thresholds set out by the Pan London Safeguarding Board. The second part of the meeting is to agree, define, co-ordinate delivery of, and monitor an annual work programme for the sub-group. The work programme for the group will seek to tackle key quality issues as identified by the group.

The membership of this group includes the Care Quality Commission, the safeguarding and pharmaceutical leads from Brent Clinical Commissioning Group and the contract monitoring and safeguarding leads from the Local Authority. The Group is chaired by the Contracts and Relationship Manager and meets bi-monthly.

Functional Responsibilities

- To share information to prevent or stop poor quality of care and/or safeguarding issues and work to improve the quality of local care provision.
- To develop and deliver a work programme to improve quality of care/address SAB issues recognised as an issue in local care provision.
- Raise any specific establishment or care provider concerns, so written action plans can be devised, defining the responsibilities of each agency to address concerns within agreed timescales.
- To identify trends, which will inform further analytical work to provide partners with the information they require to take strategic action within the market as a whole.
- To ensure all statutory partners have the information required to make decisions to optimise the safety and quality of local care services.

Strategic Planning

- To ensure there is a co-ordinated approach to quality assurance across the sector by identifying key themes and trends.
- To enhance service improvement by working with the L&D group to deliver training through the various training and forums.
- To ensure a coordinated response to providers existing the market.

Achievements:

- Developed an action plan for the group
- Joint training delivered by members

Our priorities in 2017-18:

- Deep dive (audit and analysis) of two SAB pressure ulcers cases to validate anecdotal evidence
- Develop preventative measures (not restricted to training)
- Identify, share and embed best practice across the sector
- Review our data to identify key areas of concerns and develop improvement

CASE STUDY – JOEL

CONCERN

Lacked capacity to consent to intimate relationships

Travel to another country had been booked

RESPONSE

Prevention order required to prevent marriage in another country

Refund for travel expenses secured

Course of psycho sexual therapy was sourced

OUTCOME

Following therapy capacity was reassessed and he was found to have capacity to consent

Adult At Risk and family very happy with the outcome

The partner organisations of the board

Partner Agency: Central and North West London Foundation Trust Elaine Singaram – PRCMH SAFEGUARDING LEAD

Priorities in 2016-17

- MAKING SAFEGUARDING PERSONAL – Continue to evidence that staff are working on progressing the "Making Safeguarding Personal" agenda.
- To deliver a safeguarding training programme including dedicated sessions to new starters and doctor on rotation
- To continue to build on the positive partnership/multi agency working that has been established
- To provide assurance that safeguarding concerns are followed up by the referrer and staff and that this is translated into care plans and risk assessments thus making adult safeguarding integral to service provision and delivery.
- To continue to review safeguarding concerns and share good practice via the multi-agency monthly Borough safeguarding meetings chaired by our Brent Borough Director.
- To support team safeguarding Champions in embedding policies and procedures within team practice that promotes an understanding of harm and the action to take.
- To provide a safeguarding presence at Kingswood Centre Learning Disability Service throughout the Provider Concerns Process. Ensuring a challenge and support model is adopted and that there is common understanding amongst staff on safeguarding thresholds.

Achievements In 2016-17

- MSP – Random snap shot audit of safeguarding concerns raised to establish if the Adult at Risk's wishes and outcomes were recorded. This was followed up with brief discussions with those Adults At Risk to gather verbal feedback and anecdotal evidence.
- LOCAL SAFEGUARDING TRAINING PROGRAMME – we held bespoke sessions. We considered professional boundaries, an action from the Park Royal Centre for Mental Health Sexual Safety Action Plan and learning lessons from significant sexual allegations 2014/2015.
- We provided PREVENT training sessions delivered by our Jameson Division Safeguarding Lead.
- CNWL have now made PREVENT training Mandatory for all staff.
- PARTNERSHIP WORKING – We reviewed and revised the Terms of Reference for the local Borough Safeguarding Meeting. We established supervision sessions for the Park Royal Centre for Mental Health Safeguarding Lead with the CCG Designated Adult safeguarding Nurse. This provided a forum to discuss any high level safeguarding concerns raised by CNWL and focus on learning lessons in a collaborative framework.
- EMBED POLICIES AND PROCEDURES – Audit service users clinical records to gain assurance that safeguarding concerns raised are being addressed in care planning and risk assessments /management plans and that these are being shared and followed up with relevant agencies and recommendations from LASG are actioned in a timely manner.
- Another example was the culmination of 3 years work to revise the CNWL Sexual Safety Policy which supports practice across all CNWL teams including sexual health services, mental health, learning disability, offender care and addictions services. This was delayed as it had to be ratified by several committees and boards as well achieving legal scrutiny.

- In Brent we took on board recommendations from 2 recent thematic reviews and have devised a "Keeping Safe- Sexual Safety information booklet for patients and carers which has been cascaded across all in-patient areas. This has been well received by service users and carers. It was launched at community meetings. Carers felt it was really useful general advice not just sexual safety and rather than being stored in leaflet racks needed to be handed to service users.
- PROVIDER CONCERNS PROCESS – Report completed by an independent consultant. Learning points were identified for all agencies involved. More robust processes in place at CNWL which allows for interrogation of data and intelligence.

CASE STUDY – ROSE

CONCERN

Reported physical and sexual abuse from a former partner whilst subject to a hospital admission under the Mental Health Act 1983

Rose had been subject to grooming by her former partner and became alienated from friends and family

RESPONSE

The hospital team provided support enable Rose to take back control of her life. By listening and assisting with the outcome Rose wanted

Rose was supported to make contact with HESTIA, report her ex-partner to the police, re-engage with family and friends

OUTCOME

The hospital team ensured follow up support was available to Rose as she continued to regain control of her life

The partner organisations of the board

Partner Agency: Brent Clinical Commissioning Group
Author/Board Member: Duncan Ambrose

Priorities in 2016-17

The Safeguarding Strategy for Brent Harrow and Hillingdon has the following as overall priorities for safeguarding:

- To provide senior and board level leadership.
- The senior leadership responsibility and lines of accountability for the CCG safeguarding arrangements are clearly outlined to employees and members of the CCG, as well as to external partners through the Safeguarding Policy and Annual Report.
- The CCG contributes to the work of the Local Safeguarding Children Board, Local Safeguarding Adults Board and their Safeguarding Strategic Business Plan and priorities and provides support to ensure that the board meets its statutory responsibilities.
- The CCG supports the role of Designated Safeguarding Professionals to act as independent expert advisors to the LSCB/LSAB, to contribute to and influence the work of the LSCB/LSAB and contribute to its subgroups and other national and local safeguarding implementation networks.
- The CCGs will commission services for all children, young people and adults in their area and ensure that high quality, timely care for looked after children is not disrupted by changes in placement or leaving care.
- Points were identified for all agencies involved. More robust processes in place at CNWL which allows for interrogation of data and intelligence.

What We Did in 2016/17

- During 2016/17 the Quality and Safety Team (Brent CCG) has continued to work with providers to encourage an open and transparent culture. The main providers have shared their Quality Accounts with the CCGs to identify areas for improvement. This has received positive result from provider services.
- Designated Professionals, CCG commissioners, and the Brent Safeguarding Adults Board also supported and monitored significant improvements by Central and North West London NHS Foundation Trust in the care offered to people with learning disabilities and mental illness in Brent.
- To improve the knowledge of safeguarding especially for care homes, the Designated Adult Safeguarding Nurses for Brent, Harrow and Hillingdon have updated the Adult Safeguarding flash cards to reflect the changes within the Care Act 2014. The cards have been distributed to providers, care homes and GP practices across Brent. Additional training on Mental Capacity Act, DoLs and Personalised Care Planning has been carried out by the Designated Safeguarding Adults Nurse to a number of care homes.
- The CCG has continued to ensure that patients eligible for Continuing Healthcare and Children's Continuing Care have had the right to have a Personal Health Budget. In 2016/17 the CCGs have started to plan for Personal Health Budgets to be offered more widely were evidence has indicated an individual could benefit.

Outcomes

Brent has had two major safeguarding concerns with regards to one care home and the Kingswood Centre which is a mental health hospital for learning disability clients. Both involved NHS England oversight with regards to responding to requests for monthly updates from the action plan.

The Designated Adult Safeguarding Nurse with the Continuing Health Care Team and Quality and Safety Team carried out a number of quality assurance review and assessment visits to ensure that clinical and operational governance is in place in the care homes.

This enabled development and implementation of an action plan with a clear reviewing time frame for the provider to demonstrate progress. Lessons learnt from this incident were shared with internal and external providers. The action plan included assessing training and competency of staff, and observation of their work. Assessment and review of individual patient care and support needs was carried out and patients who required to be moved were moved as appropriate.

The management and leadership within these organisations were assisted and given guidance and support to put in place appropriate safeguarding measures. The care home changed their management structure to incorporate a Quality and Compliance Manager whose role is to ensure policies and procedures are followed by observation of staff, developing monthly auditing tools and practice and teaching/training of the staff. The Kingswood Centre and the care home have had two Care Quality Commission inspections in 2017, one obtained a rating of outstanding overall and the other received a rating of good overall.

- The designated professionals support the Safeguarding Boards to deliver the Board's priorities, improving awareness, developing and reviewing safeguarding policies, procedures and safeguarding practice within the borough of Brent.
- The designated professional is a source of advice, guidance and support to the SAB and other health professionals in provider organisations. They also promote effective multi agency partnerships and ensure that commissioned services have effective systems in place for identifying and reporting abuse and neglect.
- Ensuring that compliance under the Care Act, Mental Capacity Act, and PREVENT duty, and Safeguarding Standards have been developed. These standards were presented to Providers on Monday 7th March 2015, and there have been follow up events held in order for providers to familiarise themselves with completing the new assurance tool ,the Safeguarding Health Outcomes Framework. Providers across the North West of London are now using the new assurance tool quarterly to demonstrate activity and compliance.

The partner organisations of the board

Partner Agency: London Ambulance Service NHS Trust
Author/Board Member: Alan Taylor, Head of Safeguarding

Priorities in 2016-17

- Ensuring sufficient resources to meet safeguarding requirements
- Raising safeguarding awareness across the Trust
- Introducing Safeguarding supervision
- Improving dementia awareness and safeguarding concerns
- Improving response to hoarding

Work Completed

1. Increase Safeguarding team from 2wte to 5.4wte
2. Raising awareness

- Held a Trust wide month on safeguarding and vulnerable people
- Produced posters on safeguarding and improving referrals
- Included a safeguarding poster on all payslips in November
- Placed safeguarding key rings on all service vehicles
- Held safeguarding drop in sessions at control rooms

3. Supervision

- Recruited to a project manager post to introduce safeguarding supervision to Trust
- Trained supervisors
- Piloted supervision sessions

4. Dementia

- Secured funding to produce a set of 4 bespoke films on dementia focussing on pre hospital care and care over the telephone
- Signed up to dementia friends and encouraged staff to become dementia friends

5. Hoarding

- Introduced information sharing with the London Fire Brigade to provide fire safety support for people who consented, to reduce deaths due to fires
- Provided additional safeguarding training to staff on hoarding and introduced use of the clutter index

Outcomes

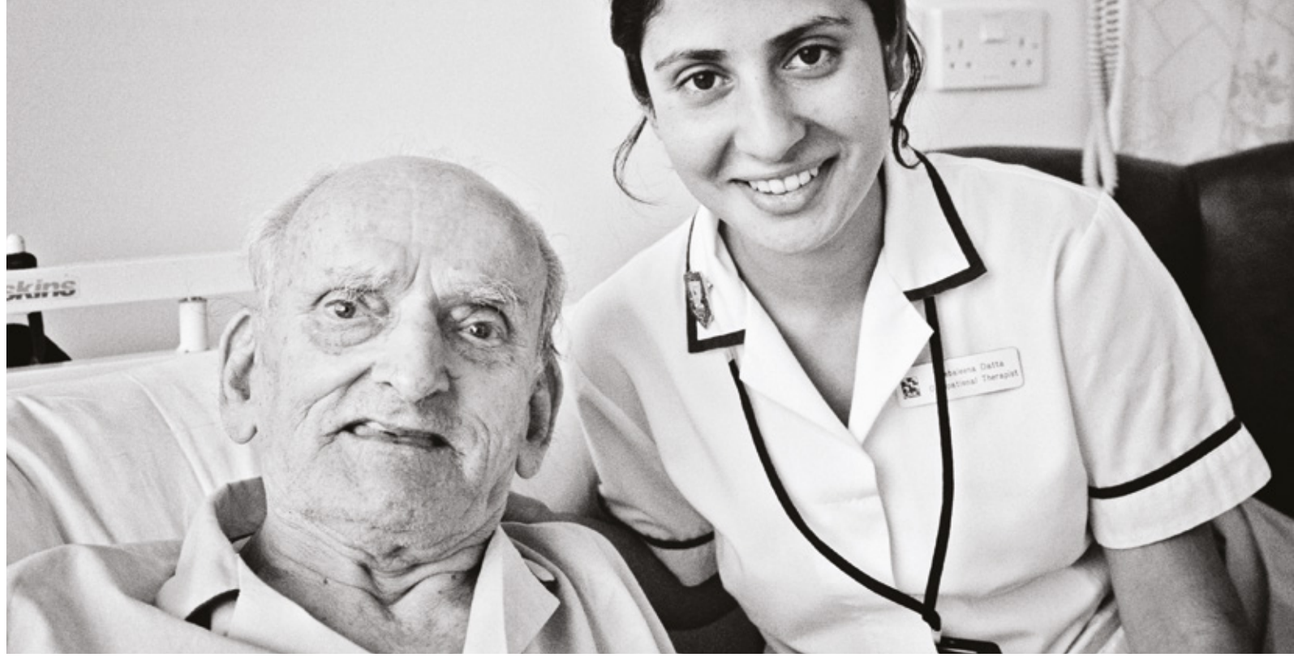
We: Produced a set of 4 short films on dementia. Used an expert in dementia care, carers and people living with dementia as well as ambulance staff.

Film one looked at the language of dementia and what it is.

Film two focussed on issues with communication over the phone in call centres and with providing clinical care to someone with dementia over the phone.

Film three looks at on scene assessment and communication difficulties dealing with challenging situations.

Film four dealt with safeguarding concerns for this vulnerable group of people, both in their own home or in care homes.



Adult Safeguarding Report for Brent, Harrow and Ealing Safeguarding Adult Board Reports

London North West Healthcare NHS Trust (LNWHT) is one of the largest integrated care trusts in the country, bringing together hospital and community services across Brent, Ealing and Harrow.

Established on 1 October 2014, the Trust employs more than 8,000 staff and serves a diverse population of approximately 850,000.

London North West Healthcare NHS Trust is responsible for:

- Central Middlesex Hospital
- Ealing Hospital
- Northwick Park Hospital
- St Mark's Hospital
- Community services across Brent, Ealing and Harrow, including Clayponds, Meadow House, The Denham Unit and Willesden Centre for Care
- Urgent Care Centres

Introduction

LNWHT has a well-established Safeguarding Adult's team; the team leads on all aspects of Adult Safeguarding across the organisation. The team is responsible for training and development, responding to adult safeguarding concerns, liaising with local safeguarding adult and children teams and data collection and analysis. The team attends Safeguarding Adult Boards and works closely with local Safeguarding Adult partners.

2016-2017 brought an increase in safeguarding adult activity at the Trust. Adult safeguarding referrals increased by 25% on the previous year and there was a significant increase in Deprivation of Liberty (DoLS) referrals.

During 2016-17 LNWHT focused on further embedding a safeguarding culture across the 8000 strong workforce, a particular focus has been on PREVENT training which has resulted in the Trust being above the target set by the Home Office PREVENT training trajectory.

Key performance information for the Adult Safeguarding Service at London North West Healthcare NHS Trust is summarised below.

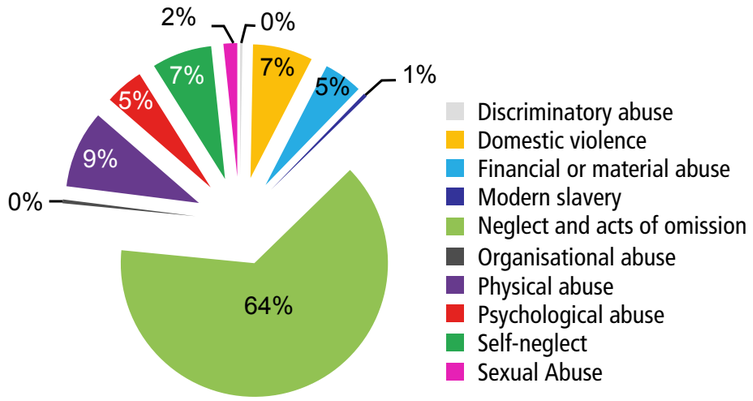
Adult Safeguarding Alerts 2016/2017 (Brent, Ealing and Harrow):

LNWHT Safeguarding Adult concerns, notified by staff, have increased by 25% during 2016/17; the increase demonstrates that a safeguarding culture exists at the Trust and that the focus on training has had a positive impact on staff awareness of their safeguarding responsibilities. The Safeguarding Adults Team monitors and analyses all concerns made at the Trust. The analysis helps the team spot trends in types of abuse and informs future development of staff training packages.

Safeguarding Concerns

	Q 1	Q2	Q3	Q 4	Total
Safeguarding Concerns 2015/2016	**90**	**109**	**128**	**143**	**470**
Safeguarding Concerns 2016/2017	**112**	**164**	**165**	**148**	**589**

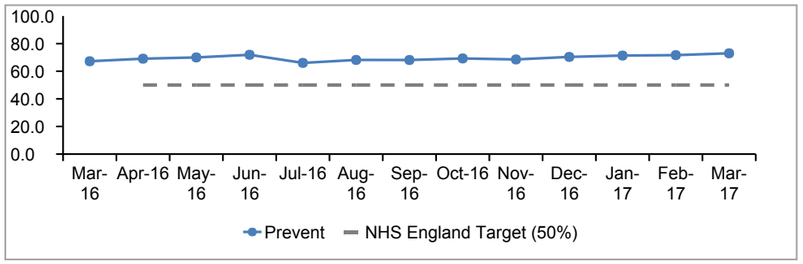
SGA Referral By Types of Abuse 2016-2017



Prevent Training

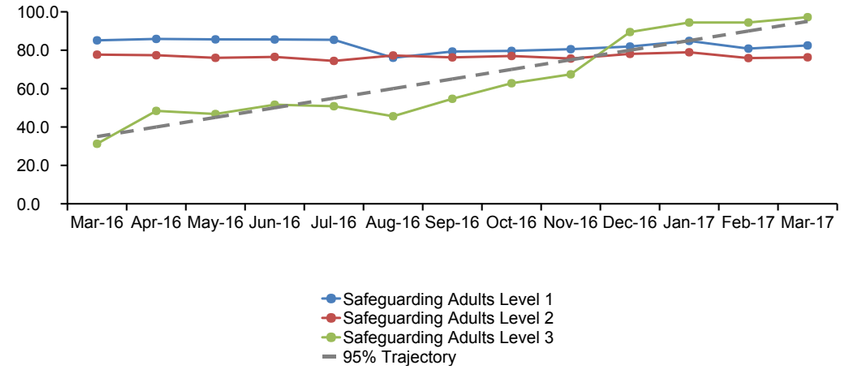
LNWHT is located across the London boroughs of Harrow, Ealing and Brent; these three boroughs are identified as PREVENT priority localities by the Home Office. In 2016/17 The Trust continued to prioritise PREVENT training for the workforce. The number of staff trained with the Workshop to Raise Awareness of Prevent (WRAP) training currently exceeds the target set by NHS England (50%).

The graph below demonstrates Trust performance against the target set by NHS England.



Training and Development

The Trust provides its staff with a number of safeguarding related training courses. A variety of training methods are used to deliver the sessions, including e-learning and face to face teaching sessions. In 2016/17 the Trust delivered training across all three required levels of safeguarding training. The Trust acknowledges that there is further work to do in respect to workforce development and will continue to focus on adult safeguarding training in the year ahead. The graph below illustrates the Trust training performance for level 1, 2 and 3 training in 2016 / 2017.



In addition to its commitment to training and development and the increased safeguarding culture, the Safeguarding Adults Team progressed a number of other work streams in the past year. Firstly domestic abuse awareness has been firmly incorporated into the training provided to Trust staff with two Independent Domestic Violence Advocates (IDVA's) employed in the Emergency Rooms at both Ealing and Northwick Park Hospitals. The IDVAs provide support to patients attending the hospital and act as a crucial resource for front line staff delivering care.

The Trust currently employs a Learning Disability Specialist Nurse. The nurse oversees the delivery of training and education to Trust staff, recently setting up and training a team of Learning Disability (LD) champions within the nursing workforce. The service provided by the LD nurse includes the assessment and support of patients with Learning Disabilities attending the Trust for care.

The adult safeguarding team have been involved in the Trust's commitment to improve care provided to patients with dementia. In the past year the team contributed to the development of a new patient pathway for patients suffering with confusion. Additionally the Trust has signed up to "John's Campaign" which enables relatives and carers of patients, who are suffering with dementia, greater access to the hospital outside of normal visiting hours.

In the past year the Trust reviewed its actions against the Kate Lampard recommendations; in particular focusing on the volunteer workforce. As a result of this review the volunteers have been properly vetted and screened, with a bespoke induction programme provided that includes a focus on Safeguarding.

In the last twelve months the governance of the adult safeguarding process at the hospital has been reviewed and improved upon. A monthly steering group provides professional oversight of the safeguarding process and an escalation report is produced that informs the Trust board of the progress made against the organisation's adult safeguarding responsibilities. A secure database has been introduced to track all safeguarding concerns made within the Trust; this also provides key data that supports the work of the team. All complaints and incidents are now reviewed and those containing safeguarding elements are identified and referred as appropriate.

The Trust has reviewed key safeguarding policies over the last year with new policies being agreed and introduced. An element of this work has resulted in the provision of supervision to staff involved in safeguarding cases. Eighteen key staff members are now trained as safeguarding supervisors with the intention of supporting frontline care staff in their safeguarding work.

The Trust remains committed to delivering its responsibilities detailed within the 2014 Care Act. The year ahead provides a number of new challenges that will be delivered by the team. The Trust will continue to work in partnership with local Safeguarding Adult Boards ensuring attendance and engagement at the quarterly board meetings. The priorities for the year ahead include the provision of new training levels to comply with the intercollegiate training recommendations and working to embed adult safeguarding supervision as good practice across the organisation. The Trust will review its current policies and practice in relation to modern slavery and ensure that there is increased staff awareness around this issue. The safeguarding adult's team will continue to raise the agenda of support for vulnerable adults throughout the organisation and continue to work closely with children's safeguarding to embed the Think Family approach into all that we do.

CASE STUDY – JACK

CONCERN

Jack was receiving treatment in hospital for symptoms of a Bi Polar Disorder when he disclosed that a "taxi driver friend" had taken £10K from him to go on holiday to Paris
A safeguarding concern was raised on his behalf in his best interest. It was hoped that he would be a more active participant as the process progressed and that his wishes could be acknowledged and taken on board as his mental state stabilized.

RESPONSE

During the course of the enquiry it was established Jack had a sister living outside the UK and a cousin living in the north of England who had joint Lasting Power of Attorney (LPA) and so had control of his finances.
It was possible to establish through bank statements, and financial withdrawals that it was highly unlikely acts of financial abuse had occurred.

OUTCOME

Jack's sister agreed that as she lived so far away it made better sense to delegate the LPA authority to Jack's cousin as he was in the UK.
As Jack used the same taxi firm to take him out and about an account was set up and the invoice was sent to the person with LPA authority to arrange payment.
Jack retained use of personal monies and the actions taken balanced restriction with personal freedoms and control.

NATIONAL PROBATION SERVICE

There are **1945** high risk harm offenders in Brent Barnet and Ealing cluster.

Their offences related to violence, sexual offences and extremism, group related offending.

There are **842** offenders in Brent

308 are in the community

80 are on community sentences.

228 are on licence supervision following release from custody.

533 are in custody.

50 to **60%** of offenders present with a range of complex issues which can put them at increased risk from others.

SAFEGUARDING IN NPS

- Brent is part of Barnet, Enfield and Brent National Probation Service cluster
- Brent NPS is managed by 2 senior probation officers who supervise **28** offender managers

PROMOTING SAFEGUARDING APPROACHES

- NPS framework of guidelines is in place to assist safeguarding adults nationally.
- In Brent **90%** of staff have attended the safeguarding adult training.
- A single point probation office contact assists colleagues with specific questions related to safeguarding adults.
- An senior probation officer is leading on the topic and briefs offender managers of any national and local developments.
- A process is in place in court to assist judiciaries in their sentencing decisions.
- Court staff assess safeguarding adult needs and liaise with local offender managers or probation officers in the field. staff assess and review offenders during their sentences to assist the offenders
- Pathway referrals to the specific agencies are followed.
  Offender managers liaise or share information with MASH, MARAC, MAPPA, police and social services to ensure public protection.

WHAT IS CLARE'S LAW?

Clare's Law is a scheme is to give members of the public a formal mechanism to make enquires about an individual who they are in a relationship with or who is in a relationship with someone they know, and there is a concern that the individual may be abusive towards their partner.

If police checks show that the individual has a record of abusive offences, or there is other information to indicate the person you know is at risk, the police will consider sharing this information with the person(s) best placed to protect the potential victim.

Your local police force will discuss your concerns with you and decide whether it is appropriate for you to be given more information to help protect the person who is in the relationship with the individual you are concerned about.

The scheme aims to enable potential victims to make an informed choice on whether to continue the relationship, and provides help and support to assist the potential victim when making that informed choice.

THE METROPOLITAN POLICE

Ongoing Safeguarding Priorities for the Metropolitan Police Service are largely influenced by the Mayor's Police and Crime plan 2017-2021. In relation to purely safeguarding principles, these are:

- Keeping children safe
- Addressing violence against woman and girls
- Working together against hate crime

This therefore dictates the priorities for Policing at the borough level and thus from the perspective of safeguarding within Brent our Priorities were:

- To maintain a fully staffed Community Safety Unit (CSU)
- To deal with hate crime by dedicated Safeguarding unit
- To support the CSU and liaise with Hestia, offering Support for Vulnerable adults and children.

This effectively mirrors the wider safeguarding prioritiess or probation officers in the field. Staff assess and review offenders during their sentences to assist the offenders.

- Pathway referrals to the specific agencies are followed. offender managers liaise or share information with MASH, MARAC, MAPPA, police and social services to ensure public protection

What we did this year

In order to support these priorities a number of actions were taken:

- The CSU has seen a recent increase in numbers of Police officers within the department
- The Safeguarding unit has maintained its support to the CSU, specifically investigating complex vulnerable adult cases
- The Safeguarding unit has now been co located within the Police station alongside Hestia to supplement the support they can provide to one another
- The Unit has introduced a new process to assist our response in relation to overnight hate crimes

We look at the links between alcohol and crime and where there are higher incidences in the borough and we deploy resources accordingly

The Duty team CSU supervisor researches the overnight hate crimes mainly from an outstanding suspect risk.

The safeguarding team analyses them from a safeguarding context looking for reports which require a safeguarding referral to the local authority.

The CSU Inspector reviews overnight crimes utilising the other two perspectives and including a public confidence perspective and forms a strategy on crimes of concern which can be taken to the borough pace setter meetings held throughout the day.

This meeting facilitates additional resources in relation to risk and is often chaired by The Borough Commander.

The appointment of the new Borough Commander also has had a significant effect upon safeguarding within the Borough.

Chief Superintendent Quantrell has a direct liaison with the CSU and safeguarding unit where he is appraised of issues, tasks and achievements on a regular basis and thus all are fully aware of the priorities and what we have done to support these priorities.

HESTIA

By close working with Hestia at Brent we have been able to increase understanding around the role of the Multi Agency Risk Assessment Conference (MARAC).

Joint training in understanding the different roles of the various partners was introduced which was not only useful in increasing each partner's knowledge of the different roles, it was seen as a positive learning experience and marked a change from a focus from reprimand to solution focus response.

The implementation of the DVPO (Domestic Violence Protection Notice) has had a positive impact in the borough.

Direct action was taken to support the VAWG strategy (Violence against Women and Girls) priority when **follow up contact on cases were completed.**

Clare's Law	Referrals	Outcomes
BETWEEN MARCH 2013 AND MARCH 2015	IN BRENT OF 25 REFERRALS THAT WERE CONSIDERED	15 (60%) DISCLOSURES WERE MADE = THE HIGHEST PERCENTAGE ACROSS MPS LONDON BOROUGHS

The Application of Clare's law has had a positive impact and is part of a wider strategy to empower victims and those at risk of domestic violence.

The Support around the MARAC has led to an increase in referrals in 2016-17

Our priorities for 2016-2018

The Mayor's Police and Crime Plan 2017-2021 has set out new priorities for the MET. For example: Restoring neighbourhood policing, and a move away from what some sources see as the rigidity of MOPAC 7 to allow Police to concentrate on the most serious crimes against Vulnerable people

High harm crime such as Domestic Abuse continues as a priority and this also includes Human Slavery, Female Genital Mutilation (FGM), and Disability hate crime, Elder Abuse and Vulnerable adults particularly in the care scenario. This focus is in tune with the SAB priorities and a move away from the previous MOPAC 7

Future Actions/Goals 2017 -2018

A Monday safeguarding integrated risk management conference call meeting is being set up to involve Multi Agency Safeguarding Hub, Gangs, Safeguarding team and International Organisation for Migration to discuss early risk strategies on a weekly basis.

There is a Safeguarding unit initiative to identify high risk repeat victims of Domestic Abuse, to implement Non- Molestation orders to protect the individual and to provide the legal enforcement as necessary.

There is a current emphasis within the MPS towards adopting a greater degree of risk management style Policing.

This approach is consistent with current practice within Brent and The SAB

Greater information sharing with support between partners, promotes an approach consistent with Brent's Stronger Community Strategy. (LINK)

From a Policing perspective Brent is experiencing a high level of partnership cooperation in the initiative to deal with high harm crime.

Although there has been a shift in emphasis within policing as a whole, in Brent there is a recognition that neighbourhood Policing will still thrive as identified by MPS Policing plans.

Traditional crime will still be dealt with robustly, Albeit with a shift in emphasis on to higher harm crime.

This approach, similar to SAB plans will be met with full support from this agency.

Brent Community MARAC

MULTI AGENCY RISK ASSESSMENT CONFERENCE
SHIRLEY HOLMES is the CMARAC Coordinator in Brent

The CMARAC is a multi-agency problem-solving meeting that promotes joint ownership and early resolution into how complex and high-risk cases affecting vulnerable people within the community are investigated and effectively managed. The CMARAC coordinator addresses the safety and protection of victims to review and co-ordinate a case management plan around the case. The aims are ultimately to reduce repeat victimisation and improve agency accountability, while also addressing service gaps and providing additional support for agencies who manage high risk cases.

The benefit of having an officer dedicated to the panel has allowed for a high number of priority cases to be referred and managed and tracked effectively. Brent for the last few years has been overspending on the Adult and Social Care budget and nationally vulnerable individuals are either over represented in the criminal justice system or are disproportionately victimised. A more holistic approach to prioritising and tackling these long term cases has been established at the CMARAC.

An annual review for 2015/ 2016 showed that 56 cases have been referred to the CMARAC, with the total risk reduction of the cohort at 46% which exceeded the annual target of 20%. The cohort ranged from mental health issues, substance misuse, gang exploitation and repeat victimisation.
This model was recently shared with other London Boroughs in December 2015, where a pan-London CMARAC approach is currently being explored.

New policing guidance released in 2017 will focus on exploitation, vulnerability and victims and the Brent CMARAC will be cited as a best practice example. As well as being highlighted in the London Together document for transforming services.

The aim of the panel is to develop the model to take on a wider role, addressing those affected by hate crime, ensuring there is an effective risk/case management plan that provides professional support. As well as applying to community cohesion issues to reduce escalation of victimisation in the community.

London Fire Brigade

Borough Commander Mark Davidson

- Aligning our Safeguarding Adults Policy with the Care Act 2014
- Developing and rolling out safeguarding training for all staff
- Delivering an information sharing pilot with the London Ambulance Service (specifically to address fire risk and hoarding behaviour)
- Undertaking an independent audit by Mayor's Office for Policing And Crime (MOPAC)to review our safeguarding children practices
- Committing £1 million to protecting vulnerable individuals via our Community Safety Investment fund

What we did

Aligning our Safeguarding Adults Policy with the Care Act 2014

The Brigade reviewed the internal Safeguarding Adults policy and updated this in line with the London multi-agency adult safeguarding policy and procedures, to incorporate the particulars of the Care Act 2014. This was published in early 2017/18 and made available to all staff via the internal intranet. The related Hoarding policy has also been reviewed and will be revised to signpost the issue (hoarding) as requiring a 'self-neglect' referral to Social Services Departments.

Developing and rolling out safeguarding training for all staff

We developed a training package for all personnel. This package is being delivered in stages and roll-out to station-based staff started in Q3 2016/17. The Senior Officer and universal E-Learning modules are being piloted in early 2017/18. Making safeguarding personal features as part of this package, which also provides staff with a clear working understanding of the Mental Capacity Act. The package complies with both the Care Act and London multi-agency policy and procedures, and will ensure all Brigade personnel receive initial and regular refresher safeguarding training.

Delivering an information sharing pilot with the London Ambulance Service (specifically to address fire risk and hoarding behaviour)

As a result of a recommendation from a Safeguarding Adult Review the Brigade delivered a pilot with the London Ambulance Service to provide Home Fire Safety Visits to high risk hoarders (as identified by the London Ambulance Service). An Information Sharing Agreement was signed by both the agencies before the pilot commenced.

Undertaking an independent audit by MOPAC into our safeguarding children practices

The Brigade undertook the first of a two-part auditing process by the Mayor's Office for Policing And Crime reviewing internal safeguarding practices to establish best practice and identify any gaps. MOPAC published their findings in November 2016.

Committing £1 million to protecting vulnerable individuals via our Community Safety Investment fund

In 2016/17, we made £1 million available via the Community Safety Investment Fund to directly support vulnerable adults (identified locally through partnerships) to reduce their risk of fire.

Outcomes

1. Aligning our Safeguarding Adults Policy with the Care Act 2014

The policy was published in early 2017/18. We will be monitoring subsequent safeguarding concerns to help assess the impact of the policy on the quality and quantity of referrals.

2. Developing and rolling out safeguarding training for all staff

According to our schedule all staff should have received safeguarding training by the end of the financial year. We will be monitoring safeguarding subsequent concerns to help assess the impact of the training on the quality and quantity of referrals. We will also be asking participants to take part in evaluation of the training in order to confirm its on-going effectiveness.

3. Delivering an information sharing pilot with the London Ambulance Service (specifically to address fire risk and hoarding behaviour)

We have undertaken an information sharing pilot with the London Ambulance Service whereby we are informed about any individuals that they encounter who are living in hoarded properties. This information has enabled us to assess risk and undertake preventative measures with those vulnerable patients who consent to assistance. This is helping to prevent risk to both the patients and others who may be affected by their circumstances.

Since May 2016, this has resulted in over 250 Home Fire Safety Visits (HFSVs) being carried out to some of the most vulnerable residents in London. Where appropriate, we have also referred these individuals on to Social Services and other relevant agencies. The pilot has been reviewed by both parties and this partnership arrangement will now become part of normal business.

4. Undertaking an independent audit by MOPAC into our safeguarding children practices

The Brigade undertook the first of a two-part auditing process by MOPAC reviewing internal safeguarding practices to establish best practice and identify any gaps. The first stage focused on child safeguarding; the outcomes from this were favourable and resulted in a small number of recommendations which are currently being embedded into working practices. The second stage will focus on adult safeguarding and will take place 2017/18.

5. Committing £1 million to protecting vulnerable individuals via our Community Safety Investment fund

Due to high demand we increased the fund available and committed over £2 million to initiatives designed to reduce the fire risk of vulnerable individuals. Examples of measures subsidised to reduce fire risk included the retrofitting of sprinklers, provision of fire retardant bedding, the fitting of arson-proof letter boxes and the issuing of personal protection systems (such as single room water misters).

6. Update the Hoarding Policy to bring this in line with our new Safeguarding Adults policy.

7. The Senior Officer and E-Learning elements of our Safeguarding Training programme will be piloted before going live in Q2-Q3.

8. The second part of the MOPAC review – Safeguarding Adults – will be carried out in Q2-3 and any resulting recommendations to practice and policy will be embedded.

9. The information sharing pilot with the LAS will be embedded into core business.

10. A new online reporting and recording system (the 'Person at Risk' form) has been in development during 2016/17. This will be fully tested during Q1-Q2 2017/18 and is anticipated to be going live in Q2-Q3. This system will improve the efficiency of our internal safeguarding referring process, allow for greater data retention and enable easier monitoring of our safeguarding referrals at both local and organisational levels.

11. The London Fire Brigade voluntarily contributed £1,000 towards Local Safeguarding Boards (Children and Adults) across the capital to a total of £26,000. During 2017/18 we will again offer to fund £1,000 towards safeguarding in each London local authority.

Healthwatch Brent

AUTHOR/BOARD MEMBER: Ian Niven

Healthwatch is unique in that our sole purpose is to understand the needs, experiences and concerns of people who use health and social care services and to speak out on their behalf.

Priorities in 2016-17:

- In 201617 we worked with Adult Safeguarding Partners, to consider ways to capture the user experience of Adult Safeguarding
- Healthwatch was an active member of the Community Engagement and Awareness Sub Group
- Ensured all Healthwatch Brent staff and volunteers received Adult Safeguarding training and briefings
- We advocated to increase the voice of service users, carers and their representatives in the work of BSAB
- In 2017-18 we will continue to be a part of engaging with community groups to raise awareness of safeguarding as a member of the Engagement sub-group
- In Making safeguarding personal - HWB will be working with partners to ensure the experience of the safeguarding process is routinely collected from service users and informs safeguarding practice responses
- To increase the voice of service users, carers and their representatives in the work of BSAB
- Healthwatch Brent will visit 6 care homes using its powers of Enter and View. We gather safeguarding experiences and explore safeguarding awareness of residents and staff
- We will continue to work actively with the Board and the Engagement Sub-group to deliver the key priorities of the BSAB Plan 2017-19

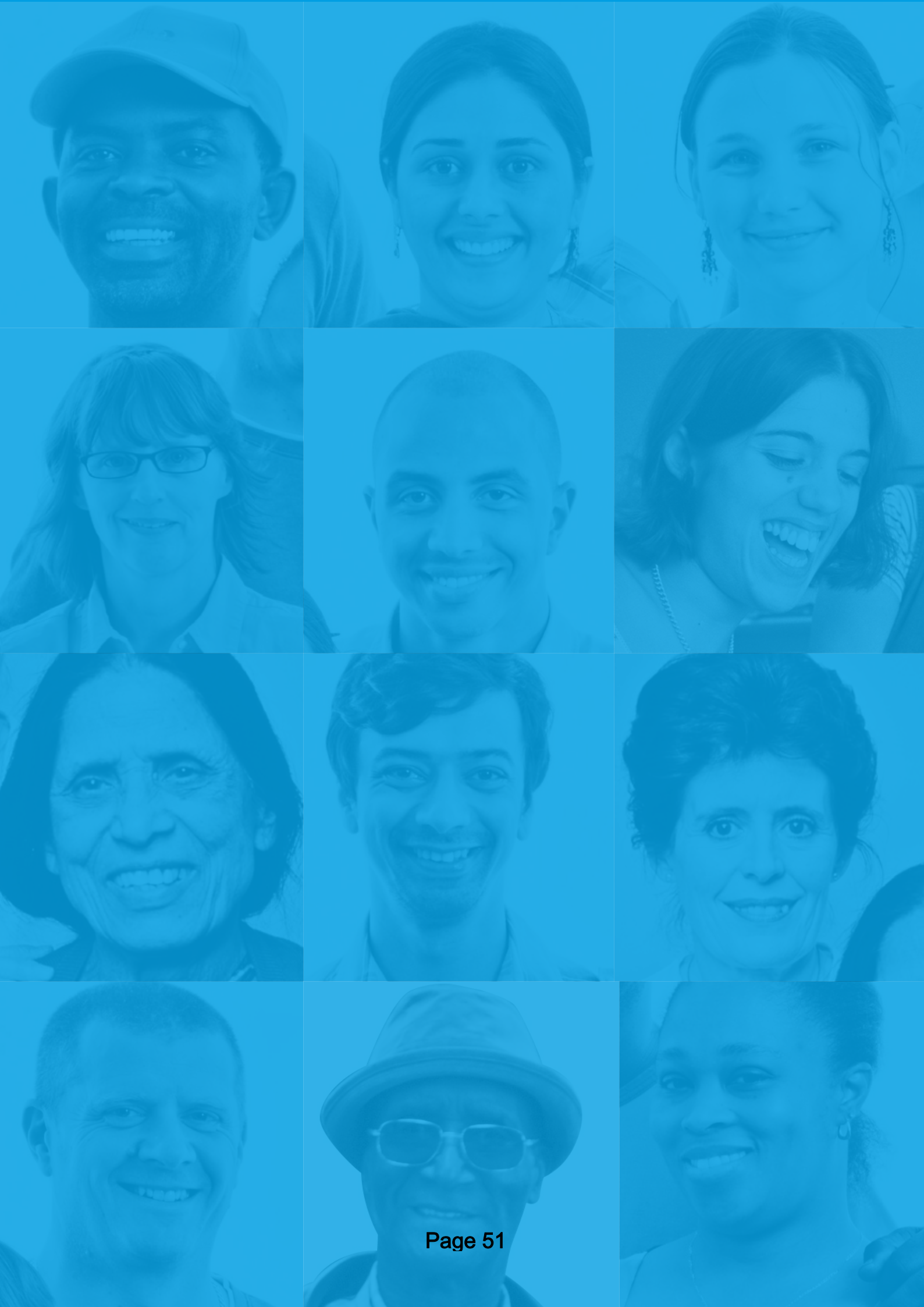
WHAT IS ENTER AND VIEW?

Enter and View visits may take place in a wide range of publicly funded health and social care services – including hospitals, care homes, nursing homes, residential units and day centres. The visits are carried out by trained Healthwatch volunteers. The volunteers will speak to service users, staff, relatives and carers, and will observe how the service is delivered, and the general environment in which it takes place. They can be planned visits or unannounced. At the end of the visit a short report is written by the team which ultimately becomes a public document.

The visits are carried out by a small team of trained volunteers who have also been DBS checked.

In Brent we have undertaken visits to care and nursing homes for older people, care homes for people with mental health conditions, hospital wards, sheltered housing units and walk-in centres.

Authorised Representatives are accountable to Healthwatch and at all times will work within the policies and procedures of Community Barnet and Healthwatch Brent.



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Brent	**Community and Wellbeing Scrutiny Committee** 19 September 2017 **Report from Brent Clinical Commissioning Group**
For information	Wards affected: ALL

Identification of Female Genital Mutilation (FGM) in Brent

1.0 Summary

1.1 Female Genital Mutilation (FGM) is illegal in the UK. This report outlines Brent Clinical Commissioning Group's (CCG) work identifying cases of FGM in Brent and seeks the support of the Committee for the work locally to address this.

2.0 Recommendation(s)

2.1 Ensure there is an effective pathway for the transfer of relevant information from maternity services to health visiting services and GP's.
This will be undertaken by commissioners of services.

2.2 Engage further with the local community to raise awareness of the impact of FGM.

2.3 Continue with training provision in order support agencies with identifying and responding to FGM, including improvements with data collection.
This will be undertaken by the Brent Safeguarding Children Board.

2.4 Monitor service user feedback to service delivery and design and respond accordingly.
This will be undertaken by relevant commissioners

2.5 Brent Safeguarding Children Board to seek assurance from across the partnership that relevant agencies have offered the required level of training and awareness on FGM as per training guidance and key performance indicators.

3.0 Detail

3.1 It is estimated that more than 200 million girls and women alive today (worldwide) have undergone female genital mutilation. Furthermore, there are an estimated 3 million girls at risk of undergoing female genital mutilation every year. The majority of girls are cut before they turn 15 years old.

3.2 Female genital mutilation has been documented in 30 countries, mainly in Africa, as well as in the Middle East and Asia. Some forms of female genital mutilation have also been reported in other countries, including among certain ethnic groups in South America. Moreover, growing migration has increased the number of girls and women who have undergone female genital mutilation - or who may be at risk of being subjected to the practice - in Europe, Australia and North America.

3.2 FGM usually happens to girls whose mothers, grandmothers or extended female family members have had FGM themselves or if their father comes from a community where it's carried out. FGM is a manifestation of gender inequality that persists for many reasons for example, in some societies it is considered a rite of passage, in others it is a prerequisite for marriage and in others it may be attributed to religious belief.

3.3 Because FGM may be considered an important part of a culture or identity, it can be difficult for families to decide against it. People who reject the practice may face condemnation or ostracism and as a result, even parents who do not want their daughters to undergo FGM may feel compelled to participate in the practice.

3.4 Girls are sometimes taken abroad for FGM, but they may not be aware that this is the reason for their travel. Girls are more at risk of FGM being carried out during the summer holidays, as this allows more time for them to "heal" before they return to school.

3.5 There are no health benefits to FGM and it can cause serious harm to physical and mental health. Cutting the nerve ends and sensitive genital tissue causes extreme pain. Proper anaesthesia is rarely used and, when used, is not always effective. The healing period is also painful. Ongoing issues can include:

- constant pain
- pain and/or difficulty having sex
- repeated infections, which can lead to infertility
- bleeding, cysts and abscesses
- problems passing urine or incontinence
- depression, flashbacks and self-harm

- problems during labour and childbirth, which can be life-threatening for mother and baby
- death from blood loss or infection as a direct result of the procedure

3.6 FGM can be an extremely traumatic experience that can cause emotional difficulties and negatively impact mental health throughout life. Some studies have shown an increased likelihood of post-traumatic stress disorder (PTSD). Women may also suffer with depression, anxiety, flashbacks to the time of the cutting, nightmares and other sleep problems. The pain, shock and the use of physical force by those performing the procedure are mentioned as reasons why many women describe FGM as a traumatic event. In some cases, women may not remember having the FGM at all, especially if it was performed when they were an infant.

3.7 Women and girls who are at risk of, or are suffering as a result of FGM can speak to their GP and other healthcare professionals. They can refer to a special therapist who can help. In some cases, a surgical procedure called a deinfibulation may also be recommended, which can alleviate and improve symptoms for those suffering with ongoing pain for example during sex. Women expecting a baby should also ensure their midwife is aware so they can arrange appropriate care for mother and baby.

3.8 Girls who were born in the UK or are resident here, but whose families originate from an FGM practising community are at greater risk. Communities at particular risk of FGM in the UK originate from:

- Egypt
- Eritrea
- Ethiopia
- Gambia
- Guinea
- Indonesia
- Ivory Coast
- Kenya
- Liberia
- Malaysia
- Mali
- Nigeria

- Sierra Leone
- Somalia

3.9 The percentage at which the identified population in Brent are recorded as having undergone FGM before the age of 18 years is 67%, with the remaining number recorded as not stated or not recorded. FGM is a particular concern for Brent compared to other boroughs nationally. A significant proportion of the population of Brent originate from countries where FGM is prevalent. The young population of Brent means that many of these women are identified through maternity services, and GP practices for ante natal care.

3.10 The Department of Health's FGM prevention programme requires NHS staff to record FGM in a patient's healthcare record only if and when it is identified during the delivery of any NHS healthcare. Professionals are reminded to be aware of the risk factors, including country of origin (see multi-agency guidelines for list of countries), and to use their professional judgement to decide when to ask the patient if they have had FGM. Local health provider policies on FGM detail this in training as well as in their policies.

3.11 In March 2014 the Tackling Violence against Women and Girls in Brent: an Overview and Scrutiny Task Report was released. The recommendations have all been progressed including:

- *Developing services to protect women and girls at risk, to include developing services to support women and girls subjected to harmful practices:* London North West Healthcare Trust is a large provider of health services for the local population. Their services for FGM are detailed in appendix 6, as is the services offered by Imperial College Healthcare. Forward UK also provide services in Brent, detailed in appendix 6.

- *Robust recording and better quality of data and sharing of data from all partners:* Data recording has improved, as evidenced by the enhanced dataset. However, there is still work to be undertaken in relation to data completeness, and understanding why the figures relating to not reported or unknown feature as highly as they do. The national data collection is helping to establish the scale of FGM and although there is work to be undertaken in relation to improving the completion of data fields, this knowledge helps to inform further training.

- *Clear and consistent guidance for reporting risk, pathways for referrals and services*: training currently delivered includes details of how undertake conversations re FGM, how to report, when to report, and when to make referrals. Additionally, information on how to undertake/complete risk assessments is covered, so that appropriate referrals are submitted to the Local Authority.

- *Provide clear guidance to all key staff and the public on how to report a crime against women affected by these issues*: the national guidance is

distributed at training events, and contact details are given. Current legislation is also referred to and details about how to access up to date information is given.

- *Single point of contact is established for those affected*: for those affected by FGM there is a range of services available. Choice is important in order to facilitate access. However, specialist practitioner's details are available, see appendix 7.

- *The adoption of good practice from elsewhere, health service, local authorities, voluntary sector organisations and educational institutions*:
    - One of the largest health providers (London North West Healthcare Trust) has invested in FGM services. Regular training events are held, and FGM is discussed at all level 3 safeguarding children training events. The current compliance rate with level 3 training at LNWHT is 79%.
    - In addition there is bespoke FGM training available to practitioners more closely involved with service users who have undergone FGM e.g. midwives, emergency department staff, urology staff, and those working in obstetrics and gynaecology.
    - Brent Safeguarding Children Board also delivers FGM training to multi agency audiences and to date 47 professionals have attended this training. It can also be delivered to smaller cohorts during dedicated team meetings. This has been taken up by both police and health. There are a further four FGM training session available between September 2017-March 2017.
    - The national guidance is distributed at training events, and contact details are given. Current legislation is also referred to and details about how to access up to date information is given.
    - Central London Community Health currently provides the health visiting and school nursing service to the population of Brent. Their compliance with level 3 training is currently 81% with a further whole day's training dedicated to level 3 scheduled for 5th September 2017. This will include FGM, as does all their level 3 training.

3.12 The multi-agency partnership has worked together through the Local Safeguarding Children Board to deliver relevant training, as well as individual agencies delivering in house training to try to meet demand. The Violence against Women and Girls Group has oversight of the FGM activity undertaken by the multi-agency partnership.

3.13 Following identification of FGM by health professionals, safeguarding referrals are submitted through the Brent Family Front Door. A robust safeguarding process is then followed in accordance with the latest pan London safeguarding procedures. Any themes arising from the Brent Family Front Door work are elicited via monthly audits. Each case is considered and responded to on individual basis with appropriately coordinated multi-agency input.

4.0 Financial Implications

4.1 None stated

5.0 Legal Implications

5.1 FGM is illegal in the UK. It has been a criminal offence since 1985. In 2003 it also became a criminal offence for UK nationals or permanent UK residents to take their child abroad to have female genital mutilation. The Serious Crime Act 2015 amended the Female Genital Mutilation Act to include FGM protection orders (FGMPOs).

5.2 It is an offence to:

- perform FGM (including taking a child abroad for FGM)
- help a girl perform FGM on herself in or outside the UK
- help anyone perform FGM in the UK
- help anyone perform FGM outside the UK on a UK national or resident
- fail to protect a girl for whom you are responsible from FGM

Anyone who performs FGM can face up to 14 years in prison. Anyone found guilty of failing to protect a girl from FGM can face up to seven years in prison.

5.3 Section 73 of the Serious Crime Act 2015 provides for an FGM protection order to be applied for. It is a civil measure which can be applied for through a family court. The FGM protection order offers the means of protecting actual or potential victims from FGM under the civil law. Breach of an FGM protection order is a criminal offence carrying a sentence of up to 5 years in prison. As an alternative to criminal prosecution, a breach could be dealt with in the family court as a contempt of court, carrying a maximum of 2 years' imprisonment. Applications for an order can be made by:

- the person who is to be protected by the order
- a relevant third party (such as the local authority)
- any other person with the permission of the court (for example, teachers, health care professionals, police, family member).

5.4 FGM protection orders are unique to each case and contain legally binding conditions, prohibitions and restrictions to protect the person at risk of FGM. These may include:

- confiscating passports or travel documents of the girl at risk and/or family members or other named individuals to prevent girls from being taken abroad

- ordering that family members or other named individuals should not aid another person in any way to commit or attempt to commit an FGM offence, such as prohibiting bringing a “cutter” to the UK for the purpose of committing FGM.

The court can make an order in an emergency so that protection is in place straightaway. FGM protection orders came into force on 17 July 2015 and apply to England, Northern Ireland and Wales.

5.5 Section 74 of the Serious Crime Act 2015 amended the Female Genital Mutilation Act 2003 to introduce the legal duty for regulated health and social care professionals and teachers to make a report to the police if:

- they are informed by a girl under the age of 18 that she has undergone an act of FGM
- they observe physical signs that an act of FGM may have been carried out on a girl under the age of 18.

It is recommended that the report is made by phone by calling 101, the single non-emergency number. When 101 are called, the system will determine the location of the caller and connect to the police force covering that area. If the call relates to a report outside the force area where the call took place, the caller can ask to be directed to the correct force.

5.6 Brent data from April 2016 – March 2017 shows newly recorded cases from the following referring organisations:

- General practice = 105 cases (45%)
- NHS organisations = 55 cases (24%)
- Not recorded = 40 cases (17%)
- Self-referral = 10 cases (4%)
- Other = 10 cases (4%)
- Not stated = 10 cases (2%)

It is worth noting caution needs to be taken when making comparisons with historic data. It became mandatory for all acute trusts to collect and submit to the FGM Enhanced Dataset from 1 July 2015 and for all mental health trusts and GP practices from 1 October 2015. Therefore only partial information is available from July 2015.

6.0 Equality Implications

6.1 The underlying trends of FGM identification demonstrate that most FGM is seen in the 30-34 year age group, closely followed by the 25-29 age groups.

6.2 The age at which the FGM was undertaken is recorded as 5-9 years of age, with a slightly smaller number recorded as unknown. This may be due to the service user not recalling their age at the time of the procedure.

6.3 Most FGM is self-reported as opposed to following examination or assessment. Self-reporting demonstrates the improved awareness of FGM in particular with the health impacts.

6.4 Country of birth and origin for the service users is most commonly recorded as Eastern Africa, as per the Brent population, with 115 and 100 recorded respectively. Most data shows the country where the FGM is either not known or not stated. This is an area for staff/practitioners to improve upon with submitting complete data, as far as possible, in order to facilitate further analysis of the information.

7.0 Analysis

In order to continue to raise awareness of the mandatory reporting of FGM and the safeguarding implications, ongoing engagement with the local community is essential:

"*The strengthening of UK legislation was seen as necessary by those who want to end FGM and a useful tool to support ending the practice. However, greater community involvement has been crucial to ensure that increased government intervention is not seen as punitive, particularly around the implementation of 'mandatory reporting'*." https://www.trustforlondon.org.uk/wp-content/uploads/2016/07/The-Tackling-FGM-Initiative-Overview.pdf

The Brent multi agency partnership has been working under the Brent Safeguarding Children Board to deliver the activity in relation to preventing and managing cases of FGM. This work continues, with the additional oversight of the Violence against Women and Girls Group. The effectiveness of this work is demonstrated through the training compliance and development of FGM services locally.

The Department for Health's prevention programme has led to a number of referrals to social care, however, there has not been any applications for FGM protection orders, unlike in other areas of the Country. In December 2015 it was reported that 18 had been granted, out of 28 applications in England. This may indicate that there is an increased recognition that FGM is illegal and harmful. However, children are not examined unless there is a clear and justifiable reason to do so, therefore there may be more unidentified cases than known. There have been no prosecutions nationwide for FGM related activity.

Background Papers

NHS Digital FGM Enhanced Dataset April 2016-March 2017

Tackling Violence against Women and Girls in Brent: an overview and scrutiny task group report March 2014

HM Government Multi-agency statutory guidance on female genital mutilation 2016

NHS England Female Genital Mutilation Prevention Programme: Requirements for NHS staff 2014

NHS Brent Clinical Commissioning Group Annual Report 2016-2017

Contact Officers

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Wembley Centre for Health & Care, Chaplin Rd
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Tel: 0208 900 5383

GILLY ATTREE
Designated Nurse Safeguarding Children
NHS Brent Clinical Commissioning Group

Appendix 1

The World Health Organisation classifies FGM in to four categories

Type 1. (clitoridectomy) – removing part or all of the clitoris.

Type 2 (excision) – removing part or all of the clitoris and the inner labia (lips that surround the vagina), with or without removal of the labia majora (larger outer lips).

Type 3 (infibulation) – narrowing of the vaginal opening by creating a seal, formed by cutting and repositioning the labia.

Type 4 Other harmful procedures to the female genitals, including pricking, piercing, and cutting, scraping or burning the area.

Prevalence of FGM

It is estimated that more than 200 million girls and women alive today have undergone female genital mutilation in the countries where the practice is concentrated. Furthermore, there are an estimated 3 million girls at risk of undergoing female genital mutilation every year. The majority of girls are cut before they turn 15 years old (see Figure 1).

Why is FGM carried out?

FGM is carried out for various cultural, religious and social reasons within families and communities in the mistaken belief that it will benefit the girl in some way (for example, as a preparation for marriage or to preserve her virginity).

However, there are no acceptable reasons that justify FGM. It's a harmful practice that isn't required by any religion and there are no religious texts that say it should be done. There are no health benefits of FGM.

FGM usually happens to girls whose mothers, grandmothers or extended female family members have had FGM themselves or if their father comes from a community where it's carried out.

Health Consequences

There are no health benefits to FGM and it can cause serious harm, including:

- constant pain
- pain and/or difficulty having sex
- repeated infections, which can lead to infertility
- bleeding, cysts and abscesses
- problems passing urine or incontinence

- depression, flashbacks and self-harm
- problems during labour and childbirth, which can be life-threatening for mother and baby

Some girls die from blood loss or infection as a direct result of the procedure.

FGM and sex

FGM can make it difficult and painful to have sex. It can also result in reduced sexual desire and a lack of pleasurable sensation.

Talk to your GP or another healthcare professional if you have sexual problems that you feel may be due to FGM, as they can refer you to a special therapist who can help.

In some cases, a surgical procedure called a deinfibulation (see below) may be recommended, which can alleviate and improve some symptoms.

FGM and pregnancy

Some women with FGM may find it difficult to become pregnant, and those who do conceive can have problems in childbirth.

If you're expecting a baby, your midwife should ask you at your antenatal appointment if you've had FGM. It's important to tell your midwife if you think this has happened to you, so they can arrange appropriate care for you and you baby.

FGM and mental health

FGM can be an extremely traumatic experience that can cause emotional difficulties throughout life, including;

- depression
- anxiety
- flashbacks to the time of the cutting
- nightmares and other sleep problems

In some cases, women may not remember having the FGM at all, especially if it was performed when they were an infant.

Appendix 2

Where FGM is practised

Girls are sometimes taken abroad for FGM, but they may not be aware that this is the reason for their travel. Girls are more at risk of FGM being carried out during the summer holidays, as this allows more time for them to "heal" before they return to school.

If you think there's a risk of this happening to you, you can download the Statement Opposing FGM and take it with you on holiday to show your family.

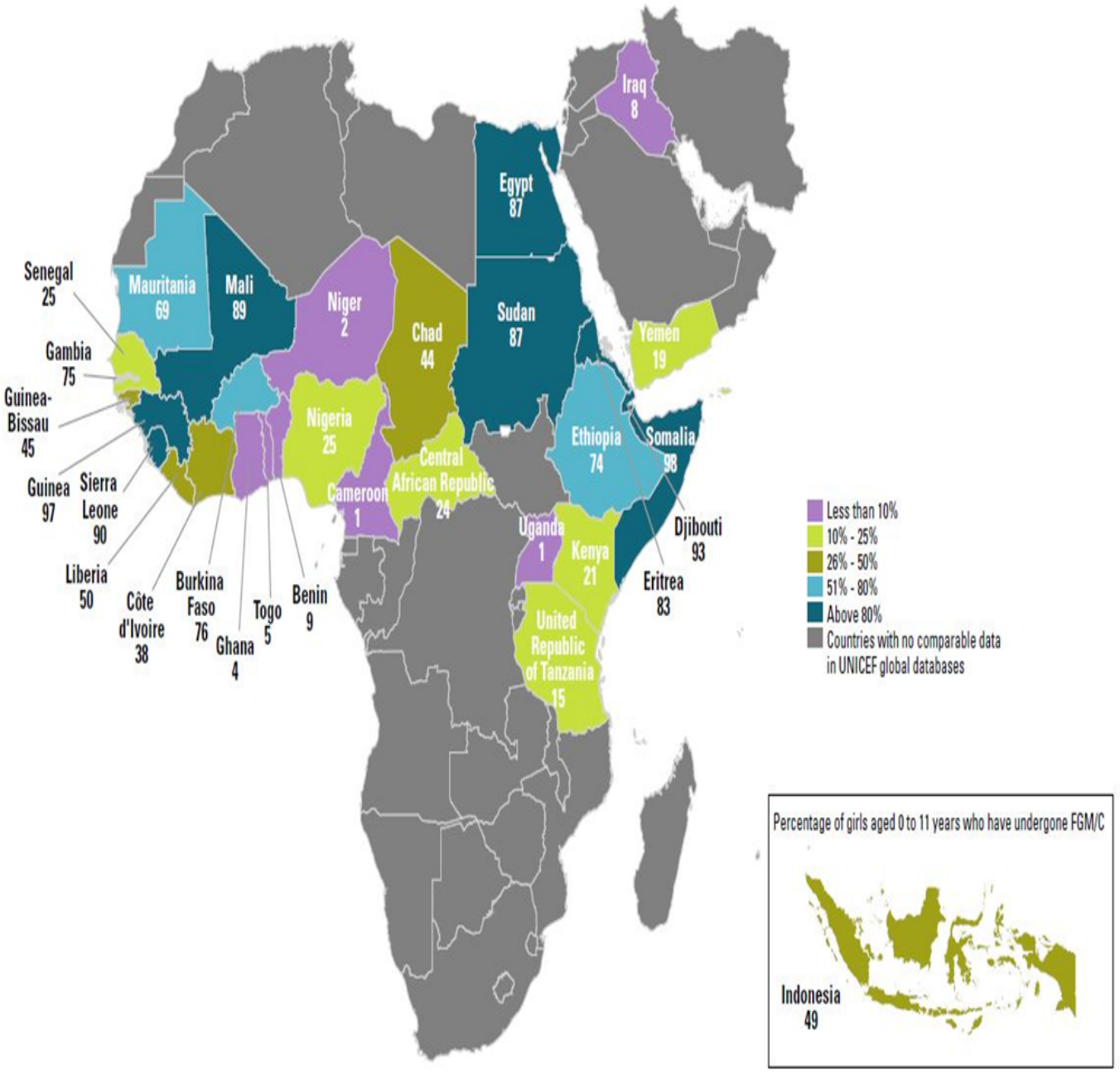
Communities that perform FGM are found in many parts of Africa, the Middle East and Asia. Girls who were born in the UK or are resident here but whose families originate from an FGM practising community are at greater risk of FGM happening to them.

Communities at particular risk of FGM in the UK originate from:

- Egypt
- Eritrea
- Ethiopia
- Gambia
- Guinea
- Indonesia
- Ivory Coast
- Kenya
- Liberia
- Malaysia
- Mali
- Nigeria
- Sierra Leone
- Somalia

Map indicating international prevalence of FGM

Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change -July 2016 www.unicef.org/esaro/FGCM_Lo_res.pdf



Appendix 3

Health consequences of FGM for women and girls

The effects of FGM depend on a number of factors, including the type performed, the expertise of the practitioner, the hygiene conditions under which it is performed, the amount of resistance and the general health condition of the girl/woman undergoing the procedure. Complications may occur in all types of FGM, but are most frequent with infibulation.

The short-term health risks of FGM include:

Severe pain: cutting the nerve ends and sensitive genital tissue causes extreme pain. Proper anaesthesia is rarely used and, when used, is not always effective. The healing period is also painful. Type III FGM is a more extensive procedure of longer duration, hence the intensity and duration of pain may be more severe. The healing period is also prolonged and intensified accordingly.

Excessive bleeding: (haemorrhage) can result if the clitoral artery or other blood vessel is cut during the procedure.

Shock: can be caused by pain, infection and/or haemorrhage.

Genital tissue swelling: due to inflammatory response or local infection.

Infections: may spread after the use of contaminated instruments (e.g. use of same instruments in multiple genital mutilation operations), and during the healing period.

Human immunodeficiency virus (HIV): the direct association between FGM and HIV remains unconfirmed, although the cutting of genital tissues with the same surgical instrument without sterilization could increase the risk for transmission of HIV between girls who undergo female genital mutilation together.

Urination problems: these may include urinary retention and pain passing urine. This may be due to tissue swelling, pain or injury to the urethra.

Impaired wound healing: can lead to pain, infections and abnormal scarring

Death: can be caused by infections, including tetanus and haemorrhage that can lead to shock.

Psychological consequences include:

The pain, shock and the use of physical force by those performing the procedure are mentioned as reasons why many women describe FGM as a traumatic event.

Long-term health risks from Types I, II and III (occurring at any time during life)

Pain: due to tissue damage and scarring that may result in trapped or unprotected nerve endings.

Infections:

Chronic genital infections: with consequent chronic pain, and vaginal discharge and itching. Cysts, abscesses and genital ulcers may also appear.

Chronic reproductive tract infections: May cause chronic back and pelvic pain.

Urinary tract infections: If not treated, such infections can ascend to the kidneys, potentially resulting in renal failure, septicaemia and death. An increased risk for repeated urinary tract infections is well documented in both girls and adult women.

Painful urination: due to obstruction of the urethra and recurrent urinary tract infections.

Menstrual problems: result from the obstruction of the vaginal opening. This may lead to painful menstruation (dysmenorrhea), irregular menses and difficulty in passing menstrual blood, particularly among women with Type III FGM.

Keloids: there have been reports of excessive scar tissue formation at the site of the cutting.

Human immunodeficiency virus (HIV): given that the transmission of HIV is facilitated through trauma of the vaginal epithelium which allows the direct introduction of the virus, it is reasonable to presume that the risk of HIV transmission may be increased due to increased risk for bleeding during intercourse, as a result of FGM.

Female sexual health: removal of, or damage to highly sensitive genital tissue, especially the clitoris, may affect sexual sensitivity and lead to sexual problems, such as decreased sexual desire and pleasure, pain during sex, difficulty during penetration, decreased lubrication during intercourse, reduced frequency or absence of orgasm (anorgasmia). Scar formation, pain and traumatic memories associated with the procedure can also lead to such problems.

Obstetric complications: FGM is associated with an increased risk of Caesarean section, post-partum haemorrhage, recourse to episiotomy, difficult labour, obstetric tears/lacerations, instrumental delivery, prolonged labour, and extended maternal hospital stay. The risks increase with the severity of FGM.

Obstetric fistula: a direct association between FGM and obstetric fistula has not been established. However, given the causal relationship between prolonged and obstructed labour and fistula, and the fact that FGM is also associated with

prolonged and obstructed labour it is reasonable to presume that both conditions could be linked in women living with FGM.

Perinatal risks: obstetric complications can result in a higher incidence of infant resuscitation at delivery and intrapartum stillbirth and neonatal death.

Psychological consequences:

Some studies have shown an increased likelihood of post-traumatic stress disorder (PTSD), anxiety disorders and depression. The cultural significance of FGM might not protect against psychological complications.

Appendix 4

The Law relating to FGM

FGM is illegal in the UK. It has been a criminal offence since 1985. In 2003 it also became a criminal offence for UK nationals or permanent UK residents to take their child abroad to have female genital mutilation. The Serious Crime Act 2015 amended the Female Genital Mutilation Act to include FGM protection orders (FGMPOs).

It is an offence to:

- perform FGM (including taking a child abroad for FGM)
- help a girl perform FGM on herself in or outside the UK
- help anyone perform FGM in the UK
- help anyone perform FGM outside the UK on a UK national or resident
- fail to protect a girl for whom you are responsible from FGM

Anyone who performs FGM can face up to 14 years in prison. Anyone found guilty of failing to protect a girl from FGM can face up to seven years in prison.

Female Genital Mutilation Act 2003 as amended by the Serious Crime Act 2015

Protection orders
Section 73 of the Serious Crime Act 2015 provides for an FGM protection order to be applied for. It is a civil measure which can be applied for through a family court. The FGM protection order offers the means of protecting actual or potential victims from FGM under the civil law.

Breach of an FGM protection order is a criminal offence carrying a sentence of up to 5 years in prison. As an alternative to criminal prosecution, a breach could be dealt with in the family court as a contempt of court, carrying a maximum of 2 years' imprisonment.

Applications for an order can be made by:

- the person who is to be protected by the order
- a relevant third party (such as the local authority)
- any other person with the permission of the court (for example, teachers, health care professionals, police, family member).

FGM protection orders are unique to each case and contain legally binding conditions, prohibitions and restrictions to protect the person at risk of FGM. These may include:

- confiscating passports or travel documents of the girl at risk and/or family members or other named individuals to prevent girls from being taken abroad
- ordering that family members or other named individuals should not aid another person in any way to commit or attempt to commit an FGM offence, such as prohibiting bringing a “cutter” to the UK for the purpose of committing FGM.

The court can make an order in an emergency so that protection is in place straightaway. FGM protection orders came into force on 17 July 2015 and apply to England, Northern Ireland and Wales.

Mandatory Reporting of FGM

Section 74 of the Serious Crime Act 2015 amended the Female Genital Mutilation Act 2003 to introduce the legal duty for regulated health and social care professionals and teachers to make a report to the police if:

- they are informed by a girl under the age of 18 that she has undergone an act of FGM

Or

- they observe physical signs that an act of FGM may have been carried out on a girl under the age of 18.

For details on what is required of professionals, see Mandatory reporting of female genital mutilation: procedural information (Home Office, 2015) in the guidance section below.

Reports of FGM should be made when FGM is either visually noted, or there is a disclosure. The reports should contain the following information:

The name, age/date of birth, and address of the service user concerned.

The details of the referrer i.e. your details, including name, contact details (work telephone number and e-mail address) and times when you will be available to be called back, role and place of work.

Making a report

It is recommended that the report is made orally by calling 101, the single non-emergency number. When 101 are called, the system will determine the location of the caller and connect to the police force covering that area. A recorded message is then heard, announcing the police force that the caller is being connected to. The caller will then be given a choice of which force to be connected to – if the call

relates to a report outside the force area which you are calling from, you can ask to be directed to that force.

Appendix 5

Brent

Data from April 2016 – March 2017, for the London Borough of Brent indicates the following statistical information:

Caution needs to be taken when making comparisons with historic data. It became mandatory for all acute trusts to collect and submit to the FGM Enhanced Dataset from 1 July 2015 and for all mental health trusts and GP practices, from 1 October 2015. Therefore only partial information is available from July 2015.

Of the newly recorded cases from April 2016-March 2017, the referring organisation was as follows:

Not recorded = 40 cases (17%)

Not stated = 10 cases (2%)

General practice = 105 cases (45%)

NHS organisations = 55 cases (24%)

Self referral = 10 cases (4%)

Other = 10 cases (4%)

Types of FGM reported:

* indicates the number is between 0-4

Not recorded * (number between 0-4)

Type unknown = 85 cases (37%)

Type 1 = 50 cases (22%)

Type 2 = 30 cases (13%)

Type 3 = 55 cases (24%)

Type 4 * (number between 0-4)

History of FGM type 3 = 5 cases

FGM type 3 re-infibulation identified * (number between 0-4)

Age at attendance for FGM

Unknown *

Under 10 *

10-17 *

18-24 = 25 cases (11%)

25-29 = 65 cases (28%)

30-34 = 70 cases (30%)

25-39 = 40 cases (17%)

40-44 = 20 cases (9%)

45-49 = 5 cases (2%)

50+ *

Age at which FGM was carried out

Not recorded = 70 cases (30%)

Not stated = 5 cases (2%)

Under 1 *

1-4 = 35 cases (15%)

5-9 = 85 cases (37%)

10-14 = 25 cases (11%)

15-17 *

18+ = 10 cases (4%)

FGM identification method

Not recorded =50 cases

Self report=135 cases

On examination=20 cases

Other clinician * (between 0-4 cases)

Other = 20 cases

Country of birth of woman

Not recorded = 50

Not stated or unknown = 45

Eastern Africa = 115

Northern Africa = 10

Western Africa *

Rest of Africa *

Western Asia *

Rest of world *

Country of origin

Not recorded = 50

Not stated or unknown = 60

Eastern Africa = 100

Northern Africa = 10

Western Africa *

Rest of Africa *

The United Kingdom *

Western Asia *

Rest of Asia *

Rest of world *

Country where FGM was undertaken

Not recorded = 55

Not stated or unknown = 105

Eastern Africa = 60

Northern Africa = 5

Western Africa *

Rest of Africa *

The United Kingdom *

Western Asia *

Rest of Asia *

Rest of world *

For FGM attendees:

Treatment provided by:

Obstetrics = 10 cases

Gynaecology = 10 cases

Midwifery services = 185

Not recorded 405 cases

Paediatric specialities = 10 cases

Other *

Rates of de-infibulation

Not recorded = 420 cases

Yes *

No = 200 cases

Advised on health implications of FGM

Not recorded = 395 cases

Unknown = 30 cases

Yes = 190

No *

Advised on illegality of FGM

Not recorded = 395

Unknown = 25

Yes = 195

No *

Appendix 6

Imperial College Healthcare

Female Genital Mutilation (FGM) Clinics

All clinics are staffed by female-only midwives.

We have specialist health advocates who speak Somali and Arabic and access to counselling support. The midwives who run the clinics are specialists who have years of experience in helping and caring for women with FGM. There is an interpreter present at all clinics, as well as an advocate, a counsellor and a social worker.

Clinic 1 – A clinic for women who are not pregnant

Address

Queen Charlotte's & Chelsea Hospital FGM clinic
Gynaecology outpatients
Ground floor
Queen Charlotte's & Chelsea Hospital
Du Cane Road
London W12 0HS

Hours

09.00 to 12.00 on alternating Fridays.

Contact information

Phone: Juliet Albert 077 3097 0738
Phone: Deqa Dirie 075 5789 4186
Email: FGMservice.gynaeICHT@imperial.nhs.uk

Clinic 2 – For pregnant women booked to have their baby at Queen Charlotte's & Chelsea Hospital

Address

Queen Charlotte's & Chelsea FGM clinic
Ground Floor
Queen Charlotte's & Chelsea Hospital
Du Cane Road
London W12 0HS

Hours

09.00 to 12.00 on alternating Fridays.

Contact information

Phone: Juliet Albert 077 3097 0738
Phone: Deqa Dirie 075 5789 4186

Clinic 3 – For pregnant women booked to have their baby at St Mary's Hospital

Address

St Mary's Hospital FGM clinic
Maternity day assessment unit
St Mary's Hospital
Praed Street
London W2 1NY

Hours

Every Tuesday.

Contact information

Phone: Zuriash Amare 020 3312 1060 or 020 3312 1730

(Foundation for Women's Health Research and Development) is committed to gender equality and safeguarding the rights of African girls and women.

London Northwest Healthcare Trust (LNWHT)

FGM Services

The London North West Healthcare NHS Trust delivers FGM services to all women who access our services. The Trust covers 3 boroughs Ealing, Brent and Harrow

The LNWHT FGM services are provided by the Women's' and Children's Services within LNWHT

There are 2 clinics, one at Central Middlesex Hospital and the other on the Northwick Park Hospital site

Open: Friday from 08:30am – 16:30pm

- Central Middlesex Hospital, Acton Lane, Park Royal, NW10 7NS Antenatal Clinic

Telephone 0208 963 7180

- Northwick Park Hospital, Watford Road, Harrow, Middlesex, HA1 3UJ Antenatal Clinic

Telephone 0208 869 2870

Daughters of Eve offer the following services accessed by Brent women

African Well Women's Clinic - Antenatal Clinic

Central Middlesex Hospital, Acton Lane, Park Royal, London, NW10 7NS

Tel: 0208 963 7177 or 0208 965 5733

Open: Friday, 9am – 12pm

Contact: Kamal Shehata Iskander

African Well Women's Clinic - Antenatal Clinic

Northwick Park & St. Mark's Hospital, Watford Rd.

Harrow, Middlesex, HA1 3UJ

Tel: 0208 869 2870

Open: Friday, 9am – 5pm

Contact: Jeanette Carlsson

FORWARD http://forwarduk.org.uk/

We are a leading African diaspora women's campaign and support organisation. We work through partnerships in the UK, Europe and Africa to transform lives, tackling discriminatory practices that affect the dignity and wellbeing of girls and women. Our focus is on female genital mutilation (FGM), child marriage and obstetric fistula.

Information from the FORWARD community programme

FORWARD have engaged in Brent by providing parent sessions and 1:1 support to women and professionals and have held coffee mornings and community events in Brent. We recognise that there is a need for more communities to engage with services on FGM and in the next year we would like to be more active in the borough.

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Brent	**Community and Wellbeing Scrutiny Committee** 19 September 2017 **Report from the Director of Policy, Performance and Partnerships**
For information	Wards affected: ALL

Update on the Committee's Work Programme 2017-18

1.0 Summary

1.1 This report updates members on the Committee's Work Programme for 2017/18 and captures scrutiny activity which has taken place outside of its meetings.

2.0 Recommendations

2.1 Members of the Committee to discuss and note the contents of the report, including changes to the agenda items for each meeting.

2.2 To note the details of Members' visits, requests for information and responses, which have been done outside of the Committee's 2017/18 Work Programme.

3.0 Background

3.1 Members of the Community and Wellbeing Scrutiny Committee agreed their work programme 2017/18 earlier this year, which is published as Appendix A. The programme sets out what items will be heard at committee and which items will be looked at as task groups. However, the assumption was that it would evolve according to the needs of the Committee, and spare capacity would be left to look at issues as they arise.

3.2 For operational reasons it may be necessary to move items to be heard at a particular committee. In addition, members and co-opted members can at any time suggest an item to be looked at during a committee meeting, which provided it is agreed by the Chair, would mean the work programme changes.

3.3 Members may request information during a committee meeting or outside of a committee meeting as part of the scrutiny process. They also may make visits to do first-hand observation in order to better understand an issue for scrutiny.

4.0 Detail

4.1 As resolved by the Committee at the meeting on 23 November 2016, the Chair of the Committee wrote to the Metropolitan Police to express the Committee's dissatisfaction with the level of funding for Brent Local Safeguarding Children Board. The letter was forwarded to the office of an Assistant Commissioner who said that he will raise the issue at a future meeting about safeguarding.

4.2 The Chair of the Committee also wrote to the Deputy-Mayor for Policing and Crime about the level of funding the Brent board receives from the Metropolitan Police. Her response about funding for Local Safeguarding Children's Boards is published as Appendix C.

4.3 At the committee meeting on 19 July 2017 members requested an update about the CCG's strategy for NHS estates. A letter sent to the Chair of the Committee by the then Chief Operating Officer which has been circulated to members of the committee. This is in Appendix B.

5.0 Financial Implications

5.1 There are no immediate financial implications arising from this report.

6.0 Legal Implications

There are no legal implications arising from this report.

7.0 Equalities Implications

7.1 There are no diversity implications immediately arising from this report.

Contact Officers
Pascoe Sawyers
Head of Strategy and Partnerships
Chief Executive's Department

Mark Cairns
Policy and Scrutiny Manager
Strategy and Partnerships
Chief Executive's Department

PETER GADSDON
Director Performance Policy and Partnerships

APPENDIX A: Community and Wellbeing Scrutiny Committee Work Programme 2017-18

Wednesday 19 July 2017

Agenda Rank	Item	Objectives for Scrutiny	Cabinet Member/Member	Attendees
1.	Sustainability and Transformation Plan - Update	Cabinet member to update scrutiny on recommendations made on 20 September 2016	Cllr Krupesh Hirani, Cabinet Member for Community Wellbeing	Cabinet member to update
2.	Task Group report Child and Adolescent Mental Health Services	To discuss and agree task recommendations made by the task group	Cllr Ahmad Shahzad Cllr Mili Patel, Cabinet Member for Children and Young People	Gail Tolley, Strategic Director, Children and Young People Duncan Ambrose, Assistant Director, CCG
3.	Primary Care Transformation	Review implications of primary care transformation for Brent	Cllr Krupesh Hirani, Cabinet Member for Community Wellbeing	Sheik Auladin, Interim Chief Operating Officer, Brent CCG Sarah McDonnell, Assistant Director for Primary Care, Brent CCG
****4.**	Children's oral health	Review of work being done to improve children's oral health in Brent.	Cllr Krupesh Hirani, Cabinet Member for Community Wellbeing	Phil Porter, Strategic Director Dr Melanie Smith Director of Public Health Jeremy Wallman/Kelly Nizzer, NHS England. Claire Robertson, Public Health England

*Items involving school education. ** Items which may involve partnership work with schools.

Tuesday 19 September 2017

Agenda	Item	Objectives for Scrutiny	Cabinet Member/Member	Attendees
1.	Brent Safeguarding Adults Board	Receive 2016-17 annual report. Review last year's recommendations by committee	Cllr Krupesh Hirani, Cabinet Member for Community Wellbeing	Michael Preston-Shoot, Chair BASB
****2.**	Brent Local Safeguarding Children's Board	Receive 2016-17 annual report. Review last year's recommendations by committee	Cllr Mili Patel, Cabinet Member, Children and Young People	Mike Howard, Independent Chair, BLSCB
3.	FGM in Brent	Review the identification of FGM in the borough and the implications for health policy-makers, the local authority and other agencies and organisations in Brent.		Brent CCG
4.	Home Care task group	Agree task group scoping paper	Cllr Krupesh Hirani, Cabinet Member for Community Wellbeing	Phil Porter, Strategic Director Community Wellbeing Helen Woodland, Operational Director Social Care

*Items involving school education. ** Items which may involve partnership work with schools.

Wednesday 22 November 2017

Agenda	Item	Details	Cabinet Member/Member	Attendees
1.*	Brent Local Area SEND Inspection	Assess the action plan in place as a result of CQC-Ofsted local area inspection and how improvements will be implemented by the local authority and Brent CCG. Assess progress of recommendations made by committee in March 2017.	Cllr Mili Patel, Cabinet Member, Children and Young People	Gail Tolley, Strategic Director, Children and Young People Sheik Auladin, Interim Chief Operating Officer, Brent CCG
2.**	Local Offer for Care Leavers	Review the effectiveness of existing Local Offer for care leavers and any changes resulting from new policy or legislation.	Cllr Mili Patel, Cabinet Member, Children and Young People	Gail Tolley, Strategic Director, Children and Young People

*Items involving school education. ** Items which may involve partnership work with schools.

Wednesday 31 January 2018

Agenda	Item	Objectives for Scrutiny	Cabinet Member/Member	Attendees
1.	GP Practices in Brent	Review accessibility to GP practices in the borough including opening times, location, appointments and waiting registers. Evaluate to what extent the recommendations of the 2015 scrutiny task group have influenced accessibility.	Cllr Krupesh Hirani, Cabinet Member for Community Wellbeing	Sheik Auladin, Interim Chief Operating Officer, Brent CCG Sarah McDonnell, Assistant Director for Primary Care, Brent CCG
2.	PLACE scores	Evaluate why certain PLACE scores for hospitals in the Trust have been below average, what action plan has been put in place and what improvements were made.	Cllr Krupesh Hirani, Cabinet Member for Community Wellbeing	North West London NHS Healthcare Trust

*Items involving school education. ** Items which may involve partnership work with schools.

Wednesday 28 February 2018

Agenda	Item	Objectives for Scrutiny	Cabinet Member/Member	Attendees
1.	Learning Disabilities	Evaluate effectiveness and efficiency of learning disability service joint commissioning and market development. Assess to what extent changes will support independence and independent living.	Cllr Krupesh Hirani, Cabinet Member Community Wellbeing	Phil Porter, Strategic Director, Community Wellbeing Helen Woodland, Operational Director Social Care
2.	TB: Prevalence in Brent	Evaluate how effectively different agencies are working together to address TB. Understand what the challenges are around diagnosis and treatment of new TB cases.	Cllr Krupesh Hirani, Cabinet Member Community Wellbeing	Dr Melanie Smith, Director of Public Health Sheik Auladin, Interim Chief Operating Officer, Brent CCG
3.	Home care task group	Agree task group report and recommendations	Cllr Krupesh Hirani, Cabinet Member Community Wellbeing	Phil Porter, Strategic Director, Community Wellbeing Helen Woodland, Operational Director Social Care

*Items involving school education. ** Items which may involve partnership work with schools

Wednesday 28 March 2018

Agenda	Item	Objectives for Scrutiny	Cabinet Member/Member	Attendees
***1.**	School Annual Standards and Achievement report	Receive report and review progress with school standards. Evaluate committee's recommendations on school standards made in March 2017.	Cllr Mili Patel, Cabinet Member Children and Young People	Gail Tolley, Strategic Director Children and Young People
***2.**	Signs of Safety	Review progress with implementation and reporting back on task group's recommendations agreed February 2017.	Cllr Mili Patel, Cabinet Member Children and Young People	Gail Tolley, Strategic Director Children and Young People

*Items involving school education. ** Items which may involve partnership work with schools.

NHS
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16 December 2016

Councillor Ketan Sheth
Chair, Community and Wellbeing Scrutiny Committee
Brent Council Civic Centre
Engineers Way
London HA9 0FJ

Dear Councillor Sheth,

NHS Estates Update, 23 November 2016, Community and Wellbeing Scrutiny Committee Meeting

Please accept my apologies for the delay in writing following the Scrutiny Committee and our subsequent telephone conversation. I have set out matters of factual accuracy and responses to questions raised in advance of the meeting, at the meeting and following the meeting from members of the Committee.

Whilst writing, I want to clarify that the content of the report was developed based on the brief provided by the Committee officers. To this end, if there are additional areas that need to be included in future reports it would be helpful if this could be provided at the outset as members indicated that the report was not in line with their expectations.

Population growth – the map used in the report was produced by the Healthy London Development Unit using GLA data. We have used the SHLAA Capped Household Size projection. The source for this data used can be accessed on the link below
https://data.london.gov.uk/dataset/2015-round-population-projections

Void costs – the policy for NHS Property Services (NHS PS) to recover the cost of void space from CCGs and NHS England (NHSE) is set by the Department of Health and not a matter for local negotiation. I have attached the Department of Health letter setting out NHS Property Services charging policy for 2016/17. The vacant space policy referred to within the document has yet to be formally agreed with NHS England.

The CCG is committed to reducing the cost of void space by commissioning health and social care services from the space and has a clear commissioning plan in place to do so. The commissioning of services is incremental and subject to formal processes so an element of void space will exist at certain sites until the new services are fully operational. The CCG is willing to consider how via its commissioning intentions it could make space available for voluntary services in the Brent sites.

Engagement - the CCG agrees to engage with the public early on in its estate development processes but requires a proposal to engage with stakeholders on in order to have meaningful engagement and dialogue.

Brent Social Value Policy – the CCG acknowledges the commitment the Council has made within its social value policy and will aim to apply the key priorities to health planning in the borough. The CCG views the estate as an enabler to successful implementation.

South Kilburn Estate – whilst not specifically mentioned within the report, the CCG has been working with Council colleagues for some time to support the inclusion of a new primary care facility for the growing population of South Kilburn.

The questions raised prior to the meeting along with the responses provided are detailed in the table below:

Question	Response Provided
The void rates for the premises listed in 4.1 of the report for 2014/15 and 2013/14	Sue Hardy reported at the meeting that void rates change from year to year for a number of reasons however the void at Willesden Centre reduced from 25% in 2014/15 to 19% in 2016/17. The void space at Chalkhill Primary Care Centre had reduced marginally over this period with Wembley Centre for Health being fairly static.
A list of services that have left NHS premises in Brent since market-based rents were introduced.	Jake Roe reported at the meeting that occupiers relocated for a number of reasons and that NHS PS does not hold specific details to enable it to respond to this request. Jake Roe reported that the move to market rents was recommended by Department of Health. A copy of the guidance issued to CCGs is attached for information.
Why rents have gone up by 800% at the Willesden centre and what sort of consultation was undertaken?	NHSPS responded prior to the meeting that rents had not increased by 800% at Willesden and provided a written response to the specific question on Brent Bereavement Service. Please advise if you would like us to request this to be resent.
Why has transport into the hospital been axed for people attending podiatry in the light of the fact that patients with health needs of that kind have difficulty walking?	The CCG has looked into this and can confirm that the Trust has not stopped transport to podiatry services, in fact from 1 February 2016 the Trust introduced a new non-emergency patient transport service across all acute and community sites. This new arrangement has standardised provision across the Trust, enabling them to offer transport to both hospital and clinic based appointments for any patient who meets the following Department of Health (DH) eligibility criteria. • Where the medical condition of the patient is such that they require the skills or support of trained ambulance personnel on/after the journey and/or where it would be detrimental to the patient's condition or recovery if they were to travel by other means. • Where the patient's medical condition impacts on their mobility to such an extent that they would be unable to access healthcare and/or it would be detrimental to the patient's condition or recovery to travel by other means.

	• The patient needs the support of persons trained and equipped for lifting and handling • Recognised as a parent or guardian where children are being conveyed. The DH criteria enable patients with significant mobility problems to receive transport and the Trust also offers a domiciliary podiatry service for housebound patients. *At the meeting Sarah Mansuralli offered to follow up the specific example Cllr Hector referred to if she would like to provide the details.*
How much is spent on commissioning services?	Approximately £420m per annum for Brent CCG and the breakdown is as follows: 63% - acute hospital care 10% - community care 9% - mental health care 9% - prescribing The remainder is spent on other provision including Continuing Healthcare, Voluntary sector provision, peer support, advocacy services etc.
Can we have the full text of the local Sustainability and Transformation Plan?	This was attached to the response but a link to the documents is provided below: https://www.healthiernorthwestlondon.nhs.uk/documents/sustainability-and-transformation-plans-stps

I hope that the above provides the Committee with the required information.

The CCG is committed to working with Brent Council to develop a single estate strategy to optimise the use and investment in the estate used for service delivery and improves access to services for local people. We would welcome any suggestions or support to achieve this in a sustainable manner.

Yours sincerely,

S Mansuralli

Sarah Mansuralli
Chief Operating Officer

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MOPAC | MAYOR OF LONDON
OFFICE FOR POLICING AND CRIME

Councillor Ketan Sheth
Chair, Community and Wellbeing Scrutiny Committee
Brent Council
c/o james.diamond@brent.gov.uk

21 April 2017

MOPAC10022017-24581

Dear Councillor Sheth,

Thank you for your letter regarding funding for Brent's Local Safeguarding Children Board and I apologise for the delay in responding to you. The Mayor and I recognise the importance of our safeguarding responsibilities and partnership working is essential in relation to safeguarding children and young people. Earlier in the year I spoke at the London Safeguarding Children Board which was attended by the local Chairs and I outlined the new Police and Crime Plan for London which was published at the end of March.

MOPAC has committed to continue to provide funding to the London Safeguarding Children Board and will continue to work with the local Safeguarding Children Boards. We are still working on the budget that will support the delivery of the new Police and Crime Plan. Whilst I appreciate your concerns over the level of funding, for me what is more important is how we get maximum value from the funding. This is something we will be developing in consulation with the London Safeguarding Children Board over the coming months and how best to align the funding to the Police and Crime Plan priorities.

I appreciate your continued support and work to safeguard and protect children and young people in London.

Yours sincerely,

Sophie Linden

Sophie Linden
Deputy Mayor for Policing And Crime

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