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Health and Wellbeing Board

Date: **THURSDAY, 6 FEBRUARY 2014**

Time: **2.30 PM**

Venue: **COMMITTEE ROOM 5 - CIVIC CENTRE, HIGH STREET, UXBRIDGE UB8 1UW**

Meeting Details: Members of the Public and Press are welcome to attend this meeting

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Statutory Members (Voting)
Councillor Raymond Puddifoot MBE (Chairman)
Councillor Philip Corthorne MCIPD (Vice-Chairman)
Councillor Jonathan Bianco
Councillor Keith Burrows
Councillor Douglas Mills
Councillor Scott Seaman-Digby
Councillor David Simmonds
Dr Ian Goodman (CCG)
Jeff Maslen (Healthwatch Hillingdon)

Statutory Members (Non-Voting)
Statutory Director of Adult Social Services
Statutory Director of Children's Services
Statutory Director of Public Health

Co-Opted Members
The Hillingdon Hospitals NHS Foundation Trust
Central & North West London NHS Foundation Trust
Royal Brompton & Harefield NHS Foundation Trust
Hillingdon Clinical Commissioning Group (officer)
Hillingdon Clinical Commissioning Group (clinician)
LBH - Deputy Director: Public Safety & Environment
LBH - Corporate Director of Residents Services & Deputy Chief Executive (VOTING)

Published: Wednesday, 29 January 2014

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Agenda

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2	Declarations of Interest in matters coming before this meeting	
3	To approve the minutes of the meeting on 5 December 2013	1 - 6
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Health and Wellbeing Board Reports - Part II (Private and Not for Publication)

14 Hillingdon CCG 5 Year Strategic Plan and 2 Year Operating Plan - VERBAL UPDATE

The reports listed above in Part II are not made public because they contain exempt information under Part I of Schedule 12A to the Local Government (Access to Information) Act 1985 (as amended) and that the public interest in withholding the information outweighs the public interest in disclosing it.

15 Any other items the Chairman agrees are relevant and urgent

Minutes

HEALTH AND WELLBEING BOARD

5 December 2013

Meeting held at Committee Room 6 - Civic Centre, High Street, Uxbridge UB8 1UW

	Statutory Board Members Present: Councillor Ray Puddifoot (Chairman) Councillor Philip Corthorne (Vice-Chairman) Councillor Keith Burrows Councillor Douglas Mills Dr Kuldhir Johal – Hillingdon Clinical Commissioning Group (substitute) Stephen Otter – Healthwatch Hillingdon (substitute) **Statutory Board Members:** Tom Murphy – Statutory Director of Children's Services (substitute) Sharon Daye – Statutory Director of Public Health Tony Zaman – Statutory Director of Adult Social Services **Co-opted Members Present**: Jean Palmer – LBH Deputy Chief Executive and Corporate Director of Residents Services Nigel Dicker – LBH Deputy Director: Public Safety & Environment Maria O'Brien – Central and North West London NHS Foundation Trust (substitute) Mike Robinson – The Hillingdon Hospitals NHS Foundation Trust (substitute) Ceri Jacob – Hillingdon Clinical Commissioning Group (Officer) (substitute) Nick Hunt – Royal Brompton and Harefield NHS Foundation Trust (substitute) **LBH Officers Present:** Kevin Byrne, Glen Egan, Nikki Wyatt and Nikki O'Halloran **LBH Councillors Present:** Councillors Phoday Jarjussey and John Major **Press & Public:** 1 public
37.	**APOLOGIES FOR ABSENCE** *(Agenda Item 1)* Apologies for absence were received from Councillors Jonathan Bianco, Scott Seaman-Digby and David Simmonds, Mr Jeff Maslen (Mr Stephen Otter was present as his substitute), Dr Ian Goodman (Dr Kuldhir Johal was present as his substitute), Dr Tom Davies, Mr Rob Larkman (Ms Ceri Jacob was present as his substitute), Mr Shane DeGaris (Mr Mike Robinson was present as his substitute), Ms Robyn Doran (Ms Maria O'Brien was present as her substitute), Mr Bob Bell (Mr Nick Hunt was present as his substitute) and Ms Merlin Joseph (Mr Tom Murphy was present as her substitute).
38.	**TO APPROVE THE MINUTES OF THE MEETING ON 31 OCTOBER 2013** *(Agenda Item 3)* **RESOLVED: That the minutes of the meeting held on 31 October 2013 be agreed**

	as a correct record.
39.	**TO CONFIRM THAT THE ITEMS OF BUSINESS MARKED PART I WILL BE CONSIDERED IN PUBLIC AND THAT THE ITEMS MARKED PART II WILL BE CONSIDERED IN PRIVATE** *(Agenda Item 4)* This was confirmed.
40.	**JOINT HEALTH & WELLBEING STRATEGY ACTION PLAN UPDATE 2013/2014** *(Agenda Item 5)* Consideration was given to the Joint Health and Wellbeing Strategy Action Plan performance achievements since 1 April 2013. It was noted that there had only been about a month since the last report had been produced and, as such, there had been little change. The Board was pleased to note that, in addition to the 44% of residents that no longer required ongoing care or support following re-ablement (the target was 50%), a further 12% required a reduced care package following completion of their intensive re-ablement plan. Concern was expressed that there were some difficulties in sharing data insofar as NHS governance prohibitions were concerned. These limitations had, on occasion, hindered the decision making process, for example, in relation to high level HIV data being available but more localised/ward based statistics being restricted. Officers were currently working to resolve this. **RESOVLED: That the Health and Wellbeing Board note the report.**
41.	**PUBLIC HEALTH ACTION PLAN 2013/2014** *(Agenda Item 6)* It was noted that an exercise had been undertaken to identify projects or schemes across the Council's key service areas that would support the implementation of priorities identified in the JSNA (Joint Strategic Needs Assessment) across the four public health domains. Furthermore, the review of the work of the transferred Public Health Team had started. Consideration was now being given to finalising the revised structure, job descriptions and person specifications. The Board was advised that the contract for the provision of the drug and alcohol misuse service was currently being renegotiated. It was anticipated that the new contract would put a greater focus on alcohol misuse as this was more of an issue in the Borough. **RESOLVED: That the Health and Wellbeing Board note the report and Action Plan.**
42.	**HILLINGDON CCG FINANCIAL RECOVERY PLAN UPDATE REPORT** *(Agenda Item 7)* A revised version of the report had been circulated to the Board. The additional information included in the report noted that the Financial Recovery Plan (FRP) formed a subset of the total CCG budgets. The report stated that, although the delivery of the FRP would contribute towards the CCG's financial position, it did not represent the final overall position. Overall, Hillingdon CCG was projecting a smaller deficit than had been set at the beginning of the financial year.

	It was noted that the 'actual' figures listed in the summary of progress that was appended to the report were subject to change. The Board was advised that there was often a time lag which resulted in the figures changing. For example, with regard to medicines management, there might be a significant delay between a prescription being written by the GP, the patient getting the prescription filled and the pharmacy requesting payment. Concern was expressed that the financial information contained within the report was not clear. It was suggested that the information provided by the CCG would benefit from being presented in a general accounting format to ensure that it was easily understood. The Board was advised that a deficit budget of approximately £12.2m and a financial savings target of £11m had been set for 2013/2014. It was anticipated that the QIPP Programme (Quality, Innovation, Productivity and Prevention) would deliver savings of approximately £9.2m towards the £11m savings target total. However, it was noted that the 2013/2014 deficit was likely to be smaller than expected at about £8m (although it was possible that this would vary through the remainder of the year). It was noted that a move to the provision of quarterly reports (rather than monthly) would give the Board a more stable picture of the CCGs financial situation. It was suggested that subsequent reports include additional information in relation to plans for future savings to enable to Board to gain a forward perspective. To this end, Mr Mike Robinson suggested that he and Mr Jonathan Wise work with the CCG to provide an independent perspective. **RESOLVED: That the Health and Wellbeing Board notes the update.**
43.	**HEALTHWATCH HILLINGDON UPDATE** *(Agenda Item 8)* Consideration was given to Healthwatch Hillingdon's update report and the information that was gleaned at the successful launch event. It was noted that a full report on the launch event and a completed work plan would be submitted to the Board's next meeting. To further raise awareness of the work of Healthwatch, representatives would be attending the Older People's Assembly on 10 December 2013. It was hoped that this would contribute towards broadening engagement with (and access to) the public. Healthwatch Hillingdon had identified areas within its remit which would require more work and was undertaking an ongoing recruitment of volunteers. It was suggested that any feedback received could be made more robust by triangulating with Patient and Public Engagement principles (PPE) and Patient Participation Groups (PPGs). It was agreed that the Council's Head of Communications would be asked to work with Healthwatch Hillingdon to include an editorial in Hillingdon People in relation to the recruitment of volunteers. **RESOLVED: That:** **1. the Health and Wellbeing Board note the report; and** **2. the Council's Head of Communications be asked to work with Healthwatch Hillingdon to produce an editorial for inclusion in Hillingdon People.**

44.	**REPORTS REFERRED FROM CABINET / POLICY OVERVIEW & SCRUTINY** *(Agenda Item 9)* The Board was advised that the recommendations contained within the report had stemmed from a review that had been undertaken by the Council's Children, Young People and Learning Policy Overview Committee (POC). The report had been considered and ratified by Cabinet at its meeting on 21 November 2013. It was noted that the report set out the frustrations that had been encountered by the POC Members during the course of the review in relation to the support provided to Looked After Children (LAC). The review had identified the need to share information that was not currently being collected. The Board acknowledged that officers were already working to address some of the issues raised in the report but that further work was needed which would require a collective buy in. It was agreed that the relevant organisations would start to collect the information as requested (although it was also noted that CAMHS did not undertake Tier 4 assessments so would not be able to provide information in relation to this area). **RESOLVED: That:** **1. the Health and Wellbeing Board note the report;** **2. the Hillingdon Clinical Commissioning Group (CCG) and Hillingdon Child and Adolescent Mental Health Services (CAMHS) acquire, maintain and share data on the following areas:** **a. Proportion of total budgets spent on Looked After Children (LAC);** **b. Proportion of LAC registered with a GP;** **c. Proportion of the CAMHS caseload that is made up of LAC;** **d. Information on what intervention / therapy is being provided by CAMHS and what health issues are being dealt with via wider case consultation; and** **e. The number of Tier 2 and 3 assessments that CAMHS undertake for LAC.** **3. officers continue to work alongside colleagues from Hillingdon CAMHS to provide a designated point of contact to provide advice and assistance for all mental health issues relating to LAC, reporting to the Health & Wellbeing Board if required;** **4. officers continue to work alongside the Council's partner agencies to develop a comprehensive understanding of where responsibilities lie between NHS England and CCGs for all aspects of the health needs of LAC and report findings back to the Cabinet Member for Education & Children's Services, the Children, Young People & Learning Policy Overview Committee and the Health & Wellbeing Board as appropriate; and** **5. in order to ensure that the mental health needs of LAC are met when placements are out of Borough, officers produce a protocol on the process of how services are brokered between CCGs and NHS England for agreement by the Cabinet Member for Education & Children's Services and the Health & Wellbeing Board.**
45.	**UPDATE - ALLOCATION OF S106 HEALTH FACILITIES CONTRIBUTIONS** *(Agenda Item 10)* It was noted that the time for using the s106 monies allocated to the new Yiewsley Health Centre was in danger of running out (one was due to expire in February 2014 (£10,651) and another in March 2014 (£51,118)). Although it had been suggested that

	this funding be vired to the HESA Centre development in Hayes, the Board agreed that this project was too far away. As a workable alternative, it was suggested that the s106 money could be used to process the planning application for the Yiewsley Health Centre scheme, which would cost approximately £160k. The Board agreed with this course of action and noted that NHS Property Services hoped to claim these funds back from the Council at a later date to put towards the fitting out costs. The Board was assured that dialogue with the development at St Andrews Park was continuing, even though there had been a change of personnel involved. These discussions had resulted in the identification of potential sites for the development and meetings were planned with the developer and tenants in mid-January 2014. The CCG would ensure that progress on the development continued. **RESOLVED: That the Health and Wellbeing Board:** **1. notes the progress being made towards the allocation and spend of s106 healthcare facilities contributions within the Borough; and** **2. agrees that officers take action to use the Yiewsley Health Centre scheme s106 funding to pay for the associated planning application.**
46.	**HEALTH AND WELLBEING BOARD SUB-COMMITTEE UPDATE** *(Agenda Item 11)* It was noted that, due to the report deadlines for this agenda, the officer group had subsequently made more progress than had been reflected in the report. An update on the Integration Transformation Fund (ITF) emerging plan would be considered at the Sub Committee's next meeting which had been scheduled for 14 January 2014. The Board was advised that officers had now received a copy of the Department of Health submission template and were in the process of producing a draft for consideration. However, it was noted that the timetable for the completion of this template was tight: it would need to be considered by the Board at its meeting on 6 February 2014 and submitted by 15 February 2014. To enable Councillors and the CCG Board to consider the template, it was agreed that the draft would be circulated to the Board Chairman and Vice Chairman and the Hillingdon CCG Chairman and Chief Operating Officer before end of December 2013. **RESOLVED: That:** **1. the Health and Wellbeing Board notes progress; and** **2. the draft ITF template be circulated to the Board Chairman and Vice Chairman and the Hillingdon CCG Chairman and Chief Operating Officer in advance of the Board meeting being held on 6 February 2014.**
47.	**BOARD PLANNER & FUTURE AGENDA ITEMS** *(Agenda Item 12)* Consideration was given to the Board Planner. Board members were reminded that they were able to add items to the Planner outside of the meeting. It was agreed that, in the new municipal year, consideration could be given to the frequency that financial reports were included on the agenda. It was also agreed that the Sub-Committee update would focus on the Integration Transformation Fund plan for the next meeting. **RESOLVED: That the Health and Wellbeing Board agrees the Board Planner, as amended.**

48.	**HILLINGDON CCG COMMISSIONING INTENTIONS 2014/2015** *(Agenda Item 13)* Consideration was given to the CCGs commissioning intentions for 2014/2015. Additional information summarising links to the Financial Recovery Plan (FRP) was circulated to Board members. It was noted that the commissioning intentions reflected the FRP and were intended to deliver financial savings through improvements in quality, outcomes and efficiency. The Board was advised that, although the CCG had set a deficit budget of £11.5m for 2014/2015, this figure was based on assumptions in relation to allocations made by the Department of Health. The CCG confirmed that, at present, the organisation was not permitted to carry a balance into the next financial year. With regard to commissioning, it was noted that the CCG used the population statistics included within the Joint Strategic Needs Assessment (JSNA). The organisation then built in a growth factor to take account of population increase. **RESOLVED: That the Health and Wellbeing Board notes the Hillingdon CCG Commissioning Intentions for 2014/2015.**
	The meeting, which commenced at 2.30 pm, closed at 3.05 pm.

These are the minutes of the above meeting. For more information on any of the resolutions please contact Nikki O'Halloran on 01895 250472. Circulation of these minutes is to Councillors, Officers, the Press and Members of the Public.

JOINT HEALTH & WELLBEING STRATEGY ACTION PLAN UPDATE 2013/2014

Relevant Board Member(s)	Councillor Ray Puddifoot Councillor Philip Corthorne
Organisation	London Borough of Hillingdon
Report author	Kevin Byrne, Administration Directorate
Papers with report	Appendix 1 – Action Plan Update

1. HEADLINE INFORMATION

Summary	This report presents progress on key actions to deliver Hillingdon's Health and Wellbeing Strategy priorities. The Board is asked to consider and comment on the update.
Contribution to plans and strategies	This paper helps the Board to see the progress being made to deliver the key actions to underpin Hillingdon's Health and Wellbeing Strategy.
Financial Cost	There are no direct financial implications arising directly from this report.
Ward(s) affected	All

2. RECOMMENDATIONS

The Health and Wellbeing Board is asked to:

1) **review and comment on the performance achievements since 1 April 2013.**
2) **recommend areas where the action plan and progress updates could be developed further to support the Board in their role to drive health improvement in Hillingdon.**

3. INFORMATION

Supporting Information

3.1 Attached to this report (Appendix 1) is an update of the 2013/14 Health and Wellbeing Action Plan to the end of December 2013. The action plan has been structured to see easily how actions being taken align to the priorities in Hillingdon's Health and Wellbeing Strategy. The actions focus on those areas identified to promote health improvement and reduce differences in health.

3.2 The updates to the action plan indicate where progress is being made and will contribute to the range of indicators which measure improvement within the outcomes frameworks for health, public health and adult social care.

3.3 Where information is available, the updates to the action plan also include local information about the difference services are making to improve peoples' lives.

3.4 A summary of the achievements to date against each of the priorities set out in the Health and Wellbeing Strategy are as follows:

Priority 1 – Improving health and wellbeing and reducing inequalities

The priority set out in Hillingdon's Health and Wellbeing Strategy is to increase the number of people taking part in regular exercise and tackling obesity.

Key Targets	Progress	Status
• An additional 7,000 people take part in regular exercise by March 2015	• Just over 3,500 additional residents are now taking part in regular exercise since April 2012 (just over half way through the 3-year target). • A range of new activities are available for Hillingdon residents of all ages and abilities, including free swimming, planned cycle rides, healthy walks, tea dances and targeted exercise programmes for children and young people, people with disabilities and older residents.	✓ On track.

Priority 2 – Invest in prevention and early intervention

The priorities set out in Hillingdon's Health and Wellbeing Strategy are: to reduce reliance on acute and statutory services; children's mental health and risky behaviours; dementia and adult mental health; and sight loss.

Key Targets	Progress	Status
• More than 50% of people receiving intensive re-ablement do not require care following the service	• A rising proportion of residents who benefit from a re-ablement service do not need ongoing support or care following re-ablement. To the end of December 2013, 47% of residents do not require ongoing care or support (44% to the end of October 2013) and a further 11% require a reduced care package following completion of their intensive re-ablement plan.	✓ On track.
• Complete a review of the CAMHS service and recommend changes for the care pathway	• Ongoing. A review of the CAMHS service and needs is underway. This includes an evaluation of the service and recommendations for developing the service to meet needs.	✓ On track.
• Continue to achieve a high percentage of children and older people being immunised to protect them from infection.	• Historically Hillingdon has a high take-up level of immunisations. • The latest data for MMR shows take-up is improving and is higher than England take-up rates. • MMR data for Apr-Sept 2013 MMR 24 Months = 93.1% (England, 92.7%) MMR (1 dose) 5 years = 94.6% (England 94.3%)	✓ On track.
• Establish a plan to maintain healthy sight and manage the impact of sight loss.	A review is underway led by the Pocklington Trust. This includes an analysis of current and future needs. Recommendations will be presented to the Board in 2014 for consideration.	✓ On track.

Priority 3 – Developing integrated, high quality social care and health services within the community or at home

The priorities set out in Hillingdon's Health and Wellbeing Strategy are to develop integrated approaches for health and wellbeing, including telehealth; and the Integrated Care Programme (ICP).

Key Targets	Progress	Status
• Full rollout of the Integrated Care Programme (ICP) to all GP practices by the end of 2013.	• As at 31st December 2013, 87% GP practices are participating. The evaluation of the first 12 months is showing very positive results. 65% of professionals attending an integrated care planning arrangement have reported they have changed their practice.	✓ On track.
• Extend the TeleCareLine service to 3,000 additional people by March 2015 (750 additional people per year over 4 years)	• As at 31st December 2013, 2,645 new service users were in receipt of a TeleCareLine equipment service. The technology is helping people to live safely and independently at home. The take-up of TeleCareline is exceeding the target of 750 new service users set for each year of the scheme and will be extended to residents aged 80 years or older from April 2014.	✓ On track.
• Provide extra care and supported accommodation to reduce reliance on residential care	• The supported living building programme is currently being reviewed to ensure it meets the current and future needs. • 4 bespoke small schemes are being developed for clients with mental health needs or learning disabilities who will benefit from shared accommodation. These will be complete within the next 3 months.	✓ On track.

Priority 4 – A positive experience of care

The priorities set out in Hillingdon's Health and Wellbeing Strategy are to develop tailored, personalised services; and establish an ongoing commitment to stakeholder engagement.

Key Targets	Progress	Status
• Increase the percentage of adults and older people in receipt of a personal budget to at least 70%	• As at 31st December 2013, overall 75% of all social care clients (2,317 clients in total – adults and older people) were in receipt of a personal budget (based on services which are subject to a personal budget). Take-up of personal budgets is higher for older people (81%, 1,814 older people).	✓ On track.
• Complete a review of stakeholder engagement and present recommendations to the Health and Wellbeing Board	• A group is reviewing stakeholder engagement across health and social care. The leads for engagement across health and social care will develop recommendations for consideration by the Board in 2014.	✓ On track.

Development of the Report

The Better Care Fund plan being developed for Hillingdon requires a specific focus on further integration and the guidance sets out the national measures as:

- Admissions to residential and care homes;
- Effectiveness of reablement;
- Delayed transfers of care;
- Avoidable emergency admissions; and
- Patient / service user experience.

As the plan for Hillingdon is developed and agreed, the Board may wish to consider developing the performance report to include these key indicators way as a way to track progress on delivering the plan.

Financial Implications

There are no direct financial implications arising from the recommendations set out in this report.

4. EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

What will be the effect of the recommendation?

The update of the action plan for Hillingdon's Health and Wellbeing Strategy supports the Board to see progress being made to towards the key priorities for health improvement in the Borough.

Consultation Carried Out or Required

Updates of actions to the plan have involved close working with partner agencies to provide information.

Policy Overview Committee comments

None at this stage.

5. CORPORATE IMPLICATIONS

Hillingdon Council Corporate Finance comments

There are no direct financial implications arising from the recommendations set out in this report.

Hillingdon Council Legal comments

The Health and Social Care Act 2012 ('The 2012 Act') amends the Local Government and Public Involvement in Health Act 2007. Under 'The 2012 Act', Local Authorities and Clinical Commissioning Groups (CCGs) have an equal and joint duty to prepare a Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs) for meeting the needs identified in JSNAs. This duty is to be delivered through the Health and Wellbeing Board (HWB).

HWBs are committees of the Local Authority, with non - executive functions, constituted under the Local Authority 1972 Act, and are subject to local authority scrutiny arrangements. They are required to have regard to guidance issued by the Secretary of State when undertaking JSNAs and JHWSs.

6. BACKGROUND PAPERS

Nil.

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Appendix 1 - Hillingdon Health and Wellbeing Strategy - Partnership Action Plan 2013/2014

Objective	Key Task	Lead	Subtasks	Dead-line for Subtask	Progress Update	RAG
Priority 1 - Improved health and wellbeing and reducing inequalities As a priority we will focus on physical activity and obesity.						
1.1 To increase physical activity levels by 5% each year for the next three years to improve health, wellbeing and help tackle levels of obesity	Develop and begin to implement a three year strategy to increase participation in physical activity	Physical Activity Strategy Group	Increase the number of residents participating in regular exercise by 7,000 people through a range of targeted initiatives including; a) Develop a programme to increase activity for adults and older people	(a)-(h) 31/03/15	On track. Just over an estimated 3,500 additional adults, older people, children and young people are now taking part in regular exercise since the programme commenced from April 2012. a) A range of programmes have been developed and delivered which is proving successful in engaging residents of all ages and abilities in regular exercise. These include: • A new programme of dances (tea dance, disco, bollywood and line dancing) is in place. There has been an estimated 1,572 people attending these dances since April 2013. Take-up of free swimming sessions for older people is increasing. From the latest information available, between 1st April 2013 and 30th November 2013, a total of 19,564 free swimming sessions have been taken up by older people: 35% higher (+5,009 swims) than the same time last year. Typically 1,900 older people take up the free swimming every year. • The Specialist Health Promotion Team arranged for 5 staff from extra care schemes to be trained to run chair based exercise programmes. Exercise events are planned during February 2014 in community settings. • The 'drummunity' project for people with dementia is proving successful. From September to December 2013 48 service users took part. 10 staff have been trained to deliver the sessions. Feedack from relatives, carers and staff has been very positive. Participants were observed to be happier and with greater strength in their drumming. • 16 people have taken part in a new stroke exercise rehabilitation class and around 80 people are engaged in cardiac referral classes at Highgrove Pool. 62 people have engaged in the free jogging programme. • Back 2 Sport programme is proving successful (April – Sept) - 330 new participants with 107 classed as new to sport. 60% increase in overall participation over July – Sept from 1970 to 3331	GREEN

Objective	Key Task	Lead	Subtasks	Dead-line for Subtask	Progress Update	RAG
			b) Develop a programme to increase activity for children and young people		(b) 23 new families have been engaged in the 2-4 programme at three Children's Centres. Training for Children's Centre staff organised. 40 young people have taken part in the 'Fit Teen' weight management programme and now expanded to Hayes and Uxbridge. 120 primary age children are engaged in the 'Ready, Steady, Boost programme'. A programme to increase delivery in Early Years settings established. Multi-sport programme for primary age children organised. Set-up dialogue with school games organisers to link with community delivery. 460 children completed bike ability levels 1 and 2. 2,651 children completed pedestrian safety training.	GREEN
			c) Set up travel plans		(c) Travel plans required for new residential and commercial development. 74 identified business travel plans in the database and 14 plans are being monitored For schools, 27 schools registered for Key stage 1 'Walk once a week': 53 schools involved with Walk on Wednesday.	
			d) Show an increase in cycling and walking		(d) New information has been produced to encourage residents to 'Explore Hillingdon'. Organised cycle rides 'Age Well on Wheels' have been organised. There are 30 residents who are registered and regularly take part in the rides. Further work is underway to encourage take-up of these cycle rides across the Borough. The Healthy Walks programme - there are 150 registered walkers who walk a minimum of once a month. Walks (Explore Hillingdon April – Sept) • Throughput 2,172 • 134 new walkers • 78 people registered with at least 1 health condition 2651 children completed pedestrian safety training.	
			e) Recruit volunteers to support local networks		(e) 'Sportunity' volunteering programme for 14-25 yr olds set up that provides incentives for young residents interested in sports leadership. Green spaces volunteering opportunities – approx 70 people with 10 new volunteers in last 12 months. Estimated 70+ volunteers at Eastcote House Gardens. New Cycle Ranger programme developed to help deliver LBH biking Borough programme.	

Objective	Key Task	Lead	Subtasks	Dead-line for Subtask	Progress Update	RAG
			f) Review and support opportunities for people with disabilities		(f) 'On Your Marks' scheme established in partnership with DASH, providing new swimming and multi-sport activities for disabled adults. A 'Shine the Light' sports event for disabled adults was held at Brunel University in the Summer to celebrate one year since the torch relay passed through Hillingdon. Around 80 people with disabilities attended.	GREEN
			g) Set up care pathways with Primary Care and Public Health		(g) Reviewed delivery of existing cardiac referral scheme. New trial scheme for stroke patients established with 'Fusion'. New 'Let's Get Moving' physical activity referral programme being explored. This will provide a general scheme available to all residents through GP's, Health Checks and other health practitioners. Diabetic patients referred by Specialist Diabetic nurses to the Walk programme. Pilot developed with Macmillan Cancer Research into walk programme to include linking in with new Cancer Information System at Hillingdon Hospital. Physical activity pathway for cancer patients in place. Opportunities for physical activity being included in training for health professionals administering NHS Health Checks.	
			h) Develop the Change 4 Life campaign to encourage residents of all ages to participate in physical activity.		(h) Pledge system established with incentives to encourage more people to be more active, more often. Regular articles in Hillingdon People, through social media etc.	

Objective	Key Task	Lead	Subtasks	Dead-line for Subtask	Progress Update	RAG
1.2 Help to tackle fuel poverty to improve health and wellbeing	Reduce fuel poverty	LBH	(a) Improve 70 private sector homes for older vulnerable people. • 30 heating measures • 30 insulation measures • Complete essential repairs to 10 homes for vulnerable & older households (b) Deliver Age UK Hillingdon's Housing Options Service and Winter Warmth Campaign	(a) 31/03/14 (b) 31/03/14	(a) Since April 2013, improvements have been made to 83 homes of older people in Hillingdon as follows: • Heating improvements have been made to the homes of 27 older people. • 46 homes with improved insulation measures. • 10 homes of older residents received essential repairs as needed. Essential repairs can include roof and glazing repairs to reduce health and safety risks. Further improvements are scheduled by March 2014. (b) Ongoing – The campaign was promoted at the Older Persons day on 1st October 2013 including an event held in Uxbridge Town Centre. The event held was very successful with a good variety of stands offering a comprehensive range of information to older people and a good flow of visitors throughout the day. The Age UK Hillingdon Information and Advice stand saw 144 people and specifically gave out 21 Winter Warmth leaflets, following discussion with visitors about the campaign. Age UK continue to provide advice and guidance to older people through their outreach work to help older people keep warm and well this winter.	GREEN

Objective	Key Task	Lead	Subtasks	Dead-line for Subtask	Progress Update	RAG
Priority 2. Prevention and early intervention As a priority we will focus on: • Reducing reliance on acute and statutory services; • Children's mental health and risky behaviours; • Dementia and adult mental health; • Sight loss.						
2.1 Reduce reliance on acute services and prevent avoidable hospital attendances, admissions and readmissions. Deliver the out of hospital strategy.	Develop and implement plans to prevent avoidable admission or readmission into hospital and avoidable demands on social care services by 31/03/15.	Integrated Care Steering Group	(a) Integrated Care Program to increase the number of people with long term conditions who have a multidisciplinary care plan, specifically targeting at risk groups with diabetes, respiratory disease and the frail elderly b) Enhance the number of people who are transferred home with support from emergency assessment beds at Hillingdon Hospital c) Increase the complexity of people managed in the community by intermediate care services to include dementia and older people with mental health needs	(a) 31/03/14 (b) 31/03/14 (c) 31/03/14	(a) Ongoing - The Integrated Care Programme (ICP) went live in 2012 providing a joined up approach to patient care across health and local authority services based around case discussion at GP practices. 87% of GP practices have now signed up to the new ICP services. The programme is targeting residents with complex care needs (older frail people, those with diabetes, people with mental health needs, chronic obstructive pulmonary disease and patients with cardiac difficulties). An evaluation of the programme from the first year is showing positive results including higher rates of agreed care plans completed, positive feedback from patients, high levels of involvement from teams and changes in the way of working which are delivering efficient practices. Further updates will be reported to the Board from ongoing monitoring and evaluation of the initiative. (b) Ongoing. Key services are in place and delivering benefits. This includes TeleCareLine, reablement and essential support from the voluntary sector through the 'prevention of admissions and re-admissions' service from Age UK. (c) On track – A flexible service will be commissioned to meet bed-based care needs on a short-term basis. Service expected to be in place by Spring 2014.	GREEN

Objective	Key Task	Lead	Subtasks	Dead-line for Subtask	Progress Update	RAG
2.2 Improve access to local Child and Adolescent Mental Health Services (CAMHS)	A review of mental health provision for children and young people across the following sectors in the borough: the NHS, social care, education, schools, public health, criminal justice, third sector, adult social care.	CAMHS	(a) Clarify statutory responsibilities for all delivery partners regarding services in scope (b) A map of local CAMHS/mental health and Learning Disabilities/Challenging Behaviour provision at all tiers for services in scope: service provision, service capacity, referral access (c) Identify local population needs and initial recommendations regarding meeting service gaps (d) An evidence review of "what works"; and feedback from users (e) Whole systems service design for child mental health support	a) 31/12/13 b) 31/12/13 c) 31/12/13 d) 31/01/14 e) 31/03/14	(a-e) Senior Team to Team meeting established with health commissioners as overarching steering group. CAMHS Working Group formed with health commissioner, local authority and provider representatives. Project charter developed. The arrangements to progress proposals are in place and updates will be provided to future meetings of the Board.	GREEN

Objective	Key Task	Lead	Subtasks	Dead-line for Subtask	Progress Update	RAG
2.3 To continue to reduce teenage pregnancy rates and reduce STIs in young people.	To promote awareness of the risks and to increase take-up of screening.	Public Health	(a) Pilot the extension of the Outreach Contraception and Sexual Health Advice to vulnerable Young People: Children Looked After, Homeless Young People, Young Carers, Drug and Alcohol Users. (b) Increase the Chlamydia Screening uptake by the Brunel University population: a) Increase Awareness of the Chlamydia Screening service on Campus, b) Refocusing the service to repeat Chlamydia testing annually or on change of partner/s.	a) 31/03/14 (b) 31/03/14	a) Currently, the focus of the pilot is on LGBT using LGBT Needs Assessment. A stakeholders meeting was held on 14.11.13 to assess current provision of services to LGBT and plan development work in partnership. Stakeholders include partners working with vulnerable groups-THT, Navigator, YMCA, Youth Service. b) Terrence Higgins Trust providers of Chlamydia Screening are investigating various ways of using IT to increase Chlamydia Screening awareness at Brunel i.e. via the university Intranet/emails. Training undertaken for University Medical Centre and Pharmacy in Term 1 (Oct-Dec).	GREEN

Objective	Key Task	Lead	Subtasks	Dead-line for Subtask	Progress Update	RAG
			(c) Develop a proposal to extend the current Emergency Hormonal Contraception service, from under 18yrs to under 25yrs and based on local evidence, include a further 9 Pharmacies in the revised TP hotspot wards (ONS 2011)	c) 31/03/14	c) Potential interested eligible Pharmacists have been identified. Emergency hormonal contraception training being developed. Patient Group Direction (note: PGD is a specific written instruction for the supply or administration of a named medicine in an identified clinical situation) has been updated and signed by the CCG, Public Health Consultant, Service Lead and Pharmacist on 5.11.13	
2.4 Develop the model of care for dementia	Reduce dependency on institutional care, including hospital bed days and care home settings.	Mental Health Delivery Group	(a) Finalise and begin to implement a joint plan for dementia services to include a service model that delivers effective assessment, treatment and community based support and intervenes earlier in the course of the disease. (b) Agree a joint implementation plan for years 2 and 3 of the Adult Mental Health Strategy.	a) 31/03/14 b) 31/03/14	(a) On track. Adult Mental Health strategy in place including dementia. A mental health task and finish group has been established to co-ordinate and implement the agreed plan for adult services of all ages. The plan will complement work already underway and being delivered which includes befriending services, dementia cafes, programmes which promote healthy living and health improvement and increasing early intervention for memory assessment. (b) Ongoing. Plan will be recommended for consideration by the Health and Wellbeing Board.	GREEN

Objective	Key Task	Lead	Subtasks	Dead-line for Subtask	Progress Update	RAG
2.5 Improve pathways and response for individuals with mental health needs	To ensure information and access to support is available for people with mental health needs, and that pathways are in place to enable appropriate responses to need	CCG	(a) to develop crisis response and ongoing support of 14 weeks for older people with mental health needs including dementia	(a) 31/03/14	(a) Service developed to an integrated model, which is embedded across the new service elements; the rapid response, ICP, memory service and intermediate care for people with mental health and dementia. The new provision will equip carers with the appropriate skills and resources to navigate patients away from unnecessary admissions and access home based care and support patients to be discharged back to home.	GREEN
			(b) to implement urgent assessment pathways and with all mental health providers to enable a consistent response and standards of care across the whole system	(b) 31/03/14	b) To implement common standards for urgent assessment and care so that service users experience a consistent response when referred for an urgent need. This will include: 1. develop and implement standardised processes for urgent referral agreed with stakeholders. Standards have been agreed. 2. Identify and address training needs and appropriate health and social care record-keeping to support effective shared care and provide high quality care pathway - local implementation plan under development with providers. 3. Ensure onward pathways are developed to support improved patient experience when accessing services via urgent referral - on track.	
			(c) to evaluate the liaison psychiatry pilot programme and identify benefits to improved liaison between physical and health care needs for 14/15 .	(c) 31/04/13	c) The psychiatric liaison pilot - interim evaluation showed benefits to service using qualitative and quantitative methods. Further work to review the extension of service model will require the development of a business case. Move to business case development stage for 14/15. Service Specification has been developed. LPS service will be based on costed service model for 14/15.	

Objective	Key Task	Lead	Subtasks	Dead-line for Subtask	Progress Update	RAG
2.6 Reduce alcohol-related harm for hazardous, harmful and dependent drinkers in Hillingdon	Commission a range of interventions to reduce alcohol-related harm and to increase the numbers of alcohol clients referred from acute and primary care settings into community-based treatment services.	Public Health	(a) Increase numbers of alcohol clients presenting to the treatment system and in structured treatment (b) Increase the numbers and rate of alcohol clients successfully completing and exiting treatment.	(a) 31/03/14 (b) 31/03/14	(a) from the latest available data, 519 clients in treatment in quarter 2 (where alcohol is the primary drug) – a small reduction compared to the previous quarter. (b) from the latest available data – 178 clients exited treatment in the 12 months ending quarter 2 2013/14, this represents a 'successful completion' rate of 34.3% - which is a slight reduction on the baseline position. The commissioning of substance misuse services (drugs and alcohol) transferred to the London Borough of Hillingdon (LBH) on 1st April 2013. The service is currently under review as part of the BID Transformation review. The aim of the review is to understand the current position and to identify priorities for a future model of delivery. The redesign of local substance misuse services will take alcohol related needs into account.	GREEN

<table>
<tr><th>Objective</th><th>Key Task</th><th>Lead</th><th>Subtasks</th><th>Deadline for Subtask</th><th>Progress Update</th><th>RAG</th></tr>
<tr>
<td>2.8 to reduce the extent of low birth rate

<u>Smoking in Pregnancy:</u> Babies from deprived backgrounds are more likely to be born to mothers who smoke and to have much greater exposure to secondhand smoke in childhood. Smoking remains one of the few modifiable risk factors in pregnancy. It can cause a range of serious health problems, including lower birth weight, pre-term birth, placental complications and perinatal mortality.</td>
<td>To develop a targeted programme in geographical areas with high rates of low birth weight babies, to increase the confidence and participation of parents/women to have healthy babies.</td>
<td>Public Health</td>
<td>(a) <u>12 week assessments</u> -Increase the percentage of women who have seen a midwife or a maternity healthcare professional, or had an assessment of health and social care needs, risks and choices by 12 completed weeks of pregnancy. (National indicator target 90%)

(b) <u>Low Birth Weight</u> - Decrease the percentage of Live and Still Births less than 2500 grams.

(c) Low Birth Weight of Term Babies: (ie. less than 2,500 grams):</td>
<td>(a) 31/03/14

(b) 31/03/14

(c) 31/03/14</td>
<td>(a) There has been a proactive effort to ensure that our target rate has been achieved.

12 Week Assessment - 2012/13 Performance:
<table><tr><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td></tr><tr><td>79.9%</td><td>79.9%</td><td>94.3%</td><td>90.2%</td></tr></table><u>2013/14</u>: The Commissioning Support Unit have confirmed that the Department of Health will not be collecting maternity assessment data until the new year and that it will be obtained directly from the providers rather than CCGs.

<u>b) Task and finish group ('Having a Healthy Baby')</u>: To plan interventions for the south of the borough which has higher rates of late bookers and low birth weight babies. Interventions include:
○ Referrals to Stop Smoking Prevention and support
○ Referrals to Healthy weight management courses
○ Linking up with Hillingdon Maternity volunteers to promote and sign-post to Stop Smoking services, Healthy Weight Management courses, 'First Aid in the home' courses.
○ Agreeing ways to gather information to help plan services including what having a healthy baby means for women (i.e. those of child bearing age and older women) living in the South of the borough and how this impacts on the uptake of pre-conception and maternity services.
○ Director of Public Health to meet with the Chair of the Hillingdon Maternity Services Liaison Committee to discuss proposed action plan regarding sign-post to Stop Smoking services, Healthy Weight Management courses, 'First Aid in the home' courses via the service users 'Walking the Patch Team'.

c. Stocktake of 'Conception to Age 2 Framework' has been completed. The outcomes of this will feed into the Maternity Services Liaison Committee, Public Health and early Years Group, Perinatal Depression Group to inform and align work around local maternity services.</td>
<td>GREEN</td>
</tr>
</table>

Objective	Key Task	Lead	Subtasks	Deadline for Subtask	Progress Update	RAG
2.9 To prevent vaccine preventable childhood diseases	To increase uptake of childhood immunisations	NHS England	To provide independent scrutiny and challenge the plans of NHS England, Public Health England and providers. (NB The national target for childhood immunisations is 95% for each of the vaccines for the under-fives childhood immunisation schedule and 90% coverage for HPV in school-aged girls).	31/03/14	NHS England Historically Hillingdon has a high take-up level of immunisations. The latest data for MMR shows take-up is improving and is higher than England take-up rates. From the latest available data; <u>MMR data for Apr-Sept 2013</u> MMR 24 Months = 93.1% (England, 92.7%) MMR (1 dose) 5 years = 94.6% (England 94.3%)	GREEN
2.10 Tackling the issues which can cause sight loss	To develop support and services locally which reduce the effects of sight loss	Vision Strategy Working Group	(a) Working with the Thomas Pocklington Trust and other local partners develop a vision plan and local support services.	(a) 31/03/14	(a) Pocklington Trust is in the process of collating needs information provided by stakeholders. A project group meeting will be taking place in December 2013 to review needs data and identify gaps. An action plan will be developed for consideration in Q4. Intention is to have priorities agreed by 31/03/14 that will inform commissioning plans.	GREEN

Objective	Key Task	Lead	Subtasks	Deadline for Subtask	Progress Update	RAG
Priority 3. Developing integrated, high quality social care and health services within the community or at home As a priority we will focus on: • Integrated approaches for health and well-being, including telehealth; • Integrated Care Pilot for frail older people as well as diabetes and mental health.						
3.1 Assist vulnerable people to secure and maintain their independence by developing extra care and supported housing as an alternative to residential and nursing care	Increase independent accommodation in line with housing support plan	LBH Officer Group/HIP	(a) Provide adaptations to homes to promote safe, independent living. (b) Extend the TeleCareLine service to a further 750 people (c) Provide extra care and supported accommodation to reduce reliance on residential care	(a) 31/03/14 (b) 31/03/14 (c) 31/03/14	(a) A total of 138 homes have had adaptations completed to enable disabled occupants to continue to live at home. This is made up of 90 Disabled Facilities Grants for owner/occupiers and private tenants, and 48 Council tenants. (b) As at 31st December 2013, 2,645 new service users were in receipt of a TeleCareLine equipment service. The technology is helping people to live safely and independently at home. The take-up of TeleCareline is exceeding the target of 750 new service users set for each year of the scheme. The scheme is being extended from April 2014. (c) On average 1 placement is made per month into extra care for older people who would otherwise have to move into residential care. Glenister Gardens, a 12 bed supported living scheme for clients with learning disabilities, is fully occupied. The supported living building programme is currently being reviewed to ensure it meets the current and future needs. 4 bespoke small schemes are being developed for clients with mental health needs or learning disabilities who will benefit from shared accommodation.	GREEN

3.2 Deliver end of life care and support services	Improve the quality of end of life care for residents	End of Life Forum	(a) Develop work with the ICP programme to assist in identification of 1% people expected to die within a 12 month period.	(a) 31/03/14	(a) The ICP for Frail Elderly patients is well developed and in use by GP's to develop advanced care plans utilising 'Co-ordinate My Care' (CMC). CMC is an electronic patient care record system that allows all organisations with access to an N3 connection to view the patients care plan and their wishes in terms of the end of life phase of their illness. Macmillan and Hillingdon CCG are working in collaboration to fund a three year GP clinical lead to provide assistance in the form of education and training to Hillingdon GPs with the process of identification of patients who should have an advanced care plan.	GREEN
			(b) Develop information sharing protocols between statutory, voluntary, private and independent sector partners regarding early identification of people approaching end of life.	(b) 31/03/14	(b) A three year strategy (2013-2016) has been documented by the Pan Hillingdon End of Life Forum.	
			(c) Develop a process for measuring quality for end of life care in Hillingdon.	(c) 31/03/14	c) Agreements are in place to measure quality in relation to documented preferences as recorded in the CMC Care plan. Patients who have their preferences recorded on CMC are more likely to achieve their preferred place of care at end of life. Figures received in November from Public Health demonstrated that for the first 6 months of this financial year, 50% of patients died in hospital – compared to the previous 6 months when 68% died in hospital .	

Objective	Key Task	Lead	Subtasks	Deadline for Subtask	Progress Update	RAG
4. A positive experience of care As a priority we will focus on: • Tailored, personalised services; • An ongoing commitment to stakeholder engagement.						
4.1 Deliver personalised adult social care services through the Support, Choice and Independence programme.	Increase the number of people in receipt of a personal budget to give residents greater choice and control over the outcomes they consider to be important.	LBH	(a) Promote take up of personal social care budgets to provide greater choice and control	(a) 31/03/14	(a) A personal care budget gives people who need care and support a greater say on deciding their support arrangements to suit their own needs. As at 31st December 2013, overall 75% of social care clients (2,317 clients) were in receipt of a personal budget (based on services which are subject to a personal budget). Take-up of personal budgets is higher for older people (81%).	GREEN

Objective	Key Task	Lead	Subtasks	Deadline for Subtask	Progress Update	RAG
4.2 Ensure that local residents have opportunities to get involved in and have a say about services which improve health and wellbeing.	Develop opportunities for residents to get involved.	Task and Finish Group to review	(a) Establish the current requirements and arrangements for stakeholder engagement across health and the Council to support improvements in health and wellbeing (b) Make recommendations to the Health and Wellbeing Board to establish a co-ordinated plan of stakeholder engagement in Hillingdon for Health and Wellbeing	(a) 31/03/14 (b) 31/03/14	(a) On track. A group has been established to review and co-ordinate stakeholder engagement across health and social care. The leads for engagement across health and social care will develop recommendations for consideration. The recommendations will be practical and focus on supporting meaningful involvement of local residents. (b) On track – recommendations will be presented to a meeting of the Board in 2014. Under the auspices of the Better Care Fund work, a stakeholder group has been formed to provide feedback on the plan. An initial meeting was held on 17th January 2014 and a further public engagement event is proposed for February 2014. A communications plan for the Better Care Fund has been drafted.	GREEN

PUBLIC HEALTH ACTION PLAN 2013/14

Cabinet Member(s)	Councillor Philip Corthorne
Organisation	London Borough of Hillingdon
Report Author	Sharon Daye, Public Health
Papers with report	Appendix 1 - Action Plan

1. HEADLINE INFORMATION

Summary	This is an action plan update regarding the integration of Public Health into the Council post transfer on 1 April 2013.
Contribution to our plans and strategies	The Council now has certain statutory duties in respect of Public Health under the Health & Social Care Act 2012. The delivery of the Council's Public Health functions are driven by the Health and Wellbeing Strategy.
Financial Cost	There are no financial costs associated with the recommendations in this report.
Relevant Policy Overview Committee	Social Services, Housing & Pubic Health
Ward(s) affected	All

2. RECOMMENDATION

That the Health and Wellbeing Board notes the report and action plan at Appendix 1.

Reasons for recommendation

To ensure that the Health and Wellbeing Board is aware of progress made against the Public Health Action Plan.

Policy Overview Committee comments

None at this stage.

3. INFORMATION

An integrated delivery model for Public Health in Hillingdon has been adopted. This is consistent with the Council's operating model and aligns functions, exploits synergies and maximises benefit to residents.

Under this approach, common activities such as finance, contracts, performance management and business support will be incorporated into existing Council services.

4. CORPORATE IMPLICATIONS

Corporate Finance

Corporate Finance has reviewed this report, noting that all costs associated with the implementation of the action plan set out in Appendix 1 are being met from the ring-fenced Public Health budget. There is no direct financial cost associated with the recommendation contained within this report.

Legal

No specific legal implications arising from this report.

5. EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

The approach taken to integration of Public Health into the Council should enable effective delivery of mandatory functions and Public Health priorities.

6. BACKGROUND PAPERS

NIL.

APPENDIX 1 **PUBLIC HEALTH ACTION PLAN 2013/2014**

Objective	Key Task	Lead	Subtasks	Deadline for Subtask	Progress Update
1. Integration of Public Health *(Post Transfer)*					
1.1 Ensure the delivery of mandatory and non-mandatory services is centred the Councils vision of putting residents first.	To deliver improved outcomes, including improved health	Jean Palmer Aileen Carlisle Matthew Kelly Sharon Daye/Nigel Dicker	1.1a Apply Council's contract management framework, incorporating category management for commissioning activities. 1.1b Undertake review of mandatory and non-mandatory services: ***Mandatory:*** ▪ National Child Measurement Programme; ▪ NHS Health Checks; ▪ Core Offer to Clinical Commissioning Groups (CCGs); ▪ Public Health responsibilities for Health Protection; ▪ Sexual Health. ***Non-mandatory*** ▪ School nursing (i.e. Healthy Child Programme for school age children) ▪ Local health improvement programmes to improve diet / nutrition, to promote ▪ physical activity and prevent / address obesity;	October 2013	1.1a Category management approach in place and work ongoing. 1.1b Full BID and category reviews of services and service specifications, liabilities and commitments currently underway. A series of workshops and discussions (led by the Procurement Team) to proceed with process mapping and commercial proposals regarding sexual health and substance misuse services have taken place during November and December 2013. School Nursing: Category management approach in place and work ongoing.

Objective	Key Task	Lead	Subtasks	Deadline for Subtask	Progress Update
			▪ Drug misuse and alcohol misuse services; ▪ Tobacco control including stop smoking services and prevention activity. 1.1c Recommendations to Cabinet for approval	TBC	
1.2 Integration of ring-fenced public health budget. (Note: Additional public health grant funding has been awarded over a 2 year period – 2013/14 & 2014/15)	To apply Council's robust approach to medium term financial forecasting, including value for money	Jean Palmer Aileen Carlisle Sharon Daye Nigel Dicker	1.2a To undertake an exercise to identify projects or schemes across Council's key service area that would support implementation of priorities identified in the JSNA across the 4 public health domains of: Domain 1: Improving the wider determinants of health; Domain 2: Health Improvement; Domain 3: Health Protection; Domain 4: Healthcare public health and preventing premature mortality.	Early July 2013	Exercise Undertaken

Objective	Key Task	Lead	Subtasks	Deadline for Subtask	Progress Update
			1.2b To raise awareness of Council staff about new Public Health responsibilities in order to identify projects.	Early July 2013	Four workshop briefings undertaken in June /July. Schemes are now being reviewed.
2. BID Review of Public Health Team					
2.1 To review the work of the transferred Public Health Team, using BID principles.	To reshape the service to support the Council's operating model and focus on building capacity and resilience.	Aileen Carlisle Jean Palmer	2.1 a To place the Public Health Team including the Specialist Health Promotion and Smoking Cessation Teams into Residents Services. 2.1b Restructure of Public Health and Specialist Health Promotion Teams as part of the integration of the Team into the Council.		Completed. Revised structure, job descriptions and person specifications currently being evaluated by Human Resources. (Note: Job descriptions for the Statutory Director of Public Health and Consultant in Public Health are also being evaluated.

Objective	Key Task	Lead	Subtasks	Deadline for Subtask	Progress Update
	To test the new service delivery model, through prototype working.		2.1b Public Health Consultants to continue providing analysis and advisory support to delivery teams. 2.1c Broaden the remit of Public Health Consultants to include developing the strategic relationship with the local health economy including the CCG, local providers, and the hospital Trusts 2.1d Operational Public Health officers to: ▪ Build local capacity and resilience; ▪ Support people to employment ▪ Support the Family Information Service ▪ Support Education and training provision for young people 2.1e Build a broader delivery (ie. 'Community Public Health Service') providing and facilitating a greater array of services to support residents to make positive, well informed decisions.	Ongoing TBC	Ongoing.))))) Restructure of Public Health and Health) Promotion Team currently under way.))))))))) BID Transformation Review Process underway

Objective	Key Task	Lead	Subtasks	Deadline for Subtask	Progress Update
3. Effective Partnerships Working					
3.1 Agreement of Memorandum of Understanding (MOU) between the Council and Hillingdon Clinical Commissioning Group (CCG) (Note: The Health and Social Care Act 2012: Mandatory responsibility for local authorities)	Ensure local NHS commissioners receive the necessary public health advice so that they can discharge their statutory duties. Agreement of Action Plan to support implementation of the MOU between the Council and Hillingdon CCG	Sharon Daye/ Nigel Dicker	3.1a To develop MOU for 2013/14 that can be jointly agreed by both the Council and Hillingdon CCG. 3.1b To develop action plan for 2013/14 that can be jointly agreed by both the Council and Hillingdon CCG		MOU Agreed at September 2013 meeting of the Health and Wellbeing Board. Action Plan agreed.

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HILLINGDON CCG FINANCIAL RECOVERY PLAN UPDATE REPORT

Relevant Board Member(s)	Dr Ian Goodman
Organisation	Hillingdon Clinical Commissioning Group
Report author	John Halsted: Interim QIPP Director
Papers with report	Appendix - Summary of Progress Against Plan

1. HEADLINE INFORMATION

Summary	This report provides an update on Hillingdon CCG's progress with its Financial Recovery Plan for 2013-2016. The CCG's Financial Recovery Plan forms an integral part of its 2013/14 Operating Plan, as agreed by the Health and Wellbeing Board (HWBB) at its February 2013 meeting and as approved by the Hillingdon CCG Governing Body at its May 2013 meeting. It also aligns closely with the Hillingdon CCG Out of Hospital Strategy. The Financial Recovery Plan forms a subset of total CCG budgets and it should be noted that, whilst delivery of this Plan contributes to the financial position, it does not represent the final overall position. Overall, HCCG is projecting a smaller deficit than set at the beginning of the financial year. Current expectations are for the CCG to deliver the majority of its £11m Recovery Plan targets by March 2014. However, there is a risk of underperformance of c £2.5 million (22% of the overall Plan) based on current activity figures. A number of remedial actions have been put in place to seek to reduce this forecast under-performance.
Contribution to plans and strategies	Joint Health & Wellbeing Strategy
Financial Cost	The Financial Recovery Plan reflects the position of Hillingdon CCG at the time of writing. Changes to funding streams and national policy impact on assumptions within the Financial Recovery Plan and the Plan has been refreshed for 2014/15 to reflect these changes.
Relevant Policy Overview & Scrutiny Committee	N/A
Ward(s) affected	All

2. RECOMMENDATION

The Board is asked to note this update.

3. INFORMATION

Supporting Information

3.1 CCG Recovery Plan 2013/14

The CCG set its budget for 2013/14 on the basis of achieving a series of financial savings targets between April 2013 and March 2016. The target for this year is £11 million, rising to £14.5 million in each of the two following years, or £40 million over the combined three years. A deficit budget of £12.15m was set for 2013/14.

The Recovery Plan – or QIPP Programme (Quality, Innovation, Productivity and Prevention) – contains 5 main programmes, with the savings target in 2013/14 shown against each:

1. Unscheduled Care (£3 million)
2. Planned Care (£3.7 million)
3. Long Term Conditions (£0.4 million)
4. Prescribing (£2.4 million)
5. Mental Health & Community Services (£1.7 million)

Each programme contains a number of separate schemes, with the overall objective of achieving faster access to care in an emergency, and improved pathways of care for all users of services, and bringing access to high-quality care in line with best practice in London and nationally. In addition to the schemes above, the CSU (Commissioning Support Unit) is responsible for ensuring contractual requirements are rigorously applied and challenges made appropriately.

The four underlying principles behind the CCG's financial planning, and the Governing Body's approach to integrated commissioning, are for the Financial Recovery Plan to deliver local financial and service stability over the next 3 years, and to be:

1. Clinically led and supported by GP commissioners
2. Informed by engagement with the public, patients and local authority
3. Robust and transparent in its process, and underpinned by a sound clinical evidence base
4. Consistent with current and prospective patient choice

Achievement of our commissioning priorities is linked to achievement of the Quality Premium (a payment CCGs receive in the following year if certain targets are achieved). Delivery is tracked weekly through our Programme Management Office (PMO), and monitored through monthly assurance meetings by NHS England.

3.2 Progress to date

Several of our schemes are already in place, and delivering the expected level of savings, for example: the successful implementation of the Urgent Care Centre at Hillingdon Hospitals (THH); negotiation and successful contract variation for a new musculo-skeletal care pathway and a new gynaecology pathway with THH; and

continuation of the successful Rapid Response and Admissions Avoidance care-pathways, in partnership with LBH, CNWL and THH.

A number of our planned care schemes have taken longer than expected to get underway, with ENT commencing on March 2014. Good progress is being made with THH in developing other late schemes as a variation to our existing contract.

Besides weekly monitoring within the CCG PMO and regular reviews at the Governing Body and CCG Committees, progress with the overall Recovery Plan has been discussed with the whole economy Recovery Programme Board and NHS England.

3.3 Hillingdon CCG Budgets and Financial Plan

The Financial Recovery Plan adopted in November 2012 has been updated to reflect latest policy guidance and more detailed plans for the delivery of QIPP savings in 2014/15. The updated Plan is with NHS England for comment and approval.

The CCG has commenced detailed budget setting based on the updated Recovery Plan and stated Commissioning Intentions.

4. FINANCIAL IMPLICATIONS

The Operating Plan 2013/14 for Hillingdon CCG is based on a deficit budget of £12.25m with a QIPP (Quality, Innovation, Productivity and Prevention) of £11m identified. Achievement of this control total is monitored through monthly assurance meetings with NHS England-Local Area Team.

5. LEGAL IMPLICATIONS

Hillingdon CCG is required to produce an Operating Plan annually.
All CCGs are required to comply with the NHS Mandate.

6. BACKGROUND PAPERS

None.

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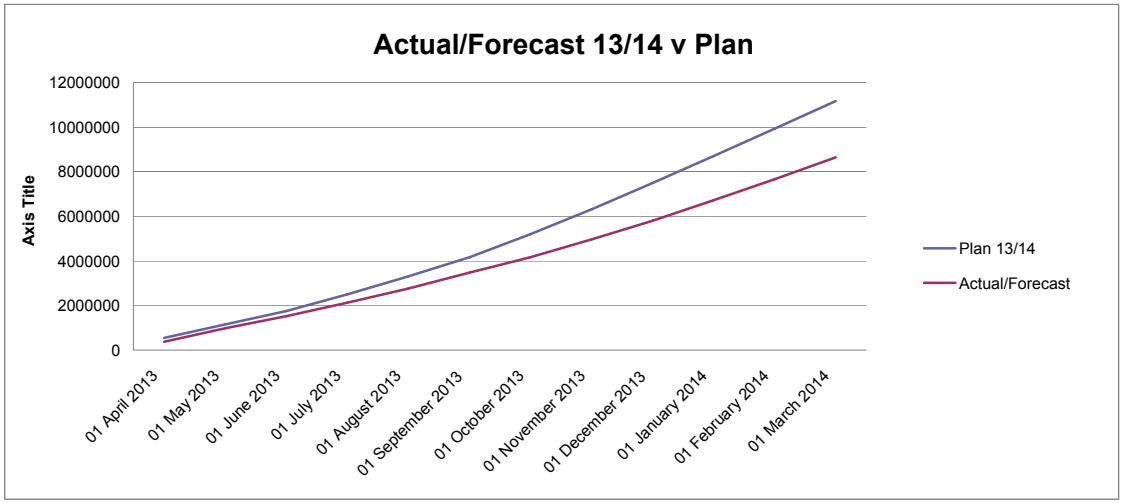
Month 9 Report

Local Scheme Name		1 Apr-13	2 May-13	3 Jun-13	4 Jul-13	5 Aug-13	6 Sep-13	7 Oct-13	8 Nov-13	9 Dec-13	10 Jan-14	11 Feb-14	12 Mar-14	Total
Intermediate Care - 1A - Scale up Rapid Response	PLAN	8,275	17,303	25,578	39,872	39,872	39,872	39,872	39,872	39,872	39,872	39,872	39,872	410,000
	ACTUAL	50,033	38,833	30,433	34,633	43,033	31,833	33,793	33,793	37,993	37,993	25,393	36,033	433,800
	VARIANCE	**41,758**	**21,531**	**4,855**	**-5,238**	**3,162**	**-8,038**	**-6,078**	**-6,078**	**-1,878**	**-1,878**	**-14,478**	**-3,838**	**23,800**
Intermediate Care - 1B - Increase scope of Rapid Response	PLAN	-	-	-	-	-	-	61,667	61,667	61,667	61,667	61,667	61,667	370,000
	ACTUAL	-	-	-	-	-	-	43,733	40,333	12,173	59,053	58,153	68,053	281,498
	VARIANCE	-	-	-	-	-	-	**-17,933**	**-21,333**	**-49,493**	**-2,614**	**-3,514**	**6,386**	**-88,502**
Excess Bed Days	PLAN	66,667	66,667	66,667	66,667	66,667	66,667	66,667	66,667	66,667	66,667	66,667	66,667	800,000
	ACTUAL	29,836	29,836	49,484	46,305	10,929	-44,099	-74,529	- 29,506	46,305	46,305	46,305	46,305	203,476
	VARIANCE	**-36,831**	**-36,831**	**-17,183**	**-20,362**	**-55,738**	**-110,766**	**-141,196**	**-96,173**	**-20,362**	**-20,362**	**-20,362**	**-20,362**	**-596,524**
ICP Pilot - diabetes/older people/diabetes/COPD/HF	PLAN	21,935	32,903	43,871	45,242	45,242	45,242	45,242	45,242	45,242	46,613	46,613	46,613	510,000
	ACTUAL	18,436	18,436	23,000	58,514	30,000	80,000	42,000	44,000	46,500	47,000	51,000	51,000	509,886
	VARIANCE	**-3,500**	**-14,467**	**-20,871**	**13,272**	**-15,242**	**34,758**	**-3,242**	**-1,242**	**1,258**	**387**	**4,387**	**4,387**	**-114**
Diabetes Pathway	PLAN	-	-	-	-	-	-	8,667	8,667	8,667	8,667	8,667	8,667	52,000
	ACTUAL	-	-	-	-	-	-	-	-	-	-	-	-	-
	VARIANCE	-	-	-	-	-	-	**-8,667**	**-8,667**	**-8,667**	**-8,667**	**-8,667**	**-8,667**	**-52,000**
End of Life	PLAN	-	-	-	43,333	43,333	43,333	43,333	43,333	43,333	43,333	43,333	43,333	390,000
	ACTUAL	-	-	-	109,152	2,515	64,254	-14,735	14,723	43,683	43,683	43,683	43,683	350,643
	VARIANCE	**-**	**-**	**-**	**65,819**	**-40,818**	**20,921**	**-58,068**	**-28,610**	**350**	**350**	**350**	**350**	**-39,357**
A & E to UCC procurement	PLAN	-	-	-	-	-	-	59,251	75,093	91,414	91,414	91,414	91,414	500,000
	ACTUAL	-	-	-	-	-	-	88,579	129,543	91,414	91,414	91,414	91,414	583,779
	VARIANCE	**-**	**-**	**-**	**-**	**-**	**-**	**29,328**	**54,451**	**-**	**-**	**-**	**-**	83,779
Gastro Pathway development	PLAN	-	-	-	-	-	-	5,397	6,682	8,480	8,480	8,480	8,480	46,000
	ACTUAL	-	-	-	-	-	78,795	-	- 4,882	8,000	8,000	8,000	8,000	105,913
	VARIANCE	**-**	**-**	**-**	**-**	**-**	**78,795**	**-5,397**	**-11,564**	**-480**	**-480**	**-480**	**-480**	**59,913**
Ophthalmology Pathway Re-design	PLAN	-	-	-	14,148	28,482	42,723	80,697	80,790	80,790	80,790	80,790	80,790	570,000
	ACTUAL	-	-	-	-	-	-	124,000	68,790	68,790	68,790	68,790	68,790	467,951
	VARIANCE	**-**	**-**	**-**	**-14,148**	**-28,482**	**-42,723**	**43,303**	**-12,000**	**-12,000**	**-12,000**	**-12,000**	**-12,000**	**-102,049**
Gynaecology Pathway development	PLAN	-	-	-	-	-	-	16,831	33,366	49,961	66,614	66,614	66,614	300,000
	ACTUAL	-	-	-	-	-	-	16,831	38,817	33,366	49,961	66,614	66,614	272,203
	VARIANCE	-	-	-	-	-	**-**	**0**	**5,451**	**-16,594**	**-16,654**	-	-	**-27,797**
Dermatology Pathway development	PLAN	-	-	-	-	-	-	17,100	22,545	27,922	34,144	34,144	34,144	170,000
	ACTUAL	-	-	-	-	-	-	-	-	-	-	-	-	-
	VARIANCE	-	-	-	-	-	-	**-17,100**	**-22,545**	**-27,922**	**-34,144**	**-34,144**	**-34,144**	**-170,000**
Urology Pathway development	PLAN	-	-	-	-	-	-	-	-	4,698	9,368	12,967	12,967	40,000
	ACTUAL	-	-	-	-	-	-	-	-	-	9,396	14,467	16,137	40,000
	VARIANCE	-	-	-	-	-	-	-	-	**-4,698**	**28**	**1,500**	**3,170**	**-0**
General Surgery Pathway development	PLAN	-	-	-	-	-	-	-	-	-	10,917	10,917	11,165	33,000
	ACTUAL	-	-	-	-	-	-	-	-	-	-	-	-	-
	VARIANCE	-	-	-	-	-	-	-	-	-	**-10,917**	**-10,917**	**-11,165**	**-33,000**
ENT Pathway Development	PLAN	-	-	-	-	-	-	-	-	-	6,316	9,878	13,807	30,000
	ACTUAL	-	-	-	-	-	-	-	-	-	-	-	6,316	6,316
	VARIANCE	-	-	-	-	-	-	-	-	-	**-6,316**	**-9,878**	**-7,491**	**-23,684**
MSK Pathway development	PLAN	33,984	42,598	50,171	105,549	176,712	176,712	176,712	176,712	176,712	176,712	176,712	176,712	1,646,000
	ACTUAL	33,984	42,598	75,171	146,549	152,142	152,425	152,425	98,435	98,435	98,435	98,435	98,435	1,247,471
	VARIANCE	**- 0**	**- 0**	**25,000**	**41,000**	**- 24,570**	**-24,287**	**-24,287**	**-78,277**	**-78,277**	**-78,277**	**-78,277**	**-78,277**	**-398,529**
MSK Pathway development - Fixed	PLAN	69,000	69,000	69,000	69,000	69,000	69,000	69,000	69,000	69,000	69,000	69,000	69,000	828,000
	ACTUAL	69,000	69,000	69,000	69,000	69,000	69,000	69,000	69,000	69,000	69,000	69,000	69,000	828,000
	VARIANCE	-	-	-	-	-	-	-	-	-	-	-	-	-
Pulmonary Rehab	PLAN	8,333	8,333	8,333	8,333	8,333	8,333	8,333	8,333	8,333	8,333	8,333	8,333	100,000
	ACTUAL	-	-	-	5,556	5,556	5,556	5,556	5,556	5,556	5,556	5,556	5,556	50,000
	VARIANCE	**-8,333**	**-8,333**	**-8,333**	**-2,778**	**-2,778**	**-2,778**	**-2,778**	**-2,778**	**-2,778**	**-2,778**	**-2,778**	**-2,778**	**-50,000**
Cardiology Pathway development	PLAN	-	-	-	-	-	-	11,700	23,325	35,025	46,650	46,650	46,650	210,000
	ACTUAL	-	-	-	-	-	-	-	-	-	-	-	35,025	35,025
	VARIANCE	-	-	-	-	-	-	**-11,700**	**-23,325**	**-35,025**	**-46,650**	**-46,650**	**-11,624**	**-174,975**

Local Scheme Name		1 Apr-13	2 May-13	3 Jun-13	4 Jul-13	5 Aug-13	6 Sep-13	7 Oct-13	8 Nov-13	9 Dec-13	10 Jan-14	11 Feb-14	12 Mar-14	Total
Community Services Programme	PLAN	42,500	42,500	42,500	42,500	42,500	42,500	42,500	42,500	42,500	42,500	42,500	42,500	510,000
	ACTUAL	42,500	42,500	42,500	42,500	42,500	95,357	95,357	95,357	95,357	95,357	95,357	95,357	880,000
	VARIANCE	-	-	-	-	-	52,857	52,857	52,857	52,857	52,857	52,857	52,857	370,000
Existing contract savings planned (MH)	PLAN	72,500	72,500	72,500	72,500	72,500	72,500	72,500	72,500	72,500	72,500	72,500	72,500	870,000
	ACTUAL	72,500	72,500	72,500	72,500	72,500	72,500	72,500	72,500	72,500	72,500	72,500	72,500	870,000
	VARIANCE	-	-	-	-	-	-	-	-	-	-	-	-	-
Lucentis Pricing Efficiency	PLAN	39,167	39,167	39,167	39,167	39,167	39,167	39,167	39,167	39,167	39,167	39,167	39,167	470,000
	ACTUAL	-	-	-	-	-	-	-	-	-	-	-	-	-
	VARIANCE	-39,167	-39,167	-39,167	-39,167	-39,167	-39,167	-39,167	-39,167	-39,167	-39,167	-39,167	-39,167	-470,000
Medicines Management	PLAN	165,000	165,000	165,000	165,000	165,000	165,000	165,000	165,000	165,000	165,000	165,000	165,000	1,980,000
	ACTUAL	31,821	260,563	152,771	- 1,245	175,029	67,340	25,315	85,864	87,596	83,697	92,361	86,146	1,147,260
	VARIANCE	-133,179	**95,563**	-12,229	-166,245	**10,029**	-97,660	-139,685	-79,136	-77,404	-81,303	-72,639	-78,854	-832,740
Reprovision of CC Beds	PLAN	27,500	27,500	27,500	27,500	27,500	27,500	27,500	27,500	27,500	27,500	27,500	27,500	330,000
	ACTUAL	27,500	27,500	27,500	27,500	27,500	27,500	27,500	27,500	27,500	27,500	27,500	27,500	330,000
	VARIANCE	-	-	-	-	-	-	-	-	-	-	-	-	-
HILLINGDON Total	PLAN	554,861	583,471	610,287	738,810	824,308	838,549	1,057,135	1,107,959	1,164,449	1,222,224	1,229,385	1,233,562	11,165,000
	ACTUAL	375,611	601,767	542,360	610,963	630,704	700,461	707,325	789,824	844,170	913,640	934,529	991,865	8,643,220
	VARIANCE	-179,251	**18,296**	-67,927	-127,847	-193,603	-138,087	-349,809	-318,135	-320,279	-308,584	-294,856	-241,697	-2,521,780



UPDATE: ALLOCATION OF S106 HEALTH FACILITIES CONTRIBUTIONS

Relevant Board Member(s)	Councillor Ray Puddifoot
Organisation	London Borough of Hillingdon
Report author	Jales Tippell, Administration Directorate
Papers with report	None

1. HEADLINE INFORMATION

Summary	This paper updates the Board of the progress being made in allocating and spending contributions towards the provision of healthcare facilities in the Borough.
Contribution to plans and strategies	Joint Health & Wellbeing Strategy
Financial Cost	None.
Relevant Policy Overview & Scrutiny Committee	Social Services, Housing and Public Health Residents' and Environmental Services External Services
Ward(s) affected	N/A

2. RECOMMENDATION

That the Board notes the progress being made towards the allocation and spend of s106 healthcare facilities contributions within the Borough.

3. UPDATE ON PROGRESS

1. Since the last report to the Health and Wellbeing Board in December 2013, a further meeting has been held between officers from the Council's Public Health Service, NHS Property Services and the Council's S106 Monitoring Officer to discuss progress and move identified schemes forward.

GP expansion schemes

King Edwards Medical Centre – Additional GP consulting room

2. A total of £20,000 from two s106 health facilities contributions currently held by the Council has now been formally allocated to this scheme (Cabinet Member Decision 06/12/2013). The scheme involves internal alterations to provide an additional GP

consulting room and is due to be completed in February 2014. Subject to a formal request, the funds are now due to be transferred to NHS Property Services who will be responsible for ensuring that the scheme is delivered in line with the Service Level Agreement.

Southcote Medical Centre – Extension to existing premises

3. The proposed scheme involves an extension to the current premises to provide an additional GP consulting room, clinical training room and increased waiting area. A Cabinet Member report to formally request the allocation and release of funds from the s106 health facilities contribution held at H/15/205F (£184,653) towards this scheme was approved by the Leader and the Cabinet Member for Finance, Property and Business Services on 9 January 2014. Subject to a formal request from NHS Property Services, the funds will now be transferred towards the cost of implementing the scheme.

Wallasey Medical Centre – Extension to existing premises

4. This scheme to extend the existing GP surgery to provide two GP consulting rooms and a clinical training room has recently been completed. A Cabinet Member report to request formal allocation and release of the funds held at H/19/231G (£193,305) towards the scheme was formally approved on 17 January 2014 and funds will be released to NHS Property Services to ensure that the funds are applied retrospectively towards the legitimate costs associated with the scheme.

Pine Medical Centre – Additional GP consulting room

5. This scheme involves the conversion of an existing meeting room into a GP consulting room. Subject to the practice providing further details of the scheme, a Cabinet Member report will be formally submitted to the Leader and the Cabinet Member for Finance, Property and Business Services in February, in order for a formal decision to be made to allow £1,800 from the contribution held at H/18/219C to be released towards the scheme.

Proposed 'Health Zone' in Hayes

6. The idea of a "health zone" to provide health check assessments and health advice on issues such as diabetes, obesity, heart disease or smoking has been supported by all parties and discussions to identify a suitable location within the Hayes area have been ongoing. One option considered would be to equip a room at the new Hesa Centre and the capital costs of equipping a room for this purpose are currently being explored. However, to set up an early intervention service at the centre would also require a new revenue commitment to which the Council's Public Health Service could not commit at the present time. This proposal will not therefore be pursued for the time being.

Hesa Health Centre expansion

7. NHS Property Services has advised that the works contracts and licences for this scheme have now been signed by NHS Property Services and that the four week mobilisation period for the works began on site in the week beginning 13 January 2014. The works are expected to take a year to complete and an amended work programme will be provided to the Council as soon as it becomes available.

8. Now that the works contracts for the scheme have been signed, and following a formal request from NHS Property Services, the three s106 contributions totalling £264,818, which have already been formally allocated towards this scheme (Cabinet Member Decision 06/04/11), have now been transferred under the terms of the SLA, to be spent towards the cost of implementing the scheme.

9. NHS Property Services has also confirmed that they have invested over and above the s106 allocation towards developing the HESA scheme, which has a budget in excess of £1 million and that the deadline for spending the contribution held at H/4/140H (£53,496) has therefore been met.

Proposed new Yiewsley Health Centre (former Yiewsley Pool site)

10. A planning application to redevelop the former Yiewsley Pool site to provide a new health centre, gym and 12 supported housing units was submitted in early December (planning reference 18344/APP/2013/3564). The proposed scheme will provide purpose built accommodation for three GP Practices currently located in the Yiewsley area, as well as community services space to provide other medical support services such as physiotherapy, phlebotomy and podiatry.

11. Subject to planning approval, the Yiewsley Health Centre scheme is expected to start on site after May 2014 and complete by November 2015. The funding required to meet the fitting out costs associated with the scheme are therefore not likely to be needed until 2015/2016. As this will be too late to spend the three s106 contributions currently earmarked towards these costs, NHS Property Services has verbally agreed to the Council utilising these contributions (totalling £70,672) towards the costs associated with the submission of the planning application.

12. Following confirmation of NHS Property Services' support for this proposal, a Cabinet Member report will be formally submitted to the Leader and the Cabinet Member for Finance, Property and Business Services in February in order for a formal decision to be made to allow the monies to be released towards the scheme.

St Andrews Park

13. NHS Property Services and the CCG are continuing discussions with the site developer, VSM, to identify a larger alternative site for the proposed health centre.

14. Proposals to create a health hub on the site are generally supported by local GPs and community services and discussions to establish on site requirements are ongoing. The CCG is also in the process of preparing a strategic case for the provision of a health hub on the site and developing an outline business case for submission to NHS England.

FINANCIAL IMPLICATIONS

As reported in the second s106 quarterly report, there is £1,334k of Social Services, Health and Housing s106 contributions available of which £41k has been identified as a contribution for affordable housing and £49k towards a social services scheme. The remaining £1,244k is available to be utilised towards the provision of facilities for health. It is worth noting that £108k of the health contributions have no time limits attached to them.

The proposals for the allocation of contributions and their time limits can be summarised as follows:

Allocated to Hesa Health Centre Hayes: - Funds transferred to NHS PS Jan 2014

S106 Funding Reference	Development	Amount	Time Limit to Spend
H/4/140H	MOD Records Office, Hayes	£53,496	Jan 2014
H/6/170C	11-21 Clayton Rd, Hayes	£30,527	Aug 2014
H/7/149D	Hayes Goods Yard	£180,795	Nov 2014
Total		**£264,818**	

Earmarked to proposed new Yiewsley Health Centre:

S106 Funding Reference	Development	Amount	Time Limit to Spend
H/5/161C	Fmr Honeywell Site, West Drayton	£51,118	Mar 2014
H/14/206C	111 – 117 High St, Yiewsley	£10,651	Aug 2014
H/1/152C	Fmr Middlesex Lodge, Hillingdon	£8,903	Jul 2014
Total		**£70,672**	

Allocated to expansion at Southcote Clinic

S106 Funding Reference	Development	Amount	Time Limit to Spend
H/15/205F	RAF Eastcote, Ruislip	£185,968	Sept 2014
Total		**£185,968**	

Allocated to King Edwards Medical Centre

S106 Funding Reference	Development	Amount	Time Limit to Spend
H/12/197B	Windmill P.H, Ruislip	£11,440	Feb 2014
H/9/184C	31-46 Pembroke Road, Ruislip	£8,560	Jul 2015
Total		**£20,000**	

Allocated towards expansion of GP Practice in Wallasey Road

S106 Funding Reference	Development	Amount	Time Limit to Spend
H/19/231G	RAF West Ruislip, Ickenham	£193,305	Nov 2017
Total		**£193,305**	

The above s106 contributions are at risk of being returned to the developers if they are not utilised by the dates stipulated above with the exception of the contributions for the Hesa Health Centre totalling £264,818 which were transferred to NHS Property Services on 8 January 2014.

LEGAL IMPLICATIONS

Under the provisions of section 111 of the Local Government Act 1972, a local authority has the power to do anything which is calculated to facilitate, or is conducive or incidental to the discharge of any of its functions. The work be carried out in accordance within this report would fall within the range of activities permitted by Section 111.

Regulation 122 (2) of the Community Infrastructure Levy Regulations 2010 states that a planning obligation may only constitute a reason for granting planning permission for the development if the obligation is:

1. necessary to make the development acceptable in planning terms;
2. directly related to the development; and
3. fairly and reasonably related in scale and kind to the development.

Circular 2005/05 goes further than Regulation 122 and suggests that a planning obligation must also be:

4. relevant to planning; and
5. reasonable in all other respects.

The monies must not be used for any other purpose other than the purposes provided in the relevant section 106 agreement. Where monies are not spent within the time limits prescribed in those agreements, such monies should be returned to the payee.

When the Council receives formal bids to release funds, each proposed scheme will need to be assessed and reported to the Leader and Cabinet Member for Finance, Property and Business Services in order for the monies to be released. As part of that process, the Council's Legal Services will review the proposal and the section 106 agreement that secures the funding, to ensure that the Council is permitted to spend the section 106 monies on each proposed scheme. The content of the section 106 agreements in relation to King Edwards Medical Centre, Southcote Medical Centre, Wallasey Medical Centre, Pine Medical Centre referred to in this report have been assessed and approved in line with those procedures prior to release of the capital monies for the schemes.

The use of section 106 monies for future scheme mentioned in the report will need to be assessed against their respective agreements when these are finalised on a case by case basis.

BACKGROUND PAPERS

None.

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BETTER CARE FUND: DRAFT HILLINGDON PLAN

Relevant Board Member(s)	Councillor Philip Corthorne
Organisation	London Borough of Hillingdon
Report author	Paul Whaymand, LBH Finance Tony Zamen, LBH Adult Social Care
Papers with report	Appendix 1 – Proposed Draft Appendix 2 – Financial Summary

1. HEADLINE INFORMATION

Summary	This report provides the Board with proposals for the Hillingdon plan in response to the Better Care Fund (BCF), formally the Integration Transformation Fund. Detailed guidance was issued by Government on 20 December 2013 as to how the fund will be applied, the information required and the financial forecasting needed. A proposed draft is attached as Appendix 1, together with the financial summary at Appendix 2, as per the guidance. The guidance requires a "first take" of the plan to be submitted on behalf of the Health and Wellbeing Board by 14 February and a final plan to be submitted by 4 April 2014, both to NHS England.
Contribution to plans and strategies	Hillingdon's Joint Health & Wellbeing Strategy Hillingdon's Joint Strategic Needs Assessment Hillingdon's Out of Hospital Strategy
Financial Cost	The announcement sets out a minimum fund of £17.991m for Hillingdon from 2015/16. The guidance also set out how this figure is arrived at, the fact that it is not new money but comes from existing budgets.
Ward(s) affected	All

2. RECOMMENDATION

2.1 The Board is asked to agree the vision and scope of the BCF plan as set out in Appendices 1 & 2, so that this can be submitted on its behalf to NHS England by 14 February 2014. In particular, the Board is asked to note that:

a) the initial plan prioritises supporting frail elderly residents as the first target group under the BCF.

b) the proposed plan is based on offering the minimum fund (of £17.991m in 2015/16) at this stage.

c) the eleven schemes set out at paragraphs 4.8 to 4.23 (and in more detail in Appendices 1 & 2) provide the starting point to develop business cases and proposals for delivery under the plan.

d) in addition to the mandatory indicators provided in the guidance and set out in detail in Appendices 1 & 2, Hillingdon sets a local indicator relating to shared care plans, all of which will support the financial reward element of the fund from 2015/16.

2.2 That an additional meeting be scheduled for 1 April 2014 to enable to Board to agree the final plan for submission by 4 April 2014.

3. INFORMATION

Reasons for recommendations

3.1. To ensure that the development of more integrated health and social care services in Hillingdon is focused on improving services for residents. In doing so, the plan also complies with the directions from Government and the NHS England on establishing the Better Care Fund (BCF) in Hillingdon.

Financial Implications

3.2. The Better Care Fund nationally amounts to £3.8billion in 2015/16 which is to be spent locally on 'adult social care services which also have a health benefit' to drive closer integration and improve outcomes for patients, service users and carers. For 2014/15, in addition to the £900m transfer already planned from the NHS to social care, a further £200m will now transfer to prepare for the implementation of the Better Care Fund in 2015/16. It should be noted that funding for 2015/16 is not new money, but reallocation of funding which is currently fully committed in both the Council and the HCCG budgets. The contributing contents of the Better Care Fund are the existing transfers to social care from heath, i.e., the s256 transfers, existing health funding, DFG capital funding and social care capital grant funding.

3.3. The s256 allocation to Hillingdon in 2014/15 amounts to £4.772m, including £3.9m previously announced for 2014/15 plus the share of additional funding amounting to £0.868m to prepare for the new Better Care Fund arrangements.

3.4. For 2014/15, the condition attached to the transfer of the additional funding of £0.868m is that both organisations must jointly agree and sign off two year plans for the Better Care Fund, which is to be provided to NHS England by 14 February 2014. The requirement for the use of the funding is that it must be used to support adult social care services within the Council which also have a health benefit, giving flexibility to determine how this investment will make a positive difference to social care services, and outcomes for service users.

3.5. For 2015/16, the allocation to Hillingdon totals £17.991m and details are set out in the table below:

	£000
Disabled Facilities Capital Grant	1,769
Social Care Capital Grant	580
Revenue Funding	15,642
Total	**17,991**

3.6. The revenue funding allocation of £15.642m includes funding for carers and reablement currently received by the CCG, and funding for the implementation of the Care Bill which have not been separately identified at a local level in the funding announcement. The Council currently receives the capital allocations for the Disabled Facilities Grant and the Social Care grant directly but, from 2015/16, legislation will be changed so that the funding goes via the NHS and is then passported to the Council through the Better Care Fund and then used in the same way as now.

3.7. In 2013/14, the Council also received revenue funding of £3.7m from the CCG through a s256 agreement to support adult social care services. This is currently allocated as follows within the Adult Social Care base budget:

Section 256 programme components	Full year budget (£k)
Telecare line service and in-house reablement	700
Demographic pressures in Older Peoples Services	2,000
Hospital social work	250
Community equipment	250
Dementia service	300
Long-term residential and nursing home care	100
Personal budgets	100
	3,700

3.8. This increases to £3.9m in 2014/15 and a further £0.868m has been provided to prepare for the Better Care Fund bringing total s256 funding to £4.8m from Health Funding. The remaining balance of revenue funding for 2015/16 of £10.8m will come from other existing Health Funding. The CCG is currently in the process of identifying which budgets will constitute this sum and have set out in the table below an early indication of the current funding that could be included in the pooled funding from 2015/16:

Programmes	Full year budget 2015/16 (£k)
Section 75 Community Equipment Programme	664
Rapid Response Programme	1,660
Integrated Care Programme	951
Community Services Programme	7,293
Qipp Programme	208
End of Life Continuing Care programme	100
Total	10,876

3.9. Currently, each partner is not automatically empowered in their own right to undertake another's duties. Therefore, the funding for 2015/16 will be managed through pooled budgets under Section 75 of the NHS Act 2006 which was introduced to allow a local authority to undertake NHS duties or the NHS to deliver local authority functions or where the partners agreed to 'pool' their resources to deliver services. It is important that the proposed Section 75 arrangements set out clearly the governance, accountability, control, risk sharing and arrangements in relation to sharing over/underspends. Either the Council or the CCG will need to hold the pooled budget.

3.10. The 2015/16 funding allocation also includes a payment for performance element which is contingent in part upon planning and performance in 2014/15 and in part on achieving specified outcomes in 2015/16. The performance element of the funding could be withdrawn if the ambitions set out in the plans are less than 70% delivered, although the guidance says that this will not happen in 2015/16. This has been identified as a key risk for each partner and therefore must be clearly recognised and mitigated through the proposed Section 75 pooling agreement.

3.11. Other risks include the possible impacts from reprioritising Health funding from acute services to preventative social care services which need to be clearly identified and mitigated.

3.12. The Council and the HCCG have good experience of Section 75 pooling agreements with two already operating in respect of Learning Disability Services and Community Equipment Services. As set out above, the Section 75 pooling relating to the provision of community equipment will from 2015/16 form part of the BCF.

3.13. The approach proposed by the two partners in Hillingdon is, initially, to pool only the minimum required funding of £17.991m. This is felt to be cautious in the face of significant uncertainty and to provide the Council and HCCG with reassurance that subsequent proposals will be affordable and subject to robust performance management and financial management, through existing accounting processes.

Legal Implications

3.14. The Borough Solicitor confirms that the legal implications are included in the body of the report.

4. BACKGROUND

4.1. The Council, the CCG and providers of health and social care services in Hillingdon have made significant strides to improve and align the services they provide in recent years. There are existing joint initiatives in place to build on; from integrated care pilots around falls to new pathways for early supported discharge from secondary care. The BCF requirements, therefore, are aligned well to this approach and are consistent with it. The BCF provides an opportunity to consolidate this partnership working and to lay the foundations for closer working in the future. It also offers a stepping stone towards new forms of potential delivery structure as a result of joint working, which the Board has indicated it may wish to consider in the future.

Published Guidance and Pro-Forma

4.2. Further guidance, technical explanatory notes and application templates were issued by Government on 20 December 2013. These set out:

- Where the funding comes from, given it is recycled money from existing budgets. Also, that the minimum level of the initial pooled funding will amount to £17.991m for Hillingdon;
- How the £3.8 billion nationally is made up for 2015/16 including how the performance related element will be applied; and
- A mechanism and metrics for agreeing measures against which performance will be assessed.

4.3. The guidance also confirms the six national conditions as being:

- plans to be jointly agreed;
- protection for social care services (not spending);
- as part of agreed local plans, 7-day working in health and care to support patients being discharged and prevent unnecessary admissions at weekends;
- better data sharing between health and social care, based on the NHS number (it is recognised that progress on this issue will require the resolution of some Information Governance issues by the Department of Health);
- a joint approach to assessments and care planning, ensuring that, where funding is used for integrated packages of care, there will be an accountable professional; and
- agreement on the consequential impact of changes in the acute sector.

4.4. Each of these conditions is addressed in the plan at Appendix 1.

Preparing for the Better Care Plan for Hillingdon

4.5. An officer and partner group, consisting of the Council, HCCG, The Hillingdon Hospital and CNWL Community Health has met to develop a broad approach and model for the BC plan in Hillingdon. The focus of the group's approach has been to identify the best ways to improve health and social care in Hillingdon, to build on strengths and good practice and to spot gaps in provision where greater attention should be given. The product of those discussions is contained in draft plan at Appendix 1.

4.6. The group has noted evidence that Hillingdon's population is growing and living longer and that the number of over 65s is set to increase rapidly over the next few years. Both the Council and the CCG have identified priorities to extend life expectancy, support independence

and to increase opportunities to enjoy old age. It was also noted that over 70% of non-elective health spend is on people aged over 75 and, together with the likely new requirements of the Care and Support Bill, services for older residents will need to develop significantly over coming years. It was identified early on, therefore, that an initial focus on services for frail older residents should be the major focus.

4.7. The existing system was mapped to identify the pathways involved across health and social care and a model developed. From this, gaps have been identified and further actions suggested which would form the basis of the Hillingdon Better Care Plan. Eleven "schemes" are proposed in the plan reflecting areas where there are identified gaps in provision and a need for closer working. These are:

Scheme one: Joined up tool for health and social care risk stratification:

4.8. Developing an existing "risk stratification" tool, which identifies people with complex health issues who are at risk of their condition deteriorating or being admitted to hospital. Thereby, identifying those people who not only have health risks but also have social risk factors, for example, change in care requirements, status of partner, social isolation, etc. This will allow services to proactively manage these risks much earlier and in a way that allows people to retain their independence and improve their overall health and wellbeing.

Scheme two: Proactive early identification of people with susceptibility to falls, dementia and social isolation

4.9. We know that people with either dementia, susceptibility to falls or who are socially isolated are disproportionately represented on our non elective admissions and in long term residential care. Most of these are identified when people reach a complex stage. In addition, most of these people are visible only to some parts of the system such as carers, social workers, GPs and alarm services. We want to ensure that the entire system understands the factors that create susceptibility to these health and social care conditions. Under Scheme 2, we will develop the frontline workforce with "brief intervention" training to identify people who are susceptible. We will define system wide responses to these issues, i.e., what do we do when we identify people with this susceptibility. One key outcome of this scheme will be to reduce the movement from lower tiers of risk into higher tiers.

Scheme three: Development of shared care plans

4.10. Hillingdon has been successfully implemented robust care plans for a proportion of identified patients with diabetes and frail elderly people with complex needs as identified through risk stratification and other means. The care plans are developed by a multidisciplinary group (MDG) of health and care professionals and will be signed-off by the service user or patient. We will extend this further to:

- scale it to all people with complex health and care needs; and
- include people with medium risk who will benefit from care planning and introduction of self-care pathways.

Scheme four: Integrated case management and care coordination

4.11. Hillingdon has a team of community matrons who manage complex cases in the community and a separate team of social workers that manage cases with complex social care needs. We have identified that a significant proportion of the 'current' workload is the same cohort of people. This comes from the fact that people with complex health needs often have social care needs and vice versa. As part of the MDG, we will develop an integrated community team with health, social care, mental health and third sector.

4.12. People who are being case managed represent cases with high risk of deterioration in health or social risk factors. These people, if not managed well in the community, may end up in the hospital or may require high level of care support or potential admission into care homes. Scheme 4 will address this.

Scheme five: Review and realignment community services to GP networks

4.13. Hillingdon has improved efficiency within community services. However, more work needs to be done to ensure that we get value for money from our existing community services, that they are much more integrated between health, social care and the third sector. Hence, we will:

- Review current community service configuration and realign resources around GP networks;
- Integrate teams based around primary care teams focused on older people. This will aim to streamline access to services by ensuring a co-ordinated response to needs at any point of entry into the service system with integrated serviced provision;
- Develop programmes to support step down from core community services to less intensive care (care bundles);
- Short term assessment and signposting services for targeted groups, e.g., older people and populations (areas with most need) - multi-agency signposting including health, housing, social care benefits; and
- Mainstream individual care planning and development of personalised care planning and patient participation with all professionals.

Scheme six: Rapid response and joined up intermediate care

4.14. Hillingdon currently runs a rapid response service within the community. This service has presence both in the A&E as well in the community and supports people to stay at home, thus avoiding inappropriate admissions to secondary care.

4.15. As part of Better Care Fund initiatives, Hillingdon will develop the model further to:

- Embed social care within the current team to ensure that joint assessments and planning is undertaken for residents;
- Include mental health liaison as part of the core offer;
- Enhance the use of the third sector in supporting residents to be transported back home and in providing support for the few hours until mainstream services commence;
- Scaling up the integrated team to ensure that every resident who could be supported at home rather than a hospital receives an opportunity to be so supported;

- Embed seven day working across all the contributors to rapid response; and
- Create a joined up, single, intermediate care team which will include reablement, community rehabilitation, equipment, telecare and homecare.

Scheme seven: Early supported discharge

4.16. Hillingdon has initiated an early supported discharge initiative in conjunction with multiple partners within the system, i.e., secondary care, community services and social care. As part of the new development, Hillingdon will:

- Scale the service to a significant impact on number of overall bed days required, delayed transfers of care and excess bed days for non elective care;
- Develop a proactive cross-service hospital discharge team with input from social care, community services and the third sector;
- Agree a discharge protocol and process that starts on the day of admission of an older person to hospital;
- Draw up appropriate risk protocols shared between hospital clinicians, community clinicians and social care with proactive case finding within the wards;
- Bring primary care fully into the discharge process; and
- Ensure that services in the community facilitate discharge out of hospital in a safe and effective way.

Scheme eight: End of life continuing care budget

4.17. We will realign and better integrate the services we provide to people towards the end of their life. Our processes will be more seamless and enable health and social care staff alongside the third sector to provide support to patients and their families and carers around end of life care.

4.18. Key components will include shared care plans, aligned budgets and common development activity. We will also work towards a trusted assessment framework and local operating model between health and social care.

Scheme nine: Care / nursing homes initiative

4.19. Too many of our admissions are from care homes directly. A number of case studies show how the level of care in care and nursing homes can be enhanced by proactive support from a multi-disciplinary team from the community.

4.20. At Hillingdon, we have initiated a number of workstreams such as provision of mental health liaison and diabetes management support but we acknowledge that a lot more needs to be done to support people within care and nursing homes to improve their quality of life and retention of independence.

Scheme ten: seven day working initiative (enabler)

4.21. We will work to meet the needs of services users and their families appropriately every day of the week to improve outcomes. We want to ensure that the Hillingdon system provides a consistent service that meets what is expected by our residents. Our proposed seven day cover will support early / timely discharge from hospital and better care at for people at home.

4.22. In liaison with all our providers, The Hillingdon Hospital is to be an "early adopter" of the seven day working model in the NHS. Our additional focus will be on extending short term assessment, rehabilitation and reablement over the weekend to facilitate discharge from hospital and continuing to support people at home.

4.23. In primary care, GPs will explore models of co-operation across localities to ensure seven day cover through GP networks, provision of telephone triage and integrating all providers to provide a holistic service seven days a week.

Scheme eleven: Development of IT system across health and social care with enhanced interoperability

4.24. This is an important aspect of the delivery of integrated care in Hillingdon. We aim to enhance the interoperability of IT systems across health and social care organisations. As part of information sharing and governance (as part of the ICP), Hillingdon is working towards the creation of a single client centred identifier and shared information across different providers. Further work is required to ensure that care plans are accessible to social care and other parts of the system.

Establishing Performance Metrics for the plan

4.25. The guidance sets out five national and, therefore, mandatory metrics for BCF the guidance:

- Admissions to residential and care homes
- Effectiveness of reablement
- Delayed transfers of care
- Avoidable emergency admissions
- Patient/service user experience

4.26. In addition to the five national metrics, local areas are required to choose one additional indicator that will contribute to the payment-for-performance element of the fund. It is proposed to establish a local indicator in Hillingdon which monitors the number of shared care plans achieved. All indicators will be baselined during 2014/15 and the indicative baseline from 2012/13 is included in the Appendix 2 where available.

Engaging with Service Providers, Patients and Residents

4.27. The officer group that met to develop proposals included The Hillingdon Hospital and CNWL Community Health as two of the key service providers locally. The plan also reflects our accumulated intelligence on resident and patient engagement through a variety of fora, events and engagement opportunities.

4.28. Healthwatch Hillingdon has submitted its views as to how the BC plan should reflect local need. An initial workshop with partners in the voluntary and community sector to "road test" the approach included in the plan was held on 17 January 2014. Over twenty organisations were represented. Partners attending this first workshop have agreed to form a reference group for the BC plan moving forwards. A resident facing event is also proposed during February and a communications plan has been developed.

Governance

4.29. Appendix 1 sets out a broad approach to governance of the BC fund, reflecting the role of the Health and Wellbeing Board in leading this work and the need for approval through HCCG and Council governance structures. The requirement for Section 75 schemes also provides a further process for governance.

Better Care Fund planning template – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**London Borough of Hillingdon**
Clinical Commissioning Groups	**Hillingdon Clinical Commissioning Group**
Boundary Differences	**Boundaries are co-terminus**
Date agreed at Health and Well-Being Board:	**06 February 2014**
Date submitted:	**<dd/mm/yyyy>**
Minimum required value of ITF pooled budget: 2014/15	**£4,772,000**
2015/16	**£17,991,000**
Total agreed value of pooled budget: 2014/15	**£4,772,000**
2015/16	**£17,991,000**

b) Authorisation and signoff

Signed on behalf of the Hillingdon Clinical Commissioning Group	
By	Dr Ian Goodman
Position	Chair Hillingdon CCG
Date	

Signed on behalf of London Borough of Hillingdon	
By	Cllr Ray Puddifoot MBE
Position	Leader of Hillingdon Council
Date	

Signed on behalf of the Hillingdon Health and Wellbeing Board	
By Chairman of Health and Wellbeing Board	Cllr Ray Pudifoot MBE
Date	

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

The Hillingdon Hospital (THH) and Central and North West London NHS FT (CNWL) are members of Hillingdon's Health and Wellbeing Board, which has set up a sub-committee specifically to take forward our work on integration. The hospital is also a member of the sub-committee.

The sub-committee has charged an officer and partner group to take forward these proposals and to work up schemes, vision, scope, changes and outcomes. Again CNWL and THH are both actively involved in these discussions.

In addition (see answer to d) below) wider providers in the voluntary and community sector in Hillingdon attended a workshop on the 17th January 2014 to share approaches and invite feedback on these proposals. This was agreed to be the start of ongoing discussions on the development of the Hillingdon BCF plan.

Schemes in the Hillingdon plan build on existing co - production work with providers as part of multiagency working on Integrated Care, intermediate care, end of life, community transformation and out of hospital care work streams. The BCF is also part of the wider whole systems work in Hillingdon, with providers fully engaged in the development of provider networks and seven day working.

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

Hillingdon Council and Hillingdon CCG regularly engage with and seek views from local residents, service users and carers to guide service redesign, maintain quality and safety, and inform commissioning intentions. In developing the BCF plans, both organisations have used this approach to inform the strategic direction.

As a first step the Council and the CCG amalgamated intelligence gathered across a two year period, from forums such as the older people's assembly, *meet the CCG* public events, disabled tenants' forum, patient and carer focus groups and public board meetings.

These findings were then cross referenced with intelligence gathered by Healthwatch Hillingdon, evidence from the Hillingdon JSNA and with local and national patient and carer satisfaction surveys to inform draft plans.

Some themes emerge from these sources, including:

- People in Hillingdon want to remain at home and as independent as possible for as long as possible.
- Telecare line is seen as important in supporting older people and in "taking away worries".
- On domiciliary care, carers and service users value the personal touch and a single point of contact.
- Feedback from forums identify need for easily accessible services in the community,

locally from GP services

- Older people have said they want to access activities in the community that promote and maintain a healthy lifestyle.
- Residents also want better access and consistency from GP services

The initial plan for greater integration and the Better Care Fund has been shared with members of the public, patients and carers via the following forums:

Patient in Partnership (PIP) public event (hosted by The Hillingdon Hospital Foundation Trust)

Better Care Fund Stakeholder Workshop (hosted jointly by HCCG and the Council) 17 January 2014 with over 20 key local community and voluntary sector organisations present.

Better Care Fund Public Meeting proposed for February 2014 (hosted jointly by the HCCG and the Council)

Feedback from these meetings has been incorporated into the plans presented. The Council and the CCG will have also utilised a number of communications channels to inform residents and stakeholders of its local plans via the following channels:

HCCG, LBH and Healthwatch Hillingdon public facing website

Hillingdon People (Borough wide magazine publication)

Under the plan this initial engagement is seen as the start of journey in working with partners, commissioners, patients, carers and providers to design a truly integrated approach that better serves Hillingdon residents. The voluntary and community sector group will be actively involved in the development of the plan.

e) **Related documentation – Please** include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Joint Strategic Needs Assessment	The Joint Strategic Needs Assessment (JSNA) is the means by which Hillingdon and its partners will describe the current and future health, care and wellbeing needs of our population and the strategic direction of service delivery to meet those needs.
Joint Health & Wellbeing Strategy	The Joint Health and Wellbeing strategy sets out the priorities and actions which the Health and Wellbeing Board are planning to carry out for the period 2013 to 2016
Hillingdon Out of Hospital Strategy	The Hillingdon Out of Hospital strategy sets out five priorities for improving access; experience of care; and the provision of care closer to home for people in Hillingdon. The BCF and development of Hillingdon Out of Hospital Hubs are aligned for care of frail older people.

Intermediate care and admissions avoidance	*Intermediate Care: review of phase one implementation* Libera Partners LLP May 2013 Briefly reviewed the efficacy of the first phase of implementation of Rapid Response at THH alongside wider admissions avoidance and early discharge initiatives.
Recovery Programme Board paper July 2013	In July 2013 the Recovery Programme Board agreed priority areas that would promote a sustainable health and care system over the short, medium and longer term. This focused on working as a whole system to reduce growth into highest risk needs from lower and medium risk groups through an integrated system of early detection and support.
Mental Health strategy and Dementia Action plan 2013-16	In March 2012, Hillingdon Clinical Commissioning Group (Hillingdon CCG) and the London Borough of Hillingdon (LBH) initiated a refresh of the strategy for adults with mental health problems aged 18-64 years[1] and the development of a plan to improve services for people with dementia in order to create a new all age adult mental health services strategy/plan.
Primary Care Development and Delivery Plan	This document sets out plans for the wider development of primary care in Hillingdon in the context of wider NW London plans.

[1] A strategy for adult services for mental health and wellbeing, 2008-13, NHS Hillingdon and London Borough of Hillingdon, 2008

2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

Our vision is that by 2019, the residents of Hillingdon will be able to *plan their own care; with professionals working together to understand their needs and those of their carer(s), so that they have control over services and that these deliver what is important to them*.

Our initial work under the BCF is therefore targeted at Hillingdon's frail elderly. As ever, this term requires further definition as some intervention programmes will be aimed at all older people and others specifically at people aged 85 and older. Our general approach is therefore to work with the population cohort aged 65 years and over with a specific focus on:

- All Hillingdon's residents aged 85 and over
- Frail older people aged 75 and over with two or more conditions
- Mature/older people who are at risk of dementia
- Mature/older people who are at risk of falling for a first time

For the above population segment(s) our services are not as joined up as they should be and this process of integration and alignment is a key objective of our work on the BCF. Having said that, we have made significant strides in addressing their needs in recent years and the programmes below constitute a good platform on which to build:

- Expanded intermediate care programmes, especially in developing the role of rapid response
- An improved and better integrated urgent care pathway
- Early supported discharge programmes
- Integrated care programmes
- Reablement
- The development of GP networks and health hubs
- End of life care including "coordinate my care."

Our plan is to put in place the steps we need to act on to configure and deliver services over the five year period. These changes will involve:

- A focus on improving health outcomes for older frail residents with one or more health

condition or care need

- Better and earlier identification of susceptibility to disease or exacerbation in that cohort alongside joined up management of conditions
- Better coordination of services that are configured around Hillingdon's older residents – including a much stronger focus on case management and prevention
- Reducing the need for older people to go to hospital – and reducing the lengths of stay where they are admitted
- Bringing greater coherence to our present pattern of service initiatives: especially in enabling older people to be treated at or close to their home wherever possible.

Changes in patterns and reconfiguration of services

The joint vision is for services that are based in Hillingdon's communities and support the needs of Hillingdon's residents. The following drivers will bear upon the final configuration of services:

- We will build on the momentum of the existing good work on admissions avoidance and supported discharge as these are successful and will form the basis of the future planned discharge service that will have in-reach characteristics
- We will offer an appropriate and consistent level of service to local people every day of the week. In some cases, this will involve reconfiguration of existing satisfactory services. In a few cases, we will need to decommission sub-optimal services and replace them with more appropriate ones
- We will ensure services for frail elderly are focussed on the person – especially those with dementia and with more than one long term health or care need. The focus on mental health will be on anxiety and depression but not initially on crisis
- We will reshape services to identify and support people who are at risk of falling a first or second time
- We will redefine the role for case management in Hillingdon – especially in being clearer about the central responsibility of GPs as system enablers.
- We will further develop reablement to work closer with wider intermediate care schemes both in the community and within the acute hospital setting.

The difference for the residents of Hillingdon

Residents will be able to say:

- I'm helped to take control of my own health and social care provision
- It doesn't matter what day of the week it is – as I get the support appropriate to my health and social care needs
- Social care and health services help me to be proactive. They anticipate my needs before I do and help me to prevent things getting so bad I need hospital

- If I do need to go to hospital, they start to plan for my social and health care in the community from day one of my stay
- I only have to tell my story once and they pass my details on to others with an appropriate role in my care
- Systems are sustainable and what might once have been spent on hospital care for me is now spent to support me at home in my community

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

We have agreed the following aims and objectives:

1. We will build on our present initiatives around admissions avoidance and supported discharge.
2. Hillingdon's residents will experience a shared set of responsibilities exhibited by all the organisations working in health and care.
3. Residents will be able to access the services appropriate to their needs on each day of the week.
4. Health and care providers will persist with a health and care problem until a solution is found, or another provider has taken responsibility for finding it.
5. Our workforce will be better equipped and better skilled to face this challenge: to residents, they will appear as a single system, with an open culture that celebrates success.
6. We will work together to proactively identify the health and care needs of older frail residents and will aim to better manage the care needs of younger people who may be susceptible to frailty as they get older.
7. We will aim to reduce levels of health inequalities in Hillingdon.
8. We will be better at predicting future health and care needs – both across the population and for individual residents.

These aims are agreed with a clear understanding that the redesign of systems or the redesign of organisational boundaries alone will not be enough to meet out aims. Instead, we will give equal weight to behaviours, systems and leadership.

Measuring success – including appropriate health gain

These are set out in detail in the BCF application template excel sheet. The principal measures

of success we will target will include:

National metrics:

1. Reduction in permanent admissions of older people in residential care per 100,000 population
2. Increase in proportion of older people who will still be at home 91 days after discharge from hospital into intermediate care (rehab/reablement)
3. Reduction in delayed transfers of discharge per 100,000 population
4. Reduction in avoidable emergency admissions in secondary care per 100,000 population
5. Patient and services user reported outcomes and reported experience

Local metric:

1. The proportion of people with a care plan who are able to manage their condition.

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

New interventions under the Better Care Fund

The short descriptions below set out the new schemes we plan over the first five years of the BCF.

Details of key schemes / changes and how we aim to implement them

The section above provided an overview of the schemes and changes within the health and care system. In this section we will provide details of key schemes and how we plan to implement them across health, social care and the wider system.

Scheme one: Joined up tool for health and social care risk stratification:

We have developed and implemented a risk stratification tool that identifies people with complex health issues and those who are at risk of their condition deteriorating or being admitted to hospital. We know that for older people social risks play a crucial role in defining the outcomes.

As part of a natural progression towards an integrated system, we will:

- Enhance the risk profiling to include social care determinants and factors. This will allow us to identify not just people with health risks but also those with social predictive factors; for example, where changes in social factors such as care requirement, status of partner, social isolation make a difference to outcomes for our population.
- We will also increase the reach of the risk stratification tool to identify people in the lower segments of the risk pyramid (medium risk) i.e. people who are at risk of their health and/or

social care needs becoming more complex. This will allow us to proactively manage them much earlier in a fashion that allows them to retain their independence and improve their overall health and wellbeing.

As part of implementation, we will develop joint health/care assessment approach and incorporate it in the risk stratification tool. In order to do that, we are exploring ways of incorporating key datasets within a common database.

Scheme two: Proactive early identification of people with susceptibility to falls, dementia and social isolation

People with dementia; susceptibility to falls; and/or in social isolation are disproportionately represented in our non elective admissions and admissions to long term residential. Too Many Most of these are identified when people reach a complex stage. There is a loss of opportunity in not being able to identify people with these conditions early on in the stage and intervene. The potential impact on outcome in the medium to long term could be significant.

Too many of these people are visible only to parts of the system such as carers, social workers, GPs, the third sector and alarm services. Hence, it is difficult to pick them up from the risk stratification tool only. We therefore need the entire system to understand factors that create susceptibility to these health and social care conditions.

Key initiatives include:

- Development of frontline workforce: brief intervention training to frontline workers for them to identify people who are susceptible. For example: carers / social workers / GPs / district nursing etc need to understand the key signs of when a person might be becoming socially isolated or susceptible to falling (history of recurrent falls without getting hurt).
- Supporting and developing the role of third sector providers to work with people in their homes and communities.
- Support to carers and caring families including the provision of respite care.
- Defining a system-wide response to these issues: setting out what to do when we identify people with this susceptibility. We have embarked on a number of initiatives such as a centralised falls service (with multifactorial assessment and management) but other areas will be developed over the next three months.
- One key outcome of this scheme will be to reduce the movement from lower tiers of risk into higher tiers of risk (medium / high risk)
- Defining risk factors for each condition, who does it and how we respond to that.

Scheme three: Further development of care plans that are shared, agreed and implemented jointly

We successfully implemented robust care plans for a proportion of identified patients with diabetes and frail elderly people with complex needs as identified through risk stratification and other means. The care plans are developed by a multidisciplinary group (MDG) of health and care professionals and signed-off by the service user or patient.

We will extend this further to: scale it to all people with complex health and care needs; and include people with medium risk who will benefit from care planning and introduction of self-care pathways.

Key aspects of this scheme are:

- The care plans will be delivered around the MDGs at the level of (or aligned to) emerging GP networks
- The plans will be personalised and centred around the person and agreed with the service user
- They will be developed by integrated and virtual provider networks representing health, social care and third sector.
- An absolute focus on optimising the independence of the person and development of self-care plans in collaboration with service users and carers
- Shared accountability and governance
- Involvement of the third sector especially in provision of health trainers (lifestyle coach or behaviour change agents) to support people, one to one or in groups
- Sharing and the active management of care plans are crucial enablers. We will explore the use of a shared record system can be part of the solution.

The following table shows the care planning spectrum and what we plan to do at each level.

Table: care actions across the planning spectrum

Low risk	Medium risk	Complex
People early in the stage, identified with one or two factors *(low risk is not to be a focus on BCF*)	People with two or more health and care issues *(need to refine the definition)*	People with multiple and complex health and care issues
Care planning will cover: • Self-management plans • Behavioural change support (groups) • Pre-diagnosis pathway (in case of diabetes) • Social factor risk mitigation (such as in social isolation)	Care planning will cover: • Self-management plans • Behavioural change support (one to one, groups) • Specific health and care interventions • Care navigation (signposting and informing how to access the system) • Social factor risk mitigation	Care planning will cover: • Self-management plans • Behavioural change support (one to one, groups) • Specific health and care interventions • Case management (proactive management of health and care conditions with a nominated lead professional) • Care coordination (active support in accessing the system using a support worker, potentially from third sector) • Social factor risk mitigation and counselling with person,

family and carer(s)

- Pre-crisis management: Availability of rapid care bundle (includes: medical monitoring support, domiciliary care, telecare, helpline and others as necessary)

Scheme four: Integrated case management and care coordination

People with complex health needs often have social care needs and vice versa. It is prudent to manage both aspects together creating a more efficient and seamless system built around the individual. We have a team of community matrons that manages complex cases in the community and a separate team of social workers that manages cases with complex social care needs. We have identified that a significant proportion of the current workload is in respect of the same cohort of residents. As part of the ICP, we will develop an integrated community team with health, social care, mental health and third sector.

Key attributes of this approach include:

- An approach built around emerging GP networks with a named case manager per person
- Managing health issues, providing reablement/rehabilitation, promoting independence and managing risk factors. A key objective is to manage complex cases in the community and provide care coordination.
- Coordinate with other services in the community such as specialist nursing, district nursing, palliative care teams, assistive technology, equipment, intermediate care (rehabilitation and reablement) and other services as necessary
- Support from care of the elderly physician for case conferences and advice
- Single (or trusted) assessment for mobilisation of resources, reducing duplication

An important point to understand is the continuum along with health and social care spectrum of risk. People who are being case managed have a high risk of deterioration in health or social risk factors. If not managed well in the community, they may end up in hospital or require a high level of care support or potential admission into care homes.

Scheme five: Review and realignment community services to emerging GP networks

We have improved the efficiency of our community health services. However, more work needs to be done to ensure that we get value for money from our existing services and that they are better integrated between health, social care and the third sector. We will therefore do the following:

- Review current community service configuration and realign resources around the emerging GP networks
- Integrate teams based around primary care teams focused on older people. This will aim to streamline access to services by ensuring a co-ordinated response to needs at any point of entry into the service system with integrated serviced provision.

- Develop programmes to support step down from core community services to less intensive care (care bundles).

- Short term assessment followed by signposting to services for target groups e.g. older people and populations with highest needs. Multi-agency signposting including health, housing, social care and benefits.

- Mainstream individual care planning and the development of personalised care planning and patient participation with all professionals

Scheme six: Rapid response and joined up intermediate care

Hillingdon currently has a rapid response service led by CNWL. This service has presence both in the A&E as well as in the community and supports people to stay at home, thus avoiding inappropriate admissions to secondary care.

As part of Better Care Fund, we will develop the model further by:

- Embedding social care within the current team to ensure that joint assessments and planning is undertaken for residents

- Including mental health liaison as part of the core offering

- Enhancing the use of the third sector in supporting residents to be transported back home and in providing support for the few hours until mainstream services commence.

- Scaling up the integrated team to ensure that every resident who could be supported at home rather than a hospital receives an opportunity to be so supported

- Embedding seven day working across all the contributors to rapid response

- Creating a joined up, single, intermediate care team which will include reablement, community rehabilitation, equipment, telecare and homecare.

Scheme seven: Early supported discharge

We have initiated an early supported discharge initiative in conjunction with system-partners. As part of the new development, we will:

- Scale the service further to its optimal level with a significant impact on number of overall bed days required, delayed transfers of care and excess bed days for non elective care.

- Develop a proactive cross-service hospital discharge team with input from social care, community services and the third sector

- Agree a discharge protocol and process that starts on the day of admission of an older person to hospital

- Draw up appropriate risk protocols shared between hospital clinicians, community clinicians and social care with proactive case finding within the wards

- Bring primary care fully into the discharge process

- Ensure that services in the community facilitate discharge out of hospital in a safe and effective way

Scheme eight: Better care for people at the end of their life

We will realign and better integrate the services we provide to people towards the end of their life. Our processes will me more seamless and enable health and social care staff alongside the third sector to provide support to patients and their families and carers around end of life care.

Key components will include shared care plans, aligned budgets and common development activity. We will also work towards a trusted assessment framework and local operating model between health and social care.

Scheme nine: Care / nursing homes initiative

Too many of our hospital admissions are from care homes directly. A number of case studies show how the level of care in care and nursing homes can be enhanced by proactive support from multi-disciplinary teams from health and social care.

We have already initiated a number of workstreams such as provision of mental health liaison and diabetes management support but we acknowledge that more needs to be done to support people within care and nursing homes to improve their quality of life and retention of independence.

Key aspects of our proposals are as follows:

- Focus of learning and development of staff within care and nursing homes through an integrated community team consisting of case managers (nurse), contracting leads, social care and care co-ordinator.
- Support from specialist clinical staff and nursing teams as appropriate and aligned input from social care teams
- The team will also support in monitoring improvements in care to people admitted in those care / nursing homes and ensure care homes understand and implement robust environmental risk assessment and dignity challenge
- Focus on managing people optimally in care / nursing homes and reduce inappropriate emergency admissions from care homes to secondary care

The first phase of implementation will commence in 2014/15 and will focus on care / nursing homes with the highest rates of admission with an objective to undertake risk assessments of complex care home residents, identify those patients in need of an advanced care plan, provide clinical support and training to manage conditions in the setting, identify the areas where staff in settings require skills' development.

We will also work with settings to develop skills at dealing with patients with complex conditions.

Scheme ten: Seven day working initiative

We will work to meet the needs of services users and their families appropriately every day of the week to improve outcomes. We want to ensure that the Hillingdon system provides a consistent service that meets what is expected by our residents. Our proposed seven day cover will support early / timely discharge from hospital and better care at for people at home.

In liaison with all our providers, The Hillingdon Hospital is to be an "early adopter" of the seven day working model in the NHS. The key areas for the seven day cover at THH include:

- Establishing seven day mental health liaison (psychiatry)
- Enhancing consultant cover during weekends (12 hour consultant cover, second consultant cover for 'downstream' wards, surgical consultant cover twice daily rounds during weekends),

increased support to junior staff from consultants
- Development of a virtual ward patient monitoring system
- Enhancing early supported discharge (Homesafe) with voluntary service access

Our additional focus will be on extending short term assessment, rehabilitation and reablement over the weekend to facilitate discharge from hospital and continuing to support people at home.

In primary care, GPs will explore models of co-operation across localities to ensure seven day cover through GP networks, provision of telephone triage and integrating all providers to provide a holistic service seven days a week.

Scheme eleven: Development of IT system across health and social care with enhanced interoperability

This is an important aspect of the delivery of integrated care in Hillingdon.

We also aim to enhance the interoperability of IT systems across health and social care organisations. As part of information sharing and governance (as part of the ICP), Hillingdon is working towards the creation of a single client centred identifier and shared information across different providers. Further work is required to ensure that care plans are accessible to social care and other parts of the system.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

Implications for the acute sector

Our BCF plans have been developed with both acute and community providers. The BCF proposals have been fully aligned with the detailed plans for The Hillingdon Hospital set out in *Shaping a healthier future* (the overarching plan for NW London's hospital provision) and Hillingdon's Out of Hospital Strategy. These set out a clear vision for the range of services to be offered by THH. Nothing presently planned under BCF will threaten the fundamental integrity of those plans.

Work to date on the development of Out of Hospital Hubs in Hillingdon has incorporated projected changes from integrated working for older people including new ways of working and seven day working.

The successful implementation of the BCF proposals should mean both fewer non-elective admissions of older people to THH and a shorter length of stay. These outcomes are jointly agreed by THH and the rest of the health and care system in the Borough. Initial modelling on assumptions, impact and outcomes for schemes that will impact on unscheduled admissions to hospital has been completed as part of Hillingdon's 14/15 plans. The projected impact on THH for 14/15 is that a minimum of seven patients a day would have their admission avoided through the provision of appropriate rapid response and community based intermediate care services.

Around 25% of Hillingdon's acute activity by cost is actually provided by other institutions and we are in the process of consulting these bodies about future commissioning intentions. Many

provide specialist services to our health and care economy and we would anticipate that flow of patients continuing in the short to medium term.

In the longer term, our separate ambitions around provider networks will have an inevitable impact on the acute sector in Hillingdon, but these changes will be carefully implemented and fully consulted upon.

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

Proposed governance

There are well-established channels of governance to build on in Hillingdon. Our BCF governance arrangements will mirror those we have in place for the management of funds under Section 75 National Health Services Act 2006, including the s.75 funds being held by the local authority.

The **Hillingdon Health and Wellbeing Board** takes full strategic oversight for health and care systems in the Borough and has been involved from the outset in the planning for BCF. The Board has established a sub-committee specifically to take forward its work on integration in Hillingdon.

The sub-committee has asked a **BCF Officer Governance Group,** consisting of director/chief operating officer from the CCG and Hillingdon Council, finance officers and commissioning programme support (for example, on older people and on Integrated Care) to coordinate planning for the BCF plan.

The BCF Officer Group meets at least monthly with the principal providers of health and care in the Borough in a **BCF Provider and Delivery Forum**. This forum facilitates linkages (for example) with hospital managers and clinicians involved in the seven day working pilot and/or in respect of supported discharge.

The **Governing Body of the CCG** plays a full part in the development of the plans and has signed off the CCG's contribution to the BCF. The Governing Body is also the forum that has facilitated wider access to GPs in developing plans for integration and alignment.

Finally, our local **Healthwatch** has taken a key role in engagement with service users, carers and patients.

3) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services

Protecting social care services within the London Borough of Hillingdon means that those identified as being in need of social care support continue to receive the care they require.

The proposals within this plan protect Adult Social care services through managing the demographic pressures; which may otherwise result in a change to the Fair Access to Care eligibility criteria threshold

Please explain how local social care services will be protected within your plans

The NHS transfer monies have been allocated to schemes which support social care and have health benefits.

This plan proposes the continuation of these schemes alongside the funding of new initiatives aimed directly at managing the demographic growth pressures. Furthermore this plan developed from identified gaps within the integration pathway; seeks to shift delivery of care from reactive interventions within an acute setting to a model of personalised joined up care. This supports our vision of Older People living healthy and well maximising their independence and enabling active community engagement. All of which protects social care services and their budgets by optimising independence and supporting people to remain in their own home.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

We will work to meet the needs of services users and their families appropriately every day of the week to improve outcomes. We want to ensure that the Hillingdon system provides a consistent service that meets what is expected by our residents. Our proposed seven day cover will support early / timely discharge from hospital and better care at for people at home.

In liaison with all our providers, The Hillingdon Hospital is to be an “early adopter” of the seven day working model in the NHS. The key areas for the seven day cover at THH include:

- Establishing a seven day mental health liaison (psychiatry)
- Enhancing consultant cover during weekends (12 hour consultant cover, second consultant cover for ‘downstream’ wards, surgical consultant cover twice daily rounds during weekends), increased support to junior staff from consultants
- Development of a virtual ward patient monitoring system
- Enhancing early supported discharge (Homesafe) with voluntary service access

Our additional focus will be on extending short term assessment, rehabilitation and reablement over the weekend to facilitate discharge from hospital and continuing to support people at home.

In primary care, GPs will explore models of co-operation across localities to ensure seven day cover through GP networks, provision of telephone triage and integrating all providers to provide

a holistic service seven days a week.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

All health services use the NHS number as the primary identifier in correspondence.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

Our present social care systems already allow the entry of the NHS number. We can adopt this number as a common identifier by 2015 which will allow time for service processes to be amended to ensure the capture of the NHS ID is completed.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

We are committed to adopting systems that have APIs and Open Standards. Our social care system provider is currently working on developing APIs for this purpose.

Through our PSN connection we already conform to the secure email standards

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

Our commitment is demonstrated by our *green light* status on the code of connections for IGSOC, N3 and PSN.

A bi monthly Information Assurance Meeting (HIAG) chaired by our SIRO has been in place for a number of years and is attended by senior member of the Council's leadership team.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

The accountable lead professional and joint assessment will build on our current Integrated Care Programme. Currently 85% of practices use risk stratification tools to enable the development of coordinated care plans for people at risk of admission to hospital. The BIRT tool will be adopted as part of the BCF work stream. We are working jointly with CLAHRC to develop a predictive tool to better aligns social and health factors as part of early detection of risk factors to enable better targeted support.

The lead professional role will be aligned with the development of GP based MDGs and emerging networks. The GP will be the responsible clinician, with care coordinators working at MDG level to ensure those identified with risk factors have individual co-designed interventions and care plan initiated with multi provider input and regular review. Complex people most at risk of

admission (circa 560 people plus include social care number) will be supported by a community matron lead professional working within a primary care based (or community based) integrated service.

4) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	Risk rating	Mitigating Actions
1. Inability to shift resources from acute into community	High	All our BCF plans have been developed in the context of *Shaping a healthier future* and its picture of the core activity of THH. Our plans have thus focussed on alignment of investment and service changes with subsequent reduction in secondary care. We have prioritised schemes in such that schemes with high impact will implement early, driving a marked reduction in need of secondary care resources. Our planning includes performance reporting that will track benefits (or a lack of benefits) in real time.
2. Lack of engagement from frontline/ clinical staff resulting in no behaviour changes in the frontline services	High	This is a long term project for us. We have been working on our integrated system for the last two years (ICP, rapid response and intermediate care) and our frontline staff (including clinicians) have been involved in designing and implementing these changes. Stakeholders have been involved through the development of the BCF plans. We will develop a detailed engagement plan for frontline workers as part of our implementation. It will recognise the deep culture change needed to change ingrained behaviours on all sides. Senior leaders have committed to demonstrating that culture in their everyday work. The clinical leadership of our projects is designed to ensure a greater sense of ownership of the proposals.
3. Continued demographic pressures	Medium	Demographic pressures will grow – addressing them poorly in the key risk. We will approach mitigation in three ways: 1. As part of BCF, we will carefully deploy resources on target groups with complex health and care needs and some whose needs are less complex. The aim being to stop increasing the risk profile and reduce acuity through concurrent investment. 2. We will undertake detailed activity modelling as part of the final submission to better understand the impact of demographic pressures at the micro level (neighbourhood, gender and ethnicity) to ensure that our capacity plans reflect that growth.

Risk	Risk rating	Mitigating Actions
		3. Our plans are based on ensuring that people are better supported holistically at home. There will an intense effort to ensure that complexities are managed through multidisciplinary teams. This will restrict growth in cases within secondary care and care homes.
4. Potential exposure of financial risks if BCF outcomes are not delivered in 13/14 and subsequently	Medium	A strong focus on benefits realisation through detailed planning Real-time performance planning and a common KPI dashboard Realistic common planning around deliverability testing will be put in place
5. Alignment with other whole system integrated care plans for Hillingdon within the time scale for BCF submission	Medium	A common strategic governance system is now in place. We will strengthen programme-level governance to align projects We will work towards jointly-commissioning a number of such initiatives in the future
6. Lack of accurate data and baseline estimates	Medium/ low	We have used clinical audit information and stakeholder validation where data was not accurate and/or easily available. We have modelled for some of the projects in greater detail to mitigate for data inadequacies schemes and intend to do the same for the remainder. We will reconcile this information through 2014/15 to ensure that any discrepancy is highlighted and addresses before project implementation
7. Other competing pressures from within the organisation (efficiency) and outside could decrease the priority in partner organisations	Low	Strong governance and leadership by elected members and the CCG GB will facilitate honest discussion about priorities. Most pressures (eg from the Care Bill as it is enacted) would have shared consequences and we recognise the need to plan together to address these. Our coterminous boundaries mean that the channels of communication are strong.

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Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Actual contribution (15/16)
London Borough of Hillingdon	Y	4,772	2,349	2,349
Hillingdon CCG			15,642	15,642
BCF Total		4,772	17,991	17,991

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

This work builds on mature schemes, where risks are already being mitigated as part of current schemes which are part of wider recovery plans. The BCF is fully aligned with CCG 3 year recovery plan and Local authority 3 year MTFF plan.

Contingency plan:		2015/16	Ongoing
Outcome All (to be developed further)	Planned savings (if targets fully achieved)	TBC	£4726k (*)
	Maximum support needed for other services (if targets not achieved)	Any pressures within LBH will be managed through in year budget management and existing governance arrangements. Similarly, within HCCG, any budget pressures will be managed through the Recovery Programme. Detailed contingency plans and risk mitigation plans will be drawn up as part of business case development for each scheme.	

Please note that above figures are in '000s

(*) The figure quoted is based on the business model for a few schemes and are attributed only to HCCG. However, detailed business modelling will be completed to inform final submission

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand the table if necessary.

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent
Scheme 1	ICP			TBC		50			
Scheme 2	CNWL	50		TBC		180		261	
Scheme 3	ICP *	50		TBC		249		*TBA*	
Scheme 4	ICP	150		TBC		1,516		650	
Scheme 5	CNWL	-		TBC		4,909		*TBA*	
Scheme 6	LBH/CNWL	3,727		TBC		7,771		3,900	
Scheme 7	THH**	-		TBC		-			
Scheme 8	HCCG	-		TBC		100		*TBA*	
Scheme 9	HCCG/LBH	300		TBC		378		176	
Scheme 10	All***	425		TBC		419		*TBA*	
Scheme 11	HCCG/LBH	70		TBC		70		*TBA*	
Capital funding	LBH					2,349			
Total		4,772		TBC		17,991		4,726	

Please note that above figures are in '000s

ICP * Integrated care programme is currently supporting whole system provider network development

Outcomes and metrics

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

DToC: Timely and appropriate transfers of care from all hospitals for all adults **91 days**: support people to regain independence and return to their own home. **Permanent admissions**: People support to remain in their own homes **Avoidable emergency admissions**: Better whole systems management in the community of people with LTCs
User Experience: That people feel more in control and satisfaction that services they receive meet their needs

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

Annual adult social care survey. ICP survey on people with care plans, Friends and family (currently putting a bid), focussed surveys and group discussions. Consolidation of other mainstream ways of collecting feedback

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

Plans to be agreed and monitored through agreed governance processes within each organisation and then through the delivery group followed by Health and wellbeing board.

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

NA

Metrics		Current Baseline (as at....)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	553.8	N/A	520.0
	Numerator	205		197
	Denominator	36,655		37,885
		(April 2012 - March 2013)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	88%	N/A	90%
	Numerator	60		108
	Denominator	70		120
		(Oct '12 - Dec '12)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	2,592.1	2,470.4	2,448.4
	Numerator	5,471	5,399	5,351
	Denominator	211,065	218,551	218,551
		(April 2012 - March 2013)	(April - December 2014)	(January - June 2015)
Avoidable emergency admissions (composite measure). Trajectories will be further developed for final submission following receipt of baseline data on 24th January.	*Metric Value*	1,979.8	1,949.1	1,918.7
	Numerator	5,648	5,654	5,656
	Denominator	285,286	290,082	294,789
		1-Apr-2012 to 31-Mar-2013	1-Apr-2013 to 30-Sep-2013	(October 2014 - March 2015)
Patient / service user experience [for local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used]			N/A	
		(insert time period)		*(insert time period)*
The proportion of people with a care plan who are able to manage their condition. Metric under development linked to ICP	*Metric Value*			
	Numerator			
	Denominator			
		(insert time period)	*(insert time period)*	*(insert time period)*

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ANNUAL REPORT OF THE LOCAL SAFEGUARDING CHILDREN BOARD (LSCB) 2012-2013

Relevant Board Member(s)	Councillor David Simmonds
Organisation	Local Safeguarding Children Board
Report author	Lynda Crellin, Independent Chairman - Local Safeguarding Children Board
Papers with report	Appendix 1 – Annual Report of the Local Safeguarding Children Board 2012-2013

1. HEADLINE INFORMATION

Summary	The Local Safeguarding Children Board is required to produce an annual report that comments on the effectiveness of local arrangements to safeguard children. Working Together to Safeguard Children (revised March 2013) requires that this report is submitted to the Leader of the Council, the local Police and Crime Commissioner, and the Chair of the Health and Wellbeing Board. Ofsted inspection standards assess the LSCB on whether the local governance arrangements enable statutory partners to assess whether they are fulfilling their responsibilities to help, protect and care for children, and also whether this assessment leads to clear improvement priorities.
Contribution to plans and strategies	None.
Financial Cost	None.
Relevant Policy Overview & Scrutiny Committee	Children, Young People and Learning
Ward(s) affected	N/A

2. RECOMMENDATIONS

The Health and Wellbeing Board is asked to:

1. **receive and note this report, the actions identified in the report that are being taken by the LSCB and its constituent agencies to improve the safeguarding of Hillingdon's children and young people, and the concerns raised about the risks to future safeguarding; and**
2. **ensure that the Health and Wellbeing Strategy gives a high priority to safeguarding and promoting the wellbeing of children and young people, and**

that particular attention is given to improving support for children who experience neglect and emotional harm.

3. **consider the development of a protocol between the LSCB and the Health and Wellbeing Board that clarifies how the two Boards will work together and inform each other's strategic priorities.**

REASONS FOR RECOMMENDATIONS

Safeguarding children and young people and promoting their welfare is the responsibility of everyone in Hillingdon. Failure to ensure this, puts at risk the lives of the children themselves and their future as citizens. The financial and emotional cost of this failure is well documented in the numbers of those who are not in work, who are guilty of criminal and anti social activity, and who have difficulties in parenting their own children.

FINANCIAL IMPLICATIONS

There are no direct financial implications from this report, although it does highlight the potential risks to safeguarding of reduced resources.

LEGAL IMPLICATIONS

None directly from this report.

BACKGROUND

1. The LSCB is a statutory multi agency body, established with the overall aim of monitoring, overseeing, supporting and challenging the work of all agencies with regard to their responsibilities to safeguard and protect children. It stands independently of other local bodies and its members are senior decision makers from all local agencies who work with children. LSCBs are required to produce an annual report which comments on the effectiveness of local arrangements to safeguard children (The Apprenticeships, Skills, Children and Learning Act 2009). This is the fifth annual report under the new requirements. Working Together to Safeguard Children was updated in spring 2013, and requires that the annual report be 'submitted to the Chief Executive, Leader of the Council and the Chair of the Health and Wellbeing Board'. The annual report was presented to the Council's Cabinet in December 2013, and the Safer Hillingdon Partnership in February 2014.

2. The following areas are required elements of the Report (Working Together 2013):
   - A rigorous assessment of the performance and assessment of local services.
   - Identification of areas of weakness and the action being taken to address them, as well as other proposals for action.
   - Lessons from reviews undertaken within the reporting period, including Serious Case and Child Death reviews.
   - Contributions made to the LSCB by partner agencies, and details of expenditure.

3. The Board uses a variety of methods, including performance information, inspections, reports from local agencies, case reports and audits to reach its assessment. On current evidence, the Board's assessment was that safeguarding achieves a cautious 'good' against the current Ofsted standards.

4. Evidence for this is sound practice and effective multi agency communication and collaboration as evidenced by case audit and review. Operational practice in respect of children who go missing, and who are at risk of trafficking or sexual exploitation is good and Hillingdon's work with Heathrow is nationally and internationally recognised as an exemplar. Changes within the children's pathway programme and the developments of early help and single assessments should ensure improved supervision and management oversight, alongside better early identification of problems and provision of support. Other positive areas include a good multi agency training programme, effective management of allegations against staff and strong working relationships with schools. Two lay members have been appointed to the LSCB in early 2013 and the Clinical Commissioning Group has engaged well.

5. The Board has a work plan agreed across partner agencies to ensure that, so far as is possible, children are safeguarded. The work plan has five main priorities:
   (i) Improve LSCB functioning.
   (ii) Assess and improve operational practice.
   (iii) Improve outcomes for children affected by key risk issues.
   (iv) Ensure a safe workforce.
   (v) Learn from case reviews.

6. The Board is continuing to develop its quality assurance mechanisms and has been able to use the audit work carried out for this purpose within the Council and other agencies, as well as multi-agency audits. Improving and acting on our quality assurance mechanisms remains a priority, along with better identification and action in respect of long term neglect, those affected by domestic violence and more effective engagement with children and young people.

7. There are, however, some important risks and concerns. Although the number of children on child protection plans has stabilised, the level of permanent staffing in children's social care continues to cause concern in respect of both service quality and management oversight. This situation appears to have deteriorated since the period covered in the annual report. This is being addressed as a priority by the Council.

8. Local and national evidence highlights the importance of identifying long term neglect and emotional harm, particularly in families where domestic violence, mental illness and substance misuse are features. In light of this, and reduced resources, it is critical that the early intervention services and revised pathways currently being developed in the Council are fully multi agency and target their work effectively in order both to reduce those coming into the child protection system and to facilitate swifter action if children are identified as being at risk of significant harm.

9. All agencies continue to experience dramatic change and financial constraints, and this puts at risk the available time and energy for safeguarding, both at operational and strategic level. The Coalition Government has reduced the amount of statutory guidance. It is therefore vital that all agencies maintain focus on safeguarding issues and key risk factors in their work, with professional communication and information sharing being of paramount importance.

10. A continuing major issue is the increasing number of children who experience neglect and emotional harm, particularly those experiencing domestic violence and/or who are cared for by adults with mental health or substance misuse problems. There is a shortage of services to support these children. It has been recognised locally that the spend on Child

and Adolescent Mental Health Services (CAMHS) is comparatively low. I understand that a review is underway and the LSCB remains keen to hear from commissioners how this problem is to be addressed.

11. Since April 2013, the Clinical Commissioning Group has been represented on the LSCB by the Executive lead and the GP lead, and their contributions have been much valued. The LSCB monitors GPs as providers through the designated nurse and LSCB health sub group.

12. The new Ofsted single inspection regime was launched in autumn 2013 and the Council services and the LSCB separately were both inspected under this new regime in December 2013. The inspection scrutinised child protection (including early help) and services for children looked after and care leavers. It included inspections of adoption and fostering services (previously stand alone) and a new element assessing the effectiveness of the LSCB. The Policy Overview Committee (POC) had also previously commissioned a review of the LSCB and this was carried out by an external consultant just before the Ofsted inspection. These reports were not yet available at the time of writing this covering report. However, Ofsted raised the issue of the independence of the LSCB as required by Working Together, and its ability to challenge local agencies. Ofsted is likely to recommend that protocols are developed to clarify the relationship between the LSCB and other bodies.

Hillingdon Local Safeguarding Children Board

Annual Report

2012 – 13

'That every child and young person is as safe and physically and emotionally secure as possible, by minimising risk as much as we can.'

INDEX

1. INTRODUCTION

This report covers the work of the Local Safeguarding Children Board (LSCB) during 12-13, plus any significant developments that took place in the early part of 2013-14. It highlights the main achievements in safeguarding Hillingdon's children and young people, and identifies the priority areas for improvement for the following year and beyond.

The main purpose of the LSCB is laid out in 'Working together to Safeguard Children' (Dept of Education 2013). It is the key statutory mechanism for agreeing how organisations in the area work together to safeguard and promote the welfare of local children, and for ensuring that they do so effectively. This latest version of the statutory guidance, based on the outcome of the Munro Review, was long awaited. It has changed much of the framework in which we work, and has given more authority to LSCBs in monitoring both child protection and early help services.

The LSCB consists of senior managers and key professionals from all agencies who work with children and young people in Hillingdon. They work together through the Board to make sure that staff are doing the right things to ensure that children are safeguarded. It ensures that key professionals are talking to each other and that children and their families and all adults in the community know what to do and where to go for help. Many of the LSCB's responsibilities therefore consist of setting up and overseeing systems and procedures

The Board regularly checks to make sure these are working well and that professionals are fulfilling their safeguarding responsibilities effectively. The main focus of our work is to ensure the safety of those most at risk or potentially most vulnerable. Through this report, and through the Hillingdon Children and Families Trust, the LSCB also recommends appropriate action to ensure that preventative work is identifying and working with those most at risk of future harm.

The year has been characterised by huge change and upheaval in partner organisations, which has continued into 2013. Although the number of children with child protection plans has stabilised, it has been at a higher level than in previous years and the workloads have remained high. There is evidence of strong practice in many areas but the challenging problems of domestic violence, mental health problems among both parents and children and difficulties in identifying and resolving long standing neglect remain. In addition, national cases have focused our minds on important issues such as sexual abuse and exploitation.

A great deal has been achieved by partner agencies in Hillingdon, and this has been confirmed by inspection and audit. All agencies demonstrate a strong commitment to safeguarding. However, the potential risks identified above make it even more critical that everyone is working together as efficiently and effectively as they can, and that resources are targeted towards those most in need.

Hillingdon is the second largest of London's 32 boroughs. It had a population of approx. 273,900 at mid 2012 of which just over a quarter were under 19.

This proportion is slightly higher than England and London. There has been an actual and projected increase in numbers of very young children, and families with the 5-9 age group projected to rise the most over the next few years. However, these growth rates are not very different from London as a whole. About 30% of the resident population and 49% of the schools population belong to an ethnic group that is not white British and this diversity is expected to increase, especially among the very young, reaching a projected 50% by 2016.

Hillingdon is a comparatively affluent borough (ranked 24th out of 32 London boroughs in the index of multiple deprivation, where 1 is the most deprived) but within that there is variation between north and south, with some areas in the south falling in the 20% most deprived nationally**.**

Heathrow airport is located entirely within Hillingdon boundaries and this has a major impact, particularly in respect of children and young people who pass through the airport. Close and effective multi-agency work has led to Hillingdon being considered a national leader in the field of protecting children and young people from potential and actual trafficking.

During 2012-2013, there was a 26% increase in the number of contacts (12,147) compared to the previous year (2011-2012). However, the number of these contacts being treated as referrals showed a 13% reduction. This was due in the main to more effective “triaging” of these contacts, ensuring that only work was accepted that corresponded to the continuum of need (Pan London Thresholds) adopted by the LSCB and its partner agencies in September 2012.

During the year, the number of core assessments increased and the number of initial assessments decreased, in line with a more holistic approach to intervention and assessment, which focused on resolving family issues rather than undue concentration on the timescales for assessments.

The number of children on Child Protection Plans continued to stabilise during 2012-2013. As at 31st March 2013 there were 213 children subject to a Child Protection Plan compared to 346 in the previous year. During the course of the year, 206 children became subject to CP Plans, whilst 383 children were removed from CP Plans. This is an indication of effective intervention, with risks being ameliorated, and a more consistent “step-down” into Universal and targeted services. As a further indicator of better outcomes being achieved during the year, only 26 children became subject to a child Protection Plan for a second or subsequent time, compared to 46 in the previous year.

The timeliness of core assessments was affected by the increased volume in the number of them being completed (1,285 compared to 1,025 in the previous year). However, this was in the context of major transformation during the year, moving from initial and core assessments to the single holistic assessment (45 days) reflected in the New Guidance – Working Together 2013 – which was published in March 2013. Overall, despite a year of significant transformational change in Children’s Social Care, the Key Performance Indicators reflected in the CIN Census, show a positive picture of practice and improved outcomes for children within the Child Protection System.

Lynda Crellin
Independent Chairman
November 2013

2. WHAT WE HAVE DONE

What we planned to do – our key priorities

A new business Plan for 2011-14 was agreed by the LSCB in spring 2011. Five priority areas were agreed, based on analysis of current information and trends, along with key Government agendas

The five priority areas of work are detailed below, with a summary of work completed against those priorities during 2012-13.

What we planned to do at beginning of 2012-13	What we did
Priority 1 Improve LSCB functioning	
Continue to implement Munro recommendations and Government requirements as required, particularly updated Working Together and related guidance.	We responded to the consultation on the new Working Together and the chair, with other independent chairs, met with representatives from the DfE to discuss concerns. We were represented on the London editorial board responsible for updating the London procedures.
Carry out a section 11 audit across agencies.	Audit carried out in late 2012. Findings reported to March Board.
Fully develop and implement the Quality assurance framework.	QA framework agreed and appointment of Audits manager resulted in more case information available to the Board this year.
Rationalise the performance information produced by social care and the Children's Trust, and feed into improved data framework for the LSCB.	By year end a more detailed analysis of performance information was available to the Board.
Incorporate views of children, young people and their families in the work of the LSCB through response to Borough survey, views of those on cp plans.	System put in place to obtain views of children going off CP plans.
Incorporate the views of staff in the work of the LSCB though responses at stakeholder day and questionnaire.	Stakeholder day held with staff and their views were incorporated into business planning. Newsletter deferred to 2013-14.
Appoint lay members to the Board.	Two lay members were appointed and are now included in Board and sub group membership.
Improve engagement with GPs and Clinical Commissioning group.	CCG representatives agreed and began attending Board March 2013.

Priority 2 Assess and improve operational practice	
Ensure all agencies fully understand the social care threshold criteria, and that it is embedded in the development of preventative services.	Use of new threshold document (based on London levels of need) agreed. Early help family assessment developed, agreed to replace CAF and piloted. Single assessment developed for social care.
Improve the oversight of single agency audits.	Done via audit form submitted in summer 2012 and section 11 audit in winter 2012/13.
Develop and learn from a multi-agency quality audit programme for the LSCB.	Case audit carried out using peer review methodology. Multi-agency work also assessed as part of social care audits reported to Scrutiny Committee.
Roll out the schools safeguarding clusters across whole Borough.	Two clusters in place by year end and working effectively. The final third cluster planned for 2013.
Priority 3 Improve outcomes for children affected by key risk issues	
Improve the identification and support for children and young people involved in sexual exploitation.	This work was incorporated in the existing operational sub group. Strategy developed and incorporated in that for missing/trafficked children. Staff from Japan and Norway visited to view Hillingdon exemplar practice at Heathrow Airport.
Improve the identification and support for children and young people involved in gang activity.	Training delivered in schools on this topic.
Improve quality of information sharing and risk assessments for children and young people who go missing, particularly looked after children.	Services for children missing from care reviewed and reported to Council scrutiny committee. Recommendations overseen by LSCB.
Continue to try and benefit from funding opportunities for children and young people affected by domestic violence.	Some short term funding provided therapeutic support for children identified through the local refuge.
Improve the effectiveness of joint working across children's and adult services in respect of mental health and substance misuse issues.	Joint protocol between children's social care/adult mental health reviewed and refreshed. Joint sessions delivered across teams. Specialist post appointed in children's social care.

Raise awareness of child abuse linked to faith or belief.	Links made with a total of six mosques and madrasahs. Training to be carried out in 2013-14.
<u>Priority 4</u> Ensure a safe workforce	
Carry out and respond to audit of single agency training.	Training census carried out December 2012. Several agencies responded but some agencies were unable to supply relevant data. Once the data is provided, the results can be analysed and reported to the Board with an action plan for improvement.
Develop ways of assessing access to and impact of training.	Introduced the NSPCC's *Connect, Share & Learn* tool to evaluate the impact of training. This is a scenario based tool that evaluate how able staff are to respond correctly to certain safeguarding situations. Changes to statutory guidance, however, require the tool to be updated.
Enhance support to front line managers. Look at more creative ways to improve access to and attendance at multi-agency training.	Action Learning events have been created for first line managers, named and designated staff to provide bespoke and in depth learning for managers.
Continue to improve responses to allegations against staff.	Increasing numbers of allegations responded to and managed appropriately, including historical following Savile revelations. Guidance and procedures on managing allegations rolled out to all schools.
Ensure compliance with new legislation and guidance around recruitment.	The Disclosure and Barring Service (DBS) has merged functions of the Criminal Records Bureau and the Independent Safeguarding Authority. The HR Sub Group has worked with partner agencies to ensure that recruitment practices maintain safeguards for recruiting suitable staff into the children's workforce. Full multi-agency training programme delivered to 2398 staff across agencies

Priority 5 Learn from Case Reviews	
Implement learning from management reviews.	Five cases considered by SCR sub group and 1 became subject of a formal management review with recommendations reported to LSCB.
Complete implementation of the actions arising from the SCIE pilot.	All actions completed, including establishment of Risk Panel to review stuck and contentious cases.
Continue to implement learning from unexpected child deaths and disseminate key messages to local professionals.	Local and national messages disseminated quickly though hospitals and early years networks –particularly in respect of safe sleeping arrangements for babies.

3. GOVERNANCE AND ACCOUNTABILITY ARRANGEMENTS

Operation

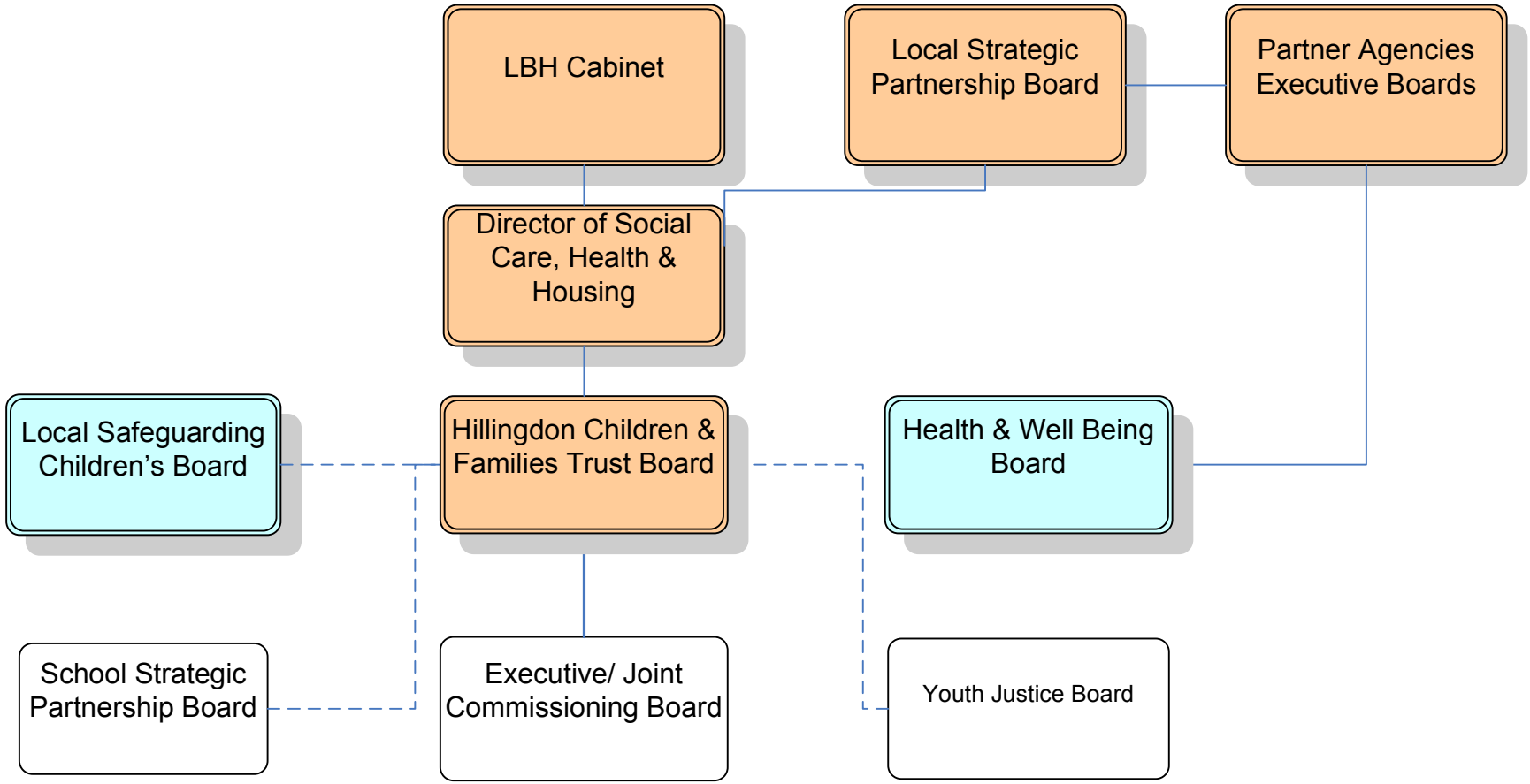
The LSCB operated during 2012-13 in accordance with Working Together 2010, updated in early 2013. Current local governance arrangements are identified below. There are currently 11 sub groups who meet between Board meetings and take responsibility for actions identified in the Business Plan. The Domestic Violence Forum is a Council led body that sits outside the LSCB governance structure, so joint work is taken forward through the Community Engagement sub group.

Sub group chairs and LSCB officers meet between meetings with the chairman to undertake detailed planning for the Board and to monitor progress against the Business Plan and Partnership Improvement plan (PIP).

Although there is no longer a statutory requirement to have a Children's Trust, the Hillingdon Children and Families Trust Board (HCFTB) continues to meet in order to oversee the Children and Families Plan. The LSCB chairman sits on the HCFTB and though regular updates ensures that the HCFTB is kept abreast of key safeguarding issues and that these can influence the Children and Families Plan and the work of the HCFTB.

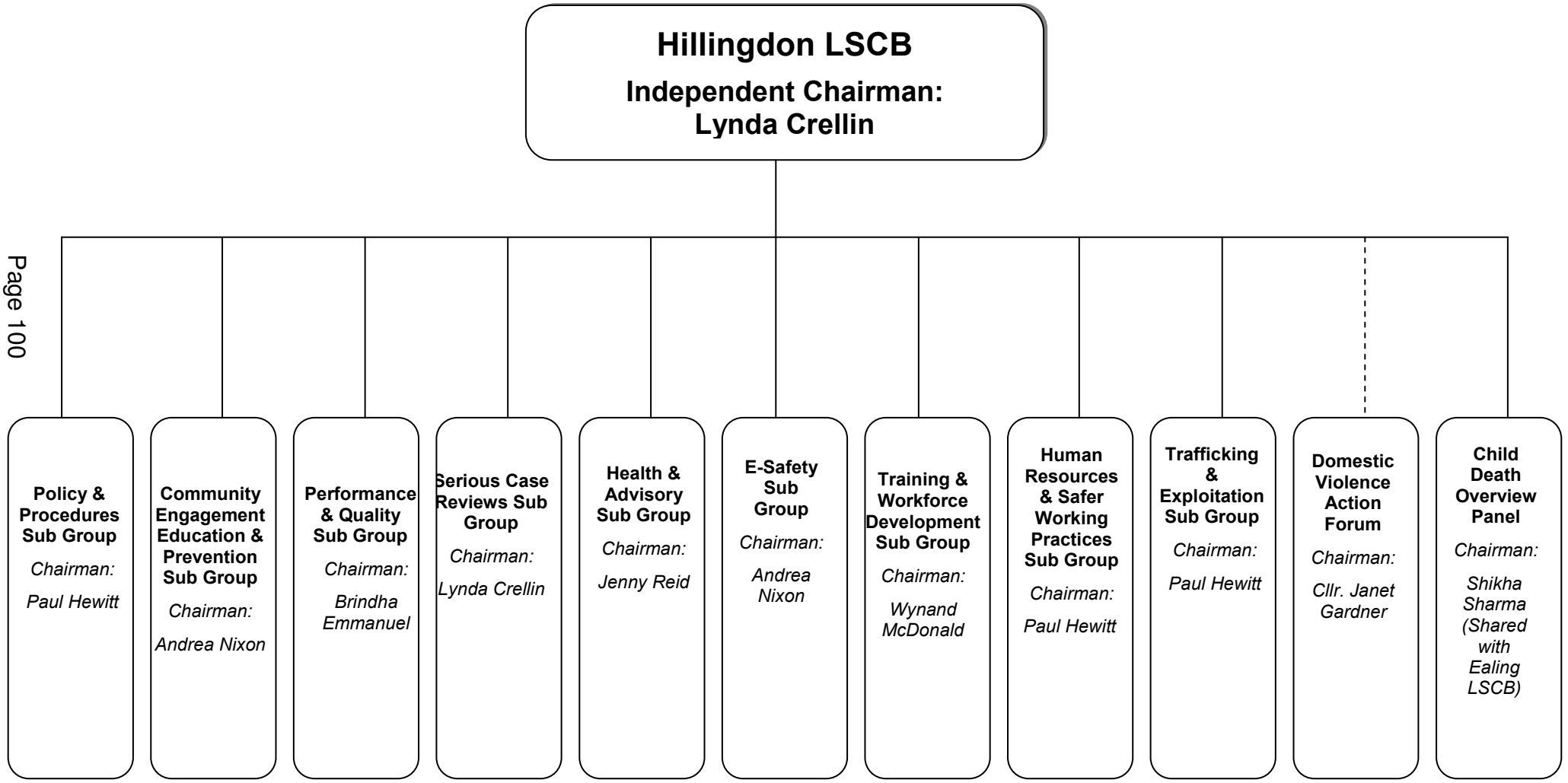
This annual report will be presented to Council Scrutiny Committee, to Cabinet and to the Health and Wellbeing Board. It will feed into the Local Strategic Partnership Board (LSP) through the HCFTB. Future arrangements may evolve further in accordance with the Munro review which recommends that the LSCB annual report is presented also to the local Police Partnership Board.

Closer links were made with the Safer Adults Partnership Board (SAPB) and, from November 2011, both Boards meet on the same day, and are chaired by the independent chairman. Each Board has been able to keep its separate identity, but we have used the opportunity to use the cross over time between Boards to look at items of joint interest. These have included domestic violence, and the development of preventative services for families.



LSCB Governance

THE STRUCTURE OF HILLINGDON'S LOCAL SAFEGUARDING CHILDREN BOARD



Membership

The LSCB is a large, inclusive and generally well attended Board, supported by strong sub groups. Overall attendance during 2012-13 was 60%, which is 16% less than last year. 100% attendees were CAIT, the Voluntary Sector, Hillingdon Community Health, NHS Hillingdon, Hillingdon Hospital, Children's Social Care and Adult Social Care. Council Education had 75% attendance and Public Health and YOS showed 50%. From schools we lost the SEN representative but primary heads had 100% representation and secondary 25% due to the departure of the lead head teacher during the year. Borough Police, Probation and Border & Immigration managed to send limited representation throughout the year due to structural changes within each of these agencies. This reflects to a certain extent changes and flux within those organisations. The Executive member acts as participant observer on the LSCB in order to ensure he is able effectively to discharge his political accountabilities. He and the Chief Executive attend on an occasional basis and receive papers. Membership was reviewed during the year to ensure the right level of senior representation across agencies. A list of members is attached at appendix 1.

In the latter part of the year the LSCB appointed two lay members who took up their role in early 2013 and have attended Board meetings since June.

The Clinical Commissioning Group (CCG) began its work formally in April 2013, having operated in shadow form during 2012-13. The CCG is represented on the LSCB by the lead GP and the Executive Lead for children. The relationship between the LSCB and GPs as providers remains work in progress.

Independent chairman

There is an independent LSCB chairman who operates within a protocol agreed by the Board and based on that recommended by the London Safeguarding Board. The chairman reports to the Director of Children's Services (DCS) and is held accountable though the Hillingdon performance framework. The chairman meets regularly with the Chief Executive, Executive member, and senior managers from partner organisations. Thus the systems are already in place to meet the new requirements in Working Together 2013 which places accountability for the LSCB chair with the Local Authority Chief Executive.

Relationship to agency boards

Each of the statutory agencies has its own safeguarding governance and audit arrangements, summarised below. Key agencies are asked to complete an LSCB audit each year summarising their internal findings and key issues for the LSCB.

Section 11 audit

The LSCB has a legal duty to ensure that statutory partners comply with section 11(1) of the Children Act 2004. During 2012-13 the LSCB undertook an audit asking agencies to demonstrate that they are compliant with their section 11 duties. The LSCB sent out a self assessment tool to all LSCB partners, using the tool developed by the London Safeguarding Board. All

relevant statutory agencies responded and also some non statutory voluntary bodies. Agencies were asked to evaluate themselves against eight agreed standards issued in guidance by the Secretary of State. Partners were asked to provide evidence to support their evaluation and the completed audits were evaluated by the Performance and Quality sub group.

Overall, agencies in Hillingdon were able to demonstrate a strong commitment to safeguarding throughout their organisations backed up by governance structures, lines of accountability, policies and procedures, recruitment processes and training. In some organisations, particularly the newly established Clinical Commissioning Group (CCG), governance structures were being reviewed and tightened up. The most significant area for development across all partner agencies was in relation to the standard that focuses on the incorporation of the views of children and young people in service development. This has been incorporated in LSCB planning.

Another area for development was the monitoring of commissioned services.

Of particular note in this audit was the enthusiastic participation of non statutory agencies who work with children. Interestingly, these agencies were more likely to comply with the standard about taking children's views into account

Following the audit, the chair met with senior managers in some key agencies to test out evidence and identify areas for improvement.

A report on the audit was presented to LSCB in March 2013 and appropriate actions agreed, particularly in respect of the involvement of children and young people.

Hillingdon Council

The Council was represented on the LSCB by the Director of Social Care Health and Housing (designated DCS) and by the Deputy Directors for Social Care and Education. Most of the statutory indicators for safeguarding rest with social care and these are monitored monthly and also shared with the Corporate Management Team, Chief Executive and Lead Members on a quarterly basis. The Lead Member and Chief Executive receive monthly updates on local safeguarding issues and attend regular safeguarding meetings with senior officers across children's social care, education, youth and early years services. The Children's Scrutiny Committee reviews key safeguarding areas – the most recent of these being children missing from care and social care audit report. Recommendations are incorporated as appropriate in the LSCB work plan. This annual report will be presented to Scrutiny Committee and Cabinet.

Internal Governance arrangements

The statutory Director of Children's Services has maintained oversight of key services relating to safeguarding children, via a monthly meeting with the Lead Member of the Council for Children's Services, and the Chief Executive. This monthly mechanism of regular reporting has enabled the prioritisation of child protection work, and allied safeguarding issues to be constantly reviewed, in the light of local circumstances. The monthly review includes a performance scorecard which enables the Chief Executive, Lead Member and

Director of Children's Services to have scrutiny of child protection activity on the ground.

Allied to this monthly meeting, there is a six monthly report made to the Corporate Management Team (CMT) across directorates within the Council. This report is also presented to the Policy Overview Committee (POC) to ensure oversight of children safeguarding performance within the Council.

Running alongside the performance scorecard has been a quality audit programme, which has also helped to strengthen safeguarding and highlight areas for improvement. The findings from these audits are reported to POC on a quarterly basis.

One of the key issues for improving and strengthening child protection practice is the quality of management oversight and supervision provided to front line social workers. This was a significant theme in the audits carried out within Children's Social Care during 2012-2013.

In order to address this issue, a one year programme of Reflective Supervision was delivered to all managers in Children's Social Care (including Residential Managers) during 2012-2013, by an expert from the Tavistock Clinic. This was regarded as a significant achievement by managers and was welcomed by the front line social workers, as shown in a survey after the Reflective Supervision.

Running alongside this programme was a plan to refresh and re-launch the Supervision Policy, with greater emphasis on the use of supervision contracts/agreements, to ensure that case discussions are properly recorded, and take account of researched and informed practice. The Supervision Policy was re-launched by the Deputy Director in February 2013. Future audits will be monitoring the implementation of the policy, with specific reference to a Supervision Contract being in place, as the foundation for Reflective Practice.

During the year 2012-2013, a Designated Principal Child & Family Social Worker was nominated within Children's Social Care, as a way of ensuring that social workers' views would be represented at a senior level. The Designated Principal Social Worker is also the head of Children Safeguarding and Quality Assurance, and meets monthly with the Chief Executive and Lead Member for Children to represent social workers' performance, pressures and achievements. This has helped to ensure that front line services are protected within the inevitable spending reductions which have affected the Local Authority.

Youth Offending Service

Achievements

All staff undertook training on assessments, resulting in an improvement in quality from 69% 84% of documents being assessed as satisfactory or above. 78% were identified as good.

The management team developed a further training exercise to improve specifically in the assessment areas of risk and vulnerability. As a result:

- The percentage of risk of harm assessments identified as good rose from 25% in August 2012 to 67% in February 2013;

- The percentage of vulnerability assessments identified as good rose from 38% in August 2012 to 67% in February 2013.

The Integrated Intervention Plan template designed to combine the activities addressing risk of harm, offending and vulnerability into one holistic plan was further revised in 12-13 to include sections on learning style, diversity and victim safety.

A practice workshop on the planning process resulting in an improvement in plan quality from 92% to 100% being identified as satisfactory by November 2012

The YOS has developed a number of new intervention programmes for both young people and parents this year including:

- A revised knife crime programme for young people;
- A bespoke programme for parents with sessions on substance misuse, knife crime and gang activity;
- One billion rising programme for young people focused on domestic violence and developing healthy relationships.

The YOS has representatives at two forums focused on gangs and associated links to exploitation one run by West London YOTS and the other by the Youth Justice Board.

In terms of outcome data:

- The number of fist time entrants into the criminal justice system continued to fall with 156 recorded in 12/13 compared to 212 in 2011/12.
- 37.5% of young people sentenced between April 2010 and March 2011 committed further offences an increase of 0.4% against the previous period. This is lower than for the London region (39.8%) but higher than for England (35.8%). The number of further offences committed by those young people was lower than both the national and London Averages.

Challenges in 2012-13

The Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LASPO) introduced a number of significant changes to the youth justice system which required a revision of existing YOS practice during 2012-13. The most significant changes were the introduction of:

- The remand to Youth Detention Accommodation, replacing the existing secure remand framework
- Looked after status for all young people remanded into youth detention accommodation.

Education

Overview

Safeguarding of children in Hillingdon early years centres and schools appears to be secure.

The structures for identifying children at risk are robust and include all schools and centres irrespective of their status: Community, Academy, Faith, Free or Independent. Regular training takes place for staff and governors; monthly briefings of officers take place with the CEO. Data is gathered systematically and analysed. The conclusions are used to inform professional practice. Where a child may be at risk there is audit evidence of prompt intervention with robust follow-up work. The work of safeguarding in education sits securely within the overall structures and processes of Children and Young People's Services.

Policy is regularly reviewed, practice is monitored and data is used to inform training and development work.

Children without a school place

A recent POC review identified some concern with schools 'off rolling' pupils, these actions are not always known to the Local Authority; therefore some vulnerable children are without a school place. Where possible they will be identified by the school's education welfare officer although there are some risks following the change in their role from September 2013.

A new provision for young people without a school place has been formally established from September 2013 following the above mentioned POC review recommendation. Hillingdon Tuition centre has responsibility for the provision and will work closely with the admissions team to offer an interim placement until a school place is secured.

The Behaviour Support team has been transferred to the Hillingdon Tuition centre management and will continue to work to the schools Service Level Agreement. There is some risk to the capacity of the team to carry out LA roles in the future.

Elective Home Education

The Elective Home Education role will be embedded within the new education structure in response to the Council's statutory role including that of safeguarding for these children and young people.

Safeguarding in schools

Safeguarding in schools in Hillingdon remains a high priority. Schools continue to access training, advice and support through the Child Protection Lead for Education. The relationship between schools and Social Care has been strengthened through the development of the Schools Safeguarding Clusters. These clusters are made up of designated teachers from primary and secondary schools and chaired by a Team Manager from Social Care. Each cluster meets termly and schools have found this discussion forum invaluable.

The Local Authority Designated Officer has been part funded through schools, which demonstrates their commitment to ensuring that pupils remain safe. This is a growing area of work, in which the LADO provides advice to schools and oversees investigations into allegations made against professionals. A monthly report is submitted to the Principal Social Worker, outlining progress and outcomes from allegations. A report is also submitted to the Local

Safeguarding Board on a quarterly basis, outlining the number of reported incidents.

The possible challenges going forward are to ensure that safeguarding responsibilities within the growing number of academies remain a high priority and our current relationship with academies remains strong.

Early Intervention Services

Main achievements 2012 - 2013

The Council's Children's Pathway Transformation process, and its associated discovery and design work, have resulted in the closer alignment of services concerned with intervening early to prevent family problems developing or escalating. This has resulted in the bringing together of a number of service areas including, local authority managed Early Years and Childcare provision, the Children's Centre programme, youth work and youth support services including, sexual health, substance misuse, counselling and support, information advice and guidance services, Youth Offending and Family Key-working Services, the Troubled Families Initiative and related programmes ranging from parenting to training programmes. A new strategic direction for these services is being developed in collaboration with partners. An Early Intervention and Prevention Strategy has been developed with the mission to:

> "Develop an integrated model for the provision of early intervention and prevention so that services may intervene early and as soon as possible to prevent or tackle problems emerging for children, young people and their families or with a population most at risk of developing problems".

Work continues to mobilise services and partners in order to realise this mission with an Early Intervention and Prevention Strategy Group established as the partnership vehicle for doing so. The focus of this group is to embed a comprehensive and integrated system for the provision of early help to families in Hillingdon. The group also oversees the development and implementation of the Strategy which includes the following key operational objectives:

- Securing an integrated preventative 'Local Offer' including early help services with the capacity and flexibility to response to locally defined need;
- Developing mechanisms for communicating the offer to children, young people and families and enabling their access to services;
- Developing and embedding early help principles and processes which enables practitioners to consistently assess and respond to whole family need in a straight forward and timely manner; and
- Secure teams of key-workers who work in collaboration with those providing the Local Offer so that their clients may receive the support and interventions they need.

To date the local offer of tier 1 and 2 provision has been mapped. A locality-based method for developing and co-ordinating the offer, the Family Centred Network, has also been developed and is being tested in the south of the Borough with a view to being rolled out across Hillingdon.

A new Family Key-working Service has also been developed. The Service is testing new ways of working concerned with providing families with different levels of need 1-1 support to overcome problems and develop resilience to avoid future difficulties

A new early help assessment tool and early help 'team around the family' process has also been developed and is in the process of being tested and rolled out.

Over the next year and beyond work will continue to develop and implement the Early Intervention and Prevention Strategy with partners with a view to strengthening our collective approach to providing families with the early help they need to avoid or overcome problems that lead to poor outcomes.

Early Years Services

The Early Years Service supports the development of quality, alongside the development of the workforce, across all sectors of early years provision. This includes developing the quality of experiences for all children attending registered provision, the quality learning and development experiences and those for children with Special Educational Needs and Disabilities (SEND).

Within the service there is a team dedicated to monitoring the compliance of settings in relation to the legal requirements for safeguarding outlined within the Statutory Framework for the Early Years Foundation Stage. The challenge for all teams within the Early Years Service is to engage private businesses in developing the quality of their provision and to ensure good practice is embedded in every day practice.

Main achievements in 2012-13

Over the last year the focus of the work has been to develop those settings that were not meeting the legal requirements for the safeguarding of children. The impact of their work can clearly be seen below.

Quality of safeguarding and well being of young children in settings:

- Overall quality – improved quality in settings that were not meeting the legal requirements (in 2011-12) by 22%. There are now 23% more settings working well in excess of the minimum quality standards.
- Quality of safeguarding – 51% of settings were not meeting the legal requirements in 2011-12. This has now dropped to only 8%. 19% more settings are working well in excess of the minimum quality standards.
- Suitable people – 34% of settings were not meeting the legal requirements in 2011-12; this has now dropped to 6% and there are now 25% more settings are working well in excess of the minimum quality standards.

Developing the workforce in relation to Safeguarding and children's well-being:

- 333 practitioners have accessed safeguarding training this year. This has included setting practitioners and childminders and has been delivered via central and in-setting training events.

- Almost 600 practitioners have accessed supervision training over the last year to improve the structure of supervision sessions to include safeguarding as a standing agenda item

Schools

Schools safeguarding audit

Following the Serious Case Review in 2010-11, a bi-annual review of schools safeguarding activity was agreed. In 2011 therefore The Safeguarding Board carried out an audit of the safeguarding roles and procedures within schools in Hillingdon. This audit is completed bi-annually and we have had a previous 100% return rate which demonstrates the commitment that Hillingdon schools have to ensuring that pupils remain protected. The audit is completed by primary and secondary schools including all Academies.

The audit also highlights gaps in provision in which the Board are then able to offer support and guidance. From the previous audit it was clear that not all schools had a key holder policy as recommended in the serious case review. In working with a Hillingdon High school a model policy was developed and circulated to all schools.

The audit has been repeated in summer 2013 and the results will be reported in due course.

Schools Safeguarding cluster meetings

The school safeguarding cluster meetings were established during the year and have gone from strength to strength. We currently have two clusters, a North cluster and a South cluster, that are very well attended. In September we hope to launch a central cluster also chaired by a Team Manager from social care. The meetings are held termly and attended by both primary and secondary schools including Academies. New policies, procedures and changes to working practice within Hillingdon are discussed and schools identify topics that they would like to raise. The second half of the meeting focuses on specific cases to either understand why decisions were made or to raise concerns that need to be addressed by other agencies.

The feedback from the cluster meetings has been very positive from schools and social care. It has improved the understanding of each others roles and opened communication between the services.

Voluntary Sector

The voluntary sector in Hillingdon is made up of around 100 independent organisations working with children, young people and/or families. They range from branches of large national charities to small local groups which may provide services to just a handful of children. Approximately 75% are volunteer led with no paid staff. The other 25% do have paid staff. Services provided also vary and include fun or play activities, services for the disabled, learning opportunities, sport, advice, support and guidance in a range of areas, counselling and diversion from crime. This list is not exhaustive.

Unlike the other agencies represented at the LSCB, the diversity and independence of the sector makes it difficult to generalise about

arrangements for safeguarding in the sector. There are as many different arrangements as there are organisations.

Branches of national charities usually have their own safeguarding advisors and training officers with robust arrangements for ensuring policies and practice are adhered to. Smaller voluntary agencies use a range of organisations for support and training. These include the NSPCC, Churches Child Protection Advisory Service (CCPAS) and Safe Network. The LSCB ensure that a local support service is also available for voluntary agencies delivering services in Hillingdon. That support service ensures that:

- Voluntary Agencies are represented on the LSCB, currently by Hillingdon Association of Voluntary Services (HAVS)
- Feedback from the LSCB, such as changes in policy and practice, is circulated to all voluntary agencies
- Voluntary agencies are able to access LSCB training
- Where voluntary agencies don't have their own arrangements for introductory training, they can attend training delivered by HAVS or the HAVS representative will deliver training 'in house'
- Voluntary agencies have support when they need it, to write and develop policies and good practice
- Voluntary agencies have someone they can speak to if there is anything they are unsure of regarding safeguarding.

This support is provided by HAVS.

In the past year, HAVS has delivered more introductory training than ever before with 6 courses delivered to 103 people in total, showing that the sector has a genuine desire to engage in the safeguarding agenda. Voluntary agencies also responded positively to LSCB processes such as the Section 11 audit and trialling of the new shared assessment process. Voluntary agencies have continued to be updated with developments such as the introduction of the 2013 version of Working Together.

Health Agencies

All the main health agencies are represented on the LSCB, including the joint Director of Public Health (DPH) who is the executive safeguarding lead, the designated doctor and designated nurse. The Designated Nurse was during this year based within the Public Health Department and, alongside the Designated Doctor, has the main responsibility for overseeing safeguarding practice in each health agency, including the Hillingdon Hospital and Harefield and Brompton Hospital Trusts. The designated professionals reported directly to the DPH. From April 2013, they report to the CCG

Each of the main Provider organisations has its own safeguarding steering group which feeds into NHS Hillingdon Safeguarding Committee. Some of the quality assurance work and monitoring of key actions rest with the health sub group of the LSCB. However, the overarching statutory duty (including quality assurance) to ensure that safeguarding and promoting the welfare of children is discharged effectively, rests with Hillingdon PCT and, from April 2013, the

successor NHS commissioning organisation, NHS Hillingdon Clinical Commissioning Group.

Central and North West London Health (Mental Health services)

Main Achievements 2012/13:

- **Establishing shared supervision arrangements**: Addiction Services have agreed times when safeguarding children cases can be presented to CSC workers for support and challenge.
- **Young Carers**: The CNWL Safeguarding Children's Advisor has worked with local partners to develop a training package for staff to raise awareness of young carers issues. CNWL has also established a Focus Group for Young Carers so that they can feedback their views on services and what improvements would make a difference to them. Hillingdon Young Carers have been present in this group.
- **Section 11 Audit**: The Trust completed a Section 11 Audit for Hillingdon and an evidence file documenting the supporting evidence of compliance was made available. Where further work was needed an action plan was developed and these actions have all been completed.
- **Supervision Audit across adult and CAMHS** – carried out by external auditors. This found all staff had been supervised with their CP cases in the previous month. The main learning point was the need to record the safeguarding children supervision on the electronic record, and to update the Supervision Policy so guidance was clear on this. **Safeguarding Helpline Audit**- showed that service in Hillingdon used this on a regular basis and there was a high level of awareness amongst staff on how to access support on safeguarding issues.
- **Attendance at safeguarding training including refresher training** – presently CNWL level of attendance on training is above 85% and the Trust is fully compliant with the David Nicholson DH requirements on this. CAMHS and staff who regularly see children received training on the CAF.

Main Challenges

We have identified some key challenges for the Trust in 2012/13:

- **Reviewing CAMHS**: Commissioners have been working with CAMHS to review the service and concerns remain within CAMHS about the level of funding and capacity to meet local needs. A Royal College of Psychiatrists review identified some areas to strengthen also potential gaps in commissioning.
- **The financial environment** and the impact on contracts with CNWL may mean that services have to reduce and may not meet the needs of children, the demand of families or the expectations of partner agencies.
- **Impact of the benefit changes** on families may result in moves of families where there are concerns and disrupt treatment packages, or risk being lost to the systems in new areas. The areas where families

may move from to Hillingdon are likely to be managed by CNWL, so this risk is mitigated.

- **Establishing information systems to gather the information needed**, that is, to collect more outcome focused measures and qualitative data to assess the effectiveness of services, including linking adults and children in the IT system. Many of the IT systems do not currently support the collection of such information.

Hillingdon Community Health, (HCH)

CNWL NHS Foundation Trust is one of the largest trusts in the UK, caring for people with a wide range of physical and mental health needs. It provides healthcare to a third of London, Milton Keynes and parts of Kent, Surrey and Hampshire. Within the borough of Hillingdon, CNWL provides both mental health and community care services (the latter is known as Hillingdon Community Health).

In relation to the community services provided in Hillingdon by CNWL, the following key areas are of note:

Governance arrangements in respect of Safeguarding Children

The Hillingdon Community Safeguarding Children Team consists of a Named Doctor, two Named Nurses, a Paediatric Liaison Health Visitor post and 2 part time administrators.

In 2012, Hillingdon Community Health was able to declare full compliance with safeguarding responsibilities as outlined in Outcome 7 of the Care Quality Commission's Essential Standards of Quality and Safety.

The community division holds a quarterly safeguarding meeting, chaired by the Managing Director for Community Services, to review policies, results of audits, training plans, lessons learnt from safeguarding alerts as well as agreeing and overseeing the annual work plan.

Representatives from the community division also attend the Trust's Quarterly Safeguarding Committee which is chaired by the Board Level Safeguarding Lead - Executive Director of Operations and Partnerships.

As a key borough partner, there is Director level representation from the community division on the Hillingdon LSCB with representation also on each of the sub groups which support the LSCB.

Outcomes for Children

In line with the concepts outlined in "Improving local safeguarding outcomes,"[1] the safeguarding team commenced work to focus on assessing outcomes for children with a particular emphasis on outcomes such as "before and after" discussions. An audit process was established whereby health visitors and school nurses were asked to compare the family's position at the commencement of a child protection plan, then at a midway and again closing

[1] "Improving local safeguarding outcomes: Developing a strategic quality assurance framework to safeguard children" (2011) Local government Group/ London Safeguarding Children Board

point. The intention was to identify what impact the intervention has had on the child's life.

This audit was undertaken in 2012 and the results were encouraging. Of the 7 practitioners interviewed, 6 felt that the child protection intervention had improved the outcome for the child/ young person in their service. A health visitor discussed a long term child protection plan for neglect. There were some improvements with a move to a different property but these improvements could not be sustained and the health visitor has concluded that the child protection plan cannot safeguard the children and the only option is moving the case to the legal framework. The other six cases demonstrated some effective multi-agency working and good communication within the core group. These outcomes will be discussed with health visitors and school nurses in supervision and in their local professional forums.

Audits

A number of audits were conducted during 2012-2013 as outlined below:

1. Child Protection Record Keeping- 2 audits in 2012-2013. The results in 2013 showed a significant improvement. There will be some ongoing work with children's services staff as an area of continued weakness is eliciting and recording the views of the child.
2. Evaluation of level 2 training. We surveyed 50 clinical staff and 28 responded. Encouragingly, 100% of respondents felt it was appropriate to their role. This included those who see adult clients only. 99% of respondents knew who to contact if they had child protection concerns and 99% believed they knew what to do if they needed to safeguard a child.
3. Evaluation of Safeguarding Supervision. Although there was a poor response to the online survey it was generally positive as nearly all the respondents stated they were receiving safeguarding supervision in a timely manner, a large majority found it promoted reflective practice and most considered it reduced work based stress.
4. Review of Information Sharing Processes in A&E. Key points being addressed with Hillingdon Hospital are around the lack of photocopies of attendances resulting in transfer of poor quality information to community staff and incomplete or blank GP discharge summaries. A new method of sending GP discharge summaries has commenced.
5. Child Protection medical examinations. Actions for the community paediatricians include:
    - Ensuring that the Team Manager number is included in initial referrals
    - Reducing the time between receiving referral and Paediatrician calling Social Worker
    - Encouraging the social worker to make referrals earlier in the day

Additional audits within HCH relevant to safeguarding children:

6. The domestic violence specialist health visitor audited the domestic violence traffic light system for police reports.
7. The children's services teams audited the safeguarding children processes action plan.

Training

Training continues to be a high priority and all training complies with the guidelines set out in the intercollegiate document (2010). Overall compliance rates remain good across the community teams as follows:

- Level 1 - 95%
- Level 2 - administrative staff - 92%
- Level 2 - clinical staff - 80%
- Level 2 - for HV and SN's - 89%
- Level 3 - Working Together Multi-Agency - 87%
- Level 3 - Child Protection Process Single Agency - 87%
- Level 4 – Named Professionals – 100%

The Community Division Named Nurses co-facilitate the level 3 multi-agency Working Together course.

Supervision

The Safeguarding Children Team continues to oversee and provide support in relation to the delivery of child protection supervision to all relevant staff groups in the community.

Risk management

The CNWL Community Services Named Nurse chairs this multi-agency risk management forum which was established by the LSCB. The Terms of Reference were revised in 2012 and the panel now provide opportunities for key partner agencies within safeguarding to review their responses to high risk cases. In addition we hope to learn from the experiences of practitioners in cases where risk is being jointly managed by the professionals. It is intended that this group will use reflective practice and learning to help to drive up standards in practice and disseminate the learning across the partnership within the Local Safeguarding Children Board. The group remains responsible for Escalation and Conflict Resolution.

The Hillingdon Hospitals NHS Foundation Trust

Safeguarding children arrangements at the hospitals have continued to strengthen during 2012/13. The Executive Director for safeguarding, who sits on the hospital Trust board oversees the annual work and audit programmes for safeguarding children and progress against these is now reported to the Trust's Safeguarding Committee which reports to the Quality and Risk Committee (a board committee) on a quarterly basis. An annual report on safeguarding activity was presented to the Trust Board in August 2012. The hospitals are well represented on the LSCB and its sub groups by the hospitals named professionals for safeguarding and senior management staff.

The Trust has a multi-agency Safeguarding Committee, which meets on a quarterly basis and covers both adults and children safeguarding work. This replaces the Safeguarding Children Steering Group (SCSG).The Committee is chaired by the Executive Director of the Patient Experience and Nursing.

Domestic violence awareness continues to be raised across the organisation with a training session delivered by HESTIA. The Trust 'Safeguarding Matters' newsletter for adults and children is sent to staff on a regular basis.

There is continued support in the development of the safeguarding midwife role. This will be strengthened by the new community team leaders being trained to provide clinical supervision of cases. This follows a community midwife reconfiguration in April 2013.

A Practice Development Nurse for Paediatrics is now in post (working primarily in Paediatrics), and an Emergency Nurse Practitioner (ENP) post has been advertised. A band 5 children's nurse is to start in June

Key Trust staff have been actively involved with the evaluation of the new Interagency Form for Child protection .The Trust has also undertaken a Section 11 Audit.

Key challenges moving forward in 2013/14 include:

- Ongoing difficulty in recruiting more paediatric nurses to the paediatric Accident and Emergency (A&E) department. Currently there is a Senior Staff Nurse and Sister dedicated to lead on the work within the paediatric A & E. This is currently on the Trust Risk Register with regard to actions that are being taken forward to mitigate any risk; this is reviewed at the Trust Safeguarding Committee.
- The achievement of >80% compliance with safeguarding children refresher training, particularly in light of revised intercollegiate guidance and the need for more staff to undertake further training.
- Ensuring high quality safeguarding practice amidst financial savings across all partner agencies, embracing the Department of Health's QIPP (Quality, Innovation, Prevention and Productivity) work-stream with regard to doings things differently to ensure the quality of care is maintained, despite cost improvement programmes.

An annual work programme has been developed to ensure priorities for 2013/14 are closely monitored and required actions progressed. The Trust is keen to work with partner agencies to ensure that information on patient outcomes in relation to safeguarding is captured to support further improvement work.

Metropolitan Police

Child Abuse investigation team (CAIT)

- The MPS has again continued to deliver a commitment to providing regular training on safeguarding, child protection and effective leadership for managers and practitioners across frontline services. The MPS provision of Multi-Agency Critical Incident Exercise (MACIE) training for each London borough has been completed and SC&O5 will work to ensure that the financial commitment (currently fully funded by the MPS) to MACIE training is maintained.
- The Specialist Joint Child Abuse Investigation Course (SJCAIC) which is a two week training course for new staff members run jointly with social workers. SC&O5 continue to run and induction week for new staff that they attend on their first day of joining the command. This course is one week and the aim is to provide basic initial understanding of the Child Protection world and partnership working.

- SC&O5 is currently in the process of preparing an 'Advanced child interview course' for very young children and children with learning or communication difficulties. This will deliver a better service to victims and witnesses of abuse and will contribute to wider efforts to enhance community confidence in the police.
- Over the last 12 months, SCD5 has continued to utilise the Child Risk Assessment Matrix (CRAM) across London to better inform decision-making. This process makes a qualitative assessment of all relevant factors relating to a child and allows appropriate and informed decision-making, and is now more comprehensively recorded on the police crime reporting data base. A thematic review of this system is intended for 2013/14 to identify any learning and further enhancements that can be made.
- Responsibility for ensuring compliance and pan London governance of CAITs sits with the SCD5 Continuous Improvement Team (CIT). The CIT includes quality assurance, training and partnership. SC&O 5 have merged with SC&O2 (Rape) Command as of 1/6/2013. The quality assurance functions and staff will be merged together to provide better resilience and capacity to develop inspection programmes, performance monitoring and identification of trends / themes and any relevant learning.
- The Command has reviewed the Specialist Child Abuse Investigators Development Programme (SCAIDP) in line with the new learning descriptors produced by the NPIA. The command is now developing the "continuing professional development" aspect to ensure that all accredited investigators maintain this qualification through evidence based assessments.
- SC&O5 has reviewed its response to Victim Care in line with the Commissioners Total Victim care ethos. The Command has reviewed systems to ensure that victims or a suitable point of contact are being updated regularly. Performance in this are is subject of monthly SMT review and during team inspections. It is recognised that the command can continue to improve in this area.
- SC&O5 works closely with local boroughs who lead on community (including youth) engagement. SC&O5 also has a dedicated partnership team, which leads on developing engagement with the communities we serve. The partnership team undertake a number of strands of work around key areas to enhance engagement and encourage community confidence .Examples include engaging with other professionals such as, LSCBs, Health, Education, Probation, LADOs to promote child protection procedures and provide safeguarding awareness. The Manual of guidance on spirit possession is being widely adapted and used. Pro-active community engagement events around issues such as spirit possession and FGM have been well received. The use of SPOCs on each CAIT to offer support and guidance in relation to spirit possession and FGM is ongoing and will ultimately promote the use of Non Government Organisations to engage with children and families. Engaging SNTs with LSCBs to

participate in safeguarding inputs to religious communities is in its early stages. Sudden Unexplained Infant Death (SUDI) training is provided for all relevant police personnel and associated professionals. This training includes work with families who have suffered bereavement. SC&O5 staff attend and also contribute to LSCB training and promotional events.

- SC&O5 has reviewed its response to Victim Care in line with the Commissioners Total Victim care ethos. The Command has reviewed systems to ensure that victims or a suitable point of contact are being updated regularly. Performance in this are is subject of monthly SMT review and during team inspections. It is recognised that the command can continue to improve in this area.
- The SMT has recently introduced a daily 'Grip and Pace' meeting which reviews all overnight issues including SUDIs and children on a CP plan being victims of new allegations. This ensures that enhanced protection for children subject to a child protection plan is reviewed by SMT, actions identified and prioritised. NVOC are recorded centrally by the Continuous Improvement team.
- Project Topaz has been implemented to work with partner agencies to safeguard and protect children who are subject to a child protection plan. Referrals staff are required to identify every occasion a child subject to a CPP becomes the subject of a new allegation. The Continuous improvement team review these incidents and Include them in the SC&O5 Daily and 'Grip and Pace' meeting.
- SC&O5's relationship with MASH is being reviewed under the direction of an SMT lead. Mash has been rolled out across 10 London boroughs and by 2014 will be across all 32 boroughs.
- SCD5 have invested significant resources into ensuring efficient and effective information sharing practices through the development of new risk based approaches and enhanced referral desk capacity. SC&O5 have collated information that shows these new practices have identified victims and allowed for safeguarding interventions which may have been missed previously. All SC&O5 training, but in particular the multi-agency training, focuses on minimising the risk to children through appropriate information sharing and empowering staff to use and develop their professional judgement. SC&O5 have also recognised that this needs to be supported by strong supervision. SC&O5 has changed its structure to ensure sergeants, in particular, are able to offer support and guidance to staff managing cases. These workloads are reviewed annually to ensure an appropriate distribution of resources.

Borough Police

This annual report highlights some of the work and multi-agency involvement in Safeguarding Children within Hillingdon Borough involving the departments of the Metropolitan Police (separate report from SCD (2)).

A large resource intensive part of this work is the Missing Person's Unit's investigations to locate, return and debrief missing children. During the period 1st April 2012 - 31st March 2013 there were a total of 750 missing Children under the age of 18.The breakdown of some of these statistics is that 24 were High Risk, 658 were Medium Risk and 68 recorded Standard Risk. There is a caveat that several of these Missing Children go missing on multiple occasions and often more than once in the same day.

These recidivists are subject to scrutiny and intervention plans when discussed at Missing Children Operational Meeting.

The Missing Person Unit has been relocated in the Grip & Pace office at Uxbridge Police station to maintain and enhance the response to Missing Children in Hillingdon.

A search to assist with the impact of Crime within Hillingdon Borough on children under 18.

Within the year there were 1948 crimes with victims under 18 years of age.

The Public Protection Desk recorded during the year Pre Assessment Checklists/Pre birth PACS in total 4508.

A breakdown of that is Apr 310,May 456, Jun 424, Jul 416, Aug 334, Sep 313, Oct 375, Nov 368, Dec 314, Jan 436, Feb 366, Mar 396.

Significantly, the Public Protection Desk footprint has been transported to the Multi-Agency Safeguarding Hub, M.A.S.H. located in the Mezzanine at the civic centre, after more than a year of planning.

This is a significant development in multi-agency working which involves a Police Sergeant two police constables and two researchers being co located with social workers to enhance the process of protecting the most vulnerable.

This has all remained focussed and constant with the Metropolitan Police radically restructuring under the Local Policing Model without loosening grip on such an important priority**.**

Work also continues in respect of liaison with specialist units to prevent and or detect sexual exploitation of children.

Multi-agency public protection arrangements (MAPPA) in Hillingdon 2012/13

MAPPA is responsible for the risk assessment, management and planning for cases under the following criteria:

Category 1: All registered sex offenders.

Category 2: All violent offenders sentenced to a custodial sentence of 12 months or more for a violent offence listed under schedule 15 of the Criminal Justice Act 2003; subject to a section 37 Hospital Order for a violent offence; any sex offenders who are not registered.

Category 3: Any offender with an eligible previous conviction (violent of sexual offence) who presents a high risk of serious harm to the public and the case requires multi-agency risk management.

This year has been another busy year for Hillingdon with up to 21 referrals received per month, under the three categories above. The cases are managed at 3 levels:

Level 1: Single agency management;

Level 2: Active multi-agency management;

Level 3: 'The Critical Few', requiring management by senior staff with the authority to commit extra resources to managing the risk.

Prior to January 2013, all eligible cases in all categories were screened by senior members of the 'Responsible Authority' for MAPPA, being police and probation, who then set the MAPPA management level.

From January 2013, all referring agencies to MAPPA – police, probation, mental health services and youth offending service screen their own cases and decide what risk level they will assign as the lead agency holding the case. This new way of working across London has brought Hillingdon and London as a whole into step with how MAPPA has always operated in the rest of England & Wales. This way of working keeps the responsibility for setting a risk level of 1 with the agency holding the case and improves risk assessment and practice in these agencies, rather than reliance upon police and probation to exclusively hold this area of expertise.

There have been two cases managed at level 3 for a number of months during 2012/13, involving senior members of staff and involving complex issues of both child protection and the risk management of child offenders. Safeguarding is not always just a matter of protecting the vulnerable from others. Sometimes, the vulnerable, such as children, can present considerable risks of committing abusive sexual and/or violent acts against other children, staff and others. We have managed two such cases this year, with Hillingdon council devoting considerable resources to place one such child in specialist foster care. Health has commissioned specialist assessment.

Since moving over to the new risk level setting arrangements in January 2013, MAPPA in Hillingdon has assessed and set risk management actions on a monthly basis for an average of 15 cases a month. Cases managed at level 1 by the case holding agency do still involve information sharing between relevant agencies and can move in and out of level 2 or 3 at any time, as required.

The issues typically addressed at level 2 meetings involve disclosure under controlled circumstances to third parties, including the parents of children, of an offender's status as a registered sex offender and the attendant risks posed. Decisions are made about where someone can be housed on leaving prison to avoid victim contact. Prison licence conditions are discussed and agreed to set limits on an offender's movements and associations, or compel treatment or completion of specific offending behaviour work to reduce the risk of harm from offenders to others. All agencies check the information held on a level 2 MAPPA subject and share their knowledge with each other.

Financial arrangements

The LSCB is funded in partnership by the following agencies: Hillingdon Council, NHS Hillingdon, Metropolitan Police, Probation, CAFCASS, and United Kingdom Border Agency. Between them, the Council and NHS Hillingdon contribute over 90% of the total budget. The Council and NHS also make contributions in kind through LSCB manager, multi-agency training, and designated health professionals, plus staff time for training delivery. Capacity is reducing across agencies but multi-agency training can only be effective if all key statutory agencies contribute to this. The LSCB budget is sufficient for day to day purposes but is always under pressure due to the need to carry out independent reviews.

The UK border agency also contributes through an overall grant made to Hillingdon Council, as a contribution towards safeguarding the needs of vulnerable as a Gateway Authority.

It should be noted that, in addition to the financial contributions, considerable in kind contribution is provided by the Council through use of staff time within Children's services.

4. LEARNING FROM CASE REVIEWS AND AUDITS

Serious Case Reviews (SCRs)

There were no Serious Case Reviews carried out in Hillingdon during the year.

However, five cases were considered by the SCR sub group and, although the criteria for serious case review were not met, each case was followed up in a proportionate way in order to generate learning.

Two cases involved children with disabilities. One, involving a young man who had expressed concerns about his care, was subject to an independent review in which he was fully involved. This review highlighted some good practice in that the Children with Disabilities Team had placed DD on a CP Plan and had responded to the situation of neglect at home using child protection procedures. However, there was evidence that all agencies collectively had not intervened early enough in DD's life, concentrating rather on single agency issues such as housing, physical aids (occupational therapy) and support of the parent, rather than recognising the child's voice and the neglectful circumstances in which DD had to live his life during his childhood. The learning from this Review has been fed into the work stream of the Children's Pathway Programme (CPP), which is now focused on special educational needs, disabilities and transition.

The second was a child with child protection plan who died unexpectedly from a life limiting condition. Good practice was identified in this case with recognition of risk factors and good communication within the core group. Any further learning will be fed back through the Child Death Overview Panel (CDOP). This will be fully reviewed by CDOP later in the year, once all information is received back from the Coroner's Office.

Two cases concerned adolescents, one of whom sadly took their own life. In both cases mental health services were provided, and in one in particular the all too common theme of long standing neglect was a feature. In both cases the main issues raised related to the issue of trying to identify and provide appropriate support at an early age through early intervention services. A multi-agency case audit review is taking place to identify further learning in one of these cases. This will be carried out in the next round of multi-agency audits in the Autumn of 2013.

A further case, of the unexpected death of a young baby, raised learning issues that will be used as a case example in the development of early intervention services and key working. The family received a range of services at different times but it was felt that they could have been coordinated in a more helpful way – although there was no association between services received and the baby's death. Some useful systems were put in place immediately by Council Housing staff and a Housing agency to enable better identification of potentially vulnerable families.

The cases in Rochdale and more recently in Oxford have continued to have considerable national resonance. The Rochdale case raised the issue of the

particular vulnerabilities of young people (young women in this case) looked after in respect of risks of sexual exploitation particularly as a result of going missing. The Government responded swiftly and a parliamentary Select Committee investigation took place with a report and recommendations published in summer 2012.

A survey of Barnardo's services in England and Wales, published in May 2013, revealed just how difficult it is to secure convictions in sexual exploitation cases. During 2012, of 56 known police investigations, only 15 have resulted in prosecutions so far. Of these 15 prosecutions only six have so far brought about successful convictions.

Part of the problem is in recognising when difficult behaviour in adolescents masks vulnerabilities and abuse, and in ensuring that young people have confidence in the systems there to support them. Convictions were only secured when young people came forward to give evidence. These are usually young people with complex needs and the Oxford trial did also emphasise some of the efforts that social workers had made to safeguard them.

Last year the Policy Overview Committee (POC) carried out a review of children missing from care, and recommendations were picked up by the sub groups of the LSCB. One of these sub groups considers all young people who are at risk of going missing, being exploited or trafficked. In Hillingdon, the multi-agency sub group for Child Sexual Exploitation (CSE) and Missing Children has considered carefully the implications of the Oxford case in terms of sharing information and local intelligence about possible CSE with all care providers in the Borough where there are vulnerable children and young people in placement. The recommendations are as follows:

RECOMMENDATION 1 – That the written guidance for staff in residential homes on what to do if a child goes missing from case, be revised and reinforced, to ensure that the information shared with the Police incorporates all information needed to help find/trace a missing child, including mobile phone numbers, oyster card numbers and known addresses.

RECOMMENDATION 2 – That the written guidance should also be extended to all staff working in private care homes, voluntary care homes and semi-independent units for children in the Borough.

RECOMMENDATION 3 – That the Local Safeguarding Children's Board be asked to extend multi-agency training on missing children to foster carers and residential staff from the private, voluntary sector and semi-independent units in the Borough.

RECOMMENDATION 4 – That the Metropolitan Police public protection desk in the Borough be asked to produce biennial statistics on the prevalence of children reported missing from six "care homes" across the Borough, and if possible extend this to include all foster placements placed in the Borough by other local authorities.

RECOMMENDATION 5 – That officers be asked to explore the findings of the review and feasibility of adopting the following:

- To explore the viability of introducing a system of dealing with the children who were repeatedly reported missing without involving the Police in the first instance.
- To investigate the use of the Multi-Agency Safeguarding Hub (MASH) as a means through which to share intelligence on missing children and, ultimately, to reduce the number of children going missing from care. Included in the MASH should be a representative from Education who could provide information on Looked After Children who were not attending school.
- To explore the possibility of the mobile youth services bus being made accessible for children in all local authority, private and voluntary organisations care homes.
- To consider the possibility of harmonising the terminology used with regards to missing people across all organisations in Hillingdon. This would help to ensure that the reporting of cases and collection of useful data would be improved and made more accurate.
- For the Local Safeguarding Children's Board (LSCB) to review statistics on children missing from care in the Borough twice annually

The five recommendations listed above have been considered and, where possible, implemented via the integrated Child Sexual Exploitation and Missing Children sub group of the LSCB. To a large extent these recommendations anticipated the changes in National Guidance, Policy and Procedures which have required greater emphasis on safeguarding Looked After Children placed out of Borough, particularly in relation to their vulnerability to exploitation as a result of going missing. The LSCB main board in Hillingdon receives quarterly reports on children reported missing, not just those who are looked after by Hillingdon, but also those placed within the Borough of Hillingdon by other local authorities.

The Ofsted requirements on reporting missing children placed in residential care do not permit a system for 'non-reporting' of children who go missing from placement, but whose whereabouts are known. It has therefore proved difficult to make viable the first recommendation from the POC review.

The Multi-Agency Safeguarding Hub (MASH) is in a 'soft-launch' mode, and is exploring how best to share information about children reported missing that focuses on levels of risk but with reduced recording of recidivist missing children whose whereabouts is known to agencies (e.g. they may have gone home without permission).

Youth Services are accessible to all children in the borough, including those in local authority and private and voluntary organisations. However, the mobile youth service is a very limited resource, and is targeted at vulnerable children who have particular difficulties with travel facilities, due to geographical location. This does not ordinarily apply to children placed in the care homes.

There remains on-going difficulty around harmonisation of terminology. This cannot be resolved locally, as agencies have policies and procedures about 'missing people' which are determined by National Government (e.g. Home Office, Department for Education, Ofsted). The focus locally has been

ensuring that associated risk indicators are used to determine the response to a child reported missing from home or care, and this has proven to be more useful from a safeguarding perspective.

As already noted, the Local Safeguarding Children Board is now receiving quarterly reports on the number of children reported missing in the locality, as part of the data set used to monitor effectiveness of practice.

In spring 2012, a root cause analysis, management review was conducted jointly by Children's Social Care and Adult Mental Health Services. This was commissioned after a parent hanged himself, shortly after his children had been taken into foster care after he admitted having harmful thoughts towards them. There were several recommendations for the agencies involved but, in the main, the joint learning was around better communication and more effective collaboration between professionals when working with parents suffering from a mental illness. The learning from this review was presented to senior representatives of all agencies at the Hillingdon LSCB and also through action learning sets and briefings at Hillingdon Hospital for managers within the Adult Mental Health setting and within Children's Social Care.

As a result of this review, the protocol between Mental Health Services and Children's Services has been re-launched and a reciprocal consultation surgery has been set-up between operational teams within the two agencies. This initiative has promoted better knowledge and understanding of how to assess risk jointly when parents are experiencing enduring mental health issues. This learning will be highly relevant in the new Multi-Agency Safeguarding Hub (MASH) once it is commenced in the Autumn of 2013.

Risk Management Panel and multi-agency case review

In February 2012, a multi-agency Risk Management Panel was established to address the safeguarding issues related to high risk cases identified by partner agencies. It was established following a case review which identified the need for an escalation process for complex and high risk cases that appeared 'stuck' even when all appropriate channels had been explored. High risk was defined as cases which were highly complex and/or subject to drift. The Risk Management Panel meets six times a year and has its own terms of reference which includes a focus on learning lessons for practice from the issues identified at the Panel meetings. All partner agencies are represented at the Risk Management Panel, including Social Care, the Child Abuse Investigation Team, Health Provider Services, Education and a Council legal representative. Where needed, Adult Mental Health Services for substance misuse and parental mental illness are invited to the Panel on a case specific basis. Schools are also able to bring forward high risk cases via the CP advisor for schools, if they have become stuck.

At the first two meetings the panel reviewed eight families whose children were all subject to child protection plans with neglect being the predominant category. These cases were put forward as they were deemed to be "stuck" and had complex family problems at their heart. The Children's Social Care CIN Team Manager was present, supported by the Service Manager to ensure that action plans were developed for each case and the panel all reviewed their plans at subsequent meetings. Key themes that emerged at

this point were around thresholds for care proceedings and in many cases the need for chronologies.

The Panel then amended the terms of reference (TOR) to ensure that case auditing would have greater prominence, and to focus specifically on learning from practice, especially in relation to high risk cases. It was envisaged that this panel would provide an opportunity for key partner agencies within safeguarding to review their responses to high risk cases, learn from the experiences of practitioners and help to drive up standards in practice. This learning would be disseminated across the partnership within the LSCB. In order to preserve its operational remit, the revised Terms of Reference included a caveat to ensure that the Risk Management Panel will remain a mechanism for escalating cases. The Risk Management Panel will only consider raising cases with the LSCB once all other efforts to progress the case or resolve any conflict have been exhausted. Proposed future work was to target ineffective child protection planning, plans over three years, especially if parental mental health issues and domestic violence are featured and track any themes that may emerge. The impact of the high turnover of staff in Children's Social Care, especially in core groups was a raised as a complicating factor and also the child protection case conference process in Hillingdon. The conference process was being addressed by the Service Manager and by all agencies to ensure that child protection plans would become more outcomes focused.

In 2013, the Risk Management Panel identified eight children who meet criteria for inclusion in the case mapping exercise that would be expected in any peer review. An audit tool was developed exploring nine key areas. The panel have used meetings to analyse the data received from the participating agencies, and emerging themes are:

- Improved analysis and planning evidenced in some cases.
- Multi-agency collaboration and communication evidenced well on the whole.
- Domestic violence remains a strong indicator of risk to children, which impacts most significantly on their emotional development.
- Access to resources for perpetrators of domestic abuse has improved, but remains limited in the locality.
- Developing 'smart' child protection plans for children who have been neglected or emotionally harmed is challenging, and can result in 'monitoring' type activities, which are not effective.
- Cases do tend to 'drift' whenever there is a change of worker, as the changes are often not communicated effectively within the core group of professionals and are not communicated to the family.
- The voice of the child is rarely appropriately evidenced in case records.
- Supervision and management oversight is inconsistent across all the main agencies, and multi-agency panel discussions not consistently recorded.

Audit of social care files

During the year, two reports (November 2012-April 2013) were presented to the Policy Overview Committee reporting the findings from the quality audits programme. There was a steady improvement noted in the quality of social work practice, file recording and staffing stability. This was driven by the impetus of the Children's Pathway Programme with its emphasis on new ways of working, reduction of bureaucracy, and professionalisation of the social work teams, in line with the Munro recommendations. The Social Work Conference, held in September 2012 in Hillingdon, promoted membership of the College of Social Work on a corporate basis with a strong local commitment to the implementation of the Social Work Professional Capabilities Framework within the Borough.

Social work activity during this period was particularly effective with a significant number of Child Protection Plans being discontinued and stepped down into lower tiers of service in Children's Centres and Universal Services.

With some posts covered by agency staff, and the number of newly qualified social workers recruited, management oversight is a critical and sometimes variable component of case management. As noted earlier, reflective supervision training has been provided and the supervision policy has been refreshed and updated. The 'POD' system of working in small groups has received positive comments from staff and it is hoped that this will also improve case management and oversight. This will be followed up by case audits in 2013-14.

Child Death Overview Panel (CDOP)

In spite of in-year fluctuations there were no significant changes in numbers of child deaths in Hillingdon. The CDOP continued to deliver important public health messages from local and national cases. The issues of sleeping arrangements continued to cause concern as an associated factor in sudden unexpected infant deaths, and this has been confirmed as a national issue by recently published research. Evidence indicates that all families are given relevant information about this issue and the LSCB is pleased to note that this is likely to be pursued at national level.

Appropriate cases of concerns were brought to the attention of the LSCB and followed up by consideration at the SCR sub group or, in one case, by follow up with a school and LSCB in another area.

Recently published data from DfE identifies that the highest proportion of 'modifiable factors' (i.e. associated but not causes) came among those aged one month-one year, and those aged 15-17. The findings for young babies are likely to reflect previously identified issues to do with safe sleeping etc. The findings for those aged 15-17 are likely to reflect the most common causes of death in that age group, i.e. road accidents and suicide. We have already referred to suicide as a significant issue among young people who have experienced long term neglect.

Overall, there is evidence from our case reviews and audits that there is good multi-agency collaboration and practice, particularly once child protection

concerns have been identified. Assessment, analysis and planning also indicate improvements.

Staff shortages potentially put this at risk and management oversight is not always consistent or recorded well. The same applies to the child's view, which may be implicit rather than explicit in case recording.

It is clear from cases looked at that problems often still become apparent very late, particularly where children are experiencing domestic violence, or neglect.

This highlights the importance of early help services in identifying and helping. Of particular relevance here is the need for earlier mental health support for children before they reach the potentially high risk adolescent years.

Use of social care thresholds remain sometimes unclear though it is hoped that this will improve as clearer guidance is rolled out, and as early help services develop and mature.

Ongoing dissemination of learning

Learning from local and national work has been fed back to staff in various ways. Key messages are incorporated in multi-agency training and passed on through staff meetings and the LSCB conference. There is a steering group for reflective supervision and front line managers attend regular safeguarding managers meetings and LSCB sub groups, all of which are used as ways of passing on learning.

5. WORKFORCE

Evaluation of single and multi-agency training

Introduction to Safeguarding training

Safeguarding Introduction Training (level 1) is compulsory for all employees in the workforce who directly or indirectly work with children. Many agencies, including Hillingdon Health, CNWL, Hillingdon Hospital Trust and the Metropolitan Police have their own tailor-made training, frequently delivered by named heath professionals. Health partners are confident that staff who require this level of training are trained and that effective governance mechanisms are in places to ensure compliance.

Local Authority staff, schools and the voluntary sector tend to use the e-learning package offered by the LSCB. In 2012/13 the LSCB issued 1327 licences to a large variety of agencies, the majority of which were issued to schools. 2012/13 figures were more in line with 2010/11 figures with 635 fewer licences issued compared to last year.

	2010/11	2011/12	2012/13
Annual conference	196	161	136
e-learning	1511	1962	1327
Training	1081	1181	935
Total	**2947**	**3304**	**2398**

Statutory training

As in previous years, multi-agency safeguarding training was the mainstay of the LSCB's training package in 2012/13. This training is intended for staff who work intensively with children (level 3) who are subject to multi-agency intervention strategies such as child in need or child protection plans. The LSCB offers training in two parts: *Working Together to Safeguard Children* (level 3, identifying and responding to safeguarding concerns, referral process and information sharing, statutory guidance and local procedures up to the point of a child protection case conference). The next course is *Core Groups and Child Protection Plans* (Multi-agency assessment, planning, intervention and reviewing process of children who are subject to CP plans).

Evidence has shown that the benefits of training staff together are: clarifying the roles of different professional and agencies, creating opportunities for staff to meet each other and, most importantly, to clarify expectations and myths that may get in the way of successful multi-agency working. It is the LSCB's expectation that managers identify staff who require this training and ensure that they attend.

Refresher training

The LSCB offers *Working Together Refresher* training for staff every three years to ensure that they remain up to date with legislative and procedural developments, research and recommendations from national Serious Case Reviews, as well as local SCRs and management reviews.

In 2012/13 the LSCB offered 12 training days and 500 places for Working Together / Refresher training and most places were taken up. The training numbers for Refresher training were lower than that for *Working Together* which raises the concern that staff may not be attending refresher training as frequently as required and that some (about 10%) attend the full day training course again.

Schools and the health sector have strict guidelines about the frequency of refresher safeguarding training, which was borne out in their attendance: 44.2%, followed by schools (32.6%), LA (13.9%), Voluntary Services (8.1%) and Mental Health Trust (1.2%).

Multi-agency training was offered to more than a 150 different agencies / schools and nurseries. The private and voluntary sector, education and health were very well represented, taking up the majority of places. Several agencies have expressed the wish that more statutory agencies attend training and that will be addressed in the work plan for 2012/13.

The LSCB have offered fewer statutory training days in 2011/12 because of the expected (but considerably delayed) statutory guidance, *Working Together to Safeguard Children 2013*. In response the LSCB will increase training opportunities in 2012/13 to train staff in the new statutory requirements.

Training evaluation framework / feedback

This year, the NSPCC's training evaluation toolkit *Connect, Share and Learn* will be introduced to understand the impact of training. This is a standardised evaluation tool that attempts to measure the extent to which courses raised the knowledge and competence of students. The toolkit may need to be adjusted because of changes in statutory and local guidance, but the impact is not yet clear.

The LSCB have analysed the results of post-training questionnaires and evaluations. More than 94% of attendees thought that LSCB courses delivered on advertised training objectives. A few students (6%) were hoping to hear about the imminent statutory changes to Working Together guidance.

90% of attendees thought courses covered what they were expecting, 10% though the content could have been better if it included an update on Working Together legislation. Even so, 88.2% rated the level and amount of content as good or very good (32.9%, 55.3%), average (9.6%) and poor (2%).

Overall, most attendees (95%) were pleased with the quality of tutors for statutory training, thinking them to be very good or good (70%, 25%). No one thought the tutors were poor or very poor. Tutors' knowledge about their subject areas showed similar results (very good 76.8%, good 23.2%).

This year saw the introduction of a new on-line course booking system which initially produced some growing-pains as people were adjusting to a different way of registering for courses. 83% of respondents thought the system was very good (35%) or good (45%).

Anecdotal feedback about statutory courses:

"When I have to be involved in core group meetings, case conferences, I shall know what to do."

"Overall a very good course which was practical and informative..."

"I have a much better understanding of the thresholds involved in referrals."

"An excellent and engaging course. I thoroughly enjoyed the course and feel that I am much better equipped to make decisions..."

"...more confident with the process if I ever had to report or ask for help if I suspected any child of being abused."

"Excellent course, good activities good networking opportunities, attendance by different agencies and having to work on activities with each other."

“I am now able to understand the correct procedures and act on this when/if I am put into a child protection situation.”

“I feel much clearer in my understanding of how to proceed should a safeguarding issue come to light in my area of work with palliative patients, their families and carers.”

6th Annual LSCB conference

This year slightly fewer people attended the LSCB conference due to an unavoidable change to a smaller and more remote venue. The programme covered the following areas:

- John Pitts spoke about the development of gangs, the themes that create an environment that supports and perpetuates a gang culture and approaches that have been taken around the country that have had an affect in reducing gang activity.
- James Blewett presented the learning from Serious Case Reviews (nationally) and management reviews (locally).
- Helen Bonnick presented on the features of parent abuse and the dilemma for practitioners in addressing the issues for both the parent and the young person/people.

Most conference attendees found the day useful, especially the presentation around national / local learning from serious cases and gangs. LSCB conference are always well attended by a large variety of agency including LA, Health, UKBA, the Metropolitan Police, Schools, Nurseries and the Private and Voluntary sector.

Stakeholder day

In order to enhance engagement with front line staff, a stakeholder workshop took place in May 2012, which was attended by 51 front line managers and key practitioners across all key agencies. The interactive session consulted on the LSCB priorities and on recently published research studies from the Department of Education (DfE). There was a lot of useful feedback, much of which is reflected in this report and in our Business plan.

Those attending agreed with the main Board priorities but emphasised the importance of those children affected by mental illness, substance misuse and/or domestic violence. Concerns were expressed about the availability of CAMHS services, particularly for young people experiencing neglect and those demonstrating risky behaviours.

Understandably, workload and recruitment and retention difficulties were felt to be risks to safeguarding. Other issues raised were:

- The need to strengthen early intervention services, whilst maintaining consistent thresholds.
- The need to carry out more joint assessments at an early stage, and to include adult services in these.
- Recognition that the Common assessment framework (CAF) was still proving problematic as a mechanism for referral or promoting intervention.

Since that time, practitioners have been able to contribute to the development of the shared early help assessment and referral process, and early intervention services have been reorganised as part of the children's pathway programme.

- The need to engage with GP services and commissioners.

The engagement with commissioners will be developed through the CCG membership of the LSCB, though engagement with GPs as providers is still identified as a work in progress

- Multi-agency training was acknowledged to be high quality but more specialist training was requested on key areas.

This has been followed up as much as possible through the multi-agency training programme

- A request for improved communication about important safeguarding issues.

This happens through line management channels but remains an issue for the LSCB. A staff survey was sent out in July 2013 and will be followed up by a regular bulletin

45 staff responded to the survey, spread across most of the key agencies working with children. 89% agreed with the LSCB priorities; the rest were 'unsure.' There were some additional comments but these related mainly to issues that are contained within the 'small print' of the LSCB business plan, e.g. trafficking, mental health.

Some concern was expressed about social care thresholds. Just over half of respondents (56%) said they used them (though 20% weren't sure) 38% felt they were clear and 20% that they were not (40% unsure). It was not possible to correlate both sets of responses but clearly there is more work to be done here. Thresholds have recently been refreshed and updated, and more remains to be done. Further comments indicated that particular attention should be paid to ensuring that the thresholds are clearly written and easily accessible, and that they have more detail about specific issues, particularly domestic violence and disability.

Staff were asked about what they thought were the most and least effective contributions to safeguarding.

Respondents to the survey helpfully highlighted Signs of Safety as being a positive development, alongside the framework around child trafficking, and the support given to agencies about safer working practices. Training and multi-agency communication and working also received many most positive comments.

Fewer respondents had negative comments but bureaucracy and lack of communication received most responses in terms of things that were not effective, along with the implementation of the CAF. There was also a body of comments that more focus needed to be given to early assessment and help, and better joining up with adult services.

Overall, there was general endorsement of the LSCB priorities. There was also endorsement of the key themes picked up in the LSCB business plan and children's pathway programme.

It is clear from the responses that the early help assessment and alignment of pan London levels of need should be prioritised within the workstreams of the LSCB. In addition, the implementation of Signs of Safety and consolidation of work around key risk issues, such as mental illness, must continue.

Implicit in many of the responses was an emphasis on communication, and liaison across agencies.

In times of straightened resources, this is an important message, as communication requires time, but is clearly very much worth it in its contribution to safeguarding.

Capacity: Workforce and Staffing in Children's social care

The number of front line social work posts in the establishment of Children's Social Care has been increased as a result of the discovery, design and implementation of the Children's Pathway Programme. This is helping to manage the demand on front line services and improve the quality of work. Overall there has been a gradual improvement of stability in the workforce, led by the Current director of Children's Services, and her senior management team.

However, because there are now more posts in the establishment it has been challenging to get experienced social workers and managers into permanent posts, and some pressure points are still present, even within the stabilisation that has occurred over the past

As at June 2013 there were 44 vacancies, of which approximately a third were at senior social worker level or above. Although many of these posts are filled by competent locum staff this does raise a major concern about the Council's ability to provide effective supervision and management oversight, which tend to be recurring themes in local and national case reviews.

Creative recruitment campaigns are now being conducted through Council internal communications team, a dedicated Human Resources (HR) officer, and the HR Business partner for Children's services

Allegations against Professionals

The Local Authority Designated Officer (LADO) role is outlined in Chapter 2 Working Together March 2013 and under the organisational responsibilities in Section 11 of the Children Section 2004. It emphasises the requirement for organisations to contact the LADO regarding an allegation against any member of staff within one working day of it coming to the employers' attention, or where allegations are made to the police.

The referrals to and consultations with the LADO have remained consistently high throughout the year (2012-13), indicating that agencies are utilising the service appropriately and in line with their own safeguarding procedures.

There have been 105 referrals to the LADO during this period which have required a strategy meeting. In addition, advice has been given about dealing

with allegations which did not meet the threshold for a meeting in relation to 71 cases.

A not surprising increase has been in historical allegations linked to the publicity about the Savile investigation, all of which have to be followed up with the same rigour as recent allegations.

The continuing high number of allegations indicates an appropriate awareness and response. However, it also indicates that determined people can continue to access organisations and that some staff can still behave inappropriately towards children and young people in their charge.

The LADO continues to liaise with colleagues in Ofsted, the Disclosure and Barring Service and the Police, in order to effectively manage the allegation process. During the year 5 criminal convictions were achieved; others received suspended sentences and had their names placed on the sex offenders register.

These allegations have highlighted the importance of keeping accurate records, even when concerns about staff conduct appear to be low level and insignificant in isolation.

The biggest proportion of LADO type work involving allegations against staff are through Hillingdon schools and academies. The head teachers' fora have been extremely complimentary of the support and help received from the LADO.

The LADO delivers a continuous programme of training and consultation with all local agencies and organisations. This has, and will continue to, include the changes to be implemented to the vetting and barring regulations by the Disclosure and Barring Service (DBS).

6. HOW WE ARE DOING: effectiveness of local safeguarding

How the LSCB monitors local safeguarding arrangements

The LSCB has put various mechanisms in place to assess individual and multi-agency performance.

The Partnership Improvement Plan (PIP).

This is a spreadsheet that picks up and monitors all actions arising from inspections audits etc. It is monitored at each LSCB meeting and completed actions are signed off by the Board. During the year 39 actions were completed and signed off by the Board. There were 25 actions progressing at the start of the year, and 22 by end March 2013, as actions were completed and new ones added on.

Performance Profile. This is a report that summarises performance against national and local indicators, plus inspection reports across all agencies. It is presented at each Board meeting and enables the LSCB to monitor progress and take action as appropriate.

Business plan and sub group action plans. Sub group action plans are reviewed at business meetings between Board meetings and feed into the end of year review of the LSCB business plan.

Audits. Each agency carries out a programme of internal audits. Key actions are fed into the PIP and also reported annually to the LSCB. The main statutory agencies are usually asked to complete an annual return to the LSCB identifying their internal audit programme and consequential actions taken. This year that was replaced by the section 11 audit. This was reviewed by the performance sub group. Following the serious case review, schools are now asked to complete a bi-annual safeguarding audit for the LSCB. These are reviewed by the Education officer and reported to the LSCB.

Action plans arising from Serious and other case reviews and Child Death reviews feed into the PIP to ensure that progress is monitored

The LSCB provides a quarterly update for the Children's Trust and, through attendance of the chairman, is able to influence the Children and families Plan, particularly development of preventative services.

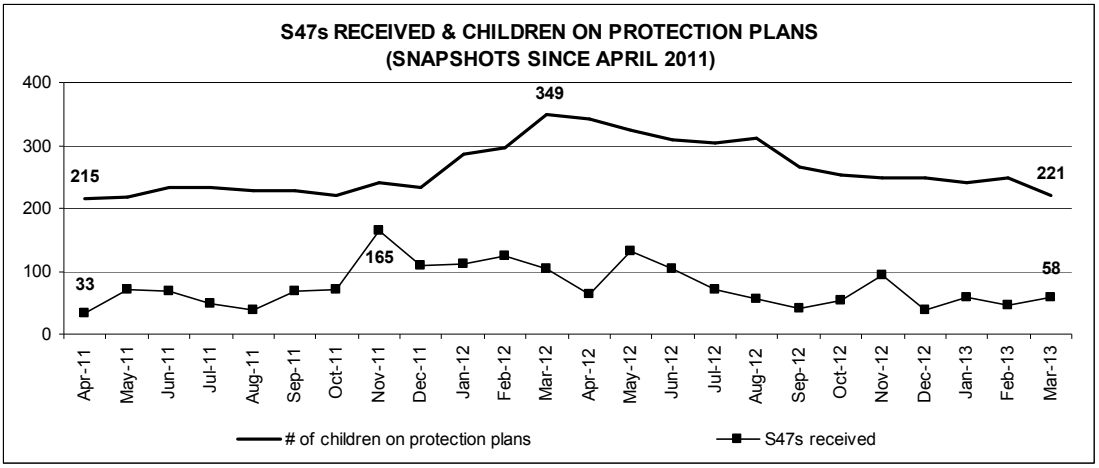
Effectiveness of local arrangements to safeguard children

The LSCB's monitoring activity has enabled us to comment on the effectiveness of local safeguarding arrangements.

Child protection activity

This section is based an annual returns for the year 2012-13.

During 2012/13, the numbers of CP enquiries reduced compared to 2011/12 (-20%), as did the number of children on CP plans (-37%). Both of these indicators have stabilised in recent months but despite this decrease, levels of demand are still higher than levels experienced in 2010/11. These trends are illustrated in the chart below:



Performance against the various child protection indicators remained good with a slight reduction in those on plan for more than two years. Timeliness of initial child protection conferences was good (97.1%) though slightly down on the previous year. Timeliness of CP statutory visits has been maintained during the year, with 97% of visits on time.

It should be noted the overall number of children subject to child protection plans throughout the year is not a static cohort. During the last year (2012-2013) there has been a significant turnover of children coming off CP Plans (334), and new children coming onto CP plans. Positive outcomes are being noted for children coming off plans who have been safeguarded, and protected, and evidence of this is being seen in the independent audits being carried out by the safeguarding Children and Quality Assurance Service. However, further work needs to be undertaken to ensure that this is consistent, and is then tracked through the whole of the Children's pathway to ensure that these outcomes are sustained.

The gender of children subject to a Child Protection Plan is virtually evenly split between Males 51% and Females 48% with 1% unknown, as they were unborn at the time of registration.

The age distribution of children on a Child Protection Plan reflects the general population of Hillingdon, which has a growing number of younger, school age children, with 83% of children on plans being under 12, with 35% being under 5, as a whole. Also significantly, there has been a rise in the number of older children, between 13 and 15, made subject to a CP Plan compared to the previous year. This represents the growing awareness of exploitation and risk outside of the family to which adolescents and teenagers are susceptible.

The ethnicity of children made subject to a plan reflects the census data for the Borough, showing a rise of children and families from non-white English backgrounds, especially Polish and Asian families.

The largest category for children on CP plan is emotional abuse, when taking into account the combined categories for registration. This reflects the growing awareness among professionals, and within the community, of the long term impact on development of those children exposed to domestic abuse.

Overall, the number of children on a plan for neglect remains high and is still the single most concerning indicator of child abuse. This is significant, given

the age distribution, with more children under 5 being subject to Child Protection Plans. This highlights the need for earlier intervention both in terms of child's early life, and also in terms of dealing with the issues early, to prevent the corrosive damage done by neglect, as shown by the research evidence linked to brain development.

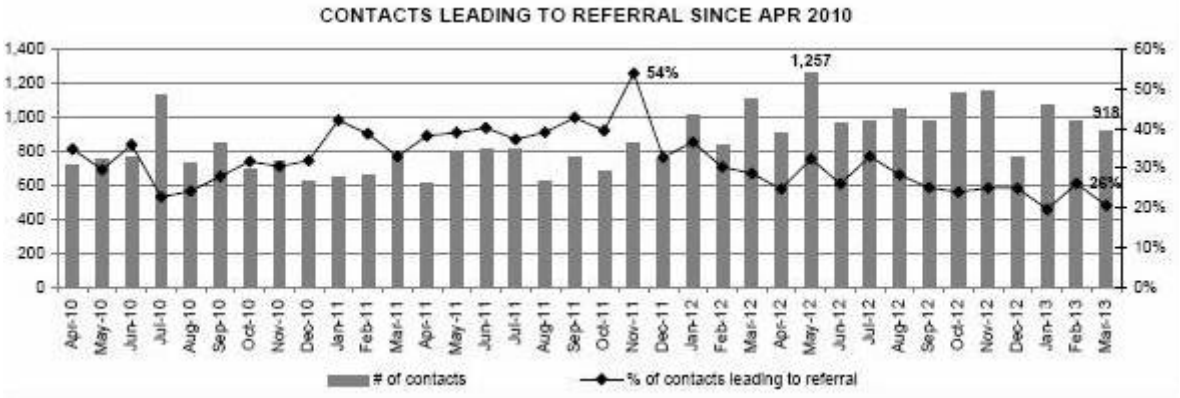
In response to these issues, the LSCB has developed refresher training on countering neglect and early intervention, for families where children are exposed to domestic abuse and chronic neglect.

Social Care activity

There were 100 more open cases and more core assessments noted in the census returns, although referral figures and child protection activity was stabilised. A greater number of children in need cases is being worked with below Child Protection, after being stepped down from a child protection plan. More consistent application of the pan-London Continuum of Need has helped the triage process within Children's Social Care, both in relation to signposting needs that do not require statutory intervention and also ensuring that the correct cases are given attention as children-in-need, even if they have not reached a child protection level of concern. Completion of assessments within timescales was down, although this did improve in the second half of the year. These timescale indicators have changed from 2013.

A possible explanation for the trend above is that there may have been a reactive response to the Ofsted pilot inspection held in November 2011 (resulting in a higher likelihood of a contact becoming a referral and a sequential effect on the number of children on child protection plans). Since then, there have been a number of improvements in management practices, and anecdotal feedback from managers indicated a greater level of confidence and consistency in decision-making, particularly in the early stages of the pathway (e.g. when applying thresholds).

A further example of more consistent practices is illustrated in the chart below which highlights a noticeable peak in the percentage of contacts becoming referrals followed by a steady reduction and eventual stability towards March 2013 (at around 20-25%). Once more, this highlights the benefits of improved triage and activities associated with CPP work streams (e.g. inter-agency referrals, better management of contacts).



Increases in demand are noticeable in some other indicators which occur further down the children's pathway. Specifically:

- Overall, there have been increases in the number of statutory visits carried out, particularly in relation to the number of LAC stat visits (+40%). This will have been influenced by the higher number of looked after children, particularly in the early part of the year.
- Timeliness of statutory visits has improved for LAC, with 81% of visits occurring within the expected timeframes (an improvement of 4%).

Children at risk through trafficking or sexual exploitation

The Local Safeguarding Children Board sub group dealing with exploited and trafficked children has continued to thrive. Membership includes representatives from national government organisations, such as End Child Prostitution & Trafficking (ECPAT) and the Child Exploitation & Online Protection Service (CEOP). The co-operation of UK Border Force staff has been crucial in ensuring the effective screening of children for issues of trafficking, arriving at Heathrow Airport, and UK Border Agency also remains a pro-active member of the sub group.

Sitting underneath the trafficking sub group are two operational groups, which meet on a more regular basis. The first operational meeting involves looking at the profiles of all children who have arrived through the airport terminals and identifying issues of trafficking or exploitation. By this process, a number of children have been identified as trafficked, and referred to the UKHTC (UK Human Trafficking Centre) via the National Referral Mechanism (NRM). Some of these children were age disputed and were deemed adults on the basis of the age assessment carried out by the local authority and partner agencies, but nevertheless they were vulnerable due to trafficking issues. In total, 11 NRM referrals were made during the year, including 3 young people deemed to be an adult. The collaborative work between the social work teams and Paladin (law enforcement) resulted in a number of court cases, which had positive outcomes in terms of disrupting the trafficking networks and safeguarding individual children.

The other operational group which sits beneath the Trafficking Sub Group is the multi-agency meeting that addresses issues relating to children who are reported missing within the community. This group includes active involvement from the Public Protection Desk of the Borough Police, and also has engagement from the Youth Offending Service, as well as the front line social work teams and registered care managers of children's homes in the locality. This meeting has identified a small cohort of approximately twenty children (mainly local children) who lead risky lifestyles through repeated episodes of being missing from home or care. The operational group has focused on collaborative interventions and has ensured that proper risk assessments are undertaken with this group of children.

Overall, the number of children going missing throughout the year has declined from 7 to 3 young people who have not been located after arrival at the airport. The London Safeguarding Board has a sub group for countering child trafficking across the capital. This sub group is chaired by Hillingdon's Head of Children's Safeguarding and Quality Assurance in recognition of the expertise in child trafficking in this local authority.

Hillingdon's model for countering child trafficking was commended nationally and cited by the Home Office in its Anti-Traffic strategy. For this reason, representatives from the Hillingdon LSCB were called to give evidence in the All Party Parliamentary Group in February 2012, for analysing the national policies for reducing the incidence of children missing, especially those at risk of being trafficked. This is testament to the continuing standards of best practice maintained by the Hillingdon LSCB.

Further high profile interviews and documentaries are envisaged in the coming year, highlighting the successes made in Hillingdon.

Private Fostering

The number of children in private fostering during the year has been relatively low (10) and represents an ongoing area for development. The Local Safeguarding Children Board has continued to deliver briefings and multi-agency training on the need to identify situations of private fostering. This has been beneficial for UK Border Agency staff at the airport terminals who have been able to notify local authorities other than Hillingdon when children are being placed in private fostering situations across the UK.

In Hillingdon itself, there are more than ninety schools, including academies and independent schools. The challenge, given to head teachers, has been for each school to examine its admissions roll and identify at least one child who is being privately fostered. This is work in progress and, so far, has not resulted in additional notifications of private fostering situations. The research evidence shows that private fostering is often a key safeguarding issue for profiling children at risk of trafficking, child sexual exploitation and exposure to domestic servitude or exploitation in the catering industry. This remains a priority for the Local Safeguarding Children Board. In the coming year, the local authority is hoping to recruit a specialist worker, based in Children's Social Care, to help raise standards in private fostering across all partner agencies.

Disabled Children

The levels of awareness about child protection and child safeguarding within the Children with Disabilities Service has continued to grow during the course of the year. Although the number of children with disabilities who are subject to a child protection plan is still not growing sufficiently to demonstrate that this vulnerable group of children are being adequately protected, there is still nevertheless a rise in numbers. During 2012/13 there were 11 children subject to a child protection plan who are known to the Children with Disabilities Team. This is significantly more than previous years.

Looked after children and care leavers

There are currently 383 looked after children, with 55% placed in borough, either in foster or residential placements, and 41% placed in out of borough placements. (Whereabouts of 4% of the children are not known, usually because they are in adoptive placements or on rare occasions have gone missing from the placement). Given the vulnerability of looked after children and care leavers who are at risk of exploitation and going missing from their placements, the Corporate Parenting Board has taken steps to ensure that the children and young people are safeguarded.

A key priority for the Corporate Parenting Board is the monitoring of compliance with required standards and ensuring looked after children and care leavers are safeguarded. This includes the monitoring of placements both within and out of Hillingdon.

The Board's work plan for 2013-15 has set two objectives that focus on the monitoring and scrutiny of residential and fostering placements. This is achieved through annual reviews of foster carers and statutory reviews for looked after children.

The Access to Resources Team (ART) within Children's Services is responsible for identifying, assessing and monitoring all private and voluntary children's homes, and for recommending a match for the young person. Officers complete a rigorous checklist for all new and change of placement, which includes references, Ofsted inspection reports, staffing details, details of other young people in placement, investigations and complaints. New resources are visited to assess suitability, a checklist and report completed. Existing resources are visited six monthly and any required actions monitored In light of the proposed amendments to the Children's Homes Regulations, the checklist now includes, contacting the local authority in which the home is located, requiring a local area risk assessment.

Elected Members on the Corporate Parenting Board also undertake regular Regulation 33 visits to all the Council's children's homes, adding the extra dimension to inspections. This gives the children and young people the opportunity to raise matters directly that affect them.

Looked after children also have independent access to support services for children and young people in care, which are provided by the National Youth Advocacy Service (NYAS).

Children's Resources Service is responsible for management of London Borough of Hillingdon's Fostering, Adoption & Permanence, Children's Homes (including the Resource service for Disabled Children, Merrifield House) and Placements & Commissioning.

Under the current inspection regime (new inspection regime in place from November 2013), Fostering and Adoption & Permanence are inspected separately every 3 years.

The current inspection has four grades, Inadequate, Satisfactory, Good and Outstanding. These apply to each area of the inspection and there is an overall rating.

In September 2012, the Fostering Service was inspected by Ofsted and awarded a Good judgement. Ofsted noted that "children and young people benefit from stable placements where there are fewer moves between placements than comparable authorities. Managers of the service have developed a good working relationship with other agencies including the police, education and health services to ensure there is a joint approach when assessing and meeting the needs of looked after children"

There were no requirements from this inspection. Recommendations for improvement identified the need to appoint independent visitors to children who have had no contact with family for over 12 months (mainly in relation to

our Unaccompanied Asylum Seeking young people), the need to ensure young people are supported to attend their review meetings, updated information regarding Ofsted contact details in the children's guide and correctly recording the manager's qualification in management. These areas have been addressed.

Hillingdon's Adoption Service was inspected by Ofsted in February 2013 and was judged as Good. Ofsted commended the strength of safeguarding and the leadership and management of the service in their report. It stated that the service is Good at keeping children and young people safe and feeling safe.

There were no requirements from this inspection. Recommendations for improvement identified the need to improve the time taken to find an adopter for a child who has been recognised as being in need of adoption and the time taken to conduct an assessment of adopters. Substantial work has taken place to address this and to bring the service in line with changes in legislation regarding timescales.

The Children's homes are inspected by Ofsted twice a year. There is one full inspection, and one interim shorter inspection that focuses on the action plan from the full inspection. The timescales will not change under the new inspection regime, but the grading will be brought in line with other statutory inspections.

The 3 Children's Homes have all had their full inspections in the first part of 2013, with the interim ones due. They all received a 'good' rating and all requirements and recommendations have been addressed

Young carers

Young carers are children who look after someone in their family who has an illness, a disability, a mental health problem or a substance misuse problem, taking on practical and/or emotional caring responsibilities that would normally be expected of an adult.

A recent report from The Children's Society 'Hidden from View' analyses government data tracking 15,000 children across England. It reveals the long-term impact that caring has on a child's life.

Findings include:

- Young carers are 1½ times more likely to have SEN or a long-standing illness or disability;
- 1 in 12 young carers are caring for more than 15 hours per week;
- Around 1 in 20 miss school because of their caring responsibilities;
- Young carers have significantly lower educational attainment at GCSE level;
- Young carers are more than 1½ times as likely to be from black, Asian or minority ethnic communities, and are twice as likely to not speak English as their first language;
- The average annual income for families with a young carer is £5,000 less than families who do not have a young carer;

- Young carers aged 16-19 are more likely than the national average to be NEET, and
- Despite improved awareness of the needs of young carers, there is no strong evidence that young carers are any more likely than their peers to come into contact with support agencies.

This is a "safeguarding issue" in its broadest sense and cuts across both the Adults and Children's Safeguarding Boards, as many young carers in Hillingdon are engaged in caring for parents with disabilities and/or recurring mental illness. In March 2013 both Boards received a presentation from Hillingdon Carers.

National estimates indicate 175,000 young carers in the UK and a BBC survey in 1996 estimated that one in 12 secondary school children would be a carer. The real figure could be much higher as many families do not recognise the caring tasks that a child is taking on and therefore do not publicly acknowledge it.

687 children have been identified in Hillingdon, of whom approximately 430 at any one time receive services from Hillingdon Carers projects. Increase in numbers identified does indicate greater awareness of the issue. Locally, 53% of young carers are in single parent families and many of these are supporting parents with mental health and/or substance misuse issues. Mental health of a parent forms the largest group overall (47%), followed by a parent with physical or sensory disability (27%) and 23% of Hillingdon's young carers assist with a disabled sibling. Around 10% of young carers identified in Hillingdon are subject to a child protection plan.

In addition to those issues identified by the Children's Society, issues raised locally include

- Bullying, or isolation due to not wanting to disclose caring responsibilities;
- Encouraging those we don't know about to come forward
- How to support young carers who may be aware of an adult at risk but afraid/unwilling to report;
- Preventing teenage carers from becoming abusers.

Children who experience domestic violence

These continue to form a high proportion of those with child protection plans, and many of them also come from families where substance misuse and/or metal illness are present.

The Board receives each year the annual returns from the Hillingdon Independent Domestic Violence Advocacy Service (IDVA). Hillingdon IDVA works with people at medium or high risk from domestic violence. The service is managed within social care but based at a local police station in order to facilitate effective day to day working with Community safety Unit. 80% of their referrals are responded to within 24 hours and they work with the victims (mostly women) and other agencies to develop safety plans. These may involve referrals to social care, housing, and may be followed by child

protection, civil or criminal proceedings. Often up to eight services may be involved with the family.

Total referrals for the year were 627, of which 85% engaged with services. 865 children were involved. Many had experienced physical abuse themselves and all would have experienced emotional harm. A significant number were young (16-24) and this number is likely to increase considerably with the recent legislative definitions to include 16-18 year olds. Ethnicity of referrals was roughly comparable with Borough proportions, but 18% of referrals involved cultural issues or honour based violence.

Families at high risk are referred to the monthly MARAC meeting for more intensive safety planning and interventions. MARAC is chaired by the Detective Inspector responsible for the Community Safety Unit and meets monthly. A very wide range of agencies are represented at these meetings, both statutory and voluntary. The meeting shares risk assessments and develops plans for the families. During 2012-13 MARAC looked at 168 cases involving 325 children. Most referrals came from Police or the IDVA service.

The IDVA service provides training in awareness and risk assessment as part of the LSCB training programme and also delivers training in schools. This training continues to achieve highly positive evaluations. They have recently produced a Stay Safe leaflet to support families who have to move away.

The LSCB has expressed concern about the lack of provision to support children and young people who have experienced emotional harm through living with domestic violence. In 2012-13 funding was provided for a local housing association to provide support for children placed in the refuge and for those in the community through workshops**.** Outcome information is not easily available, but anecdotal evidence from staff is that the improved risk assessments and joint communication has greatly improved the safety of many families and children, including development of a child protection plan when appropriate.

Referral to IDVA/MARAC often occurs quite a long time after the precipitating incident of domestic violence so there is a delay in providing services and support. Earlier identification and response therefore remains an issue.

Clearly, much is being done to provide practical resolutions of domestic violence issues. However, it is well known that children who are affected by domestic violence frequently experience long term emotional harm, as evidenced by the numbers who end up in the care or youth offending systems. This was confirmed by NSPCC research which found that young people who witness domestic violence are five times more likely to run away, four times more likely to become violent/carry a weapon, three times more likely to be involved in drugs, crime or anti social behaviour The cost to society and the emotional cost to the young people are clearly high.

The actual or perceived high thresholds for mental health services means that these children do not have access to support services, and support for these children remains a priority for the LSCB and the Children's Trust.

It is also known that those children who experience abuse directly are more likely to become perpetrators themselves. This includes the increased

numbers of teenage perpetrators. The Youth Offending Service includes domestic violence in its work programmes with young offenders

The definition of domestic violence has now been expanded in law to cover more victims.

Young people aged 16 to 17 and coercive control – a pattern of controlling behaviour – is now included in the legal definition for the first time.

The new cross-government definition will raise awareness about the many types of domestic abuse that can ruin lives and encourage more people to seek help.

The Association of Chief Police Officers has commented on the challenges of enforcing the new definition for domestic abuse, but is positive about the change.

Locally a rise in those aged 16-18 experiencing domestic abuse has been noted, so this change is welcomed.

The LSCB plans a case review of referral pathways and responses to domestic violence in early 2014, and availability of training, but current evidence indicates that:

- Response is often late, when the situation becomes very serious. It is hoped that referrals through MASH (when operational) may improve this situation.
- There is a need for more interventions for children and young people, both to support emotional health, and to break the cycle of violence.
- Specific work with adolescent boys is indicated in this context.
- There is a small but significant number of perpetrators who are willing to be helped, if more help and support were available.

Child Abuse Investigation Team (CAIT)

Headline figures from last financial year for Hillingdon:

- 1144 referrals
- 576 crimes - 30.7% detected (charged)
- Serious sexual offences 82 - 57.3% detected
- Rape - 24 / 70.8% detected
- Violence with Injury - 177 20.9% detected

Potential risks to safeguarding

Resources

The lack of sufficient competent and permanent staff continues to pose a risk to safeguarding children. The main risks represented are lack of supervision and management oversight and the impact of a changing staff group on continuity of communication both with other agencies, and with children and their families. It can also lead to unnecessary drift. This issue is most marked in social care, but is also apparent in other agencies, e.g. Police.

Some agencies, due to their wide span, have difficulty in representation on the LSCB, e.g. CAFCASS, Probation, NHS London.

Reorganisation

Virtually every organisation is, or has recently reorganised. This is sometimes due to the need to make savings, sometimes to manage new government requirements, and sometimes to increase the effectiveness of services. These reorganisations create opportunities, but also risks. There are inherent risks in staff losing focus in the midst of change, and some consequential increase in vacancies. There are also potential direct risks to services, e.g. recent changes to Operation Paladin by the Metropolitan Police, which could potentially put at risk some young people arriving at Heathrow, changes in Border Force processes and procedures.

Lack of coordination of early intervention work

This is frequently an issue in case reviews, and results in some children coming to notice too late, often after many years of neglect. This has been addressed by development of the children's pathway programme and the CAMHS review of early intervention services. However, these changes are at time of writing at an early stage.

Heathrow

The presence of Heathrow Airport within the Borough boundaries poses particular risks in respect of a transient population, particularly those at risk of trafficking and exploitation. This has been mitigated by effective and organised multi-agency cooperation and action which has reduced the numbers of children and young people at potential risk.

Inspection and quality assurance

The LSCB has through the year been better able to assess the quality of practice through case reviews and audit. This has been in the main through the appointment of a manager with specific responsibility for quality assurance and audit. However, this needs to be further developed into a fully comprehensive quality assurance framework. There have also been changes in the external inspection regime carried out by Ofsted. The new framework recently introduced will focus very much on Council services for children in need of protection, who are looked after, or who are care leavers. It will include a judgement on the LSCB. However, attempts to create a genuine multi-agency inspection have so far failed, so other agencies will not be adequately represented in the process, and there are concerns whether LSCB can be adequately inspected as a multi-agency partnership under this methodology.

Potential opportunities to improve safeguarding

Staffing

In spite of the concerns raised above, on the whole children are effectively safeguarded in Hillingdon through the efforts of skilled and hard working staff across all agencies. There is much evidence of staff working and communicating well with each other and with children and their families. The

LSCB will continue to ensure the delivery of a strong multi-agency training programme and will do more to engage with staff and obtain their views.

There is a strong senior management commitment to safeguarding and a willingness to be held to account by the LSCB.

Reorganisation

The development of the children's pathway programme and key worker system, supported by the shared assessment and referral process, should ensure better identification of the need for early help and coordination of early intervention services. In the long term this should reduce the need for protection, or at least identify much earlier in the child's life, what the risks are, and how they should be addressed.

Signs of Safety

All agencies, through the LSCB, have agreed to implement the Signs of Safety model of assessment. This, by definition, is more involving of families and should be better able to identify child and family strengths, and produce a child protection plan that is clear and achievable for the family. It very much follows the recommendations of the Munro Review

However, this methodology is not as yet fully evidenced in this country, and practitioners will need to continue to challenge families and not be misled into the 'rule of optimism' through a family's apparent cooperation

Inspection and quality assurance

Hillingdon Council is building a culture of continuous quality oversight and improvement based on the inspection standards and this will be augmented by the LSCB quality assurance framework. This work is supported by the appointment of a specialist quality assurance manager, and practice development officer, who has helped to embed the learning from quality assurances processes.

External inspection, although the framework continues to change, does provide some independent external measure of practice.

7. NATIONAL AND LOCAL CONTEXT: implications for safeguarding

Working Together 2013 and London Child Protection procedures

The revised Working Together to Safeguard Children was released in March 2013 and represents a radical shift in the way that the child protection system will operate in England. This includes a new approach to the oversight of serious case reviews, new guidelines for assessing the needs of vulnerable children, and a huge reduction in the level of national child protection guidance.

The new guidance focuses strongly on legislative requirements, and removes large sections of non-statutory practice guidance. In response to consultation, it still includes more detail on the roles and responsibilities of partner agencies such as health and the police. The guidance is clear that "safeguarding is everyone's responsibility" and other headlines include:

- The reinstatement of statutory timescales for assessing the needs of vulnerable children, which had been removed from the consultation documents;
- A removal of the distinction between initial and core assessments, replaced by ongoing, locally developed, assessments of need;
- A change in the governance arrangements for independent Chairs of Local Safeguarding Children Boards (LSCBs), who will now be appointed and held to account by the local authority Chief Executive rather than the Director of Children's Services;
- The establishment of a national panel to hold LSCB Chairs to account on whether serious case reviews should be carried out, which independent reviewers should be commissioned to lead the review, and to challenge any decision that the report should not be published;
- There is a statutory requirement (retained in the new guidance) for a multi-agency serious case review (SCR) to be carried out for every case where abuse or neglect is known or suspected, and either:
    - the child dies, or
    - the child is seriously harmed, and there are concerns about how organisations or professionals worked together to safeguard the child.
- A strong reiteration of the government's intention that all serious case reviews should be published in full, and more detailed guidance on what this means in practice;
- A reversal of the consultation's proposal for all future serious case reviews to be undertaken using so called "systems methodology", with LSCBs instead free to use any model that is broadly in line with stated principles, and
- A requirement on LSCBs to develop a local framework for learning and improvement, including regular reviews of cases that may not meet the

criteria for a full serious case review, as part of an on-going process of learning and development.

Hillingdon LSCB has been reviewing its own local processes to ensure that they are fit for purpose. Multi-agency briefings have been undertaken planned to ensure that practitioners within the Children's workforce are updated and this is aligned to the transformation being driven through the Children's Pathway programme.

London Child Protection Procedures 5th edition

Further to the publication of the revised National Guidance *Working Together 2013,* the London Child Protection Procedures have been rewritten, and were sent round for across all London Boroughs.

The full procedures will be launched at the London Conference in December 2013, and will be discussed and agreed as appropriate at the LSCB in Hillingdon

The Savile case

A high profile investigation during the year involved Jimmy Savile and subsequent revelations.

Her Majesty's Constabulary Inspectorate's' (HMIC) review of allegations made against Jimmy Savile during his lifetime found that mistakes were made by the police and, while policies and practices designed to improve the experience of child victims are now available, the report raises serious concerns over why so many victims felt unable to come forward and report what had happened to the authorities.

To improve understanding of why no specific allegations against Savile were recorded before 2003, HMIC considered policy and practice changes in the Police Service and the wider criminal justice system over Savile's period of offending. HMIC found that a child reporting sexual abuse today is likely to be better treated than 50 years ago. But there is still more to do if children are to receive the full protection of the changes that have been introduced since then.

While this report found only seven records, HMIC has wider concerns about the way the police manage and use information, and whether national guidance is being given full effect in all forces. HMIC will examine this further as part of its review into child sexual abuse and sexual exploitation, which is due to start in summer 2013.

Since the Savile review, the Metropolitan Police in London have decided that the Child Abuse Investigation Teams (CAITS) will have the lead responsibility for investigating child sexual exploitation outside the family home, as it recognized that CAIT officers are more likely to have the skill set and expertise to conduct these investigations. All LSCB chairs/chairmen have been notified of this change. Whilst welcoming this in principle, it is not yet clear whether this will result in additional capacity being built into the CAIT teams, and our local police colleagues have expressed some concern over this, as it is not yet clear what the levels of additional demand will be. The LSCB will be monitoring this carefully.

Government response to Lord Carlile's report on the Edlington case

In March 2012, the Secretary of State for Education, asked Lord Carlile to conduct an independent review of the case of the 'J' children in Edlington. The 'J' children had committed a very serious assault on 2 young victims in April 2009, having assaulted another young victim the previous weekend.

Doncaster LSCB commissioned a Serious Case Review and published the executive summary in January 2010. The purpose of Lord Carlile's further review was to look at the issues raised by the case and action taken in response locally, and also to consider where there may be a need for improvements more widely in the child protection system.

This document, published in January 2013, is the formal response to Lord Carlile's report on the Edlington case. It is intended to prompt further debate and discussion of the challenges he sets for LAs and central Government.

Children's services have considered this document carefully in the process of completing the strategic plans for Hillingdon children's services, in alignment with the Children's Pathway Programme. For example, the Government's expectation of robust and swift early intervention to safeguard children may mean more children being taken into care, especially when the parents are unable to change sufficiently to meet their children's needs.

The number of care proceedings in Hillingdon is continuing to show an upward trend, which will put pressure on the 26 week timescale for completion of care proceedings, envisaged by the Family Justice Court review. This is in line with a national picture which shows an increase in care proceedings since Baby Peter. In order to test this further and drive up the standards, Hillingdon children's services has joined up to the West London care proceedings pilot, which will have the benefits of improving social work assessments, thus negating the need for reliance on external experts.

Children who experience neglect

<u>Neglect and serious case reviews</u>

The NSPCC and the University of East Anglia have published (11/03/13) a systematic analysis of neglect in serious case reviews in England between 2003 and 2011. Findings include the fact that 59% of children known to social services who died or were seriously injured had been on a child protection plan for neglect at some point in their lives.

Recommendations include: an expert social worker in every local authority to advise on child neglect cases.

The Children's services, social care transformation programme, allows for the recruitment of Advanced practitioners who will have expertise in this kind of research. Researched and informed practice will then be integrated into the "PODs" being developed and piloted through the Children's Pathway programme.

Also a précis of this research has been uploaded onto Hillingdon's Social Work research web page which is currently being built on Horizon.

SPCC report “How safe are our children?”

This report, issued by the NSPCC at the beginning of April 2013, compiles up-to-date child protection data that exists across each of the four nations in the UK. It sets out 19 different indicators and each indicator looks at the question from a different perspective. These indicators will be regularly updated as new statistics are published.

The report allows us not only to understand how many children are being abused and neglected, but also to track progress so that society can be held to account for its responsibility to children. Only by monitoring the extent of child abuse and neglect in the UK can we judge whether efforts to prevent maltreatment and to protect children are actually working.

A summary of the NSPCC report has been disseminated to practitioners via the Local Safeguarding Children Board (LSCB) Training and Development Manager, and the research will be fed into the action learning sets, which will be rolled out over the next few months to support our local reflective supervision programme, as it is bedded into practice.

Neglect is a critical issue. A large percentage of children with a child protection plan have experienced neglect (42% of children on CP plans in Hillingdon are under the category of neglect). Long term neglect is a feature in the lives of many adolescents who come to notice, often through criminal behaviour. But, as can be seen from some national cases, this behaviour masks vulnerabilities that can be exploited by criminals or paedophiles.

“Always Someone Else’s Problem"- Office of the Children’s Commissioner’s Report on illegal exclusions

The Children’s Commissioner’s report provides quantitative evidence from teachers and school leaders about the scale and nature of illegal exclusions from schools in England. This practice, as far as it can be measured, appears to affect a small but significant minority of schools, and therefore pupils.

The Children’s Commissioner found evidence of:

- pupils being excluded without proper procedures being followed; these exclusions are usually for short periods, but may be frequently repeated, meaning that the child misses substantial amounts of education;
- pupils being placed on extended study leave, on part time timetables, or at inappropriate alternative provision, as a way of removing them from school;
- pupils being coerced into leaving their current school, either to move to another school or to be educated at home, under threat of permanent exclusion;
- schools failing to have due regard to their legal responsibilities regarding the exclusion of children with statements of SEN or Looked After Children;
- schools failing to have due regard to their responsibilities under the Equality Act 2010, and

- LAs failing to deliver their legal responsibility to provide full time alternative education for children from the sixth day of exclusion.

This is an issue which had already been picked up by the Local Authority Officers within Hillingdon, and had been incorporated into a recent report by the Education and Children's services Policy Overview Committee, (POC) in which a number of key recommendations have been made to help address this concern.

Parents with mental health problems

What about the children? Joint working between adult and children's services when parents or carers have mental ill health and/or drug and alcohol problems.

Ofsted and the Care Quality Commission (CQC) have called on the government to make it a mandatory requirement for mental health services to collect data on children whose parents or carers have mental health difficulties and report on such data nationally. (25-04-2013). The recommendation is contained in a joint survey which highlights how the lack of identification of children living with parents with mental ill health has led to them not receiving the help they need, with some being left at risk of harm.

Currently, it is a mandatory requirement for adult services to gather information about children and report to the National Treatment Agency for Substance Abuse where their parents have drugs/and or alcohol problems. However, this is not the case for children whose parents have serious mental health difficulties.

In Hillingdon, a joint protocol is being drawn up between Children's social care and adult service to make sure that there is a more integrated, and holistic approach to working with families, where parents have enduring mental health issues, or even mild conditions which may impact on the well-being of children.

National Health Service

Clinical Commissioning Group (CCG)

The CCG began operating officially in March 2013. This is the body responsible for most Health commissioning in the area. (Some specialist services will be commissioned by a national body – NHS England)

The designated nurse and doctor for safeguarding now work to the CCG which has lead representatives on both the Children and Adult Safeguarding Boards. They continue to sit on the LSCB.

The Director of Public Health (DPH) is now based in the local authority, and all local authorities now have the lead for public health assessment and planning in their area.

The DPH, representatives from the CCG, sit on the LSCB and the LSCB report will also be presented to the Health and Wellbeing Board.

Local Developments

Children's Pathway Programme

Building on the good work achieved through the Family Intervention Programme the Children's Pathway Programme has been looking at children's services across the Children's Pathway in both Education and Children and Family Services, following the journey of the child through the system across all levels of need.

This work culminated in a transformed structure, which integrates early intervention services in schools and Children's centres, through to Children's social care. A new top level organizational structure has been agreed to embed this integration.

A number of work streams have been developed, which have included a number of pilots around better ways of working with families. These include "keyworking" services in tiers 1 and 2, and "POD" working in statutory services. The Children's Pathway Programme is continuing to drive all the changes mentioned below:

Single Holistic Assessment

Working Together 2013, has relaxed the requirement to have an initial assessment of need (10 working days) and a Core assessment (35 working days), with greater emphasis on the need for professionals to apply their judgment about need, and to problem solve and intervene with families at the earliest opportunity, in the most timely way for the child. The Children's Pathway Programme had already sponsored and anticipated this more effective way of working through piloting a single holistic assessment during the early part of this year. The evaluation showed some positive outcomes for children and better quality communication with other agencies. From May 1st 2013, the single holistic assessment went fully live across the social work teams in the Mezzanine offices, and is now being piloted within the Children in Care teams and Leaving Care Teams, which are also being restructured.

Early Help Assessment and multi-agency referral form

It was generally agreed that the common assessment framework (CAF) had not been used most effectively and had been deployed mainly as a referral to social care. The CAF has now been replaced by a shared family Early Help Assessment which will be used in early help services to develop the assessment and planning though the team around the Family and key working processes.

Alongside that, a referral form has been developed to clarify the reasons for referral to social care.

Both of these were developed by practitioners across agencies and piloted prior to full roll out in summer 2013.

It is hoped that the multi-agency referral form can be further developed and used for referring to all specialist services, e.g. CAMHS.

Signs of Safety (SOS)

The Signs of Safety is a model for working with families, based on systemic theory and principles. This approach has been adopted by a number of local authorities, both across London and nationally, to enable a stronger focus on early intervention and promoting better outcomes for children. The Signs of Safety Model has grown from researched and informed practice in Western Australia and more latterly is becoming widespread in the UK, and other parts of Europe.

The Signs of Safety approach is a practical framework, aimed at equipping practitioners with the techniques they need to elicit partnership working with children and families, who are involved in the child welfare system.

The Model draws on the language and tenets of brief solution focused therapy. This is a 'client centred approach' developed by Steve de Shazer et al (1985). It operates on the premise that, even in the face of difficulty, the 'family' is already in possession of resources, which if supported, can be mobilised to elicit positive changes in their circumstances. Contrary to the traditional approaches to risk, which tend to focus on the deficits of a client's circumstances, the Signs of Safety model looks at the existing strengths, and potential safety capacity, for children to thrive within their own family context.

The use of this approach has been endorsed by partner agencies across the LSCB, and is being integrated into the Children's Pathway Programme, as it will help to improve outcomes for Hillingdon's vulnerable children and families. A project steering group has been set up 2013, to drive the implementation of Signs of Safety reporting into the Director for Children's Services.

An external trainer, an expert in Signs of Safety, has been deployed to run some of the formal training sessions, in order to accredit local officers and designated professionals, who will become trained as specialists in Signs of Safety in Hillingdon. Some LSCB and Children's Trust Board Members have also been briefed in the techniques of Signs of Safety.

Further training will be rolled out for practitioners through briefings and action learning sets, so that the application of the techniques of Signs of Safety is properly learnt and understood across all agencies at all levels. This will be delivered via the LSCB multi-agency training programme.

The Signs of Safety will be incorporated into the Business Plans of the LSCB and Children's trust as well as PADA training objectives, as part of the continued professional development of social workers, teachers, Health visitors etc and their managers.

Key Operational Managers, Professionals and Designated/Named Professionals within each agency (designated teachers, nurses etc.) will be expected to lead the changes in practice. They will receive bespoke training to enable the model to be embedded in practice throughout the system, across all the levels of need, within Hillingdon's Operating Model.

Multi-Agency Safeguarding Hub (MASH)

The MASH model is a national multi-agency initiative to provide information sharing arrangements across all agencies involved in safeguarding children.

Those involved are employed by their respective agency e.g. police, health and local authority, and located in one office.

The MASH model is intended to provide information that is already known within separate organisations in a coherent format that enables “real time” effective and appropriate response to concerns or referrals received by the MASH.

The principles of MASH are consistent with the recommendations in the Laming Report (2009), Munro review of Child Protection (2011) and Serious Case Reviews, where inconsistent, un-coordinated information exchange has had a detrimental impact on safeguarding functions.

The MASH model is regarded as best practice for managing the information flow between agencies to strengthen safeguarding practice. The London Safeguarding Board is fully supportive of the model and the Metropolitan Police Service has made a significant financial commitment to implement MASH across the London Boroughs.

Hillingdon’s Approach to MASH

Hillingdon have signed up to developing the MASH model at the point of referral within Children’s Social Care. Hillingdon have further committed to managing Adult Safeguarding referrals using the MASH model. In doing so they would be one of the first London Borough to achieve this duel role.

Progress so far

A MASH Operational Delivery Group has been set up and taken responsibility to deliver Hillingdon’s MASH in autumn 2013. The group includes representatives of all the key agencies involved in safeguarding. Each of the agencies has committed to be part of the MASH:

- Children and Families Social Care
- Adult Safeguarding
- Local and Regional Metropolitan Police
- Community Health and Health Commissioning
- Probation
- Education
- Housing

The operational group is currently assessing what level of commitment each partner needs to ensure the success of the MASH.

Delivering MASH

There are several key strands of work underway to ensure MASH is ready to be implemented in autumn 2013.

To date there has been significant enthusiasm for this Project across all agencies, despite the tight timescales and resource implications. There is a genuine professional belief that working together to safeguard Hillingdon’s children within the MASH will produce positive outcomes for vulnerable children.

Education changes

The main emphasis of Government education policy is an increase in the independence of schools and the consequential reduction in the influence of the local authority. There are therefore potential risks to safeguarding both in terms of the monitoring of individual schools and the lack of consistency in external commissioning of support services

In Hillingdon, although most secondary schools are now academies, all schools have remained fully engaged with the LSCB. This will be supported through the further development of safeguarding clusters across the Borough.

8. WHAT WE NEED TO DO: priorities for LSCB 2013 onwards

Our evaluation of the progress against our priorities plus our assessment of the effectiveness of local safeguarding arrangements, consideration of relevant national issues and feedback from staff have led us to identify the main priorities for the Board's work from 2013.

N.B. The LSCB is now required to influence and assess the development of early intervention services, as these are critical in improving the safeguarding of children, and in ensuring that only those in highest need receive social care services. The LSCB will also monitor the interfaces between preventative and statutory services to ensure that thresholds are clear and consistent. However, it is important that The LSCB continues to keep as a main priority those children and young people who are most at risk of harm, i.e. those who come into the social care system in need of protection.

We have a challenging work plan, but, whilst all require attention, the Board has decided that particular priority should be given to:

- Oversight of the early help assessment and plans, and alignment of pan London levels of need with thresholds with early help and social care services.
- Developing the community voice within the LSCB by better understanding of the child's view and making effective use of our lay members.
- Getting a better understanding of domestic violence pathways in order to identify earlier and ensure that the most effective interventions are in place.
- Further improving our quality assurance processes so we have a clear window on local practice and systems.

Priority 1 Improve LSCB functioning

- Roll out implementation and training for Working Together 2013 and London procedures
- Improve LSCB scrutiny of early help services
- Implement Multi-Agency Safeguarding Hub
- Implement Signs of Safety approach to child protection
- Improve engagement with, and involvement of children and young people
- Improve engagement with staff across all agencies
- Establish effective engagement with new health agencies, and the Health and Wellbeing Board.

Priority 2 Assess and improve operational practice

- Embed revised threshold criteria across all levels of need
- Embed early help shared assessment and single holistic assessment process in line with revised Government guidance

- Further develop and improve learning from multi-agency audit process.

Priority 3 Improve outcomes for children affected by key risk issues

- Continue to develop and improve practice in respect of children newly arrived, those who go missing and are at risk from sexual exploitation and gang activity
- Review services to those affected by domestic violence
- Oversee development of CAMHS tier 2 services.

Priority 4 Ensure a safe workforce

- Continue a full multi-agency training programme that meets needs of agencies
- Roll out training programme for Working Together 2013 and London procedures
- Further develop the LADO training to include faith and community groups.

Priority 5 Learn from Case Reviews

- Continue to learn from cases and meet the requirements of chapter 4 of Working Together 2013
- Continue to implement learning from unexpected child deaths and disseminate key messages to local professionals –translate information on safe sleeping into relevant languages.

Individual agency plans

YOS key plans for 2013-14:

- With partners, review multi-agency work with children and young people who sexually offend, against the good practice and recommendations contained within the HMIP Inspection report published in February 2013.
- Implement pre-court disposals (as of April 2013), monitor and review process and interventions.
- Review existing practice for children and young people placed away from home who offend, against the good practice and recommendations contained within the HMIP Inspection report published in December 2012.

Voluntary Sector

- In 2013/14 HAVS will continue to update voluntary agencies, and in particular the introduction of the DBS update service and the roll out of the new shared assessment.
- In addition, some of the boroughs mosques and madrasahs will be supported for the first time to understand their responsibilities to implement 'Working Together' and develop quality policies and practice in safeguarding. Training is planned for mosque and madrasah staff and volunteers.

Early years Key plans for 2013-14:

- To ensure settings and practitioners are better informed in relation to keeping children safe. This will be achieved through 20 additional setting managers have accessed the “working together” training and 20 settings have accessed domestic violence training.
- To support practitioners in gaining a deeper understanding of “low level” child abuse. This will be achieved through supporting 90% of settings to implement an effective supervision structure that enables staff to share all concerns in relation to the safeguarding of children. Training, advice and support will also be provided.

CNWL HCH Priorities for 2013-2014:

- The named professionals will use training and supervision sessions to ensure the workforce are aware of the key changes contained in the revised statutory guidance Working Together to Safeguard Children (2013).
- The named professionals have responded to the London Safeguarding Children Board editorial group request for comments on the draft version of the London Child Protection Procedures. The safeguarding children team will provide a link to the guidelines when they are launched.
- Work in partnership with the local authority in order to identify and safeguard children at risk of sexual exploitation. Ensure HCH staff are aware of how potential or actual victims may present and what the local arrangements are.
- HCH will revise the mandatory safeguarding children training programme to increase compliance levels whilst maintaining adherence to the intercollegiate document. Develop a dashboard system to collect child protection activity data.
- Ensure children’s services staff and the HCH Safeguarding Group receive feedback from the 8 cases that were audited as part of the preparation for the peer review. The named nurses will participate in 2 further multi-agency audits in 2013 as part of the remit of the Risk Management Panel.
- Re write the record keeping audit tool to collect qualitative data in order to assess the recording of children’s views. This audit will be undertaken in January 2014. The named nurses will continue to support staff develop their skills in this area.
- Embed the Signs of Safety model and support staff attending the new style of case conference. Develop and roll out a new template for case conference contributions from health staff in line with the new signs of safety case conference format.
- The named nurses will provide support and supervision to the nominated health professional allocated to the Multi-Agency Safeguarding Hub (MASH).

CNWL Mental health services plans for 2012-13

- The “think family” agenda is a huge issue for adult services and one where there is much to learn from CAMHS colleagues. There are impacts of hidden harm that the services need to identify consistently. To address this, the Trust has established a project in Spring 2013 to promote “think family” as part of service delivery in service lines.
- Mental health services are moving to payment by results as its major funding source from 2014/15. This means 2013/14 will be a shadow year for these changes. The Trust is carefully monitoring the impact of changing service delivery into service lines and would welcome partner agencies views on any unforeseen impacts.
- CAMHS, like other service lines, have plans to complete service redesign/ improvement work. This will include developing groups across the service with children, young people and their carers and other stakeholders to test out our ideas on service planning and redesign.
- The Trust will be looking to tender the software packages used and it is hoped that this will allow the opportunity to resolve some of these data issues.
- CNWL may apply for Children and Young People IAPT, which embeds a CBT model of service delivery with extensive outcome evaluations using a range of measures. Other Boroughs are currently doing the training and the learning may be rolled out to Hillingdon staff in the next year.

9. CONCLUSIONS AND RECOMMENDATIONS TO THE CHILDREN'S TRUST AND OTHER BODIES

Our overall assessment of safeguarding in Hillingdon is a cautious 'good'.

We see evidence of sound practice and effective multi-agency communication and collaboration at the front line. Operational practice in respect of children at risk through going missing or trafficking is sound and nationally and internationally recognised. Work around understanding child deaths and in managing staff allegations is strong and there is an effective multi-agency training programme

Once a crisis has occurred families and children on the whole seem to receive effective help and appropriate actions are taken.

Changes and developments within children's pathway services should ensure, on one hand, improved supervision and management oversight, and also better identification and support through early help services

Potentially these strengths could be put at risk through staff shortages and lack of management vigilance and oversight. It is noted that the Council is putting considerable effort and resource into staff recruitment and this is welcomed.

There has been no reduction in the impact of some of the more intractable problems, such as domestic violence, mental health, and long term neglect – often not picked up until adolescence. Children at risk of trafficking and/or exploitation will always require continued vigilance, particularly in the context of Heathrow.

It is vital therefore that early help services are effective in picking up these issues early and coordinating best action to support and avoid duplication. It is also vital that best use is made of early intervention services to support families and prevent escalation of problems. In times of financial constraint, reduction in support services is a false economy, but services should be carefully targeted. Shortage of CAMHS early support services remains a concern.

Changes in partner organisations continue into 2013-14. Issues such as CAFCASS changes, the new Probation model, changes in Health services, and Metropolitan Police changes (e.g. Paladin) impact heavily on staff morale and multi-agency working. These changes have also impacted on involvement at a strategic level on the LSCB. However, the local Clinical Commissioning Group (CCG) is now well represented going into 2013-14.

One of the clearest messages coming out of local and national case reviews and research is the vital importance of staff communicating clearly with each other, preferably face to face, but also though more effective IT systems. This is the whole basis of core groups, Team Around the Child etc. Although many changes are unavoidable in the current climate, communication and information exchange must remain a priority.

Some reorganisation and review mean that some agencies and services are not yet mature, e.g. Clinical Commissioning Group, Early Help services and CAMHS tier 2. This will hopefully be addressed during 2013-14.

APPENDIX 1: LSCB membership

Chairman and officers of the LSCB

- Lynda Crellin - Chairman (Independent)
- Maria O'Brien – Deputy Chairman, Managing Director, Provider Services, Hillingdon PCT
- Paul Hewitt – LSCB Lead Officer
- Wynand McDonald - LSCB Training and Development Officer
- Carol Hamilton - Manager, Child Death Overview Panel (CDOP)
- Andrea Nixon - Schools Child Protection Officer
- Joseph Matia - LSCB Legal Advisor
- Julie Gosling - LSCB Administrator

Observers

- Cllr David Simmonds - Deputy Leader of the Council & Cabinet Member for Education & Children's Services
- Fran Beasley - Chief Executive, London Borough of Hillingdon

Local authority representatives

- Merlin Joseph - Deputy Director, Children & Families, Social Care, Health & Housing
- Pauline Nixon - Interim Chief Education Officer
- Lynn Hawes - Service Manager, Youth Offending Service, Social Care, Health & Housing
- Nick Ellender - Service Manager, Safeguarding Adults, Social Care, Health & Housing
- Pauline Moore - HR

Health representatives

- Maria O'Brien - Managing Director, Provider Services, Hillingdon PCT
- Sharon Daye - Director of Public Health, LBH and Hillingdon PCT
- Jacqueline Walker - Deputy Nurse Director, Hillingdon Hospital NHS Trust
- Catherine Knights - Director of Operations Central North West London Trust
- Chelvi Kukendra - Designated Doctor, Hillingdon PCT
- Jenny Reid - Designated Nurse, Hillingdon PCT

Police and probation representatives

- Richard Turner - Detective Chief Inspector, Hillingdon Borough Police
- Paul Monk - Detective Chief Inspector Child Abuse Investigation Team (CAIT), Metropolitan Police
- Paul Brannahan - Detective Inspector, Child Abuse Investigation Team (CAIT), Metropolitan Police
- Marcia Whyte – Senior Probation Officer, London Probation

School representatives

- Sue Pryor - Head teacher, Swakeleys School/Kim Rowe – Head teacher, Bishopshalt School
- Catherine Moss - Head teacher, St Bernadette's School
- Representative for special schools – not in post

Other representatives

- Gavin Hughes - Deputy Principal Officer - Uxbridge College
- Rose Alphonse - Uxbridge College Children's Centre
- Fiona Millar – Children, Youth and Family Manager, HAVS
- Danielle Lambert – Regional Director, UKBA
- Chris Condon – Projects Officer

APPENDIX 2: Glossary

A&E	Accident and Emergency Services
CAF	Common Assessment Framework
CAIT	Child Abuse Investigation Team (Metropolitan Police)
CAFCASS	Children and Family Court Advisory and Support Service
CAMHS	Child and Adolescent Mental Health Service
CDOP	Child Death Overview Panel
CSE	Child Sexual Exploitation
CNWL	Central and North West London Trust
CIN	Children in Need (sec 17 Children Act)
CP	Child Protection
DCS	Director of Children's Services
DfE	Department of Education
DPH	Director of Public Health
GP	General Practitioner
HCFTB	Hillingdon Children and Families Trust Board
HCH	Hillingdon Community Health
HMIP	Her Majesty's Inspector of Prisons
ICT	Information and Communication Technology
IDVA	Independent Domestic Violence Advocate
ISA	Independent Safeguarding Authority
JSNA	Joint Strategic Needs Analysis
LADO	Local Authority Designated Officer (allegations against staff)
LAC	Looked After Children
LSCB	Local Safeguarding Children Board
LSP	Local Strategic Partnership

MASH Multi-Agency Safeguarding Hub

NSPCC National Society for Prevention of Cruelty to Children

NPIA National Policing Improvement Agency

PIP Partnership Improvement Plan

POC Policy Overview Committee

PCT Primary Care Trust

PEECS Planning, Environmental, Education Community Services

SAPB Safer Adults Partnership Board

SCIE Social Care Institute for Excellence

SCR Serious Case Review

SEN Special Educational Need

SIT Safeguarding Improvement Team (NHS London)

SOS Signs of Safety

THH The Hillingdon Hospital

YOS Youth Offending Service

UKBA United Kingdom Border Agency

APPENDIX 3: LSCB Budget

Income 2012-13

Health	60,000
Local Authority	61,250
Metropolitan Police	5,000
UK Border Agency	5,000
Probation	2,000
CAFCASS	565
Government Grant (Munro funding)	38,000
TOTAL	171,815

Outgoings 2012-13

Staffing	92,000
LSCB Chairman	22,000
Consultancy (PIP management & website)	7,000
Independent reviewer (SCIE Pilot)	7,500
e-Learning training licence	7,000
Office running costs (stationery/telephone etc)	4,500
Catering – LSCB conference	5,000
TOTAL	144,500

The balance of £26,315 has been rolled over to the current financial year (2013-2014) to pay for Independent multi-agency case reviews and development of Signs of Safety.

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ANNUAL REPORT OF THE SAFER ADULTS PARTNERSHIP BOARD (SAPB) 2012-2013

Relevant Board Member(s)	Councillor Philip Corthorne
Organisation	Safer Adults Partnership Board
Report author	Lynda Crellin, Independent Chairman – Safer Adults Partnership Board
Papers with report	Appendix 1 – Annual Report of the Local Safeguarding Children Board 2012-2013

1. HEADLINE INFORMATION

Summary	This paper presents the annual report 2012-13 of the Safer Adults Partnership Board (SAPB). It summarises the work done during the year and identifies areas priorities for action in 2013-14.
Contribution to plans and strategies	None.
Financial Cost	There are no direct financial implications from this report, although some additional resources may be required in 2013 when the statutory requirements are clear.
Relevant Policy Overview & Scrutiny Committee	Social Services, Housing and Public Health
Ward(s) affected	N/A

2. RECOMMENDATIONS

The Health and Wellbeing Board is asked to:

1. **receive and note this report, and actions identified that are being taken by the SAPB and its constituent agencies to improve the safeguarding of vulnerable adults in Hillingdon;**
2. **consider the development of a protocol between the SAPB and the Health and Wellbeing Board in preparation for the enactment of the Care Bill; and**
3. **note the implications of the actions arising from the Winterbourne Review.**

REASONS FOR RECOMMENDATIONS

There has over recent years been an increased awareness of the potential risks for vulnerable adults of experiencing abuse and neglect. The Care and Support Bill, currently going through the Parliamentary process, sets out the first ever statutory framework for adult safeguarding which stipulates the responsibilities of local authorities, and those with whom they work, to

protect adults at risk of abuse and neglect. The Bill also identifies the role and remit of Safeguarding Adult Boards, and is likely to require that the annual report is presented to the Health and Wellbeing Board

FINANCIAL IMPLICATIONS

There are no direct financial implications from this report, although some additional resources may be required in 2013 when the statutory requirements are clear.

LEGAL IMPLICATIONS

None directly from this report at this stage, but the Board will be placed on a statutory footing when the Care Bill is enacted.

BACKGROUND

1. Local Authorities have a responsibility to follow the Department of Health guidance outlined in "No Secrets" (2000) and to be the lead agency in coordinating the multi-agency approach to safeguarding adults at risk of abuse in their area. As part of this, the Safeguarding Adults Partnership Board (SAPB) leads on strategy, monitoring and reviewing the safeguarding arrangements in Hillingdon. It publishes an Annual Report, detailing what the partnership has achieved over the year, local and national developments and it decides the service priorities.

2. The Care Bill proposes to set safeguarding adults at risk on a statutory footing, placing a duty on Local Authorities to carry out enquiries into any allegations of abuse or exploitation. Having a SAPB will become a statutory requirement requiring the co-operation of agencies to work together to protect adults at risk. It is likely that a relationship with the Health and Wellbeing Board will be a requirement as it currently is for the Safeguarding Children Board.

3. The Safeguarding Adults Partnership Board is currently a non-statutory, multi-agency partnership of independent and charitable organisations, statutory agencies and others with an interest or responsibility for safeguarding adults at risk. Local Authorities, as required by Government guidance, are the lead agencies in co-ordinating the response to safeguarding adults at risk, part of which is to ensure an effective Safeguarding Adults Board. The remit of the Board is to oversee the strategic development of safeguarding adults and the effectiveness of local arrangements.

4. The report presents a retrospective of safeguarding work over the year. Key local developments and service changes in 2012-13 have been:
    - Changes to risk assessment process to better assess the impact of interventions.
    - Continued implementation of the pan London policies and procedures.
    - Dissemination of learning from case reviews.
    - Establishment of sub group to plan and develop response to the Winterbourne Inquiry. Compliance with initial phase of Winterbourne action plan.
    - Began work to incorporate response to issues of safeguarding vulnerable adults in development of Multi Agency Safeguarding Hub (MASH).
    - Developed relevant local guidance, e.g., Deprivation of liberty, serious case review guidance, Hoarding Policy.

5. The SAPB priorities for development for 2013 onwards have been built around the eight ADASS standards of:
    - Outcomes
    - Leadership
    - Strategy
    - Commissioning
    - People's Experiences of safeguarding
    - Service delivery and effective practice
    - Performance and resource management
    - Local Safeguarding Board

6. Of particular priority is a need to improve our response to abuse, particularly financial abuse, which appears to be growing. We also need to ensure that the positive commitment to personalisation does not lead to increased risks. There is no evidence so far that this will be the case. The SAPB also wishes to increase its quality control mechanisms and to test our local practice against national concerns such as the Winterbourne events. The SAPB is well positioned to comply with the likely statutory requirements of the Care and Support Bill.

7. All relevant agencies have contributed to the Annual Report, and the Clinical Commissioning Group has been represented on the Board by the adult safeguarding and GP lead since April 2013. The SAPB's membership has been further strengthened in the latter part of 2013 by the inclusion of Healthwatch Hillingdon.

8. It should be noted that the role, expectation and workload of the Adult Safeguarding Board have increased hugely over the last year, and this will continue when the Care Bill becomes law. Resourcing of the Board will become an issue and it seems unlikely that the Government will be prescriptive in terms of expected contributions from partner agencies. Some business management and administrative time will be essential to ensure effective functioning of the Board.

9. Of particular priority during 2013 and continuing has been the action plan arising from the Winterbourne review. Part of this plan is the expectation that some long term users of hospital care will be moved to the community by summer 2014. This relocating of highly vulnerable people will present a challenge to all local agencies.

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Hillingdon Safer Adults Partnership Board Annual report 2012-13

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INTRODUCTION

This report covers the work of the Safer Adults Partnership Board (SAPB) during 2012-13. It highlights the main achievements in safeguarding Hillingdon's vulnerable adults, and identifies the priority areas for improvement for the following year and beyond. Any significant developments in the early part of 2013-14 are also included.

This work relies on strong commitment and collaboration across services, and this is evident though the work of the Board, and from the contribution that each agency has made to this report. From these contributions we can see the efforts that are being made in Hillingdon to keep adults safe.

Hillingdon has dedicated safeguarding adults teams in social care and in the Police, which makes us well placed to respond effectively to concerns raised.

We have this year further developed our local processes and procedures and have introduced a new risk assessment framework which should enable us to better assess the effectiveness of interventions. The local response to Winterbourne and Francis enquiries has been robust and timely.

This has also been the first full year of collaboration with the LSCB. This collaboration is enabling us to work closely on some key issues, such as the planned Multi Agency Safeguarding Hub (MASH) and joint work across Children's and Adult Mental Health Services.

The evidence we have indicates that we are keeping adults as safe as we can within Hillingdon. However, there are some important challenges.

Local demographic data tells us that numbers of vulnerable adults in the Borough will rise.

National events, such as the Winterbourne Inquiry and the Francis report, remind us that we need to do more to ensure we are able to better monitor the care of vulnerable adults, particularly those who are in homes or hospitals.

We need to develop improved quality assurance mechanisms to assess the quality of our interventions on the ground. The personalisation agenda, whilst extremely positive, means that we must help people assure themselves of the quality of care they are purchasing.

Government plans to place Safeguarding Adult Boards on a statutory footing are now clarified in the Care Bill which outlines proposed role, membership and requirement to produce an annual report. Hillingdon SAPB is well positioned to meet the requirements of the new legislation and this annual report will be presented to the Health and Wellbeing Board and the Council Cabinet

Hillingdon is the second largest of London's 32 boroughs. It has a population of 273,900 at March 2011 (ONS) and a projected population of 281,756 for mid 2012 of which approximately a quarter are under 19.

Numbers aged over 65years old are projected to increase to over 38,614 by 2018 (GLA projection). Although many of these will be living in the more affluent parts of the Borough, there are estimated to be upwards of 4700 frail

elderly, many living in unsuitable housing and in areas of multiple deprivation. Numbers of adults with a learning disability and/or a mental illness are also projected to rise.

The most recent information indicates that 25% of women over 60 are non white. For men, measured at 65, it is 30%. The ethnic diversity of the Borough is steadily increasing.

Hillingdon is a comparatively affluent borough (ranked 24th out of 32 London boroughs in the index of multiple deprivation, where 1 is the most deprived) but within that there is variation between north and south, with some areas in the south falling in the 20% most deprived nationally**.**

During 2012-13 2480 adults received an assessment from Adult Social care. There were 5561 reviews of existing service users and 3914 people were in receipt of adult social care services.

Lynda Crellin

Independent Chairman

June 2013

1. WHAT WE HAVE DONE

What we planned to do – our key priorities

WHAT WE SAID WE WOULD DO	WHAT WE DID
Empowerment	
• Ensure that decisions are person led through informed consent whenever possible	• User's and/or their representative's views are specifically referred to as part of investigation reports, case conference minutes and in the closure summary • Increased attendance of service user and/or their representative at case conferences • Increased use of "best interests" meetings to ensure wishes and preferences of service users are considered.
• Staff development and training to remain a priority, and to focus on key identified issues	• Increased training opportunities within partner agencies. • Training completed to address key area of mental capacity. • For social workers, development of the professional competency framework and membership of the College of Social Work to underpin practice
Protection	
• Pan London procedures safeguarding adults at risk – continue the roll out the new policies and procedures and ensure they are embedded in practice	• Policy and procedures available on line to all agencies along with good practice guidance. • Continuing with programme of briefings to ensure alerting staff and managers are clear of their responsibilities. • Amendments to the policies and procedures in progress to reflect structural changes in Health and the Police. • Continued engagement with the London Network on ensuring good practice and partnership working and that policies remain relevant.
• Improve our awareness and response to abuse or exploitation	• Learning from individual cases disseminated.

originating via electronic means, e.g. smart phones, social websites etc.	• Working towards a more comprehensive training package to increase staff confidence and knowledge in this area.
• Ensure and improve response to allegations of financial abuse	• More proactive prevention of financial abuse by management of service users' finances through Deputyship (74) and Appointeeship (221) • Financial abuse being identified in 26% of referrals. • Need to do more in cross agency working with the private sector.
• Implement the recommendations from the Winterbourne Report ,and Care Qualities Commission Review of learning disability services	• All Winterbourne relevant cases reviewed to ensure safe care as first phase of the action plan. • Multi-agency action response plan agreed and being carried forward under SAPB monitoring
• Amend recruitment policy and guidance to comply with revised CRB guidance and the Protection of Freedoms Act.	• This has been carried forward to 2013-14 although all agencies have been updated on the implications of the various changes
Prevention	
• Develop better ways of assessing risk across partner agencies	• New risk assessment framework developed and implemented to enable better assessment of outcome in terms of increased safety
• Develop better identification and support through MASH	• Began work towards developing Multi Agency Safeguarding Hub (MASH) which will include vulnerable adults. • Implementation date September 2013
• Increase staff awareness of issues of self neglect and how to respond.	• Self neglect protocol developed and agreed and disseminated across agencies. Panel to be set up linked to this and hoarding behaviour
• Evaluate advocacy service • Consider use of mental capacity advocacy service (IMCA)	• Evaluating use of advocacy service in safeguarding deferred due to re-tendering of the contract. • Use of the mental capacity advocacy service identified as

	low. To raise awareness across provider agencies through training workshops.
• Increase access to e-learning safer adults awareness training	• 168 social care staff completed training. • 138 social care staff have enrolled to complete the training.
Proportionality	
• Ensure that interventions are carried out in a way that is proportionate to the circumstances presenting and achieve the desired outcomes in the least intrusive way. • Develop and disseminate local guidance around deprivation of liberty and restraint	• Local guidance on deprivation of liberty developed and disseminated with joint working with the Hillingdon Hospital Trust to improve practice. • Safeguarding Team Managers review closures of SA processes to ensure appropriateness. • Reviewed the proportion of cases progressed are consistent with comparable Boroughs and representative of the community.
Partnership	
• Improve SAPB quality control through case audits and scrutiny of performance • Develop an outcomes framework to show what difference we are making	• Assessed SAPB functioning using ADASS outcomes framework • Improved access to real time performance data • Further work needed to evidence the level of positive outcomes.
• Ensure that lessons are learnt through cases, particularly SCRs	• Redrafted local Serious Case Review guidance • One case reviewed using SCR methodology
• Seek representation of the CCG and GPs as providers on the SAPB	• Representation on the Board from Clinical Commissioning Group (CCG) agreed and put in place. GPs a providers followed up through lead GP
Accountability	
•	• Each agency regularly reports to SAPB and through annual report on progress against objectives
	• Health SAAF reported to Board and actions updated on exception basis

2. GOVERNANCE AND ACCOUNTABILITY ARRANGEMENTS

The Safeguarding Adults Partnership Board is a multi-agency partnership comprising statutory, independent and charitable organisations with a stakeholder interest in safeguarding adults at risk. The Board aims to protect and promote individual human rights, independence and improved wellbeing, so that adults at risk stay safe and are at all times protected from abuse, neglect, discrimination, or poor treatment.

The role of the Board and its members is:

- To lead the strategic development of safeguarding adults work in the borough of Hillingdon.
- To agree resources for the delivery of the safeguarding strategic plan.
- To monitor and ensure the effectiveness of the sub-groups in delivering their work programmes and partner agencies in discharging their safeguarding responsibilities
- To ensure that arrangements across partnership agencies in Hillingdon are effective in providing a net of safety for vulnerable adults
- To act as champions for safeguarding issues across their own organisations, partners and the wider community, including effective arrangements within their own organisations
- To ensure best practice is consistently employed to improve outcomes for vulnerable adults.

Membership

Membership comprises all the main statutory agencies and voluntary groups who contribute to the safeguarding of vulnerable adults. A full list of members can be found at appendix 1.

Attendance at the Board was good during the year with CNWL Community Health, Hillingdon and Brompton Hospital and DASH and Council services all achieving 100%

75% attendees were Hillingdon Carers, London Fire Brigade, and Hillingdon Community Health.

50% attendees were Borough and Metropolitan Police, HR (LBH), Age UK and Adult Mental Health had 50% attendance

The Cabinet lead member for Adult Social services sits on the Board, as well as the Corporate Director, Social Services, Health and Housing

From April 2013 the Clinical Commissioning group (CCG) is represented on the SAPB by the Lead GP and the Executive Lead for Adults.

When the Government's intentions are clear with regard to the Care Bill, we will review and update the membership and terms of reference of the Board.

Independent chairman

Since November 2011 the SAPB has been chaired by an independent chair, who also chairs the LSCB. More local authorities are moving towards independent chairing, especially those who have returned to a combined

children and adult social care system. In March 2012 the SAPB agreed a protocol that set out the roles and responsibilities of the chair

Relationship to agency boards

There are links across to the Safer Hillingdon Partnership and Healthier Communities for Older People. Safeguarding also links to the Multi Agency Public Protection Arrangements (MAPPA) and the Multi Agency Risk Assessment Conference (MARAC) We have tried in this annual report to better reflect the partnership work in Hillingdon, and have asked the agencies represented on the SAPB to make their own direct contributions to this report. We asked about governance and contributions to safeguarding, along with training activity and these are included below. Actions planned within each agency are included in section 7.

Hillingdon Council

The Council is the lead agency for safeguarding adults**.** The Director of Adult Social Care (statutory DASS) sits on the Board and the annual report is presented to Council's Policy and Overview Committee and to Cabinet.

LB Hillingdon has a dedicated safeguarding adults' service that handles all allegations of abuse, working with adult services' teams and partner agencies. Each major partner has an appointed safeguarding lead manager or senior practitioner to link with LB Hillingdon on operational issues and to work jointly on investigations, where their expertise is needed. The partner leads also act as the champion for safeguarding adults in their organisations. In addition, the safeguarding service works closely with LBH's contracts inspection team, and with the Care Quality Commission (CQC).

LB Hillingdon in 2013 is reconfiguring the adult social care pathway to ensure unnecessary duplication and barriers to effective cross working are eliminated. For example, for adults with disabilities this has taken the form of an "all age" service that looks to smooth the transfers from childhood to adulthood. Similarly, with the service for older people, new ways of working seek to increase contact time with service users, provide more responsive, timely assessments and reviews and to offer better care solutions.

VOLUNTARY SECTOR

Voluntary Sector agencies are critical to our work, and are well represented on the Board.

Age UK Hillingdon

Internal governance arrangements in respect of adult safeguarding

Age UK Hillingdon is committed to the protection of vulnerable adults. The organisation has reviewed a range of policies and procedures to ensure that Safeguarding is given a high priority within the organisation and to provide its staff and volunteers with the confidence and knowledge to identify potential abuse and act on it appropriately:

These policies are included in the Staff Handbook, highlighted as part of the induction training of all staff and volunteers and reinforced through

safeguarding training. Safeguarding is a standing agenda item for staff and volunteer meetings and is included in our Supervision and Appraisal forms.

All trustees or senior managers involved in recruitment must have undergone Safer Recruitment training.

Main achievements 2012 - 2013

Age UK Hillingdon and Hillingdon Carers worked together to provide a support group for relatives of residents in care homes in Hillingdon (RRICHH). Volunteers recruited through RRICHH were trained to act as advocates for people living in care homes in the borough. The Black and Minority Ethnic Access Project run by Age UK Hillingdon has facilitated meetings with older members of the Black and minority communities to raise awareness of abuse and has supported individual victims to report abuse.

Age UK Hillingdon's Human Resources Manager has been an active member of the Safeguarding HR Sub Group.

Main Challenges/developments

500 volunteers and staff work for Age UK Hillingdon to support older people with the organisation and each volunteer will have training on safeguarding adults as part of their induction. Ideally they should each be provided with regular on-going training on safeguarding however it has been hard to access affordable training in this area. The organisation has therefore recently reviewed its policies and procedures and will raising awareness of these with all staff and volunteers so that there is a clear process for reporting abuse.

Disablement Association Hillingdon (DASH)

DASH is a disability charity and works with many vulnerable people on a daily basis. We have strong policies and procedures and have regular training to ensure that all staff are fully aware of the need to understand and follow the procedures.

We have advocates who work with people who are going through the safeguarding process to ensure that they are fully supported through the interviews and that their voices are heard.

We follow safer recruitment procedures and all staff and volunteers are CRB/DBS checked.

Through our direct payments work with the Council we also assist people employing Personal Assistants to follow safer recruitment procedures and CRB check the people they choose to employ.

With new procedures for DBS checking it will be more difficult in the coming year to ascertain at what level we can check our staff and volunteers. In the past everyone could be checked at enhanced level but as we are not involved in personal care this will be less clear cut particularly for our sports sessions. It is our intention to check at the highest level permitted but to ensure that we maintain our safer recruitment procedures to ensure we have full references and work history.

It is our intention to continue to educate the people we work with to ensure that they understand what safeguarding means and to expect high standards

from people who are working with them. We will also encourage them to raise concerns if they feel they are at risk.

Hillingdon Carers

Internal arrangements

During 2012-13 a review of internal arrangements has been commenced in response to changes arising from the Disclosure and Barring Service requirements. This has resulted in:

- Changes to safer recruitment arrangements to ensure levels of checking are appropriate in relation to employee roles;
- Review of processes in relation to recruitment and on- going checks for volunteers;
- Refinement of role descriptions and defining the scope of roles to ensure practice reflects current legal frameworks;
- Review of *Hillingdon Carers Safeguarding Vulnerable Adults Policy* to ensure the policy reflects Pan London policies and guidance.

Over the year 2012-13 Hillingdon Carers has continued:

- Specific inclusion of *safeguarding issues* in every staff supervision (including administrative staff responding to telephone and e-mail contact from our clients);
- *Regular training* for all staff/volunteers who have regular, unsupervised contact with children and/or vulnerable adults (one third of staff completed e-learning update during year);
- *Safeguarding prompts* on all assessment documentation/checklists for casework with young carers and adult carers supporting vulnerable adults;
- *Centralised record* includes referrals to local authority safeguarding team.

HEALTH AGENCIES

Health services remain in a state of change, with the move to Care Commissioning Groups led by GPs due from April 2013.

The Hillingdon Hospitals NHS Foundation Trust

Internal governance arrangements in respect of adult safeguarding

Safeguarding Adults arrangements at the hospitals have continued to strengthen during 2012/13. The Executive Director for safeguarding, who sits on the hospital Trust board oversees the annual work and audit programmes for safeguarding adults and progress against these is now reported to the Trust's Safeguarding Committee which reports to the Quality and Risk Committee (a board committee) on a quarterly basis. An annual report on safeguarding activity was presented to the Trust Board in August 2012.

The Trust has a multi agency Safeguarding Committee, which meets on a quarterly basis and covers both adults and children safeguarding work. This replaces the Safeguarding Adults Steering Group (SASG).The Committee is chaired by the Executive Director of the Patient Experience and Nursing.

The Self Assessment Assurance Framework (SAAF) is a tool devised by NHS London (NHSL) for organisations to assess themselves in terms of Safeguarding assurance. The SAAF is now cross-referenced with CQC Outcome 7 (regulation 11): 'Safeguarding people who use services from abuse'. The SAAF was validated at a multi-agency event chaired by NHSL in September 2012.

The Trust was also involved in the validation of the Learning Disability SAAF. The Trust section of the SAAF was validated.

Both of these tools provide the Trust with substantial assurance in terms of safeguarding governance; both Are reviewed bi-annually at the Safeguarding Committee . There is a strong working relationship with both Clinical and Information Governance at the Trust in relation to Safeguarding.

There is also regular attendance at the Hillingdon PREVENT Partnership Group.

The Hillingdon Hospitals NHS Foundation Trust's contribution to and achievements in improving safeguarding during 2012-2013

The Trust hosted the third 'Benchmark of Best Practice' workshop in April 2013. The event allows Trust staff to engage with service users and carers and with colleagues from local health, social care and voluntary sector organisations to benchmark our services for patients with a learning disability and for people who are vulnerable against the NHS London Benchmark of Best Practice tool. The most recent event was attended by nearly 100 people. The event focused primarily on the experiences of patients and service users accessing services at the Trust, including a multi agency case study on the care of a person with severe learning disability and very complex health needs and two people with autism talking about their condition. A summary on Dementia care at the Trust and the Equality Delivery System was also provided.

The Trust has been referenced again in March 2013 in the NHSL (now NHS England, London Branch) Pan-London Thematic review of the SAAF as an example of good practice, in relation to listening to and acting on user views.

The Trust 'Safeguarding Matters' newsletter for adults and children is sent to staff, on a regular basis.

In 2012/13, there was re-audit of staff knowledge and awareness of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The results indicated that more awareness sessions were needed for staff specifically on MCA and DoLS and to reiterate who to contact for advice and support.

There was also an audit conducted on Learning Disability awareness and of vulnerable patients focussing on how the Trust staff look after these patients in hospital. The results were positive; staff knew who to contact if there were concerns. There needs however, to be increased awareness and use of the patient passport.

Key challenges moving forward in 2012/13 include:

- The achievement of more than 80% compliance with Safeguarding Adults training.
- A greater understanding and embedding of MCA and DoLS

Central and North West London Health (CNWL)

CNWL NHS Foundation Trust CNWL is one of the largest trusts in the UK, caring for people with a wide range of physical and mental health needs. We provide healthcare to a third of London, Milton Keynes and parts of Kent, Surrey and Hampshire. Within the borough of Hillingdon, CNWL provides both mental health and community care services, (the latter is known as Hillingdon Community Health).

In relation to the community services provided in Hillingdon by CNWL:

Hillingdon Community Health

Governance arrangements in respect of adult safeguarding

In 2012, Hillingdon Community Health was able to declare full compliance with safeguarding responsibilities as outlined in Outcome 7 of the Care Quality Commission's Essential Standards of Quality and Safety.

The community division holds a quarterly safeguarding meeting, chaired by the Managing Director for Community Services, to review policies, results of audits, training plans, lessons learnt from safeguarding alerts as well as agreeing and overseeing the annual work plan.

Representatives from the community division also attends the Trust's Quarterly Safeguarding Committee which is chaired by the Board Level Safeguarding Lead - Executive Director of Operations and Partnerships.

As a key borough partner, there is Director level representation from the community division on the local Hillingdon Safeguarding Partnership Board with representation also on the sub-groups which support the Partnership Board.

Main Achievements 2012-13

During 2012/13, the community division completed the London-wide Safeguarding Adults Self Assessment Assurance Framework (SAAF). There was evidence to show good performance across all of the indicators with only two amber rated (Mental Capacity Assessment and PREVENT). Since the initial assessment, the community safeguarding lead has undertaken significant work in relation to both these areas and the division is now rated as "green."

During 2012/13, three detailed audits related to adult safeguarding were undertaken:

Learning Disabilities – this focused on the quality of care planning and evidence of reasonable adjustments being made for this vulnerable group. Overall, the results found that care planning was good with reasonable adjustments for individual patients identified. Recommendations were made around improving care plan review dates and a planned re-audit is scheduled

for 2013/14. This audit positively reflects the significant work which has been undertaken as a priority for the division during 2012/13 which comprised training for staff, development of further easy read literature and the designing of bespoke care planning tools for staff.

Dignity - this audit was undertaken to assess (from a patients perspective) whether they felt that they had been treated with dignity and respect. The audit showed a very positive outcome with patients feeling that they are listened to, respective and involved in decisions about their care.

CNWL Mental Heath Services

Introduction

Information about the areas the Trust serves, our internal governance arrangements for safeguarding children, updates on last years planned actions and plans for 2012/13, together with the revised approach to training is included in the CNWL Safeguarding Children Annual Report 2011/12. The link to this on the web is: http://www.cnwl.nhs.uk/Board_Directors_papers.html. The paper is listed under the Meeting of 11th July 2012.

Please see below the Mental Health and Allied Specialties contribution:

1. Main Achievements 2012/13 have been:

- **Establishing shared supervision arrangements**: Addiction Services have agreed times when safeguarding children cases can be presented to CSC workers for support and challenge.
- **Young Carers**: The CNWL Safeguarding Children's Advisor has worked with local partners to develop a training package for staff to raise awareness of young carers issues. CNWL has also established a Focus Group for Young Carers so that they can feedback their views on services and what improvements would make a difference to them. Hillingdon Young Carers have been present in this group.
- **Section 11 Audit**: The Trust completed a Section 11 Audit for Hillingdon and an evidence file documenting the supporting evidence of compliance was made available. Where further work was needed an action plan was developed and these actions have all been completed.
- **Supervision Audit across adult and CAMHS** – carried out by external auditors. This found all staff had been supervised with their CP cases in the previous month, the main learning point was the need to record the safeguarding children supervision on the electronic record, and to update the Supervision Policy so guidance was clear on this. **Safeguarding Helpline Audit**- showed that service in Hillingdon used this on a regular basis and there was a high level of awareness amongst staff on how to access support on safeguarding issues.
- **Attendance at safeguarding training including refresher training** – presently CNWL level of attendance on training is above 85% and the Trust is fully compliant with the David Nicholson DH requirements on this. CAMHS and staff who regularly see children received training on the CAF.

2. Main Challenges

We have identified some key challenges for the Trust in 2012/13:

- **Reviewing CAMHS**: Commissioners have been working with CAMHS to review the service and concerns remain within CAMHS about the level of funding and capacity to meet local needs. A Royal College of Psychiatrists review identified some areas to strengthen also potential gaps in commissioning.
- **The financial environment** and the impact on contracts with CNWL may mean that services have to reduce and may not meet the needs of children, the demand of families or the expectations of partner agencies.
- **Impact of the benefit changes** on families may result in moves of families where there are concerns and disrupt treatment packages, or risk being lost to the systems in new areas. The areas where families may move from to Hillingdon are likely to be managed by CNWL, so this risk is mitigated.
- **Establishing information systems to gather the information needed**, that is, to collect more outcome focused measures and qualitative data to assess the effectiveness of services, including linking adults and children in the IT system. Many of the IT systems do not currently support the collection of such information.

<u>Royal Brompton & Harefield NHS Foundation Trust</u>

Outline of Trusts Governance arrangements in respect of Adult Safeguarding.

The Trust has an Executive Safeguarding Lead that reports directly to the Trust Board and supports the Trust' Safeguarding Lead to:

- Deliver strategic objectives and lead across the service, supporting individuals and departments in their engagement in safeguarding cases and providing advise on safeguarding escalations and Investigations
- Work collaboratively with community health and social care partners, reporting and attending Local Safeguarding Partnership Board Meetings
- Prepare Trust-wide annual reports of safeguarding adults Activity and coordinating internal meetings. The Safeguarding steering group has merged with the newly established Mental Health and Safeguarding Committee where the safeguarding agenda is disseminated and there is an opportunity to allocate time for case reviews. This committee reports directly to the Governance and Safety Committee which selects items and takes them to the Risk and Safety Committee (a non-executive committee of the Trust Board)
- Ensure training content is in line with national guidelines and local requirements.

Furthermore the Trust has a local policy in line with national guidance that includes the Pan London Policy and Procedures, Prevent Strategy and Savile allegations requirements. The Policy outlines the referral process and roles and responsibilities of all staff.

Main achievements in 2012-13

Achieved 90% of the set target for safeguarding mandatory training. Continue to strengthen the training strategy for all areas of safeguarding: Level 2 "The referring manager Role" was commissioned and brought in-house from January 2013; Mental Capacity Act tailored "Understanding the legal use of restraint" training was set up to improve safeguarding measures and provide guidance and processes to govern the use of restriction and restraint and to understand the Mental capacity code of practice.

Launched the Prevent Strategy in line with government guidelines to address radicalisation and stop people becoming terrorists or supporting terrorism.

Completed the 2012 NHS Operating Framework for Adults at Risk (known as SAAF- Safeguarding Adults Assurance Framework). Received good outcomes.

Well established links with tissue viability which has made it possible to implement the pressure ulcer/safeguarding reporting protocol (designed by the K&C Safeguarding partnership board).

Main challenges/developments

Continue to develop and guidance and processes to govern the use of restriction and restraint in the context of safeguarding.

Ongoing work with regards to patient, users and carers involvement with regards to safeguarding. The following areas are still developing and need improving: collecting the evidence

Development of a Mental Health and Safeguarding board, platform to discuss serious case reviews.

Metropolitan Police

1. MPS governance regarding Safeguarding Adults at Risk is contained within:

1. **S.O.P. Investigations into Domestic Violence**
2. **S.O.P Investigations into Disability Hate Crime**
3. **S.O.P. Safeguarding Adults at Risk**

These policies introduce an enhanced and prioritised procedure for the investigation of Safeguarding Adults at Risk cases to create a framework for all staff to provide an effective, professional and corporate level of service. The MPS is keen to ensure that not only does it maintain its commitment to London's diverse population with regard to the investigation of Safeguarding Adults at Risk incidents but also that the organisation builds on the work developed since the establishment of Community Safety Units.

2. The Safeguarding Adults at Risk Unit (S.A.R.) based at West Drayton Police Station has worked throughout the 2012/13 period weekly if not daily with Hillingdon Adult Social Services (A.S.S.) on joint investigations , strategy

meetings and interventions as well as supplying A.S.S. with advice re referrals where necessary.

The most prominent investigation was the conviction of a member of staff for poisoning six dementia in a care home. This was a protracted complex investigation that resulted in three years imprisonment . The case was reported locally, nationally and reported on national television news.

A further focus visit by the Uxbridge Gazette highlighted the innovative work of the Safeguarding Adults at Risk Unit at West Drayton.

3. The retaining of the SAR unit under the new London Policing Model ,LPM which goes live on 24th of June 2013 in Hillingdon Borough.

4. 2013-14 ,The SAR unit retains functionality under LPM within the C.I.D. command based at Uxbridge Police Station with two dedicated Detective Constables

5. The CSU has conducted throughout 2012/13 training in care homes for staff and managers where flawed procedures have been identified .A further presentation for the other 30 CSU managers was held at New Scotland Yard highlighting the work and investigation techniques of the Hillingdon SAR Unit.

London Fire Brigade

1. Hillingdon Borough has 4 Fire Stations with 160 operational personnel. All of these have received internal training in Adult Safeguarding protocols and Child Safeguarding.

2. The London Fire Brigade has dedicated policies covering ‘adult safeguarding’ and a separate one for children and this details what to do and how to recognise the signs. It also explains the reporting mechanism and the timescales involved.

3. Over the last year local crews identified 5 ‘adult safeguarding’ cases and as far as I am aware all of these were known to social services. One child referral was sent through. Again, social services were aware of this family but there had been a deterioration in conditions since their last visit. Thus this identified to me that crews were correctly identifying some of the most vulnerable people in the community and that these had already been picked up on by social services and were being assisted.

4. Crews carried out 2647 ‘Home Fire Safety Visits’ across the borough last year. Although this is not directly linked to safeguarding, we are accessing some areas that some other partners are not. Through our visits we target those most at risk within the community.

5. We fitted 5 arson proof letter boxes to those that may have been at risk of an arson attack. This is work we do with social services or the police or internal departments. Some of these are where there has been a separation of the husband and wife and one has threatened the other with an arson attack.

6. We supplied two sets of flame retardant bedding to two individuals known to us.

7. We assisted the Police, local council and bailiffs with an eviction in March 2013. The person being evicted claimed that he would set light to his property if evicted and this could have endangered his neighbours. For this we were on hand to supply smoke alarms for the neighbours and supply some flame retardant bedding to the council to use for the person being evicted in his new property.

London Ambulance Service

The London Ambulance Service are not currently members of the Board, but have London wide identified various actions arising from the Winterbourne Review:

- Reviewing contracts, to make whistle blowing a condition of employment.
- Developing “Easy Read” complaints information.
- Exploring how best to collate and share safeguarding alerts from same location with LA.

All actions identified from the review will be monitored by the LAS Safeguarding Group and will be added to the LAS Safeguarding Adult Action plan.

Care Quality Commission

Safeguarding 2012- 2013

Background

The Care Quality Commission is the single, integrated regulator for health and adult social care in England to ensure care services are meeting government standards. This includes services provided by the NHS, local authorities, private provider companies and voluntary organisations – whether in hospitals, care homes or in people’s own homes. Part of CQC’s remit is also to protect the interests of people whose rights have been restricted under the Mental Health Act.

CQC Improvement Activities 2012-13

Over the last 12 months we have continued to improve our systems and process in response to lessons learnt from high profile cases. Significant development work has continued across CQC’s safeguarding systems and processes. This work includes;

- Revising and publishing our safeguarding protocol
- Development and implementation of safeguarding quality assurance systems
- Development of tools that allow us to improve the interrogation of safeguarding information

Completed all the safeguarding recommendations arising from the CQC Individual Management Review (IMR) arising from the preparation for the Serious Case Review into the events at Winterbourne View

Partnership Working

In our revised safeguarding protocol we have strengthened our commitment to develop working relationships with local safeguarding partnerships. We are committed to attend appropriate safeguarding strategy meetings and local safeguarding boards at least once a year to share regulatory information, promote the role of CQC in safeguarding or discuss a local or regional safeguarding matter. CQC meets with the safeguarding leads from the Association of Directors of Adult Social Services on a quarterly basis to share information and discuss regional and national safeguarding issues.

Winterbourne View

CQC has completed all the safeguarding recommendations arising from the CQC Individual Management Review arising from the preparation for the Serious Case Review into the events at Winterbourne View. We have already made significant changes to various areas of our work that includes ensuring that we are better placed to respond to concerns of whistleblowers in order to protect vulnerable people. Other changes relate to the way we follow-up on action plans when services aren't meeting national standards, build new ways to work with local safeguarding teams and develop the way we analyse safeguarding information so we can spot trends in care.

CQC is also contributor to the Department of Health Concordat – Programme of Action devised in response to Winterbourne View. The concordat commits a range of agencies and public bodies to a programme for change to transform health and care services and improve the quality of the care offered to children, young people and adults with learning disabilities or autism who have mental health conditions or behaviour that challenges to ensure better care outcomes for them.

Findings from Inspections

Our inspections of safeguarding (Outcome 7) in 2011/12 found that 90% of NHS hospital-based services and 89% of community services met the standard. We found that information-sharing in respect of safeguarding needs improvement in NHS services – there can sometimes be a lack of clarity about responsibilities and procedures, so that some cases are not referred to local authority safeguarding teams where it would have been appropriate to do so. NHS mental health, learning disability and substance misuse services performed less well than other NHS services.

Some independent healthcare services performed fairly well in 2011/12 in respect of safeguarding people from abuse – of those CQC inspected, 90% of independent hospitals and community services met the standard in

the year However, this was not replicated in independent mental health, learning disability and substance misuse services – here 73% of the services inspected met the standard.

There were less positive findings in relation to safeguarding in nursing homes and residential care homes. Of the locations inspected, 83% of nursing homes and 88% of care homes met the standards in 2011/12.

In the first dental care inspections 93% of dental services inspected met the standards on safeguarding and safety. Overall inspectors found good

awareness of child protection issues but providers understanding of safeguarding vulnerable adults were patchy.

NB. This report presents the national picture. Discussions are underway locally to discuss how CQC local work can be represented.

Financial arrangements

The Coalition Government has indicated in the draft health and social care (now Care) Bill that they intend to put Adult Safeguarding Boards on a statutory footing. Depending on the statutory scope of the SAPB's work this may have financial implications for LB Hillingdon and partners in needing to support the work of a new Board. Currently the commitment of partner agencies is through officer time and some designated posts. However, LB Hillingdon's adults and children's Boards working with each other have enabled efficient use of existing resources.

Sub groups

Most activities relating to the SAPB business plan have been led by the Service Manager supported by sub groups, mainly established in 2012. Human resources (joint with LSCB)

- Policy and performance
- Learning and Development
- Serious case Review sub group (ad hoc as required)
- Financial Exploitation (short life group commenced in 2013)
- Winterbourne sub group (short life group commenced 2013)

Terms of reference for sub groups are included as an appendix to this report.

3. LEARNING FROM CASE REVIEWS AND AUDITS

Serious Case Reviews (SCRs)

LB Hillingdon had no serious case reviews in 2012-13. National evidence showed some lack of consistency in use of criteria and methodology, so the SAPB reviewed and updated local procedure and guidance in line with recommendations from ADASS and in accordance with the draft requirements of the care and support Bill

The Board did carry out one case review, using the SCR methodology. This review was completed in summer 2013 and concerned a person with varying capacity about whom professionals could not agree about their degree of competence

Those who carried out the review agreed that this sort of situation presented huge challenges for professionals in terms of assessing capacity and risk and that the recommendations and plan should form a substantial element of the SAPB work plan for 2013-14,

In addition to individual agency recommendations, the multi agency recommendations were:

- Raise awareness of Mental Capacity Act; how and when to use, clarification of when a 'best interests' meeting is appropriate and risk management of people with varying capacity. Assessment to include risk of fire in the home (working smoke alarm/home living environment/cooking habits).
- Have in place agreed thresholds for review of care plan for somebody with fluctuating capacity. Ensure robust risk assessment tools are in place to identify risks and to be clear what strategies are put in place to address risk and what monitoring of that risk is in place.
- Improve discharge planning process for people with complex needs and varying capacity including consistency in assessment of decision specific capacity. To specifically address in respect of multi agency working and information sharing
- Maximise the effectiveness of the integrated care pilot for people with complex needs and varying capacity.
- Ensure staff and front line managers are aware of decision making process contained in the London SA procedures concerning when to refer to the safeguarding team.
- Ensure all available community safety options are included in all assessments, where appropriate.

A management review in respect of another case was carried out in spring 2012. The review involved a family with children where a parent had a mental illness, and was a joint review by Hillingdon Council and CNWL. The following key learning points were identified:

- The need to refresh and reactivate the existing inter-agency protocol between Mental Heath services and Children & Families Service,

particularly the need for professionals to meet and develop a fully multi agency assessment of need, and an understanding of language used in case planning across the two agencies

- The need to ensure that staff in both services are able to take account of the impact of actions on children and adults in a family.
- The need to improve management oversight in order to ensure that the two actions above could be implemented

Safeguarding Adults Team has worked to improve links with the Central NW Mental Health Foundation Trust and each mental health unit has a designated safeguarding lead. Workshops have been set up with mental health managers and front line workers to focus on safeguarding issues and how our services work with each other using the London multi agency safeguarding procedures. Referrals from Mental Health Services have increased.

4. WORKFORCE

Whilst safeguarding adults is the responsibility of all staff, the Safeguarding Adults' team is responsible for investigating and managing reports of abuse, except where a criminal offence is believed to have occurred where the Police take the lead. In the LB Hillingdon Safeguarding Adults' team there are currently 12 qualified social workers (10. 5 full time equivalents) with close management oversight, signing off each stage of the safeguarding process. Partner agencies have also strengthened their response to safeguarding adults through safeguarding lead posts, either as a specific responsibility or as a part of their existing responsibilities. This has helped to create a network of staff across Hillingdon to lead in this area of work.

There is an e-learning module on safeguarding adults' awareness available to all relevant agencies. 168 social care staff have completed this module and 138 have registered to access this learning module.

Understanding mental capacity and working within the code of practice of the Mental Capacity Act 2005 is an important aspect of safeguarding the adults we work with, whilst maximising their choice and independence. Training for front line staff was completed by 102 staff over four sessions and 23 managers were provided with training to promote good practice in capacity assessments.

Training activity across agencies

The Hillingdon Hospitals NHS Foundation Trust

Safeguarding Lead, (which included a presentation at Level 1 mandatory training in Vulnerable Adults is delivered monthly with an additional 30 minute awareness session on Learning Disability. In addition, monthly training at level 1 is delivered to all new starters to the Trust. Bespoke sessions are also arranged. Specific presentations for MCA and DoLS have also been delivered by the Medical the surgical audit meeting) and by the Psychiatric Liaison Consultants based at Riverside. A domestic violence session has been delivered to Trust staff by Hestia.

CNWL – HCH

A Safe and Effective Workforce

All HCH staff who may potentially have contact with clients at risk attend Hillingdon's safeguarding adults in-house, mandatory training programme. Sessions are offered at least once every month. Compliance with attendance on this mandatory training programme, including refresher training, is monitored monthly and has been consistently high between 86-95% throughout the year as shown below:

Training Level	Summary of Course	Audience	Trainer	Compliance
Investigators Training	This is a higher level course aimed at staff who may be asked to take a part in safeguarding adults' investigations.	Safeguarding adults team	Social Services	100% completed
Level 2	Referrers training. This is to ensure that anyone working closely with the public can identify adult abuse and will be confident to refer an adult to safeguarding.	All clinical staff	HCH's Safeguarding Adults Team	85% completed
Level 1	Alerters' training. This is to raise awareness about abuse of vulnerable adults. The training gives direction to staff on what signs to look for and who to tell if they identify abuse.	All clerical staff	HCH's Safeguarding Adults Team	97% completed

Between April 2012 and April 2013 70 admin attended Level 1 alerters' training, and 199 clinicians attended level 2 Referrers training.

The community safeguarding adults' team delivers training for Mental Capacity Assessment to all staff. There were 4 sessions during 2012/13; the team has given dedicated MCA and Deprivation of Liberty Standards (DoLS) training to staff working at the Northwood and Pinner Intermediate Care Unit, also the community matrons. The safeguarding adults' team also attends team meetings and discuss safeguarding adults' case studies with the teams; these case studies always include mental capacity.

In line with Trust Policy, all staff working with vulnerable adults have enhanced Criminal Records Bureau Checks undertaken before being allowed to commence in post; this is closely monitored via the Human Resources Department and the division is fully compliant in this area.

HCH Training – this audit was conducted over a 6 month period to assess the effectiveness of training delivered by the safeguarding adults team. The audit was conducted anonymously over a 6 month period. The results were positive with staff feeling that the training met their needs and was geared to their work place. Comments received from some returns have been incorporated into the new training plan for 2013/14.

Brompton and Harefield

The Trust delivers level **1 "Raising *Awareness"*** which focuses on developing a shared understanding with what is abuse and what constitutes an adult at risk; an understanding of the signs and symptoms of abuse. Also what to do if you witness abuse or are told about it. **Level 2 "*The Referring***

***Manager Role"*, focusing on dealing with disclosures for those who need to complete the alert form as part of their professional role; determining risk, vulnerability and seriousness; examining the implications of the three 'C's – capacity, consent and confidentiality and to understand dignity and respect when working with individuals.

Level 1 is provided through corporate induction sessions and as classroom training and level 2 is provided as classroom training only.

Furthermore we have now developed an in-house e-learning tool, mainly used by the medical teams but opened to all trust staff.

The figures below show training for the period 1/4/12 to 31/3/13
684 people received SGA training of which;
331 Level 1- Induction
337 Level 1- classroom
36 Level 2- classroom
By staff group:
Level 1: Nurses 263, Doctors 83, Other Clinical 193, Non-clinical 109
Level 2: Nurses 27, Doctors 1, Other Clinical 5, Non-Clinical 4
This represents 90% of the set target of 726.

Prevent Strategy training: 13

Age UK

Safeguarding Training 2012-13

The following training has been completed by our staff and volunteers, where appropriate:

- DBS - Duty to Refer
- Safeguarding Adults – e-learning
- Safer Recruitment
- Safeguarding Policy
- DBS – Counter signatory Training

Hillingdon Carers

Hillingdon Carers has continued to contribute to raising awareness of the need to safeguard vulnerable adults and helping the general public report abuse and access support services by:

- Maintaining a *'Report Abuse' prompt* on the home page of Hillingdon Carers website www.hillingdoncarers.org.uk throughout the year;
- Displaying posters from the *Safeguarding Vulnerable Adults campaign* in the Carers Advice Centre in Uxbridge High Street;
- Including *safeguarding issues* in all Carer Awareness sessions delivered to professionals (34 sessions in 2012-13);
- Making a presentation to the joint LSCB-SAPB meeting in March 2013 to raise awareness to a multi-agency audience of *potential*

safeguarding issues related to Young Carers and the family members they support.

- Inviting a safeguarding lead from Hillingdon Community Health to attend two events for carers in primary care venues in the north of the borough during 2012-13.

5. HOW WE ARE DOING: effectiveness of local safeguarding

How the SAPB monitors local safeguarding arrangements

The SAPB uses a variety of information to assess the effectiveness of local safeguarding arrangements. These include annual returns, inspection reports, and quality audits. During 2012-13 we were able to receive improved performance information based on the annual safeguarding adult returns submitted to the Department of Health. The focus will include more outcome data to ensure intervention is effective.

Effectiveness of local arrangements to safeguard adults

Performance information

Key Information - Safeguarding Performance.

LB Hillingdon provides an annual return to the Department of Health on safeguarding adults' activity. The highlights from these returns for 2012-13 are presented below with commentary and comparison with 2011-12. Percentages, where quoted, are rounded up or down.

Referrals

Alerts	Referrals	Repeat referrals	Completed referrals
825	523	68	538

Alerts are safeguarding contacts made to LBH that do not progress further under SA procedures and referrals are contacts made that do progress. Repeat referrals are where a previous contact has been made and progressed in the same year and completed referrals are those progressed that have been completed in the year, although some may have started in the previous counting year e.g. March 2012.

Alerts and referrals amount to 1,348 which is up 7% on last year. The percentage progressed under SA procedures remained about the same although the total is up on last year. Repeat referrals are low, which is a good indication that SA concerns are being dealt with first time. Despite the increase of total SA contacts, the percentage of completed referrals has increased slightly to 40%. Existing staffing resources have managed this increase in activity.

The gender of contacts remains consistent with last year. Around 60% of contacts are for women and 40% for men. The number of women alleged victims of abuse increases with age. In the 18-64 years group it is 51% and in the 75 years plus group it is 71%.

Ethnicity of Contacts

Alerts	White	Non-white	Referrals	White	Non-white
786 (ethnicity recorded)	79%	21%	522 (ethnicity recorded)	79%	21%

These figures are little changed from 2011-12. Release of the National Census figures for ethnicity profiled by Borough and age indicate, in the 65 years plus age group, 84% are white and 16% are non-white. Two thirds of contacts concerning safeguarding adults relate to people over 65 years old, so the profile seems reasonably matched to the Borough profile. The contacts relating to ethnic minority groups that progress to a referral remains consistent, indicating the screening process does not unintentionally disadvantage people.

Main source of Referral

Social Care staff	Health Care staff	Self/Family and Public
33%	19%	21%

Compared with last year there has been a slight increase from 30% to 33% in social care staff reporting abuse, a 6% decline in health staff and the self/family/public percentage has remained steady at 21%.

Nature of Alleged Abuse

Physical	Sexual	Emo/Psych	Financial	Neglect	Discrim	Institut
28%	6%	17%	26%	22%	0%	2%

Compared with last year's figures there has been little change with a small increases in sexual and psychological abuse by 2% in each category, a 3% increase in financial abuse and physical abuse and neglect remaining exactly the same.

Location of alleged abuse

Own Home	Care Home setting	Supported accomm setting
55%	19%	7%

The number of people allegedly abused in their own home has decreased slightly from 61% to 55% compared with last year. It is difficult to know if this is good news, being an overall drop in this setting (a difficult area to monitor) or whether the drop is due to non-reporting. Care Home settings are down from 21% to 19% although supported accommodation is up by 3% representing the growth in this type of service option.

Main Perpetrator categories

Strangers/unknown	Social Care staff	Partner/Family Member	Neighbour /Friend
18%	15%	34%	10%

As in previous years, the highest category of perpetrator is someone already known to the person at risk with family, partner, neighbour and friend accounting for 44% of referrals. This is down by 5% on last year. The next category is social care staff 15% of which the majority are domiciliary care staff. This would be in keeping with the large volume of social care provision consisting of domestic support to people in their homes. Abuse from strangers or people unknown constitutes 18% of referrals. The remaining 23% are other professionals, other service users or health care staff.

Case conclusion

Substantiated	Partly substantiated	Not substantiated	Inconclusive
31%	6%	44%	19%

The overall number of cases reaching a conclusion has increased from 478 to 531, an increase of 10%, The percentage substantiated has gone up by 2%, partially substantiated by 5% and there has been a decrease in not substantiated by 9%. Inconclusive has risen slightly by 2%. Overall, this trend is pleasing as the service is being increasingly challenged, whether by individuals or social care providers on the validity of evidence to support our conclusions. This would indicate our investigations are robust.

Outcomes

In the majority of cases there is “no further action” which is slightly misleading as it implies nothing has been done when, in fact, the circumstances of the individual might have been put “back on track” and existing support refocused. The next largest category is increased support (26%) followed by a cluster of categories such as removal to another setting, different care arrangements or arrangements to manage the person’s finances. Currently, acceptance of the protection plan, that is the arrangements made with the person to prevent future harm, is a rather crude measure of outcome. 46% of people accepted their protection plan arrangements, which is low. Some of this is due to lack of mental capacity but also it must represent a significant number who have capacity and choose to remain in circumstances we would consider risky. Changes in the annual returns for 2013-14 will have more focus on outcomes with a new requirement to determine if SA action has lead to risk reduction or not. Also, there will be a category to indicate where a SA investigation ceased at the request of the individual concerned.

Comparison with other Local Authorities

The Health and Social Care Information Centre publish a report for LB Hillingdon, comparing our performance with other Local Authorities with a similar profile (our “comparator group”) and comparing with safeguarding performance with the figures for England. The comparator report for 2012-13 has not been finalised in time for use in the annual report so reporting is restricted to comments on emerging themes from the report.

- Alerts and referrals for LB Hillingdon are higher than our comparator group indicating a good level of awareness of safeguarding adults in the community.

- Repeat referrals as a percentage of all referrals are lower than our comparator group indicating safeguarding concerns are resolved first time.
- Despite an increase in safeguarding activity, there are a higher number of completed referrals as a percentage of all referrals than our comparator group indicating partners are reaching a resolution of the safeguarding concern.
- Referrals from the public are higher than our comparator group indicating good community awareness of safeguarding adults at risk
- The percentage of abuse falling within the “inconclusive / not determined” category is lower than our comparator group indicating better decision making and recording processes.

There are indications of improvement needed in ensuring basic information on primary client group and ethnicity is recorded and up to date. Also, acceptance of protection plans to ensure future protection of the person abused is lower than our comparator group. This data will change for 2013-14 to allow recording of acceptance by a carer or other person if the victim of abuse lacks capacity to accept the plan themselves. It is anticipated the figures will then improve.

Mental Capacity Act and Deprivation of Liberty

Responsibility now rests with to the Local Authority as the sole Supervisory Body. There are currently 7 Best Interests Assessors and the work of the Supervisory Body is overseen by the Service Manager for safeguarding adults, with support from a Senior Practitioner and Administrative Officer.

The number of applications for a deprivation of liberty remains low for the period April 2012 to date. In all there have been 9 requests for a standard authorisation, 5 cases from Hospital and 4 cases from Care Homes. In 4 of the Hospital cases they were not granted, the circumstances not meeting the statutory criteria. The one case where it was granted related to a person who was placed on the mental health unit where deprivation of liberty safeguards were deemed the more appropriate route rather than detention under the Mental Health Act.

In relation to Care Homes, 3 requests were not granted as either the best interests assessment criteria were not met and alternative, less restrictive options could be used or, the circumstances did not amount to a deprivation of liberty but a reasonable and lawful restriction. Of the 2 granted, in both cases representation for the person was arranged.

LB Hillingdon has robust monitoring of registered Care Homes and the Inspection staff are well aware of circumstances that could be seen as a deprivation. Care Homes and Hospitals are the settings where deprivation of liberty safeguards apply. Therefore we are reasonably confident there are not circumstances where people are being unlawfully deprived of their liberty. However, as part of the learning from WBV (see paragraph 13 above) there is a focus on ensuring reviews consider if the circumstances of care could be considered a deprivation of a person’s liberty. All adult social care staff have

received additional training in this area, funded through the specific mental capacity grant money.

The NHS SAAF indicated amber for mental capacity assessments and deprivation of liberty applications. It was felt that staff, generally, were un confident in this area, and this was confirmed by case review. Of particular difficulty are cases where capacity seems to vary and fluctuate over time. Recommendations from the case review have been incorporated into our action plan for 2013-14

Outcomes of audits and Inspections

The safeguarding adults at risk service works closely with their colleagues in the inspection team of LB Hillingdon. The role of this team is to monitor the service provision and quality of care of those providers contracted to the LB Hillingdon. The team undertakes reviews of services, including unannounced inspections, and ensures the provider is working to good standards of care and is contract compliant. Monthly reports on service providers are submitted to LB Hillingdon's senior management team and contract monitoring meetings are held with the service providers themselves.

In 2012/13 the team made 97 visits to registered care home where LB Hillingdon has placed people. The outcome of visits and any recommendations arising are recorded with subsequent tracking of individual care homes to ensure recommendations are actioned by them. Similarly, complaints about social care providers are tracked and followed up. In this way the team can build up a picture of how individual care providers are meeting the needs of those people who are in their care. The team are working on new ways to collate overall performance of social care providers contracted to LB Hillingdon.

The team are particularly important in monitoring required improvements for settings where there have been safeguarding concerns and in linking with colleagues in the Care Quality Commission (CQC) on the regulatory standards providers must comply with. Recent joint action involving the police, CQC, our inspection team and the safeguarding adult team concerned a domiciliary care agency and resulted in a prosecution.

Personalisation

Personalisation is centred on putting the individual and their family in control of their care and support enabling them as far as is practicable to make their own choices and manage their care and support as they would wish to for themselves. A significant part of personalisation is the provision of personal budgets; funds which the individual and their family can manage and spend to provide for their care and support needs. Personal budgets are at the heart of transformation of adult social care. The aim is not only to provide funds via personal budgets but assistance to manage funds and working with providers and the voluntary sector to build alternative support services so that service users have more choice, opportunities and can be more innovative on how their needs can be met. There is a move away from traditional, social care providers to a broader range of provision, some of which may fall outside current regulated services, for example the employment of personal assistants and small voluntary groups to meet care needs. This has posed a challenge

as to how the existing framework of safeguarding will ensure the safety and protection of vulnerable adults within this new context of greater choice, individual control and proportionate risk enablement. For the year 2012-13 69.7% of eligible service users were in receipt of a personal budget. Risk enablement is an integral part of the support planning process for these service users seeking to make their own support arrangements. Risk enablement guidelines and processes have been introduced and these have been covered as part of a wider self directed support training programme. This has not impacted on safeguarding adults at risk. The service will continue to monitor the situation and advise the SAPB accordingly. To date there is no indication of a disproportionate number of SDS referrals being made to the safeguarding team.

Feedback from staff

In May 2012 17 staff and managers from across agencies attended a half day workshop. It was an interactive day that focused on the SAPB priorities, and on messages from Serious case Reviews across London. The aim was to incorporate views of front line staff into SAPB planning.

Those attending supported the main priorities of the SAPB and identified the following areas for action:

- A need for more training and awareness across agencies, particularly in respect of mental capacity and deprivation of liberty. In response, sessions were set up for all front line staff to receive training in mental capacity and to be aware of potential deprivation of liberty circumstances. Work has also taken place across partners in this area e.g. Hillingdon Hospital Trust have strengthened their protocol.
- Use of cases, case audits and case examples to inform and improve practice. Adult Social Care have introduced a quality assurance framework that includes case file audits which is now embedded in normal supervisory practice and can be collated to identify strengths and weaknesses in practice.
- A need to improve partnership working and information exchange –with Police, CPS, care providers. This is being addressed through the development of the Multi-Agency Safeguarding Hub (MASH) which enables better sharing of intelligence about safeguarding both children and adults at risk.
- The need to be able to use inspection and monitoring of care providers to drive up standards. The LB Hillingdon Inspection team works closely with the safeguarding adults' service and has developed a risk matrix that collates concerns about care providers, thus enabling them to focus their inspections on particular areas where providers are not meeting proper standards of care. In the future the client data system will also support this work through enabling recording and reporting of safeguarding concerns about organisations providing care.
- Better support services, particularly in respect of mental health and support for carers. There have been recent developments to improve

advocacy services with the re-tendering of the service and greater focus on outreach support to adults at risk living in the community.

Some staff also identified trigger points when things could go wrong – particularly at point of movement -e.g. discharge from hospital, change of placement.

Staff welcomed the opportunity to engage with the Board and wanted more interactive days and more communication from and to the SAPB

Effectiveness of the SAPB

The peer review framework for safeguarding adults at risk, as used by the LGA, has been adopted by the SAPB as its outcome framework. This will mean the Board, through the performance and policy sub group, reviewing each of the themes within the framework to measure and improve LB Hillingdon's performance in safeguarding. Two themes have already been reviewed; outcomes and people's experiences of the safeguarding process and a paper on this was presented to the June 2013 Board. Subject to confirmation of the Board, there are areas that need strengthening, for example how we link with the wider community safety agenda involving the anti-social behaviour team, trading standards and domestic violence. Also, what work is undertaken with perpetrators, where this is appropriate, to change their behaviour.

The SAB independent chairs have developed a quality assurance tool for SABs and this will be considered and adapted for the Hillingdon SAPB in consultation with Board members.

Overall effectiveness

The information we have gives reassurance that the multi agency system to safeguard adults in Hillingdon is working well. There is strong multi agency commitment through the SAPB and evidenced by the information provided in this report. Our performance figures are broadly in line with comparator authorities, and, where they are not, in the case of high numbers of alerts, action has been taken to address the issue. Performance figures overall indicate high levels of awareness and robust response to safeguarding concerns

The dedicated investigation team ensures that concerns can be responded to promptly and effectively and has been quoted as an example of good practice London wide.

The progress of work across London and nationwide is ensuring that agencies are working within a context of sound practice and guidance, thus ensuring greater consistency and higher standards of care. In this context the SAPB has developed further local guidance and procedures to ensure robustness of response to concerns.

Hillingdon is compliant with the initial review requirements from the Winterbourne Review and the SAPB is developing ways to monitor progress against the recommendations contained in the Francis Report.

We are well placed to comply with any requirements arising from the Care Bill and are looking to further develop our work in 2013-14 to use information from

risk assessments to assess the effectiveness of the safeguarding response to concerns.

6. NATIONAL AND LOCAL CONTEXT: implications for safeguarding

Government policy

The statement of the 16th of May 2011 of Government policy on adult safeguarding by the DH made clear that the "No Secrets" statutory guidance would remain in place until at least 2013. The principles within the statement were building on this guidance, reflecting what had come out of the national consultation process. They made clear that the Government's role was to provide the vision and direction on safeguarding, ensuring the legal framework, including powers and duties, is clear and proportionate, whilst allowing local flexibility. Safeguarding is seen as everyone's business encouraging local autonomy and leadership in moving to a less risk adverse way of working, focusing more on outcomes instead of compliance.

The Government set out six principles by which local safeguarding arrangements should be judged.

- Empowerment – presumption of person lead decisions and informed consent.
- Protection – Support and representation for those in greatest need.
- Prevention – It is better to take action before harm occurs.
- Proportionality – Proportionate and least intrusive response appropriate to the risk presented.
- Partnership – Local solutions through services working with their communities.
- Accountability – Accountability and transparency in delivering safeguarding.

The coalition Government refreshed these principles with a further statement on the 10th of May 2013 which drew on safeguarding national events since 2011. It placed the following emphasis on local safeguarding activity

- Collaborative working to improve outcomes and avoidance of duplication
- Providers' core responsibilities to ensure safe, effective and high quality services
- Work collectively to respond appropriately to safeguarding concerns as well as those concerns that relate more to service standards.
- Ensure commissioned services are of a high quality and arrangements are robust for responding to concerns.

The statement retained the principles outlined above but wanted more emphasis on prevention and proportionate response to concerns.

The Care Bill

The Government has accepted the recommendation of the Law Commission in making SAPBs statutory. The Care Bill being progressed through

Parliament outlines proposed changes for safeguarding adults. These included:

- Confirming Local Authorities as having the lead co-ordinating responsibility for safeguarding adults at risk.
- Placing a duty on Local Authorities to investigate or cause an investigation to be made by other agencies in individual cases.
- Local Authorities will have the power to request co-operation and assistance from designated bodies during adult protection matters and the requested body will have to give due consideration to the request.
- There will be a new definition of an adult at risk which may broaden those adults considered at risk.
- The functions of the SAPB will be defined in statute.
- Section 47 of the National Assistance Act 1948 will be repealed as incompatible with the European Convention on Human Rights.

Depending on the statutory scope of the SAPB's work and requirements placed on the Local Authority, there will be financial implications for LB Hillingdon and partners in needing to support the work of a new Board. Currently the commitment of partner agencies is through officer time and some designated posts. However, LB Hillingdon's adults and children's Boards working with each other has enabled efficient use of existing resources. Despite this, it is noted that administrative gaps do emerge with the need, for example, to take forward the work of the Winterbourne View Hospital review outcomes

NHS changes

The NHS continues to evolve and by the end of 2012-13 the local cluster groups were replaced by GP led Clinical Commissioning Groups (CCGs) . In Clinical Commissioning Groups (CCGs) taking over their responsibilities, there was an assurance process required of them by the NHS Commissioning Board which includes reference in several parts to safeguarding, both children and adults. E.g. "Clear line of accountability for safeguarding is reflected in CCG governance arrangements" and the CCG "has arrangements in place to co-operate with the local authority in the operation of the LSCB and SAB." The respective Boards worked with the CCGs on the assurance process which has been completed and usefully defines the expectations on our new Health partners. A related change also occurred in April 2013 when the former Hillingdon PCT handed over their Supervisory Body functions under the Mental Capacity Act / Deprivation of Liberty Safeguards to the Local Authority. LB Hillingdon was in the fortunate position of operating a joint Supervisory Body with the PCT prior to this transfer and there was no significant impact. A small Central Government grant to facilitate this change meant there are also no financial implications.

Winterbourne View and the Francis Report

The scandal of Winterbourne View (WBV) Hospital has been prominent with the conviction of the perpetrators of abuse at this private Hospital for people with learning disabilities and autism, run by Castlebeck. The convictions in

August 2012 enabled the release of the Serious Case Review (SCR) by Gloucester Social Services and on the 10th of December 2012, the publication of the Government's report into Winterbourne View. The SAPB has already been briefed on the recommendations arising and reviewed the ADASS compendium of recommendations which draws together the number of reports published on WBV.

LB Hillingdon and partners' response to WBV has been to set up a sub-group of the SAPB, linked in to the Learning Disabilities Partnership Board and reporting to both Boards. An Action Plan, based on the Department of Health's final report recommendations and the LGA "stock take" of WBV actions, issued recently, has been drafted and was discussed at the SAPB in June 2013. LB Hillingdon and partners are compliant in meeting the immediate and critical deadline of June 2013 for reviewing all Learning Disability service users placed in assessment and treatment facilities commissioned by Health.

The SAPB are also looking at the outcomes from the Francis Report into the neglect of patients at the Mid-Staffordshire Hospital, with a presentation by the Hillingdon Hospital Trust at the joint LSCB and SAPB slot in June.

Local developments

The London multi-agency safeguarding adults at risk policies and procedures are now implemented in all London Boroughs underpinned by practitioner's guidance. The policy and procedures introduces a consistent framework by which adults are safeguarded. It means having consistent definitions of roles and responsibilities, timescales for responding and promotes better partnership working and in particular, cross boundary working. There have been no financial implications for LB Hillingdon. These policies and procedures are being reviewed across London, in the light of some partner changes e.g. Health, and there will be some minor amendments to the procedures. There are no planned major changes in the way safeguarding adults operate across London until the final outcome of the Care Bill. As indicated earlier in this report some reconfiguring of the adult care pathways

Will take place in 2013-14 to improve multi agency working and reduce duplication

Multi-Agency Safeguarding Hub [MASH]

The MASH model is a national multi-agency initiative to provide information sharing arrangements across all agencies involved in safeguarding children. Those involved are employed by their respective agency i.e. police, health and local authority and located in one office.

Hillingdon have signed up to developing the MASH model at the point of referral within Children's Social Care. Hillingdon have further committed to managing Adult Safeguarding referrals using the MASH model. In doing so they would be one of the first London Borough to achieve this duel role.

A MASH Operational Delivery Group has been set up and taken responsibility to deliver Hillingdon's MASH by end of September 2013. The group includes representatives of all the key agencies involved in safeguarding

7. WHAT WE NEED TO DO: priorities for SAPB 2012 onwards

Performance activity, local and national learning, plus consultations with staff and partners, has indicated that our priorities are the right ones. We have reframed these for 2013-14 in line with the ADASS standards for safeguarding and performance. They are detailed below with our planned activities identified under each one.

There is a challenging work programme for 2013-14 but the Board wishes to give particular priority to obtaining users views and outcomes of interventions, and in supporting staff to work with people of varying and uncertain capacity

Priorities 1,2: Outcomes, People's experiences of safeguarding

- Ensure decisions are person led
- Ensure outcomes are assessed and measured

Priorities 3,4,5: Leadership Strategy and Commissioning

- Oversee implementation of recommendations from the Winterbourne Report and CQC review of learning disability services
- Oversee implementation of recommendations of the Francis report

Priority 6: Service Delivery and Effective practice

- Continue to ensure that policies and procedures are embedded in practice
- Improve awareness and response to abuse and exploitation by financial means
- Increase staff awareness of issues of self neglect/hoarding and how to respond
- Improve response to allegations of financial abuse
- Develop better ways of assessing risk across partner agencies
- Develop better identification and support of vulnerable adults through MASH
- Ensure effectiveness of staff training and recruitment processes

Priority 7: Performance and resource management

- Develop and disseminate local guidance regarding mental capacity and Deprivation of Liberty

Priority 8: Local Safeguarding Board

- Ensure effective working relationships with new Health agencies and the Health and Wellbeing Board
- Improve effectiveness of the SAPB quality assurance processes
- Implement learning from case reviews
- Ensure SAPB meets the requirements of Government regulation and guidance

Individual agency plans

Age UK

Key Plans for 2013-14

- Keep up to date with new developments in Safeguarding and Disclosure and Barring.
- Add information on safeguarding adults to our website.

Hillingdon Carers

A continued focus on safeguarding will be reflected in:

Carers Conference 2013 – a key note presentation will cover issues arising from mental capacity, Power of Attorney, confidentiality and consent. (The Carers Conference is an annual event organised by Hillingdon Carers in partnership with three voluntary sector and two statutory organisations);

Carers Fair 2013 in Mall Pavilions Shopping Centre Uxbridge will involve over 40 organisations and provide an opportunity for promotion and highlighting of safeguarding messages by statutory and voluntary sector partners within a community event.

Young Carers Plus – a new service for young carers of parent or parents with mental ill health in the south of the borough will provide new opportunities to identify and support families where there is a risk that safeguarding could become an issue.

The Hillingdon Hospital

To increase awareness and confidence for staff in using the MCA by increased training and the use of Trust MCA forms. Re-audit on the application of the MCA and understanding and care of Learning Disability patients will take place. There will be implementation of a Vulnerable Adults section divider to be placed in the patients medical notes. The Safeguarding Adults policy will be reviewed in addition to the SAAF review.

Brompton and Harefield

Identify key plans for 2013-14:

- To continue to deliver safeguarding leadership, training and guidance to strengthen processes and procedures in line with government and local guidance including the Prevent Strategy.
- To develop specific guidance to govern the use of restriction and restraint.
- To improve current work with regards to patient, users and carers involvement with regards to safeguarding.
- To learn from serious case reviews.

CNWL HCH Proposed Developments

HCH has chosen to reflect the 6 safeguarding adults priorities as has SAPB as its objectives, with a target attached to each one.

- Priority 1 – Empowerment: Staff development remains a priority, focus on key issues of safeguarding.
- Priority 2 – Protection: To ensure that all national drivers and new documents for safeguarding adults' are considered and if appropriate reflected into practice or learning for HCH staff.
- Priority 2 – Protection: To raise the profile of Prevent and aid staff to recognise patients who may be at risk of being targeted to be involved in the systematic use of violence and intimidation to achieve political ends.
- Priority 3 - Prevention: To target the gaps in clinical staffs' knowledge regarding caring for a person with a learning disability. This will be done by providing targeted training on the subjects identified in the Learning Disabilities audit.
- Priority 3 – Prevention: To lead on at least two meaningful audits. There will be a re-audit of RiO care plans for people with LD and an audit of clinical staff's safeguarding adults awareness including the referral process, to ensure that the training given is clear and memorable.
- Priority 4 - Proportionality: To ensure that all staff have an opportunity to increase their knowledge about MCA and DoLS, by offering good training and continuing with offering case studies and discussion with individual teams and by attending service leads' meetings.
- Priority 5 – Partnership: To continue and build on the work regarding carers. This is a Quality Priority for HCH during 2012/13
- Priority 6 – Accountability: To keep policies up to date, to ensure that they reflect current documents and legislation.

CNWL mental health services

- The "think family" agenda is a huge issue for adult services and one where there is much to learn from CAMHS colleagues. There are impacts of hidden harm that the services need to identify consistently. To address this, the Trust has established a project in Spring 2013 to promote "think family" as part of service delivery in service lines.
- Mental health services are moving to payment by results as its major funding source from 2014/15. This means 2013/14 will be a shadow year for these changes. The Trust is carefully monitoring the impact of changing service delivery into service lines and would welcome partner agencies views on any unforeseen impacts.
- CAMHS, like other service lines, have plans to complete service redesign/ improvement work. This will include developing groups across the service with children, young people and their carers and other stakeholders to test out our ideas on service planning and redesign.
- The Trust will be looking to tender the software packages used and it is hoped that this will allow the opportunity to resolve some of these data issues.

- CNWL may apply for Children and Young People IAPT, which embeds a CBT model of service delivery with extensive outcome evaluations using a range of measures. Other Boroughs are currently doing the training and the learning may be rolled out to Hillingdon staff in the next year.

London Fire Brigade

For 2013-14 we will endeavour to carry out in the region of 2500 further Home Fire Safety Visits, again targeting the most vulnerable.

We are also attempting to visit all Local Authority Sheltered Housing schemes within the Borough to give fire safety input to the residents.

APPENDIX 1: SAPB membership

Chairman Lynda Crellin -Independent

Local Authority

- Cllr Phillip Corthorne – Cabinet Member (SCH&H) LBH
- Merlin Joseph – Deputy Director (SCH&H) LBH
- Nick Ellender – Service Manager, Safeguarding Adults at Risk LBH
- Karen Wardlaw – Human Resources LBH
- Paul Hewitt – Service Manager, Safeguarding Children LBH
- Marcia Eldridge – Learning & Development Manager (SCH&H) LBH

Health

- Barbara North – Safeguarding Adults Lead, Hillingdon Community Health
- Maria O'Brien – Managing Director, Provider Services, Hillingdon PCT
- Jacqueline Walker – Deputy Director of Nursing, Hillingdon Hospital Foundation Trust
- Anna Fernandez – Safeguarding Lead, Hillingdon Hospital Foundation Trust
- Sandra Brookes – Service Director, Adult Mental Health Services, CNWL
- Ana Paz -Lead Social Worker/ Complex Discharge Coordinator at Royal Brompton & Harefield Hospital Trust Lead
- Dr Reva Gudi – CCG GP Lead
- Ceri Jacob – CCG Executive Lead
- Esme Young – CCG Management Lead

Police

- Graham Hamilton – Detective Inspector, Public Protection Group, Met Police

Voluntary Sector

- Angela Wegener – Chief Executive, DASH
- Chris Commerford – Chief Executive, Age UK Hillingdon
- Jill Patel – Director, MIND
- Claire Thomas – Chief Executive, Hillingdon Carers

Other

- Phil Butler – Borough Commander, London Fire Brigade
- Amanda Brady – Compliance Manager, CQC

APPENDIX 3: SAPB Sub-Groups.

1. Policy and Performance sub-group

Remit:

a) To ensure the London Multi-Agency Safeguarding Adults at Risk Policy and Procedures are embedded in practice across all partner agencies in Hillingdon.
b) To review any new legislation or guidance relating to safeguarding adults at risk and to provide recommendations to the SAPB on any changes in local practice required.
c) To identify areas for improvement in the arrangements for safeguarding adults at risk in Hillingdon and devise ways of implementing these improvements in partnership with agencies.
d) To provide performance activity data to the SAPB, the content and frequency to be confirmed by the SAPB.
e) To carry out an annual partnership audit / self assessment of safeguarding activity based on one or more of the following four themes*
Outcomes for and the experiences of people using the service.
Leadership, strategy and commissioning.
Service delivery. Performance and resource management.
Working together.
f) To identify and disseminate learning from safeguarding adults at risk (e.g. serious case reviews outcomes).

2. Financial Exploitation sub-group (time limited).

Remit:

a) To identify the type and volume of financial abuse referred in Hillingdon.
b) To identify the barriers to successful and timely investigation or prevention of financial abuse in Hillingdon.
c) To establish good practice examples from other areas / agencies.
c) To identify, in an action plan to be presented to the SAPB, what changes should be made to improve Hillingdon's response to financial abuse and which key partners should be involved to achieve this.
d) To undertake the work, with partners, to implement the action plan agreed by the SAPB.
e) To review the effectiveness of changes made by Hillingdon partners in response to allegations of financial abuse.

3. Safeguarding Adults at Risk Learning and Development sub-group.

Remit:

a) To review and confirm the key competencies / learning required for safeguarding adults at risk work at the different levels of involvement in the processes of safeguarding.
b) To ensure safeguarding adults at risk learning across partner agencies conforms to the agreed competencies and is of a consistent standard.
c) To collate safeguarding adults learning and development completed by staff across partner agencies, so there is a total picture of staff who have received training.

d) To identify new safeguarding learning and development needs and devise a partnership response to these needs.
e) To promote “joined up” learning and development across partner agencies in order to maximise budget resources.
f) To provide safeguarding learning and development information to the SAPB as and when required.

4. Human Resources sub-group.

Remit:

(Joint with the LSCB – remit already established.) Current attendees: Nick Ellender,

5. Serious Case Review sub-group.

To be chaired by the chair of the SAPB. Membership must consist of a minimum of Hillingdon Adult Social Services, normally Head of Service level, Met Police at Detective Inspector level, NHS representation at Service Director / Manager level, Legal and CQC.

Remit:

a) To decide whether the particular circumstances of the adult at risk meets the criteria for a serious case review and, if so, to ensure the review is carried out in line with agreed procedures.
b) Where the circumstances do not meet the criteria, to decide what alternative action by partner agencies should take place.
c) To ensure the purpose of a serious case review is adhered to as set out below:

- To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to safeguard adults at risk.
- To establish what those lessons are, how they will be acted upon and what is expected to change as a result.
- To improve inter-agency working and to better safeguard adults at risk.

Also that any recommended actions arising from the serious case review are considered by the sub-group and decisions made on how they will be implemented.
(* Thematic framework devised in conjunction with SCIE, ADASS, Local Gov Group and the NHS Confederation.)

6. Winterbourne View Hospital Recommendations

This is a time limited sub-group, formed with a remit to review the outcomes and recommendations arising from the Department of Health review of Winterbourne View Hospital and other relevant reports, and to frame a local multi-agency response. It is chaired by the Service Manager for Disabilities LB Hillingdon.

Remit.

a) To review the contents, outcomes and recommendations of the following documents and any other relevant information the sub-group deems appropriate.

- "Transforming care: A national response to Winterbourne View Hospital" (Department of Health final report – December 2012)
- "DH Winterbourne View Review Concordat: Programme for Action" (December 2012)
- "Winterbourne View – A Compendium of Key Findings, Recommendations and Actions" (ADASS)

b) To formulate a multi-agency Hillingdon response to the recommendations identified in the documents in a) above, write an action plan of key tasks to be completed, with timescales, (bearing in mind Government requirements) and to recommend which Hillingdon individuals or agencies should be responsible for the key tasks. To also prioritise these key tasks and identify and include any actions already taken that relate to recommendations in the documents above.

c) To identify any actions required that fall outside the remit of partner agencies within Hillingdon or other 'gaps' and to recommend what actions be taken, at what level, with regard to these.

d) To identify to the Safeguarding Adults Partnership Board Chair and Learning disabilities Partnership Board Chair any significant areas of risks ahead of presenting the completed action plan with recommended actions.

c) To present the completed action plan to the Safeguarding Adults Partnership Board and Learning Disabilities Partnership Board for approval by 29th June 2013 (SAPB) and 9th of July 2013 (LDPB)

d) To recommend what monitoring arrangements should be in place for ensuring the action plan is completed and how this monitoring is maintained after completion.

e) To recommend what future commissioning arrangements should be for services, to ensure they are in line with the model of service delivery in the action plan

REVIEW OF THE BOARD'S TERMS OF REFERENCE & MEMBERSHIP

Relevant Board Member(s)	Councillor Ray Puddifoot
Organisation	London Borough of Hillingdon
Report author	Nikki O'Halloran, Administration Directorate
Papers with report	Appendix 1 – Board's Terms of Reference & Standing Orders Appendix 2 – Board Membership

1. HEADLINE INFORMATION

Summary	The Health and Wellbeing Board has been established since 1 April 2013. Board members are now asked to review its Terms of Reference and membership.
Contribution to plans and strategies	Joint Health & Wellbeing Strategy
Financial Cost	None.
Relevant Policy Overview & Scrutiny Committee	N/A
Ward(s) affected	N/A

2. RECOMMENDATIONS

That the Health and Wellbeing Board:

1. **reviews the Board's Terms of Reference and Standing Orders in Appendix 1 and considers any amendments;**
2. **notes the Statutory Board Membership and the Co-opted Members, as set out in Appendix 2, and considers any amendments; and**
3. **notes that all non-voting Co-opted Members will be required to sign a confidentiality agreement.**

3. INFORMATION

Supporting Information

Terms of Reference

The Health and Social Care Act 2012 required the Council to establish a Health and Wellbeing Board from 1 April 2013 as a Committee of the Council to oversee the production of the Joint

Health & Wellbeing Strategy, Joint Strategic Needs Assessment and to encourage integrated health working to improve the quality of life for local residents.

At the Council's AGM on 9 May 2013, the new Health and Wellbeing Board was formally approved as a Committee of the Council. As such, any amendments made to the Board's Terms of Reference need to be formally agreed at a Council meeting. The following amendments were agreed at Council on 12 September 2013 and are attached to the report at Appendix 1:

- the ability for the Board to set up Working Groups as well as Sub Committees;
- enabling Co-opted members to nominate a named individual to substitute for them in the event that they were unable to attend a meeting; and
- affording voting rights to the Deputy Chief Executive and Corporate Director of Residents Services.

The Council's Democratic Services Team is responsible for supporting the operation of the Board and the Chairman. Whilst the Board operates similarly to a Committee, The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 brought in some unique differences in terms of membership and voting.

Membership

The Board is chaired by the Leader of the Council. It has Statutory Members, as required by law, which includes officers of the Council, a representative of local Clinical Commissioning Group and a representative of Healthwatch Hillingdon.

The Local Trusts and NHS representatives are invited to attend Board meetings as Co-opted Members. Statutory Members and Co-opted Members are allowed a single nominated/named substitute. During the course of this municipal year, the Board agreed to include a representative from the Royal Brompton and Harefield NHS Foundation Trust as a Co-opted non-voting member. An additional Co-opted non-voting membership was also given to the Hillingdon CCG to enable one to be an officer and the other to be a clinician. The updated membership had been attached to this report at Appendix 2.

It is possible that, during the course of the yearly cycle of meetings, different organisations will approach the Board seeking to join as Co-Opted Members. The Terms of Reference provide for the Board to agree any such appointments as and when.

Voting Rights

In addition to Councillors, the statutory representatives from the local Clinical Commissioning Group and Healthwatch Hillingdon (and their substitutes if required) will be entitled to vote at meetings but Co-opted Members and Council officers will not.

The only exception to these voting rights is that the Deputy Chief Executive and Corporate Director of Residents Services, as a Co-opted Member, has voting rights. This is due to her significant corporate and resident facing remit across a whole range of Borough-wide services, including public health.

The national regulations surrounding the Board require that all 'voting' members sign up to the Council's Code of Conduct. The Code of Conduct is a set of golden rules by which Elected Councillors must follow to ensure high standards in public office. It includes a public declaration of any interests. It should be noted that the term “Co-opted Member” so far as the Code of Conduct is concerned is different to that of a Co-opted Member on the Board.

The Board requires that the confidential nature of reports containing exempt information within the meaning of section 100I of the Local Government Act 1972 (commonly known as Part II reports) is observed at all times and by all members of the Board. As Co-opted non-voting members of Hillingdon's Health and Wellbeing Board are not bound by the Council’s Code of Conduct, these members are asked to complete a confidentiality agreement. This agreement notes the confidentiality requirement and the need to refrain from discussing or disclosing any aspect of confidential reports to any individual or body outside of the meeting.

Financial Implications

There are no financial implications arising from the recommendations in this report.

4. EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

What will be the effect of the recommendation?

N/A

Consultation Carried Out or Required

Consultation with the Chairman of the Board and relevant officers.

5. CORPORATE IMPLICATIONS

Hillingdon Council Corporate Finance comments

There are no financial implications arising from the recommendations in this report.

Hillingdon Council Legal comments

Section 194 of the Health and Social Care Act 2012 requires the Council to establish a Health and Wellbeing Board to comprise a number of Statutory Members and such other persons, or representatives of such other persons, as the local authority thinks appropriate.

Sections 195 and 196 of the Health and Social Care Act 2012 specify the functions of the Board. These duties are to encourage persons engaged in the provision of any health or social care services "to work in an integrated manner" and to "provide advice, assistance or other support" to encourage joint working between local authorities and NHS bodies. Section 196 also specifies that the Board is to exercise the Council's functions under sections 116 and 116A of the Local Government and Public Involvement in Health Act 2007 - assessment of health and social care needs in the Borough and the preparation of the Joint Health and Wellbeing Strategy.

In addition, The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 set out how the Board should operate as a Committee of the Council. Regulation 6 provides that the existing legislation on voting rights need not apply unless the Council so directs. However, before making such a direction on voting rights, the Council is required to consult the Board. Regulation 7 makes there no requirement to have all political groups within the Council represented on the Board.

Section 49(7) of the Local Government Act 2000 requires any external members of a Council committee to adhere to the Members Code of Conduct if they have an entitlement to vote at meeting of the committee.

6. BACKGROUND PAPERS

9 May 2013 Council Meeting Agenda and Decisions
http://modgov.hillingdon.gov.uk/ieListDocuments.aspx?CId=117&MId=1280

APPENDIX 1

HEALTH AND WELLBEING BOARD TERMS OF REFERENCE

(a) Introduction

In accordance with the Health and Social Care Act 2012 and any subsequent related legislation, the Health and Wellbeing Board will seek to improve the quality of life of the local population and provide high-level collaboration between the Council, NHS and other agencies to develop and oversee the strategy and commissioning of local health services.

The Board will operate as a Committee of the Council in accordance with the Committee Standing Orders and Access to Information Procedure Rules set out in this Constitution.

The core functions of the Board are not executive functions and are not therefore subject to any scrutiny call-in procedure.

The Board will seek to comply with its duties under the Equality Act 2013, Freedom of Information Act 2000 and the Data Protection Act 1998.

(b) Membership

Statutory Members

The Chairman of the Board shall be the Leader of the Council. The Vice-Chairman of the Board shall be the Cabinet Member for Social Services, Health & Housing.

Other Statutory Members that may attend meetings are:

1) Cabinet Members from the London Borough of Hillingdon
2) A representative from the Clinical Commissioning Group covering Hillingdon
3) A representative from Healthwatch Hillingdon
4) Statutory Director of Adult Social Services
5) Statutory Director of Children's Services
6) Statutory Director of Public Health

Political Balance

There is no requirement to have all political groups within the Council represented on the Board.

Substitutes for Statutory Members

Cabinet Members may nominate any other Elected Member of the Council as a substitute. Other Statutory Members of the Board must nominate a single individual who will substitute for them and have the authority to make decisions in the event that they are unable to attend a meeting.

Co-opted Members

From time to time and upon the agreement of the Board other individuals or representatives may attend Board meetings as Co-opted Members. Co-opted Members may nominate a single, named individual who may substitute for them in the event that they are unable to attend a meeting, e.g. representatives of local NHS Hospitals or Trusts.

Voting rights

Voting rights will apply to the following Statutory Members:

- All Elected Members of the Council on the Board;
- The representative from the Clinical Commissioning Group covering Hillingdon; and
- The representative from Healthwatch Hillingdon.

Voting rights will apply to the following Co-opted Member:

- The Deputy Chief Executive and Corporate Director of Residents Services.

Subject to consultation with the Board, the Council may then direct whether or not voting rights apply to any other Statutory Member or Co-opted Member.

Code of Conduct

All voting Members of the Health and Wellbeing Board will be bound by the Council's Code of Conduct for Members, as adopted.[1]

(c) Sub-Committees and Working Groups

The Board may establish and appoint to sub-committees and working groups. The Board may delegate any of its functions to sub-committees or working groups or request them to undertake task and finish reviews or project work in the pursuit of the Board's goals.

Members of a sub-committee or working group may be a Statutory or Co-opted Member of the Board or any Elected Member of the London Borough of Hillingdon. Additional members of a sub-committee or working group will be agreed by the Board.

Sub-committees and working groups will cease to exist upon a decision by the Board.

(d) Terms of Reference

1. To fulfil statutory requirements to improve the health and wellbeing of the local population, specifically to:

   (a) Lead on the duty to assess and publish information about the needs of the local population (joint strategic needs assessment (JSNA);

[1] Non-voting Co-opted members are required to complete a Confidentiality Agreement.

(b) Deliver the duty to prepare and publish a Joint Health and Wellbeing strategy based on the JSNA, to consider Health and Social Care Act flexibilities in developing the strategy and involve local residents and others as appropriate;

(c) Promote integrated and partnership working across areas, including through the promotion of joined up commissioning plans across the NHS, social care and public health; and

(d) Support, be involved in and provide opinion on joint commissioning plans and the review of how well the Health and Wellbeing strategy is meeting needs. This includes providing an opinion on how well the Clinical Commissioning Group (CCG) contributes to the delivery of the joint Health and Wellbeing strategy.

2. To be responsible for:

(a) Providing leadership in developing a strategic approach for health and wellbeing in Hillingdon;

(b) Developing the statutory Health and Wellbeing Strategy;

(c) Ensuring that the Health and Wellbeing Strategy is informed and underpinned by the JSNA and is focused upon:
- Improving the health and wellbeing of the residents of Hillingdon;
- The continuous improvement of health and social care services;
- The reduction of health inequalities;
- The involvement of service users and patients in service design and monitoring; and
- Integrated working across health and social care where this would improve quality;

(d) Reviewing performance on delivering the Health and Wellbeing Strategy and other key strategic targets;

(e) Holding partner agencies to account for performance on agreed priorities in conjunction with the External Services Scrutiny Committee;

(f) Influencing and approving the Clinical Commissioning Group (CCG) commissioning plan and annual update;

(g) Collaborative working to develop social care and health related commissioning plans to improve the health and wellbeing of residents of the Borough and monitor implementation and performance;

(h) Monitoring the performance of Public Health and reviewing services in conjunction with the External Services Scrutiny Committee; and

(i) Reviewing the Terms of Reference and operation of the Board regularly, making recommendations to Council as required.

HEALTH AND WELLBEING BOARD STANDING ORDERS

These Committee Standing Orders apply to the Health and Wellbeing Board set out in Article 8 of the Constitution, with the following exceptions to these rules taking precedence at any time:

1. Any speaking rights for Elected Members who are not Members of the Board do not apply to meetings of the Board or any of its sub-committees or working groups.

2. A Quorum of the Board shall be 50% of its statutory membership. A Quorum of any sub-committees or working groups of the Board shall be 50% of their membership or 3 members (whichever is the greater).

3. Any meeting of the Board may establish and appoint to its sub-committees or working groups.

4. Upon any recommendations from the Board, Statutory Membership will be approved by full Council.

5. Upon request from an organisation, approval of any appointments to the Board as a non-statutory Co-opted Member will be agreed by the Board, in consultation with the Chairman and the Head of Democratic Services.

6. Decisions shall be made on the basis of a vote and show of hands of a majority of members present. Subject to the vote being tied, the Chairman will have a second or casting vote.

7. The Board and any sub-committees or working groups shall meet as required, with the agreement of the Chairman and/or in the circumstances where the Chairman receives a request in writing by more than 50% of the Statutory Members of the Board.

APPENDIX 2

HEALTH AND WELLBEING BOARD *subject to the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.*

ORGANISATION	NAME OF MEMBER	SUBSTITUTE
STATUTORY MEMBERS (VOTING)		
Chairman	Councillor Puddifoot	Any Elected Member
Vice-Chairman	Councillor Corthorne	Any Elected Member
Cabinet Members	Councillor Simmonds	Any Elected Member
	Councillor Mills	Any Elected Member
	Councillor Bianco	Any Elected Member
	Councillor Burrows	Any Elected Member
	Councillor Seaman-Digby	Any Elected Member
Healthwatch Hillingdon	Mr Jeff Maslen	Mr Stephen Otter
Clinical Commissioning Group	Dr Ian Goodman	Dr Kuldhir Johal
STATUTORY MEMBERS (NON-VOTING)		
Statutory Director of Adult Social Services	Mr Tony Zaman	Mr Nick Ellender
Statutory Director of Children's Services	Ms Merlin Joseph	Mr Tom Murphy
Statutory Director of Public Health	Ms Sharon Daye	Ms Shikha Sharma
CO-OPTED MEMBERS (VOTING)		
LBH	Ms Jean Palmer	N/A
CO-OPTED MEMBERS (NON-VOTING)		
The Hillingdon Hospitals NHS Foundation Trust	Mr Shane DeGaris	Mr Mike Robinson
Central and North West London NHS Foundation Trust	Ms Robyn Doran	Ms Maria O'Brien
Royal Brompton and Harefield NHS Foundation Trust	Mr Robert J Bell	Mr Nick Hunt
LBH	Mr Nigel Dicker	N/A
Clinical Commissioning Group (Officer)	Mr Rob Larkman	Ms Ceri Jacob
Clinical Commissioning Group (Clinician)	Dr Tom Davies	Dr Kuldhir Johal

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BOARD PLANNER & FUTURE AGENDA ITEMS

Relevant Board Member(s)	Councillor Ray Puddifoot
Organisation	London Borough of Hillingdon
Report author	Nikki O'Halloran, Administration Directorate
Papers with report	Appendix 1 – Board Planner

1. HEADLINE INFORMATION

Summary	To consider the Board's business for the forthcoming cycle of meetings.
Contribution to plans and strategies	Joint Health & Wellbeing Strategy
Financial Cost	None
Relevant Policy Overview & Scrutiny Committee	N/A
Ward(s) affected	N/A

2. RECOMMENDATION

That the Board considers and provides input on the Board Planner, attached at Appendix 1.

3. INFORMATION

Supporting Information

Reporting to the Board

The Board Planner, attached at Appendix a, is presented for consideration and development in order to schedule future reports to be considered by the Board. Members may also wish to consider any standing items (regular reports) and on what frequency they are presented.

The Board Planner is flexible so it can be updated at each meeting or between meetings, subject to the Chairman's approval.

Board agendas and reports will follow legal rules around their publication. As such, they can usually only be considered if they are received by the deadlines set. Any late report (issued after the agenda has been published) can only be considered if a valid reason for its urgency is agreed by the Chairman.

Advance reminders for reports will be issued by Democratic Services. Reports should be presented in the name of the relevant Board member.

With the Chairman, Democratic Services will review the nature of reports presented to the Board in order to ensure consistency and adequate consideration of legal, financial and other implications. It is proposed that all reports follow the in-house “cabinet style” with clear recommendations as well as corporate finance and legal comments.

The agenda and minutes for the Board will be published on the Council's website, alongside other Council Committees.

Board meeting dates

The following dates for the Board meeting were agreed by Council on 16 January 2014 and will be held at the Civic Centre, Uxbridge:

- Tuesday 17 June 2014 at 2.30 pm - Committee Room 6
- Tuesday 23 September 2014 at 2.30 pm - Committee Room 6
- Thursday 11 December 2014 at 2.30 pm - Committee Room 6
- Tuesday 17 March 2015 at 2.30 pm - Committee Room 6

Board meeting dates for 2015/2016 will be considered by Council in due course as part of the authority’s Programme of Meetings for the new municipal year.

Financial Implications

There are no financial implications arising from the recommendations in this report.

4. EFFECT ON RESIDENTS, SERVICE USERS & COMMUNITIES

What will be the effect of the recommendation?

N/A

Consultation Carried Out or Required

Consultation with the Chairman of the Board and relevant officers.

5. CORPORATE IMPLICATIONS

Hillingdon Council Corporate Finance comments

There are no financial implications arising from the recommendations in this report.

Hillingdon Council Legal comments

Consideration of business by the Board supports its responsibilities under the Health and Social Care Act 2012.

6. BACKGROUND PAPERS

NIL

APPENDIX 1

BOARD PLANNER

17 Jun 2014 2.30pm Committee Room 6	**Business / Reports**	**Lead**	**Timings**
	Reports referred from Cabinet / Policy Overview & Scrutiny (SI)	LBH	**Report deadline:** 3pm Friday 30 May 2014 **Agenda Published:** 9 June 2014
	Joint Health and Wellbeing Strategy Action Plan Update 2014/2015 (SI)	LBH	
	Public Health Action Plan 2014/2015 (SI)	LBH	
	Hillingdon CCG Financial Recovery Plan Update (SI)	HCCG	
	Healthwatch Hillingdon Update (SI)	Healthwatch Hillingdon	
	Update – Allocation of S106 Health Facilities Contributions (SI)	LBH	
	Better Care Fund (formerly the Integration Transformation Fund) - Progress Report	LBH	
	Board Planner & Future Agenda Items (SI)	LBH	

23 Sept 2014 2.30pm Committee Room 6	**Business / Reports**	**Lead**	**Timings**
	Reports referred from Cabinet / Policy Overview & Scrutiny (SI)	LBH	**Report deadline:** 3pm Friday 5 September 2014 **Agenda Published:** 15 September 2014
	Joint Health and Wellbeing Strategy Action Plan Update 2014/2015 (SI)	LBH	
	Public Health Action Plan 2014/2015 (SI)	LBH	
	Hillingdon CCG Financial Recovery Plan Update (SI)	HCCG	
	Healthwatch Hillingdon Update (SI)	Healthwatch Hillingdon	
	Update – Allocation of S106 Health Facilities Contributions (SI)	LBH	
	Better Care Fund (formerly the Integration Transformation Fund) - Progress Report	LBH	
	Board Planner & Future Agenda Items (SI)	LBH	

11 Dec 2014 2.30pm Committee Room 6	Business / Reports	Lead	Timings
	Reports referred from Cabinet / Policy Overview & Scrutiny (SI)	LBH	**Report deadline:** 3pm Friday 21 November 2014 **Agenda Published** 3 December 2014
	Joint Health and Wellbeing Strategy Action Plan Update 2014/2015 (SI)	LBH	
	Public Health Action Plan 2014/2015 (SI)	LBH	
	Hillingdon CCG Financial Recovery Plan Update (SI)	HCCG	
	Healthwatch Hillingdon Update (SI)	Healthwatch Hillingdon	
	Update – Allocation of S106 Health Facilities Contributions (SI)	LBH	
	Better Care Fund (formerly the Integration Transformation Fund) - Progress Report	LBH	
	Board Planner & Future Agenda Items (SI)	LBH	
	Hillingdon's Joint Strategic Needs Assessment	LBH	

17 Mar 2015 2.30pm Committee Room 6	Business / Reports	Lead	Timings
	Reports referred from Cabinet / Policy Overview & Scrutiny (SI)	LBH	**Report deadline:** 3pm Friday 27 March 2015 **Agenda Published:** 9 March 2015
	Joint Health and Wellbeing Strategy Action Plan Update 2014/2015 (SI)		
	Public Health – Action Plan 2014/2015 (SI)	LBH	
	Hillingdon CCG Financial Recovery Plan Update (SI)	HCCG	
	Healthwatch Hillingdon Update (SI)	Healthwatch Hillingdon	
	Update – Allocation of S106 Health Facilities Contributions (SI)	LBH	
	Better Care Fund (formerly the Integration Transformation Fund) - Progress Report	LBH	
	Board Planner & Future Agenda Items (SI)	LBH	
	HCCG 5 Year Strategic Plan and 2 Year Operating Plan	HCCG	
	Local Safeguarding Children's Board (LSCB) Annual Report	LBH	
	Safeguarding Adults Partnership Board (SAPB) Annual Report	LBH	

** SI = Standing Item*

Other possible business of the Board:

1.