Open Agenda

Healthy Communities Scrutiny Sub-Committee

Tuesday 27 January 2015
7.00 pm
Ground Floor Meeting Room G02A - 160 Tooley Street, London SE1 2QH

Supplemental Agenda

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Date: 23 January 2015

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Healthy Communities Scrutiny Sub-Committee

MINUTES of the OPEN section of the Healthy Communities Scrutiny Sub-Committee held on Monday 8 December 2014 at 7.00 pm at Ground Floor Meeting Room G02C - 160 Tooley Street, London SE1 2QH

PRESENT:	Councillor Rebecca Lury (Chair) Councillor David Noakes Councillor Jasmine Ali Councillor Paul Fleming Councillor Kath Whittam Councillor Bill Williams
OTHER MEMBERS PRESENT:	Councillor Mark Williams, Cabinet Member for Regeneration, Planning and Transport
OFFICER SUPPORT & COMMUNITY REPRESENTATIVES:	Dr Ruth Wallis, Director of Public Health Jin Lim, Assistant Director, Public Health Rose Dalton - Lucas, Health Improvement Partnership Manager, Public Health Simon Bevan, Director of Planning Professor Brendan Delaney, Stop Killing Cyclists Alastair Hanton, Southwark Cyclists Bruce Lynn, Southwark Cyclists Jeremy Leach, Southwark Living Streets Julie Timbrell, Scrutiny project manager

1. APOLOGIES

1.1 Councillor Maria Linforth-Hall sent apologies.

2. NOTIFICATION OF ANY ITEMS OF BUSINESS WHICH THE CHAIR DEEMS URGENT

2.1 There were no urgent items of business.

3. DISCLOSURE OF INTERESTS AND DISPENSATIONS

3.1 There were no disclosures of interests or dispensations.

4. MINUTES

RESOLVED

The minutes of the meeting on 11 November 2014 will be amended to record an action point for Guy's and St Thomas' (GST) & King's College Hospital (KCH) will provide details on the number of people without homes that they treat and require assistance, as well as the links the hospitals have with agencies that work with homeless people.

5. REVIEW: HEALTH OF THE BOROUGH

5.1 The chair invited everybody to introduce themselves: Councillor Mark Williams, Cabinet Member for Regeneration, Planning and Transport; Simon Bevan, Director of Planning; Dr Ruth Wallis , Director of Public Health ; Jin Lim, Assistant Director, Public Health; Rose Dalton –Lucas, Health Improvement Partnership Manager; Stop Killing Cyclists representative Professor Brendan Delaney (an expert on GP Practice) ; Southwark Cyclists representatives Alastair Hanton & Bruce Lynn (former professor of Physiology at University College London) and Jeremy Leach, Southwark Living Streets.

5.2 The chair then invited the cabinet lead, Councillor Mark Williams, to introduce work the council is doing to improve active travel, including the draft cycling strategy. He opened by remarking that his brief: Transport, Planning and Regeneration, all links to the reviews theme of improving physical health. Sustainable transport promotes active travel - for example cycling. The cycling strategy is now being consulted on and seeking a range of views - including those that do not cycle as the strategy wants to overcome barriers preventing more people cycling. There will be a grid and spine network of cycle lanes and provision. The delivery of this will be linked to regeneration by using a mix of funding from developers, Transport for London and the Mayor for London. The council will also be developing a walking strategy. The cabinet lead said that good quality Public Transport is also key to improving health and promoting active travel as people have to walk to access this. Public Transport also helps with air quality and promotes well-being as it links people and communities up.

5.3 The cabinet lead spoke about the importance of improving air quality and said this was killing 130 Southwark residents each year. The evidence is that fine particulates (PM 10) stunts children's lungs for life. The council is lobbying the Mayor for London for an Ultra Low Emission Zone to cover a wide area, and to make it more robust as at the moment it is very fluffy. He said he was worried that a small Ultra Low Emission Zone could push more pollution around the periphery

and the level of pollution around the Old Kent Road is already very high for fine and very fine particulates (PM10 and PM 2.5). He added that the council is looking at what we can do to improve the green space around Old Kent Road to reduce this.

5.4 Simon Bevan, Director of Planning , commented that the Planning Department is not going solve some of these issues very quickly as the restrictions will only stop some proliferation of problems, rather than reducing existing ones . Walking routes are also about attractive routes that are safe and people want to use. Regeneration schemes will enable the council to act on long term plans like Old Kent Road.

5.5 The cabinet lead commented that the recent parliamentary report (Action on Air Quality) suggested moving schools and houses away from traffic, but the council think it is more straightforward to move the traffic.

5.6 A Southwark Cyclists representative suggested using all the parks to link up cycling throughout the borough and the cabinet lead assured the representative that there are many such plans in the strategy.

5.7 The issue of railings disappearing was raised and there was a suggestion that the council provide more bike hangers to ensure there is ample parking space for cyclists.

5.8 A member welcomed the strategy but commented that it was not nearly ambitious enough and suggested putting the target of increasing cycling up from 10% to 20 %. He went on to mention a recent presentation he had attended by Andrew Grieve of King's College Hospital, on Air Quality and how shocked he was by the levels of pollution in the borough , particularly that caused by diesel engines and the concentrations around main roads – it is so severe that the sensible thing is to get off main roads and into side streets.

5.9 The cabinet lead responded to the proposal that the cycling strategy raise the target by remarking that now up to 4 and a half journeys are made by cycling, so going to 10 percent would mean doubling the number of journeys taken. He said if the council make progress on reaching this target, then it could be raised to 20%.

5.10 The Stop Killing Cycling representative said that the steps outlined in the cycling strategy were good, but did not go nearly enough. He emphasised the need to set a much bolder target, and said to do that we need to be re- prioritise transport away from cars. He said that as a GP he recommends cycling for health and when he asks people why they do not cycle people say it is too dangerous. We therefore need to change our provision so people feel safer to cycle. Another cycling representatives also welcomed the strategy and the recommendations but agreed it was not nearly ambitious enough.

5.11 The proposals to extend the Ultra Low Emission Zone were discussed and the impact on areas outside the congestion zone, and it was suggested that it would be possible to improve conditions on Jamaica Road by banning cars, or pressurising TFL to do this. The Director of Pubic Health said that a Southwark Congestion Zone has been muted.

5.12 Cycling representatives asked if Public Health money could be invested in this. The Public Health Director said that out of a budget of £22 million about a third spent on sexual health, a third on drugs and alcohol and a third on health checks, smoking prevention and obesity. It was suggested more be spent on active transport as it would prevent obesity, which is a root cause of much ill health. The Director of Public Health commented that money is committed to active travel and agreed with the importance of tackling obesity. Public Heath officers reported that there were programmes supporting cycling. The Public Health Director said that about 20% of the population are not moving much.

5.13 The cabinet lead explained the pressures that the council budget faces; out of a former council budget of £400 million, £90 million has already been lost and the council is due to lose £35 million every year. The opportunities to make infrastructure changes now come from leveraging in developers money and also TFL.

5.14 A cycling representative said he was not suggesting raiding the £22 million Public Health budget but emphasised the importance of tackling ill health by promoting clean air and active travel.

5.15 A cycling representative referred to the Clinical Commissioning Budget and its current expenditure on things that do not make sense rather than tackling the root causes of ill health. He suggested accessing that. The cabinet lead commented that this is a very large budget of £400 million per year. Another cycling representative agreed it was madness to put half the population on statins and perform Bariatric Surgery rather than improve the environment.

5.16 A member said that she was preoccupied by the attainment gap and interested in the links between obesity, lack of exercise and the impact on education. She said that the council do need to think how about how we communicate with people. Another member agreed and pointed out the benefits of social media.

5.17 A cycling representative produced a graph which showed that children in Southwark are the most obese in the in UK and only 1 out of 150 are cycling to school, whereas 5% cycle to school in Richmond and obesity is much lower. The cabinet lead commented that the council will know we have got it right if parents let their children cycle to school. He said there was a "Bike It" officer in post to promote cycling in Dulwich.

5.18 A member commented that the Publish Health money is well spent as the council is at the wrong end of performance on sexual health and drugs & alcohol. He asked if Section 106 money, which developers pay to the council, has to be spent on capital. The cabinet lead responded that some can be spent on revenue, and that better use could be made of Community Infrastructure Levy (CIL) funding. He said that money from this has been used to improve walking and inward investment around the Tate Modern.

5.19 Jeremy Leach commented that embedding walking is very important and congratulated the council on the 20 mile an hour borough, which is a very bold step. He advocated reducing permeability for motor vehicles, investment in local high streets and in play streets and making them work in more difficult areas. He

said that road pricing is back on agenda and that we need to recognise the dis-benefits of motor vehicles and face that.

5.20 A member commented that the community perception can be that a small minority have moved into the area and promoted an anti car, pro-cycling & walking agenda, but this is not true; actually 70 percent are in favour of promoting walking, cycling, public transport and reducing the role of cars. He said that we do need to ensure that local advocacy and community groups are representative and that we need to reach out to a broader group of people.

5.21 A member asked the Director of Planning if the Marmot Indicators on Public Health are used to judge developers proposals. The Director said that more could be done; there are sustainability appraisals for larger schemes and the planning department encourage developers to provide a cycle store in housing schemes as this really does support people. The member suggested a Public Health assessment be done on every development. Another member commented that when the planning committees looks at developments the assessment of the impact on air quality and sustainably often do not say much – councillors and officers could be more demanding. Members agreed and also about being more robust in the defence of car free planning with the public. The cabinet lead commented that now only about a third of the population actually have a car.

5.22 A member raised the issue of alcohol and the expressed disappointment that minimum alcohol pricing was not agreed at national government level, and expressed concern that the council's alcohol planning policy is not working at a cumulative level and effecting individual planning decisions sufficiently.

6. INTERVIEW WITH THE CABINET MEMBER FOR PUBLIC HEALTH, PARKS AND LEISURE

6.1 This item was postponed as the cabinet member was unwell.

7. REVIEW: PERSONALISATION

7.1 The personalisation review was discussed and the need to get evidence from the voluntary sector and service users.

7.2 A member suggested that good practice at Richmond Council be considered.

7.3 The officer present recommended a presentation by Hestia, who conduct reviews on behalf of the council .

7.4 A member raised concerns with delays in disability benefits assessments by ATOS, who conduct these on behalf of the government.

RESOLVED

- The following voluntary sector organisations will be contacted and invited to give evidence: Community Action Southwark, Age Concern, Southwark Carers and Voluntary Day Centres.
- A survey will be devised for service users.
- Hestia will be asked to provide evidence.
- Good practice by Richmond Council will be considered.

8. WORK-PLAN

8.1 The work-plan was noted.

NHS
Southwark
Clinical Commissioning Group

Accident and Emergency Department Performance

Southwark Healthy Communities Overview and Scrutiny sub-Committee

27 January 2014

Background and context

NHS Southwark Clinical Commissioning Group

The NHS Constitution includes a pledge that 95% of patients attending an A&E department will be seen and either discharged or admitted to hospital within 4 hours. This target applies to all 'types' of A&E services, which include:

- Type 1 A&E departments: A consultant-led 24 hour service with full resuscitation facilities.
- Type 2 A&E departments: A consultant-led single specialty A&E service (e.g. ophthalmology, dental)
- Type 3/4 A&E departments: Other type of A&E / minor injury units / Walk-in Centres / Urgent Care Centre, primarily designed for the receiving of accident and emergency patients.

Data included in this briefing shows trusts' performance for all patients attending local A&E sites, rather than for Southwark patients only. However, we do know that approximately 90% of A&E attendances by Southwark patients are at either King's Denmark Hill site, St. Thomas' A&E or Guy's Urgent Care Centre; with a relatively equal spilt in activity between the two providers.

Whilst GSTT has consistently delivered the national A&E standards in 2014/15, King's have not. However, the performance of King's Denmark Hill A&E department has been significantly better than performance at King's Princess Royal University Hospital emergency department (and by virtue of that, the aggregate trust-wide performance position).

Performance at Denmark Hill had improved since September 2014, with the dip in December mirroring a national trend at this time of year. At present the King's Denmark Hill site is performing amongst the top half of A&E departments in London, although it does remain under significant pressure from high levels of activity.

Urgent care performance – A&E waits

NHS Southwark Clinical Commissioning Group

A&E waits all types (target 95%) - % of patients who spent 4 hours or less in A&E before treatment or admission

	Jan	Feb	Mar	2014/15	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
KCH (all sites)	87.6	87.3	87.5		87.4	89.4	89.9	91.0	90.6	90.9	89.8	90.9	84.4
KCH (Denmark Hill)	93.3	94.0	92.2		92.0	93.3	93.1	92.6	92.5	93.9	95.1	95.8	90.9
GSTT	96.9	96.8	96.2		97.1	97.0	96.4	96.2	96.6	96.3	95.9	95.8	94.3

A&E waits type 1 (target 95%) - % of patients who spent 4 hours or less in A&E before treatment or admission

	Jan	Feb	Mar	2014/15	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
KCH (all sites)	83.3	82.4	82.8		82.8	85.6	86.2	87.5	87.2	87.6	86.1	87.7	78.5
KCH (Denmark Hill)	91.9	92.7	90.6		90.7	92.1	91.8	91.2	91.3	92.9	94.1	95.0	89.2
GSTT	96.0	95.8	95.1		96.2	96.2	95.2	94.9	95.4	95.2	94.6	94.4	92.9

Urgent care performance – weekly data

NHS Southwark Clinical Commissioning Group

Weekly A&E waits all types (target 95%) - % of patients who spent 4 hours or less in A&E before treatment or admission

	30/11/14	07/12/14	14/12/14	21/12/14	28/12/14	04/01/15
KCH (all sites)	91.3	86.0	82.5	81.9	87.7	81.3
KCH (Denmark Hill)	94.8	90.2	92.3	88.6	93.0	89.3
GSTT	95.7	95.2	93.9	92.6	96.2	95.5
London	92.9	91.4	89.7	89.0	91.2	88.8

Weekly A&E waits type 1 (target 95%) - % of patients who spent 4 hours or less in A&E before treatment or admission

	30/11/14	07/12/14	14/12/14	21/12/14	28/12/14	04/01/15
KCH (all sites)	88.4	80.9	76.1	74.4	83.1	74.3
KCH (Denmark Hill)	93.8	88.5	92.3	86.3	91.9	87.3
GSTT	94.4	93.8	92.2	90.5	95.4	94.6

Summary of Q2 and Q3 performance position

NHS Southwark Clinical Commissioning Group

GSTT have met the performance standard in all three quarters of 2014/15. King's (Denmark Hill) failed the last four quarters targets up to and including quarter 3 2014/15. The A&E department at King's Denmark Hill site achieved the performance standard for the months of October and November, though performance deteriorated in December 2014.

There are a number of issues which have contributed to performance failure in 2014/15:

- Bed capacity issues and fluctuations in demand.
- Delays in the repatriation of specialist patients (e.g. stroke, trauma, neurology and cardiac) from Denmark Hill to their local hospitals.
- Delayed discharges of patients medically fit for discharge (though this is minor issue for Southwark patients).
- The reported increased 'acuity' of patients presenting at King's emergency department.

The system response to A&E pressures in 2014/15

NHS Southwark Clinical Commissioning Group

The Lambeth, Southwark and Bromley System Resilience Group has developed a System Resilience Plan which details all actions that all organisations within the system are taking to improve performance and return to sustainable achievement of the national performance standards. These plans draw on existing recovery plans from KCH and cover both elective and non-elective care pathways across Lambeth, Southwark and Bromley. Plans were comprehensively assured by NHS England and were supported by funding for Denmark Hill of £2.6m.

An external agency was commissioned to complete a Demand and Capacity review, which has been used to inform the trust's management plan. This plan involves reconfiguring the utilisation of capacity at Denmark Hill, PRUH, QMS and Orpington sites and the trust taking steps to improve internal and external productivity and efficiency.

Commissioners from Southwark, Lambeth and Bromley CCGs, NHS England and Monitor oversee the implementation of action plans through regular 'tripartite' meetings. National winter pressures funding has been made available to the local health economy to support improved performance in both emergency and elective care. Recovery plan is also funded through 2014/15 contract agreement with additional out of hospital investment to support site performance.

Summary of actions taken to improve performance

NHS Southwark Clinical Commissioning Group

1. **Denmark Hill site capacity:** Commissioners and trusts completed a demand and capacity analysis for each site in south east London in order to establish, on a specialty-by-specialty basis, how many beds are likely to be needed to meet future demand in 2014/15 . For Denmark Hill, a bed gap of 68 was identified. Work was initiated to transfer elective capacity from Denmark Hill to Orpington and PRUH; improving internal efficiency, and making full use of increased community capacity in order to free beds on the Denmark Hill site.

CCGs and KCH agreed repatriation protocols with Lewisham and Greenwich NHS Trust as these had previously proved to be problematic and had disrupted patient flows at Denmark Hill over the previous 12 months. The Lewisham and Queen Elizabeth hospital stroke units have now consolidated onto one site for several months, which is better facilitating repatriation pathways and freeing bed capacity at KCH.

2. **Mental Health:** Additional bed capacity commissioned at SLaM and an additional psychiatric liaison nurse post at KCH A&E has been funded by CCG. Further investment has also been identified for SLaM through the winter funding process to provide additional support to Denmark Hill A&E and improve emergency pathways for people presenting with mental health problems. Winter funds are being utilised to extend support to both St Thomas' and Denmark Hill emergency departments in and out of hours. This additional staffing is in place to ensure timely responses and assessments of patients.

Summary of actions taken to improve performance

NHS Southwark Clinical Commissioning Group

3. **Primary care access:** The CCG agreed to commission extended capacity in primary care so that patients would be able to access services 8am-8pm, 7 days a week. The CCG received approximately £1m from the Prime Minister's Challenge Fund, which is being used for setup and infrastructure costs and we have also invested a further recurrent £2.1m to maintain enhanced access to primary care. To date, the following have been established:

   - Mobilisation of first extended access site (Lister Health Centre) on 11 November with positive initial feedback from patients and practices.
   - Pathway in place to allow patients to be re-direction from King's A&E department to the Lister Health Centre.
   - On-going work around staffing, practice readiness, IT and premises to mobilise second site (Bermondsey Spa) in February 2015.

Summary of actions taken to improve performance

NHS Southwark Clinical Commissioning Group

4. **Repatriations:** A south London-wide repatriation coordination project has been funded for six months to support improved management of repatriation of patients across south London and to identify any underlying issues which impact on the effective repatriations of patients. The programme began in mid-October 2014 and has since then successfully improved the level of data and information being supplied about patients awaiting repatriation. So far this had led to a greater focus on the impact of repatriation delays and has enabled progress to be made on inter-provider escalation and management of repatriation delays.

5. **Guy's Urgent Care Centre:** The provider of this service changed in Q1 this year and services are now delivered by GSTT in partnership with primary care support.

6. **Multi-disciplinary team assessment/social care:** A weekend social care worker pilot at GSTT to support seven day working has been established and will be evaluated.

December / January actions to sustain performance

NHS Southwark Clinical Commissioning Group

	Issue	Action	Implementation Date	Additional capacity
1	Closing bed gap and establishing contingency	Plan in place to close bed gap in full and provide contingency capacity over Q3 and beginning of Q4..	September 2014 to March 2015	68 beds (plus contingency)
2	Discharge - repatriations and rehabilitation	Opening of a 20 bedded Orpington unit for outer south east London/Kent patients (phased opening) GST Neuro rehab winter resilience scheme (Dec 2014) L&G stroke unit consolidation (Nov 2014).	Phased opening over Q3/ early Q4	20 repatriation 20 rehab beds
3	Ring-fenced elective capacity	Significant element of outsourced activity secured for October and November with negotiations now commencing with private sector for December onwards, and increased on site elective ring-fenced beds.	October – December 2014	16 elective beds
4	Productivity and efficiency across the emergency care pathway	With focus on discharge plus front end assessment pathways are the key areas of internal and interface focus.	November and December 2014	7 admission avoidance 16 productivity 12 community
5	Managing periods of peak demand - winter initiatives	Enhanced capacity to support peak winter period, including 7 day working, enhanced staffing, increased out-of-hours care capacity, initiatives to support alcohol and mental health.	December 2014 to March 2015	
6	Safer Faster Hospital Week (SFHW)	SFHW in December 2014 to further step up and embed performance, with a planned focus on discharge the major improvement objective of the week, plus a January 2015 London wide Breaking the Cycle Week.	December 2014 and January 2015	

Impact on performance – All initiatives will support delivery of 95% trajectory plus provide further contingency capacity for managing expected peak winter demand.

Further actions to address current challenges

NHS Southwark Clinical Commissioning Group

Winter Resilience initiatives: As of 12 December 2014 one third of system resilience group (SRG)Denmark Hill related initiatives were in place and impacting. Concerted action to implement remaining initiative and ensure impact is maximised is being taken with daily SRG oversight of implementation.

Enhanced escalation in relation to key out of hospital issues: The SRG undertakes a daily review and escalation of actions to support repatriation and mental health delays. The SRG also completes daily review of out of hospital care capacity to ensure community-based admission avoidance and supported discharge services are fully utilised in line with available capacity.

Internal trust recovery: Refreshed escalation processes in place, including reinforcing Internal Professional Standards. The process was implemented at pace following days of performance challenge including 'internal incident' status.

An **increase available emergency capacity** in Q4 to maximise available on site emergency capacity.

Managing demand: Joint work is being completed to maximise A&E diversion and support better utilisation of UCCs, A&E diversion schemes, and referral to general practice. **Expediting discharge** with a major escalation focus on timely discharge to free up in hospital capacity and support good patient flow.

King's College Hospital NHS
NHS Foundation Trust

Briefing: Trust update

Briefing for: Lambeth, Southwark and Bromley Health Overview and Scrutiny Committees

Date January 2015

Subject Emergency Department performance and new enhanced recovery ward at Orpington Hospital

Contents

1. Introduction

The performance of A&E departments across the country has been a notable feature within the press for a number of weeks. The latest figures undoubtedly reflect the immense pressure that A&E departments are under. Our position here at King's is not unique however we would like to share what the situation looks like for us.

We would also like to update you on a recent new development at Orpington Hospital that increases our capacity for neuro rehabilitation, and frees up beds at our Denmark Hill site and the Princess Royal University Hospital (PRUH).

2. Emergency Department performance

We continue to face record levels of demand for emergency care at both our Denmark Hill (DH) and Princess Royal University Hospital (PRUH) sites and this is reflected in our recent performance.

The data below is for the final quarter of 2014. It covers attendance at our Emergency Departments from arrival through to admission, transfer or discharge within four hours. Data is shown at Trust and site level.

All type performance

	Oct	Nov	Dec	Q3
Trust	89.90%	90.90%	84.39%	88.50%
	Oct	**Nov**	**Dec**	**Q3**
PRUH	82.74%	84.24%	75.91%	81.05%
DH	95.15%	95.84%	90.92%	94.07%

When comparing Emergency Admissions via our Emergency Departments for the same quarter with those seen the previous year, we have seen significant increases on both sites.

At the PRUH there were 5, 184 admissions in the last three months of the year compared to 4, 781 during this period in 2013. This reflects a 7.4% increase.

At DH there were 7, 674 admissions in the last three months of the year compared to 7, 496 during this period in 2013. This reflects a 2.4% increase.

The areas that have experienced the greatest impact overall are Geriatric Medicine and General Surgery.

This increases places further pressure capacity at King's that is impacting on the availability of beds in key areas such as those detailed above.

We are working hard to manage the pressure using the range of measures we have already put in place through programmes including:

- **demand management e.g.** emergency medical admissions avoidance through Acute Assessment Unit/ Medical Assessment Unit and King's Older Person Assessment Unit

- **productivity and quality improvements e.g.** Creation of protected beds for elective activity with an on-the-day admissions lounge for orthopaedics, surgery and neurosurgery. This frees up bed capacity as patients are not admitted the day before their procedures

- **utilisation and capitalisation of off-site care provision e.g.** Homeward - increased use of community care at home post discharge, use of other acute providers, both NHS and private for elective procedures (though at an extra cost to the Trust)

In addition to existing measures we are constantly reviewing options to support existing initiatives.

King's College Hospital NHS
NHS Foundation Trust

3. New enhanced recovery ward

The transformation of Orpington Hospital continues as we open new services and facilities on site. The most recent was in November last year when we opened a brand new facility for neurorehabilitation.

The Ontario ward offers an 'enhanced recovery service'. It has been specifically designed to provide care for patients who are medically stable after having neurosurgery or have a neurological condition, but would benefit from more time in a care setting with a suitable level of rehabilitation.

There are currently 10 beds on the ward, with plans to increase this to 20 in the coming months. Patients for this service live in Bromley, Bexley or further into Kent. No Lambeth or Southwark patients are transferred to this ward. Patients are referred to the ward following their neurological procedure at King's College Hospital in Denmark Hill or the Princess Royal University Hospital (PRUH).

Over 40 patients have already been referred to the ward and the feedback has been very positive, with patients praising staff and reporting a good experience.

Not only is the ward providing patients with a quiet and tranquil space for the final stage in their recovery it is helping to free up much needed capacity at Denmark Hill and the PRUH.

Agenda Item 6

Item No.	Classification: Open	Date:	Meeting Name: Healthy Communities Scrutiny Sub-Committee
Report title:		Southwark Safeguarding Adults Board Report 2013-2014	
Wards or groups affected:		All	
From:		Deborah Klee, Independent Chair of Southwark Safeguarding Adults Board	

RECOMMENDATIONS

1. The sub-committee is requested to:

   Note the Annual Southwark Safeguarding Adults Board Report at appendix 1.

EXECUTIVE SUMMARY

2. The Annual Report was agreed by the Safeguarding Adults Partnership Board in January 2015. The Board includes representatives from the local authority, NHS, Metropolitan Police, and community organisations.

3. Statutory guidance No Secrets (2000) requires the Local Authority to convene a Safeguarding Adults Board to determine policy, co-ordinate activity between agencies, facilitate joint training, and monitor and review progress in achieving stated aims and objectives. The Board has an independent chair. The current chair has been in post since January 2014 and this is her first annual report to the Board.

4. This report is one of the methods whereby the Safeguarding Adults Board enables challenge and transparency across the multiagency partnership in Southwark. This report relates to the work of the Board and its partner agencies in the year 2013-2014. Agencies represented on the Board have contributed to the writing of the Report and have commented on the final draft.

BACKGROUND INFORMATION

5. The report provides information on the activity and effectiveness of the Safeguarding Adults Partnership as it has responded to both national initiatives and legal changes and local circumstances in order to better safeguard adults at risk in Southwark.

6. The report describes how the Southwark Safeguarding Adults Partnership has responded to the demands of the Care Act 2014. It outlines the local initiatives to deliver local care to people with learning disabilities who challenge services that the Winterbourne Hospital Review and Concordat requires. The report also describes the local initiatives to promote compassionate care demanded by the Francis report on

Mid-Staffordshire Hospital.

7. The report includes details of the quality strategy for residential and nursing care homes developed by the Safeguarding Partnership in conjunction with My Home Life and provider partners.

8. 2012 – 2013 highlighted a comparatively high percentage of alleged abuse carried out by social care workers in Southwark. As a result of the quality strategy and better monitoring of care provided in care homes and the person's own home numbers of allegations of abuse by social care workers have fallen by 4% and are now below the national and comparator group median.

9. In April 2013 local authorities became the statutory supervisory body for all Deprivation of Liberty Safeguards (DoLS) authorisations. In March 2014 the Supreme Court gave additional clarification of DoLS which effectively widened the circumstances under which a person could be seen as being deprived of their liberty. This led to an immediate significant increase in referrals for authorisation. This challenge will continue.

10. A multi-agency thresholds document has been produced by the Safeguarding Adults Team to assist staff in determining whether allegations should become safeguarding enquiries. This was adopted by the Board in March 2014

11. Arrangements have been put in place to ensure the 2014-2015 Annual report will be produced and circulated earlier.

KEY ISSUES FOR CONSIDERATION

12. This report outlines development areas for the coming twelve months to improve the work of the Board and ensure compliance with the Care Act 2014. These are:

- Develop Three Year Strategy and annual work plan for the Safeguarding Adults Board

- Establish subgroups with realistic work plans to deliver the work required.

- Ensure partners and providers are aware of the widening of the Deprivation of Liberty Safeguards Criteria and create resources to deal with the increased workload including training more qualified best interest assessors

- Ensure all partners and providers are aware of their wider responsibilities under the Care Act 2005 (e.g. best interest decisions) through provision of appropriate training in all sectors, such that the Board is in a strong position to take on its statutory role in 2015.

- Develop a protocol and forum for joint work with the Southwark Safeguarding Children's Board, the Safer Southwark Partnership and the Health and Well-being Board

- Carry out a qualitative and process audit of safeguarding adults practice

POLICY IMPLICATIONS

13. The work of the Safeguarding Adults Board is consistent with the Council's Farer Future priorities as stated in the four-year Council Plan.

COMMUNITY AND EQUALITIES STATEMENT

14. The work of the Safeguarding Adults Board particularly affects adults at risk/vulnerable adults and their families. It is a partnership set up under statutory guidance to ensure effective safeguarding of adults at risk in Southwark and ensure accountability of partner agencies.

LEGAL IMPLICATIONS

15. The Safeguarding Adults Board is set up under statutory guidance contained in No Secrets (2000). From April 2015 it will be a statutory board as a result of provisions contained within the Care Act 2014

FINANCIAL IMPLICATIONS

The activities of the Safeguarding Adults Board are currently wholly funded by Southwark Council

BACKGROUND PAPERS

Background Papers	Held At	Contact
No Secrets (2000)		John Emery
Winterbourne Hospital Review and Concordat (2012)		John Emery
Mid-Staffordshire NHS Foundation Trust Inquiry Report (2013)		John Emery
Care Quality Commission; State of Care 2013-2014		John Emery
Health and Social care Information Centre: Safeguarding Adults Report England 2013-2014		John Emery

APPENDICES

No.	Title
Appendix 1	Southwark Safeguarding Adults Board Annual report 2013-2014

AUDIT TRAIL

Lead Officer	Jay Stickland		
Report Author	Jon Newton/John Emery		
Version	Final Report		
Dated	20 January 2015		
Key Decision?	No		
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER			
Officer Title		**Comments Sought**	**Comments Included**
Director of Legal Services		No	No
Strategic Director of Finance and Corporate Services		No	No
Strategic Director of Children's and Adults' Services		No	No
Date final report sent to Scrutiny Team			21 January 2015

Southwark Safeguarding Adults Partnership Board

Annual Report 2013-14

Contents

Foreword by the Chair of the Southwark Safeguarding Adults Partnership Board

This is my first annual report as Independent Chair for the Southwark Safeguarding Adults Partnership Board. I joined the Board in January 2014. It has a history of strong partnership working and was impressed with the commitment of all its partners.

The Board has had a busy and productive year and its agenda has grown. It was a year of change. The Care Act was being drafted. The Act will put adult safeguarding boards on a statutory footing. *Making Safeguarding Personal* (LGA and ADASS April 2013) was published, a pivotal report for a change in culture, making safeguarding adults outcome focused rather than process driven. I was privileged to be the project manager of this national study and author of the report. People achieving the outcomes that they want and feeling in control when supported by safeguarding services is an aspiration for the Board and one that we will work towards in 2014.

Sadly the year started with two major national reports highlighting unacceptable care involving the neglect and abuse of vulnerable adults. Both of these inquiries led to recommendations and actions for partnership boards and statutory agencies and the annual report covers them in detail.

The Winterbourne View serious case review report (Dec 2012) followed a Panorama programme that uncovered the systematic abuse of vulnerable adults in a unit for adults with a learning disability. The Safeguarding Adults Board has been working with the local Winterbourne View Steering Group to ensure that lessons have been learned and actions taken to safeguard vulnerable adults in Southwark.

The second report was Francis report on the Mid Staffordshire NHS Foundation Trust inquiry (Feb 2013). The NHS Foundation Trusts represented on the Board provided regular reports to the Board on the implementation of programmes to deliver compassionate care in response to the lessons learnt in Mid Staffordshire.

This year the board has focused on getting assurance that the quality of care provided by social care workers in the person's own home and in care homes is being monitored, that action is taken to prevent abuse by improving the quality of care and that responses to abuse and neglect are proportionate and robust. This was in response to a comparatively high percentage of alleged abuse carried out by social care workers in Southwark in 2012-13. This has now reduced by 4% and is below the national and comparator group median.

In April 2013 local authorities became the statutory supervisory body for care home and hospital Deprivation of Liberty Safeguards (DoLS) authorisations. The Board monitored this change in the management of DoLs applications. In March 2014 the Supreme Court offered additional clarification of DoLS, effectively widening the circumstances under which a person could be seen as being deprived of their liberty. This led to a significant increase in referrals for DoLs from March 2014, a challenge that is likely to continue.

In April 2015 safeguarding adults boards will be on a statutory footing, so our Board needs to develop a strong infrastructure with sound governance arrangements so it works effectively in safeguarding adults in Southwark. As Independent Chair I will ensure that this is achieved.

Deborah Klee
Independent Chair
Southwark Safeguarding Adults Partnership Board

Section 1: Introduction - What is abuse?

In 2000 the Government published ***No Secrets***. This required local authorities to set up a multi-agency framework to ensure not only a coherent policy for the protection of vulnerable adults at risk of abuse, but also a consistent and effective response to circumstances that gave grounds for concern. It gave local authorities a role in coordinating safeguarding activities.

No Secrets defines a vulnerable adult as:

A person aged 18 years or over "Who is or may be in need of community care services by reason of mental or other disability, age or illness: and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation",

And abuse as:

"A violation of an individual's human or civil rights by any other person or persons".

Both definitions are adopted by the *Protecting adults at risk: London multi-agency policy and procedures* from which Southwark derives its protocols and guidance.

Abuse may consist of a single act or repeated acts. It may be physical, verbal or psychological, it may be an act of neglect or an omission to act or it may occur when a vulnerable adult is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the person.

Abuse can happen anywhere and take place in any context, for example, in someone's own home, in nursing, residential or day care settings, in hospital, in public places or in custodial situations. Vulnerable adults may be abused by a range of people including relatives, neighbours, other service users, professional workers, friends and strangers.

The Care Act 2014, which will consolidate provisions from various Acts into a single, framework for care and support, is a fundamental reform of the way the law works. With wellbeing at the heart of the Act, it will provide a new framework for adult safeguarding. As the first ever statutory framework for adult safeguarding, it will stipulate local authorities' responsibilities, and those with whom they work, to protect adults at risk of abuse or neglect. These provisions require the local authority to carry out enquiries into suspected cases of abuse or neglect and to establish Safeguarding Adults Boards in their area.

Section 2: The National Context

Introduction

The year ending March 2014 continued a period of unprecedented change and increased demand for health and social care services. Key documents published in 2013-2014 influenced the safeguarding agenda. They include:

Making Safeguarding Personal (April 2013)[1]

This document is the final report of the Making Safeguarding Personal project and brings together the findings from the four test sites and other councils. Making Safeguarding Personal focuses on establishing a person-centred, outcome focused approach to adult safeguarding. The document sets out the following:

- Practicalities and lessons learned from the projects
- Outcomes for people
- Impact on social work practice
- Cost effectiveness

Southwark will increasingly work on MSP principles from 2014.

The Care Act (May 2014)[2]

This Act consolidates provisions from many Acts into a single, framework for care and support. It is a fundamental reform of the way the law works. It places the wellbeing, needs and goals of people at the centre of the legislation to create care and support which fits around the individual and works for them. It provides a new focus on preventing and reducing needs, and putting people in control of their care and support. For the first time, it brings carers into the law, on a par with those for whom they care.

The Act also provides a new framework for adult safeguarding. It sets out the first ever statutory framework for adult safeguarding, which stipulates local authorities' responsibilities, and those with whom they work, to protect adults at risk of abuse or neglect. These provisions require the local authority to carry out enquiries into suspected cases of abuse or neglect and to establish Safeguarding Adults Boards in their area. The role of these Boards will be to develop shared strategies for safeguarding and report to their local communities on their progress.

The Act repeals local authority intervention powers to remove adults from their homes. It does not propose any new intervention powers in their place, but recognises the views of some stakeholders that local authorities should have some ability to intervene positively to protect adults from abuse or neglect.

[1] http://www.adass.org.uk/AdassMedia/stories/making%20safeguarding%20personal.pdf

[2] http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

The Care Act received Royal Assent in May 2014.

Section 3: Local Context

2013/14 saw the Southwark's Safeguarding Adults Partnership Board membership continue to expand. The Board's governance structure now meets much of the expectation of the forthcoming Care Act. Work continues to ensure this remains the case.

Members of the Board include representatives from the Local Authority, Southwark Clinical Commissioning Group, South London and Maudsley NHS Foundation Trust, Guys & St Thomas NHS Foundation Trust, Kings College Hospital NHS Foundation Trust, Metropolitan Police, London Fire Brigade and Community Action Southwark (representing local community and voluntary organisations).

Locally, the Local Authority and the Clinical Commissioning Group developed their roles in relation to safeguarding adults, particularly as 'chairs' of Board's sub groups.

Generally, there were a number of priority areas that were worked on during 2013-14. They include:

- preparing to meet the demands of the Care Act 2014
- continuing to develop responses to the Winterbourne View Concordat
- enhancing local initiatives to provide compassionate care to hospital patients (a response to the Francis Report).
- ensuring a better approach to safeguarding in residential and nursing care

This report will describe the actions taken locally to meet these challenges.

Section 4: Southwark Multi- Agency Training

Southwark safeguarding multi-agency training

The Safeguarding Adults' Board training and development sub-group comprises a cross section of organisations, contributing to adult care in the borough, to review and create the right training interventions and, to maintain a highly skilled workforce.

In 2013/14 a formal review and benchmarking exercise was undertaken to evaluate the content and delivery of the learning programme. As a result, the Adult Safeguarding Learning Strategy was reviewed, supported by a delivery plan to provide a focused framework for future workforce skills and knowledge.

The learning strategy creates a shared vision and purpose for learning and development. It clearly outlines multi-agency standards and ambitions. Work also commenced on integrating adults' and children's safeguarding learning programmes, where appropriate, as well as providing access to particular Southwark social care professional development support.

Key training performance indicators 2013/14

There has been a significant increase in the number of people completing the online awareness raising programme (level 1). This was primarily due to a specific campaign amongst housing and community services workers. It is open to anyone working with adults at risk in Southwark (https://safeguarding.southwark.gov.uk) and over 5,000 people have completed the e-learning since its launch in 2010.

Overall attendance at safeguarding training sessions has increased by 34% in the past year. Courses are well received with an average 81% positive impact evaluation from participants[3]. There was an increased take-up for Safeguarding Alerter courses from across the partnership and increased demand for domestic violence training.

There is further work to do around non-attendance in certain areas, particular with associates, both in terms of the learning and financial impacts.

Ongoing work

Work continues to support effective learning and development in this area, including:

- Development standards (competency) framework – a universal online tool to support staff to assess "continuing personal development" and practice supervision
- Developing an accreditation framework for all safeguarding training
- Undertake a programme of "impact assessments" to evaluate the effectiveness of learning in practice in the business
- Continuing to increase e-learning programmes – providing greater accessibility to learning opportunities and pre-learning before attending workshops
- Ongoing review and update of training and development requirements in line with wider changes in legislation, including the Care Act

[3] This is based on a post-evaluation survey completed four days after a learning programme.

- Specific targeted programme of interventions to focus on raising the knowledge and awareness of the Mental Capacity Act and Deprivation of Liberty Safeguards

Section 5: Partner Highlights

Southwark Council

Overview of 2013-14

April 2013 saw Adult Social Care reorganise its structure and approach to ensure more focus on personalisation. Support from the Safeguarding Adults Service however, was unaffected and continued to support the newly formed services and teams. The Safeguarding Service continues to support the functions of adult safeguarding across adult social care through policy implementation, practice guidance and quality assurance in adult protection, mental capacity and deprivation of liberty safeguards.

Key Achievements

Following the review of the Southwark Safeguarding Adults Partnership Board (SAPB) sub groups the Head of Organisation Development chairs the Learning and Development Sub-group. The purpose of the sub-group is to offer the SAPB assurances around the purpose and quality of the training offer around safeguarding adults.

The local authority continued to work in partnership with the CCG to meet the requirements of the Winterbourne View Concordat. This work has been supported the Winterbourne View Steering Group and a development of a CCG and LA Strategic Local Area Plan with high level outcomes for people with learning disabilities. Progress is monitored against this action plan at the steering group.

Southwark Safeguarding Partnership together with My Home Life and provider partners produced a quality strategy covering quality assurance, integrated working, safeguarding, workforce development and working together in the future.

A multi-agency thresholds document was produced by the Safeguarding Team. This followed an event in December 2013 aimed at developing a joint threshold with a neighbouring Borough with the aim of supporting mutual local partners. Based on work of other London Boroughs, a Threshold agreement was adopted in March 2014 (see Appendix One).

Southwark Clinical Commissioning Group

Overview of 2013-14

Southwark Clinical Commissioning Group (CCG) came into being on 1 April 2013. The CCG has continued to work in close partnership with the Local Authority (LA) with regards safeguarding adults.

The CCG's has a Safeguarding Executive Committee with membership from all key partners. The Clinical Lead for Safeguarding is a member of the Executive Committee. The Safeguarding Executive Committee reports to the Southwark Clinical Commissioning Committee via the Integrated Governance & Performance Committee and directly to NHS England, via the Chief Nurse.

As commissioners of heath care provision Southwark CCG are committed to ensuring that all contracted services have the appropriate systems in place to safeguard and are compliant with the safeguarding alerting processes in Southwark.

Key Achievements

Following the review of the Southwark Safeguarding Adults Partnership Board (SAPB) sub groups the CCG Head of Continuing Care & Safeguarding chairs the Quality and Performance Sub-group. The purpose of the sub-group will be to offer the SAPB assurances around the quality and of the local safeguarding adult responses and though this to improve the effectiveness of the Board.

The CCG continued to work in partnership with the LA to meet the requirements of the Winterbourne View Concordat. This work has been supported the Winterbourne View Steering Group and a development of a CCG and LA Strategic Local Area Plan with high level outcomes for people with learning disabilities. Progress is monitored against this action plan at the steering group.

The CCG monitors and reports to NHS England on all health care commissioned hospital placements and client placed inappropriately in hospital (assessment and treatment) to ensure that these clients are transferred to community based transport as soon as possible. Working in partnership with the LA and Mental Health Services, a number of discharges to community based care for clients, originally identified as being in hospital for a significant period of time, have been achieved. These include transfers to supported living arrangements and family homes.

In order to raise awareness around the Mental Capacity Act (MCA) and the roles and responsibilities of health practitioners the CCG have provided training within the protected learning time programme. The CCG have also secured further funding from NHSE to support a specific training programme on MCA for General Practices 2014/15.

Section 6: Priority Areas for 2013-14

Safeguarding Adults Partnership Board Response: Care Act 2014

As noted earlier the Care Act became law in April 2014. However, in response to the expected changes the Act will bring Southwark Safeguarding Adults Partnership has, following the appointment of Deborah Klee as the new independent chair reviewed its membership and created a simplified sub-group structure. The membership now includes representatives from Southwark Housing, Healthwatch, GP's, and Community Action Southwark in addition to representatives from Adult Social Care, NHS and the Police. The new sub-groups are: Prevention and Awareness Raising chaired by the local authority Head of Organisational Development, and Quality and Performance chaired by the CCG Head of Continuing Care and Safeguarding. The HR and Recruitment sub-group (joint with Southwark Safeguarding Children's Board) will continue as previously. On the basis of guidance provided thus far by the Department of Health these sub-groups, which concentrate on quality, prevention and safer recruitment, will provide a solid basis on which to comply with the demands of the Act and, more importantly, improve outcomes for adults at risk of abuse in Southwark.

Information leaflets published by the Department of Health regarding safeguarding adults under the Care Act are clear that safeguarding enquiries should not be a substitute for commissioning action via contract compliance nor should they be a substitute for management action on the part of a provider. In response to this guidance in December 2013 Southwark Safeguarding Adults Partnership in conjunction with Lambeth Safeguarding Partnership held a joint seminar to develop common thresholds for initiating formal safeguarding enquiries. Whilst it was not possible to develop a common agreement between the two boroughs Southwark safeguarding Adults Partnership has gone on to develop a thresholds document (see Appendix 1) that offers guidance to operational staff carrying out safeguarding enquiries.

Care Act guidance states that each Safeguarding Adults Board must produce a strategic 3 year plan and associated work plan. Guidance to the Act also states that the Board should seek to integrate its work with other relevant Boards such as the Southwark Safeguarding Children's Board and Safer Southwark Partnership. The Southwark Safeguarding Adults Board will seek to complete both of these areas during 2014-2015.

The Care Act is explicit in stating that all safeguarding enquiries should seek to achieve the outcome or outcomes stipulated by the adult at risk, or their representative in situations where the adult at risk lacks capacity to make an informed decision regarding the alleged allegation of abuse. To achieve this end Southwark Safeguarding Adults Partnership will sign up to the national 'Making Safeguarding Personal' initiative in autumn 2014 with a view to achieving 'Gold' standard over three years. During year one the Partnership will aim to achieve 'Bronze' standard by demonstrating that together with the adult at risk we identify their preferred outcomes from the safeguarding enquiry, that we involve the person throughout the enquiry and that we can demonstrate that we have done these things and achieved their preferred outcomes at the end of the process.

Response to the Winterbourne Hospital Review & Concordat

A multi-agency steering group undertook the response to the DH Winterbourne View Hospital Review and its associated Concordat. The group, chaired by the Director of Adult Social Care, initiated a programme of work to meet the demands of the Concordat. Beginning initially with reviews of all service users placed in hospital or assessment and treatment settings and then moving towards the ultimate aim of development of greater capacity locally to provide services that meet the needs of both children and adults with learning disabilities that challenge services. The foundations for this ultimate aim will be laid between April 2013 and June 2014.

The table in Appendix Two lists key achievements thus far and illustrates how these initiatives correspond with safeguarding principles:

Significant progress has been made during the last year on the actions set out in the 2013 Winterbourne View Steering Group Action Plan.

In July 2013 Southwark took part in a national stocktake which was designed to enable local areas to assess their progress against commitments in the Winterbourne View Concordat, share good practice and identify development needs. The report, published jointly by the Local Government Association and NHS England, was an analysis that covered all 152 Health and Wellbeing Board areas.

Feedback from the Joint Improvement Programme Team stated that Southwark's submission provided a comprehensive picture about some excellent progress and pointers to the priorities we had identified for further work.

A Strategic Local Area Plan was completed and submitted to the Winterbourne View JIP by the deadline required by *Transforming Care* (April 2014).

Local Initiatives to Provide Compassionate Care to Hospital Patients

The Francis Report (2013)[4] into the care at Mid Staffs Hospital between 2005 and 2008 concluded that the large number of deaths were due to the concentration on targets and the achievement of foundation trust status at the expense of maintaining compassionate values in the delivery of care.

Guy's and St Thomas' NHS Foundation Trust has continued to develop its 'Barbara's Story' training package which now consists of six episodes and is now available in shortened form on You Tube for the general public to see. The package has been evaluated for effectiveness by London South Bank University and concluded that the first episode of Barbara's Story made a lasting impression on staff, prompting them to reflect on their own practice and that of others, leading to resolutions for improvements. It was also reported that there was strong evidence that Barbara's Story raised awareness of dementia and, more generally, patients' experience and their need for help.

Both King's College Hospital NHS Foundation Trust and South London and Maudsley NHS Foundation Trust have strengthened their safeguarding adults teams during 2013 – 2014. King's have appointed a Head of Safeguarding for the Trust and are looking to appoint to a number of safeguarding posts across their sites whilst SLAM have appointed a Director of Social Care and are looking to appoint an Adult Safeguarding Lead. Both trusts are looking for these posts to improve responses to adult safeguarding allegations and also to embed a compassionate approach to care in both organisations.

[4] Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry

Quality in Residential and Nursing Care

The CQC in its State of Care 2013/2014[5] report stated there was a slight improvement in the quality of adult social care overall. However, performance on safety and safeguarding was slightly weaker than 2012/2013. In particular, the CQC found that people living in nursing homes continued to receive poorer care than those living in residential homes with no nursing provision whilst care homes with a registered manager in place delivered better quality care than those without a manager.

Against CQC performance standards homes with a manager delivered 10-15% higher performance than those without. In Southwark the prevalence of alleged abuse of adults at risk who live in care homes in 2013/2014 was 22% of the total number of alerts whilst in comparator boroughs it was 22.5% and 36% nationally. (See Appendix 2 Chart 3.5)

Southwark Safeguarding Partnership together with My Home Life and provider partners has produced a quality strategy covering the following domains:

- Quality Assurance
- Integrated Working
- Safeguarding
- Workforce Development
- Working Together in the Future

The strategy can be found here:
http://moderngov.southwark.gov.uk/mgIssueHistoryHome.aspx?IId=22385&optionId=0

The impact of the strategy will be evaluated in November 2014, and the findings will be used to produce a refreshed action plan.

In addition to working with providers proactively to improve services the Southwark Safeguarding Partnership still responds robustly to instances of poor care and neglect. For example, one care home in the borough has been under embargo since February 2014 as a result of issues with care planning, multiple medication errors, staffing and management. Staff from Adult Social Care, Southwark Commissioning and NHS partners have been working with the provider to implement a recovery and improvement plan.

[5] State of Care 2013/14

Mental Capacity Act/DoLS Activity 2013/2014

The Mental Capacity Act Deprivation of Liberty Safeguards (MCA/DoLS) came into effect on 1st April 2009.

It amended a breach of the European Convention on Human Rights and provided for the lawful deprivation of liberty of those people who lack the capacity to consent to arrangements made for their care or treatment in either hospitals or care homes, but who need to be deprived of liberty in their own best interests, to protect them from harm.

Until April 2013, CCG's and local authorities (designated as 'supervisory bodies' under the legislation) had the statutory responsibility for operating and overseeing the MCA/DoLS whilst hospitals and care homes ('managing authorities') have responsibility for applying to the relevant CCG or local authority for a Deprivation of Liberty authorisation. After April 2013, local authorities became the sole statutory supervisory body for both care home and hospital DoLS authorisations and in Southwark, the Safeguarding Adults Team manages this responsibility. In 2013-2014 the team processed a total of 45 DoLS authorisations of which 41 were authorised and 4 refused. (See Appendix Three for further details)

The legislation includes a statutory requirement for all care homes and hospitals as well as local authorities to keep clear and comprehensive records for every person deprived of their liberty. This includes records of applications for authorisations, details of the assessment process, information about the relevant person's representative and the documentation related to termination of authorisation.

On March 19th 2014, the Supreme Court handed down its judgement in the case of *P v Cheshire West and Chester Council* and another' and *P and Q v Surrey County Council*. In this judgement, the Court ruled that a deprivation of liberty takes place when the person is under continuous supervision and control, and is not free to leave, and the person lacks capacity to consent to these arrangements.

The Court held that factors that are not relevant to determining a deprivation of liberty include the person's compliance or lack of objection and the reason or purpose behind a particular placement. The Court also said that the relative normality of a placement given the person's needs was not relevant. The Court also held that a deprivation of liberty can occur in domestic settings where the state is responsible for imposing such arrangements. This includes supported living arrangements and, on occasion, the person's own home. Where there is likely to be a deprivation of liberty in such placements these must be authorised by the Court of Protection.

The effect of this judgement will be to create a great demand for DoLS assessments. As an indication of this increased demand, by the end of March 2014 the Safeguarding Adults Team had received requests for 41 assessments for DoLS authorisations compared with 45 requests for the whole of 2013-14.

Section 7: Safeguarding Statistical Analysis

Safeguarding activity continued to increase in general through 2013-14 and there were particular increases higher than the previous year. Appendix Three contains Southwark's statistics in comparison to our (nationally recognised) comparator councils.

Highlights

- 665 safeguarding adults referrals progressed to a safeguarding enquiry
  This represents a 24.7% increase in enquiries over 2012/2013.
  This is 40% higher than the median of 475 in Southwark's London comparator group. (See Appendix Four, Chart 1)[6].

- Referrals divided equally between younger adults (18-64) & older adults (65+) - 50%.
  Comparator group figures are 43.5% (18-64) and 57.5% (65+)
  Nationally figures are 37% (18-64) and 63% (65+)
  (Appendix Four, Chart 1.1)

- 54% of alleged abuse of older adults is against the older elderly (75+).
  This is recognised as a factor in national surveys (e.g. Action on Elder Abuse 2007). Those aged 75+ are more likely to be in poor health, dependent on others and are more likely to live alone or be isolated all of which are factors that increase the likelihood of abuse.

- Nationally the most prevalent form of abuse reported was neglect and acts of omission at 30% of all reports, followed by physical abuse with 27%. Whilst in Southwark 22% of allegations were concerning neglect, whilst 27% of allegations were regarding financial abuse and 25% involved physical abuse.

- The most common location for allegations of abuse was the adult at risk's own home, the respective figures being nationally 42%, in Southwark 46% and the local comparator group median 51%. Care homes were the next most common location for allegations of abuse with the national figure being 36%, the local comparator group median 22% and Southwark 23%.

- The most common source of risk (alleged perpetrator) was most commonly someone known to the alleged victim but not in a social care capacity. The figures were local comparator median 52.5%, Southwark 43%, nationally 49%. Social care employees were the source of risk in 36% of allegations nationally. The local comparator median was 30% and in Southwark the figure was 28% compared with 32% in 2012/2013.

[6] Health and Social Care Information Centre: Safeguarding Adults Return Annual Report England 2013-14

Section 8: Priorities for the next 12 months

- Develop Three Year Strategy and annual work plan for the Safeguarding Adults Board

- Establish subgroups with realistic work plans to deliver the work required.

- Ensure partners and providers are aware of the widening of the Deprivation of Liberty Safeguards Criteria and create resources to deal with the increased workload including training more qualified best interest assessors

- Ensure all partners and providers are aware of their wider responsibilities under the Care Act 2005 (e.g. best interest decisions) through provision of appropriate training in all sectors, such that the Board is in a strong position to take on its statutory role in 2015.

- Develop a protocol and forum for joint work with the Southwark Safeguarding Children's Board, the Safer Southwark Partnership and the Health and Well-being Board

- Carry out a qualitative and process audit of safeguarding adults practice

Appendix One: Southwark Safeguarding Adults Threshold Decisions

Threshold decisions are made in relation to whether or not an alert concerning an adult, who meets the *No Secrets* definition of 'vulnerable', is allegedly subject to abuse by a third party and is in need of consideration by the Protecting Adults at Risk: London Multi Agency Policy & Procedure to safeguard adults from abuse http://southwarkadults.proceduresonline.com/pdfs/protect_adults_at_risk.pdf

Threshold decisions are made on the basis of a combination of the factors the most important of which is **significant harm** to the individual concerned. The power dynamic between people in a harmful situation also needs to be assessed as a contributor to significant harm as it may render them powerlessness to stop or prevent on-going abuse (i.e. being unable to protect oneself).

The following two tables encompass 1) a description of areas for consideration in making threshold decisions, together with 2) a range of scenarios which may reflect either poor practice or abuse, dependent upon the facts of the particular case/incident to be considered.

This document is only a guide to decision-making and should not replace professional judgment. Any incident that poses a risk of abuse or has resulted in abuse of a vulnerable adult should be reported as a safeguarding incident. However, when conducting safeguarding enquiries /investigations it is imperative to establish what outcomes the adult at risk wants from such an investigation and at the end of the investigation to check that these have been achieved.

Acknowledgement - this information has been adapted from work by Kate Spreadbury undertaken for the South West Joint Improvement Partnership Adult Safeguarding Programme

Acknowledgement – this information has been adapted from *Collins M. Thresholds in Adult Protection- the Journal of Adult Protection Volume 12 Issue 1, February 2010*

With thanks to the London Borough of Camden Safeguarding Adults/DoLS Service

Areas for consideration in decision making

Consideration	Possible Information Source	Decide
Nature of alleged abuse	Persons own account Witness account Reports to police, CQC Alerter account	Does this alleged abuse meet the definitions of abuse in No Secrets? **If not:** Consider whether it is possible to effectively signpost to another source of support **If yes:** Did the alleged abuse lead to actual harm? Is there a strong possibility it will lead to future harm? Is there significant harm?
Power issues		
The person needs the assistance of others to attend to their basic needs	Persons own account Alerter account Agency records	Is the person experiencing difficulties in accessing protection or ensuring their own human or civil rights are met? Is there potential for the risk to increase because the alleged perpetrator is responsible for the persons care or well being?

Consideration	Possible Information Source	Decide
The person lacks the mental capacity to assess risk or decide on protective courses of action	Mental capacity assessment	Is the person's vulnerability and likelihood of significant harm increased as a result of them being unable to assess risk or decide on a course of action increases?
The person is under duress	Persons own account (interview separately) Accounts of others, e.g. alerter, other agencies Existing records	Are there others in control of the person's life, either by controlling access to services, delivering care, living at the same address, who are exerting duress?
The person is isolated	Persons own account Accounts of others, e.g. alerter, other agencies Existing records	Is the isolation making it hard for the person to self protect or get assistance? Do they have family or friends who will speak up on their behalf if needed? Is there the likelihood of the person being targeted by people who want to exploit them?
The person has experienced previous abuse	Persons own account Accounts of others, e.g. alerter, other agencies Police records Other records	Does the person's internalised feelings of worthlessness or low expectations of others people (possibly as a result of experience of either their own abuse or the abuse of others) affect their perception of the situation? Has the person experienced domestic abuse? Are they still in an abusive relationship? Does the person feel powerless and unable to change their situation? If a previously abusive partner or family member is now dependent on the person they have abused (domestic abuse or child abuse) could there be a possibility of retribution, or maintenance of previous power dynamics?

Consideration	Possible Information Source	Decide
The person, or person allegedly harming them, is addicted to substances or gambling	Persons own account Accounts of others, e.g. alerter, other agencies Existing records	Is the addiction affecting the alleged abusive situation? Is it likely to prevent action being taken to resolve the safeguarding situation? Is the person dependent on the alleged abuser to sustain their addiction? Is the alleged abuser focused on using the person to maintain their habits and not on the person's well being? Is the influence of addiction leading to risky behaviour, dis-inhibition and poor judgments?
Impact of the alleged abuse on the person		
Physical impact	Documented injuries Accounts/reports from medical practitioners Persons own account Accounts of others	Safeguarding adults procedures are designed to protect people who are unable to protect themselves without assistance, therefore any physical injury should lead to consideration of use of SA procedures If SA Procedures deemed inappropriate but concerns remain consider effective signposting to appropriate agency/source of support.
Emotional impact	Persons own account Observations of others	What impact is the emotional distress having on the persons' quality of life? Is the impact immediately obvious? Is there potential that it will emerge at a later date? Does the person appear to be having difficulty remembering the cause of the incident or event, but is showing general anxiety or fearfulness? Is the person having difficulty articulating their feelings?

Consideration	Possible Information Source	Decide
Other risks		
This has occurred in the past	Existing records Persons own account Accounts of others	Is there a pattern of incidents suggesting this is not a "one off "event and that there is potential that the people, or others, are still at risk.
Likelihood that the risk will occur again	Risk assessment using all the above	Does the allegedly abusive person still have contact with the person? Is the person still living in circumstances that mean other incidents may occur if risk factors are not explored?
Others, including children, are at risk of further harm	Existing records Persons own account Accounts of others	Is there a need to make a referral to safeguarding children's services? Should information be passed to MAPPA and MARAC? Should Information be passed to the Hate Crime/Safety Intervention Panel?
Course of action		
What is the persons preferred course of action?	Persons own account	Has the person concerned indicated that they want no further action taken?
	Persons expressed desired outcome?	Is there any early information on what their preferred course of action would be?

Allegations which may not pass the threshold for use of the Safeguarding Adults Procedure	Allegations which will pass the threshold for use of the Safeguarding Adults Procedure
Poor Practice: Person does not have within their care plan/service delivery plan/treatment a section that addresses need such as • Management of behaviour to protect self or others • Need for liquid diet because of swallowing difficulty • Cot sides to prevent falls and injuries but no harm occurs	Possible abuse A failure to specify in a person's plan how a significant need must be met. Inappropriate action or inaction results in harm such as injury, choking, etc. * **If this is also a common failure in all care plans in the Care Home/Hospital/Care Agency then the threshold will be passed for whole service/ institutional abuse investigation*
Poor Practice: Person's needs are specified in treatment or care plan but plan is not followed. Needs are not met as specified but no harm occurs	Possible abuse: A failure to address a need specified in the persons plan and which results in harm. This is especially serious if it is a recurring event or is happening to more than one adult. **If this practice is evident throughout the care home/hospital/care agency, and not just being perpetrated by one member of staff, the threshold will be passed for whole service/institutional abuse investigation*

Poor Practice: Person does not receive necessary help to have a drink/meal on one occasion	Possible abuse: A recurring event or one that is happening to more than one adult. Harm occasion: weight loss, hunger, thirst, constipation, dehydration, malnutrition, tissue viability, medication problems. **If this is a common occurrence in this setting or there are no policies/protocols in place regarding assistance with eating or drinking, or prescribed medication, the threshold will be passed for whole service/institutional abuse investigation*

Allegations which may not pass the threshold for use of the Safeguarding Adults Procedure	Allegations which will pass the threshold for use of the Safeguarding Adults Procedure
Poor Practice: Person does not receive the necessary help to get to the toilet to maintain continence, or have appropriate assistance such as changed incontinence pads on one occasion	Possible abuse: A recurring event or one that is happening to more than one adult. Harm: pain, constipation, loss of dignity and self-confidence, skin problems. *If this is a common occurrence in this setting, or there are no policies/protocols in place or evidence of staff knowledge of pressure sore risks, the threshold will be passed for whole service/institutional abuse investigation*
Poor Practice: Medication is not administered as set out in the care plan to a person as prescribed or is not given to meet the persons current needs	Possible abuse: A recurring event or one that is happening to more than one person. Inappropriate use of medication that is not consistent with the person's needs. Harm: pain is not controlled, physical or mental health condition deteriorates/person is kept sleepy/unaware; side effects noticeable; put at risk. *Continual medication errors, even if they result in no significant harm are a strong indicator of poor systems, staff compliance or training. Urgent remedial action, either via safeguarding adults or quality improvement strategies must be undertaken.*

Allegations which may not pass the threshold for use of the Safeguarding Adults Procedure	Allegations which will pass the threshold for use of the Safeguarding Adults Procedure
Poor Practice: Person who is known to be susceptible to pressure ulcers has not been formally assessed with respect to pressure area management, but no discernible harm has arisen yet	Possible abuse: Person has not been formally assessed and/or advice not sought with respect to pressure area management; or plan not followed. Harm: avoidable significant tissue damage. *If this is a common occurrence in the setting, or there are no policies/protocols in place or evidence of staff knowledge of pressure ulcer risks, the threshold will be passed for whole service/institutional abuse investigation*
Poor Practice Person does not receive recommended assistance to maintain mobility on one occasion	Possible abuse A recurring event or one that is happening to more than one person resulting in reduced mobility. Harm: loss of mobility, confidence and independence. *If this practice is evident throughout the care home/hospital/care agency, and not just being perpetrated by one member of staff, the threshold will be passed for whole service/institutional abuse investigation*

Allegations which may not pass the threshold for use of the Safeguarding Adults Procedure	Allegations which will pass the threshold for use of the Safeguarding Adults Procedure
Poor Practice: Appropriate moving and handling procedures are not followed or staff are not trained and competent to use the required equipment but the person does not experience harm	Possible abuse: Person is injured or the non-use of moving and handling procedures makes this very likely to happen. Harm: injuries such as falls and fractures, skin damage, lack of dignity. If *this practice is evident throughout the care home/hospital/care agency, and not just being perpetrated by one member of staff, the threshold will be passed for whole service/institutional abuse investigation*
Poor Practice: Person has been formally assessed under the Mental Capacity Actand lacks decision specific capacity e.g. from traffic. Steps taken to protect them are not `least restrictive`. Steps need to be reviewed and a referral for Deprivation of Liberty Safeguards may be required Monitor via reviews	Possible abuse Restraint/possible deprivation of liberty is occurring (e.g. cot sides, locked doors, complete control over person's daily life, medication) and the person has not been the subject of a best interests meeting or DoLS assessment Follow up required via Safeguarding Adults/DoLS team. Harm: loss and freedom of movement, emotional distress.

Allegations which may not pass the threshold for use of the Safeguarding Adults Procedure	Allegations which will pass the threshold for use of the Safeguarding Adults Procedure
Poor Practice: Person is spoken to once in a rude insulting and belittling manner, or other inappropriate way by a member of staff. Respect for them and their dignity is not maintained but they are not distressed.	Possible abuse: A recurring event or one that is happening to more than one person. Insults contain discriminatory e.g. racist, homophobic abuse. Harm: distress, demoralisation, other abuses may be occurring as rights and dignity are not respected. If *this practice is evident throughout the care home/hospital/care agency, and not just being perpetrated by one member of staff, the threshold will be passed for whole service/institutional abuse investigation*
Poor Practice: Person is discharged from hospital without adequate discharge planning, procedures not followed but no harm occurs.	Possible abuse Person is discharged with significantly inadequate discharged planning, procedures are not followed and experiences significant harm as a consequence. Harm: care not provided resulting in increased risks and/or deterioration in health and confidence; avoidable readmission. *If the incident shows poor discharge planning throughout a hospital trust or on a specific ward then urgent remedial action, either via a whole service/institutional abuse investigation, or quality improvement strategies, must be considered.*

Allegations which may not pass the threshold for use of the Safeguarding Adults Procedure	Allegations which may not pass the threshold for use of the Safeguarding Adults Procedure
Poor Practice Person does not receive a scheduled domiciliary care visit and no other contact is made to check on their well-being, but no harm occurs	Possible abuse Person does not receive scheduled domiciliary care visit(s) and no other contact is made to check on their well-being or calls are being missed to more than one adult at risk Harm: missed medication and meals, if they are put at risk of significant harm including neglect *If this practice is evident throughout the care agency, and not just being perpetrated by one member of staff, the threshold will be passed for whole service/institutional abuse investigation.*
Poor Practice Adult at risk in pain or otherwise in need of medical care such as dental, optical, audiology assessment, foot care or therapy does not on one occasion receive required/requested medical attention in a timely fashion	Possible abuse Adult at risk is provided with an evidently inferior medical service or no service at all, and this is likely to be because of their disability or age or because of neglect on the part of the provider Harm: pain, distress and deterioration of health *If there is evidence that others have also been affected, or that there is a systemic problem within the provider service than a whole service/institutional abuse investigation must be initiated*

Allegations which may not pass the threshold for use of the Safeguarding Adults Procedure	Allegations which will pass the threshold for use of the Safeguarding Adults Procedure
Poor practice by housing providers: Person is known to be living in housing that places them at risk from predatory neighbours or others in the community and housing department/association is slow to respond to their application for urgent re-housing - but no harm occurs	Possible abuse Housing provider fails to respond within a defined and appropriate timescale to address the identified risk and harm occurs. Harm: financial, physical, emotional abuse
Poor practice by housing providers: A resident in a warden complex reports that s/he finds the warden overbearing and intrusive	Possible abuse At least one resident is intimidated and feels bullied by the warden and they are too frightened to talk about why. Harm: emotional/psychological distress
Poor practice by housing providers: Adults at risk need housing repairs arranged by their landlord. There is undue delay but repairs are completed eventually and no harm has occurred.	Possible abuse Landlord persists in not arranging repairs that are urgently required to maintain the safety of the person's environment. Harm: physical and/or emotional e.g. from dangerous wiring, damp, or lack of security
Incident between **two adults living in a care setting** One adult` taps` or `slaps` another adult but has left no mark or bruise and the `victim` is not intimidated and significant harm has not occurred. **Or** One adult shouts at another in a threatening manner and victim is not intimidated and significant harm has not occurred.	Possible abuse: Predictable and preventable (by staff) incident between two adults where bruising, abrasions or other injuries have been sustained and/or emotional distress caused. *A significant level of violent incidents between adults living in care or health settings can be an indicator of poor staff attitude, training, risk assessment, or poor supervision and management of the service. In such situations consideration should be given to whole service/institutional abuse Investigation*

Appendix Two: Winterbourne View Strategic Area Plan

Challenging Behaviour Pathway	Principle
During 2014, the council has worked with partners in SLaM and GSTT to pilot an **Enhanced Intervention Support Service** which offers: • An intensive intervention service and additional support during times of crisis for service users and their families or care providers; • Enhanced clinical service planning and step-down short-term intervention for people with complex needs and challenging behaviour returning back to borough from out of area; • Preventative work with other partners and providers (internal and external) who support people with complex needs in order to strengthen local services through training in development of capable environments, positive behavior support, consultation and quality audit; • Opportunities for the reduction in expenditure on high cost specialist residential assessment and treatment services. • A training programme for the social work team to further develop support for people with complex / challenging behaviour. Outcomes for the 6 service users included in the pilot have been positive, supporting: • Step down from assessment and treatment (1 person) • Return from out of area residential care (2 people) • Diversion from out of area residential placement (2 people). The pilot has also achieved financial savings and a business case for a permanent team is being developed. The extension of the pilot to include young people is also being explored. This initiative has been identified by the National Winterbourne View Joint Improvement Board as being an area of good practice.	Partnership & Prevention
Better support for struggling families	
An Enhanced Family Linkage Scheme has been commissioned to promote and facilitate peer support networks for those families who care for people whose behaviour challenges services. This initiative will be co-ordinated by the Challenging Behaviour Foundation and sit within Southwark Carers.	Prevention / Partnership Empowerment
Autism Pathway	
• The Joint Strategic Needs Assessment has been extended to cover both learning disabilities and autism and is an all age needs assessment. This is being developed by Adults' and Children's Services, the CCG and Public Health and will inform strategies and service provision. • Options for the development of an Adult Autism MDT are in	Partnership

progress.	
Review and move people on from hospital settings	
All adults and children as defined in *Transforming Care* were involved in their person centred reviews within the timescales set out by the Winterbourne View Joint Improvement Board. Their progress towards the least restrictive, community setting which is appropriate to their needs continues to be monitored by the Winterbourne View Steering Group. New community based, rehabilitation and step down services are being developed locally to support those people who want to move back to Southwark. This forms part of the strategic care pathway and progression approach to achieving optimum independence and choice. Providers have been encouraged to share ideas, work in partnership and develop innovative, personalised services.	Accountability/ Proportionality/ Partnership
Quality Improvement and Quality Assurance	
A multi agency Quality Improvement and Safeguarding Group meets regularly and has enhanced links with local providers. During 2014/15 work will continue to encourage providers to develop the Driving Up Quality standards across their services. This quality assurance framework will support service user and family involvement in the evaluation of services.	Partnership / Prevention / Accountability / Empowerment

Appendix Three: Deprivation of Liberty Safeguards Statistics

DOLS Summary Sheet		Count	%
Authorisation granted/not granted			
1	Granted	41	91%
0	Not Granted	4	9%
Total		*45*	*100%*
Age at case start			
18-64		15	33%
65 and over		30	67%
Total		*45*	*100%*
Gender			
1	Male	22	49%
2	Female	23	51%
Total		*45*	*100%*
Ethnic Origin			
1	White	29	64%
2	Mixed/Multiple ethnic groups	2	4%
3	Asian/Asian British	0	0%
4	Black/Black British	8	18%
5	Other Ethnic origin	1	2%
6	Not stated	5	11%
7	Undeclared/Not Known	0	0%
Total		*45*	*100%*

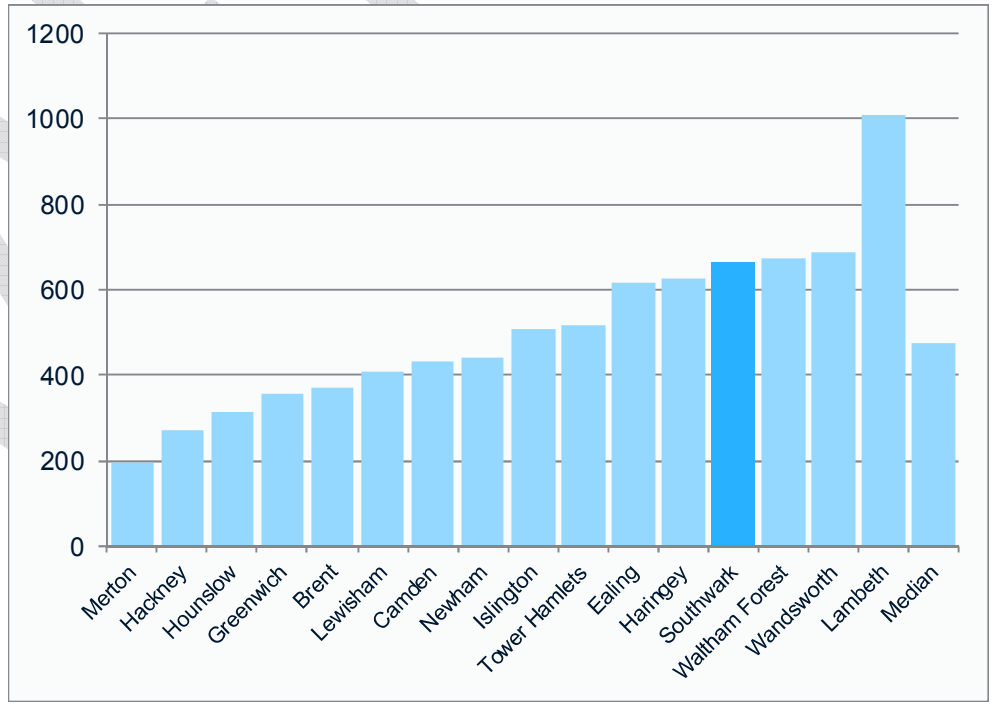
Appendix Four: Statistics 2013 - 2014

Southwark's Safeguarding Adults Return 2013-14, compared to our comparator councils

The 15 councils included in the tables below, in addition to Southwark, are those councils which the Chartered Institute of Public Finance (CIPFA) has identified as being demographically and statistically similar to Southwark.

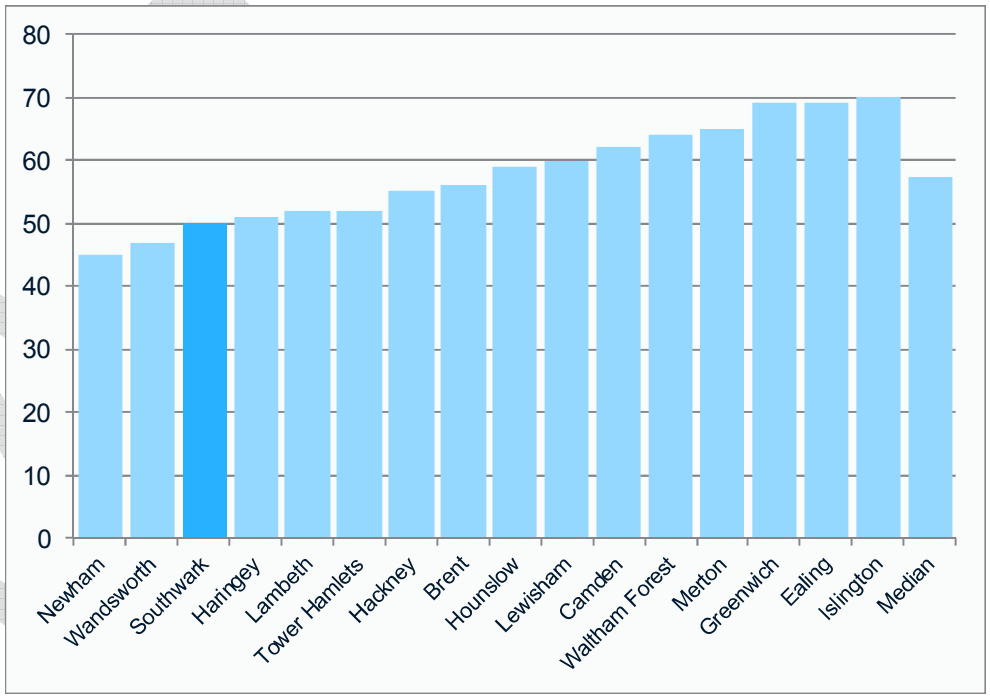
1. Individuals with an open referral

Council (in rank order)	No
Merton	195
Hackney	270
Hounslow	315
Greenwich	355
Brent	370
Lewisham	410
Camden	435
Newham	440
Islington	510
Tower Hamlets	520
Ealing	615
Haringey	625
Southwark	665
Waltham Forest	675
Wandsworth	690
Lambeth	1010
Median	475



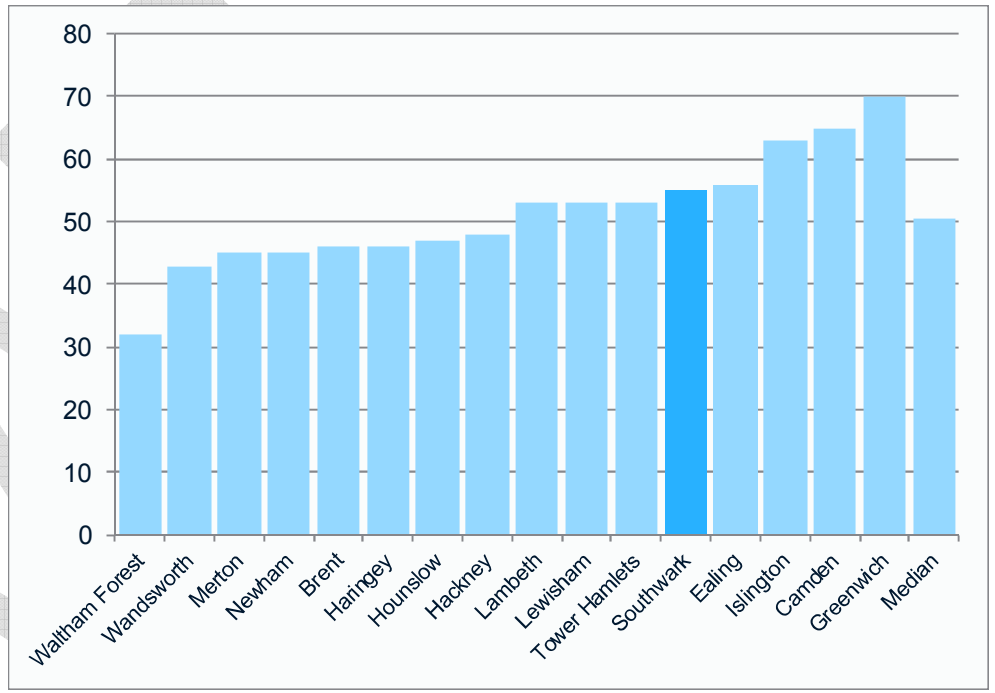
1.1 Of the open referrals, the percentage which were for people aged 65 and over

Council (in rank order)	No
Newham	45
Wandsworth	47
Southwark	50
Haringey	51
Lambeth	52
Tower Hamlets	52
Hackney	55
Brent	56
Hounslow	59
Lewisham	60
Camden	62
Waltham Forest	64
Merton	65
Greenwich	69
Ealing	69
Islington	70
Median	57.5



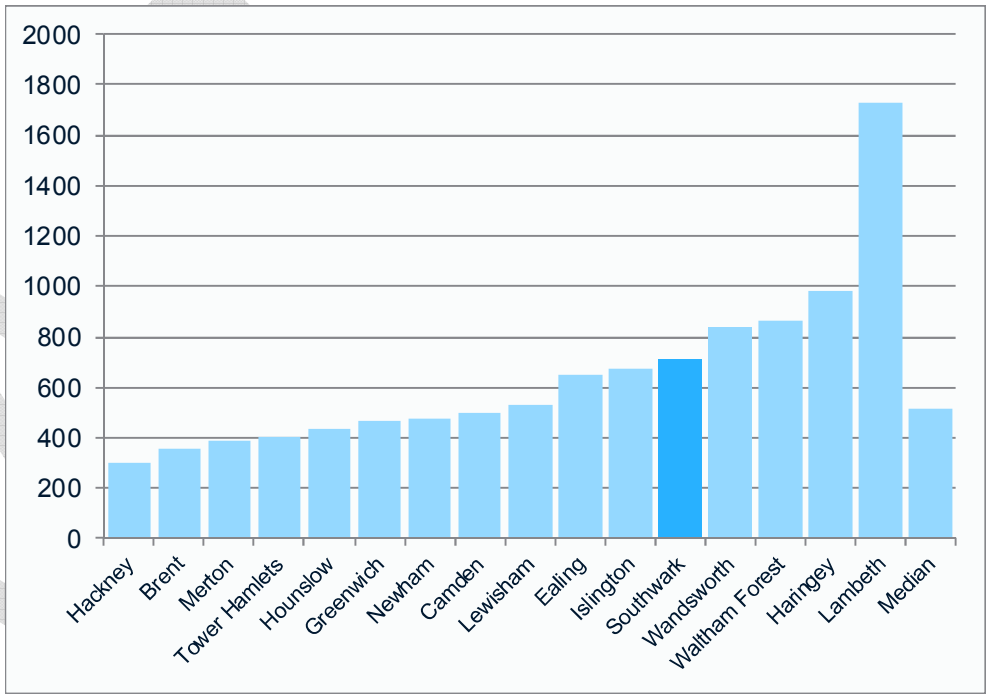
1.2 Of the open referrals, the percentage which were for people with a physical disability

Council (in rank order)	No
Waltham Forest	32
Wandsworth	43
Merton	45
Newham	45
Brent	46
Haringey	46
Hounslow	47
Hackney	48
Lambeth	53
Lewisham	53
Tower Hamlets	53
Southwark	55
Ealing	56
Islington	63
Camden	65
Greenwich	70
Median	50.5



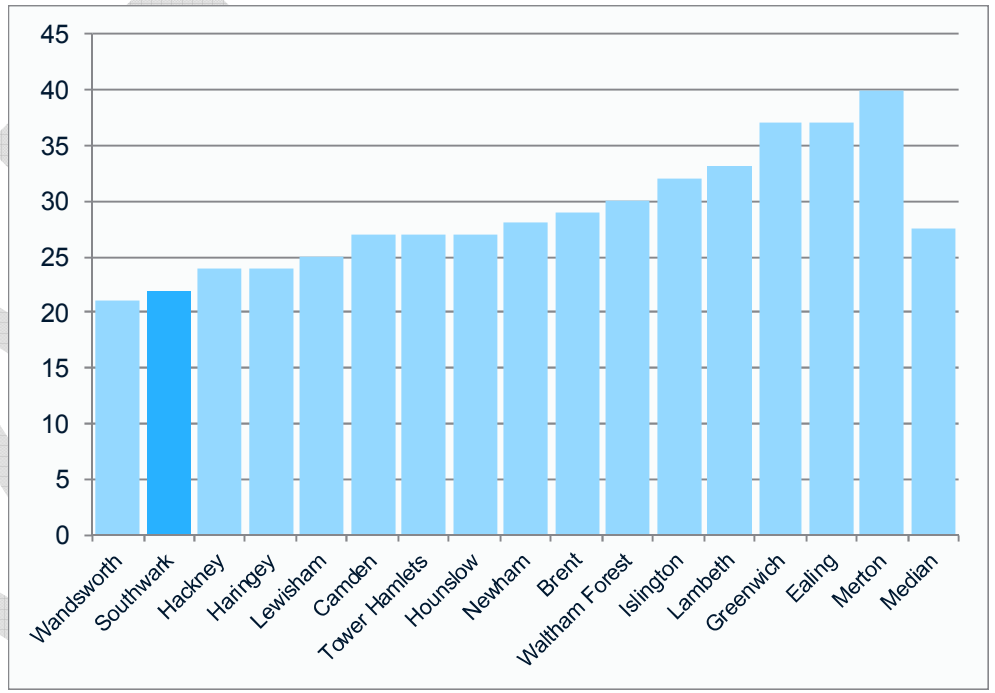
2. Total number of concluded referrals where the risk was identified

Council (in rank order)	No
Hackney	300
Brent	360
Merton	385
Tower Hamlets	400
Hounslow	435
Greenwich	465
Newham	475
Camden	500
Lewisham	530
Ealing	650
Islington	675
Southwark	710
Wandsworth	840
Waltham Forest	860
Haringey	980
Lambeth	1725
Median	515



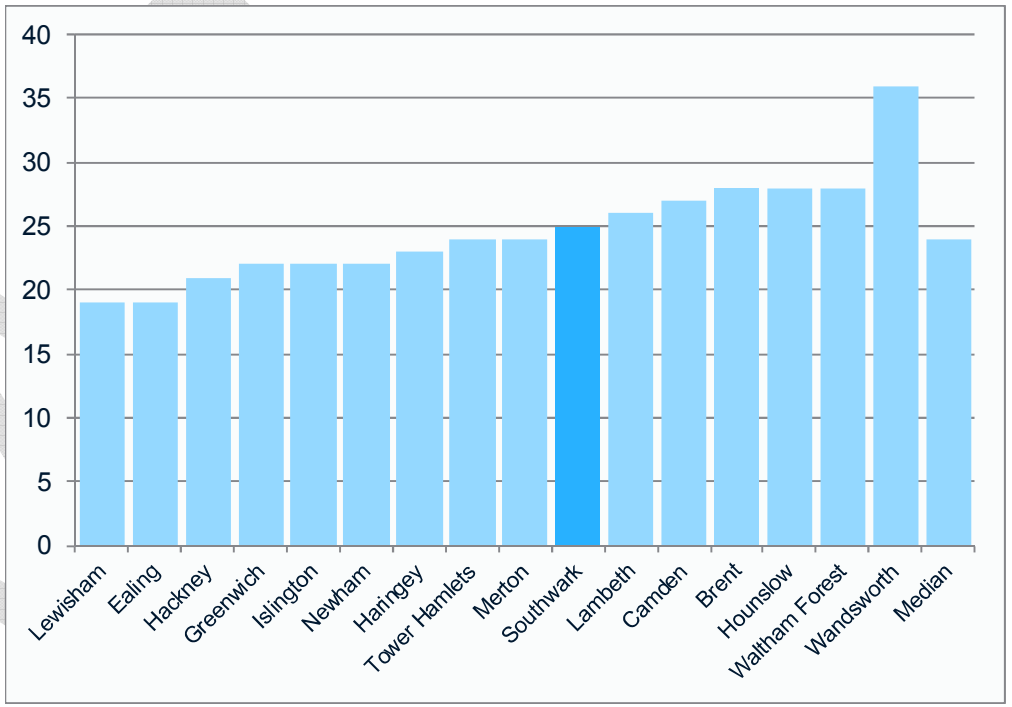
2.1 Of the concluded referrals, the percentage where the risk was identified as neglect

Council (in rank order)	No
Wandsworth	21
Southwark	22
Hackney	24
Haringey	24
Lewisham	25
Camden	27
Tower Hamlets	27
Hounslow	27
Newham	28
Brent	29
Waltham Forest	30
Islington	32
Lambeth	33
Greenwich	37
Ealing	37
Merton	40
Median	27.5



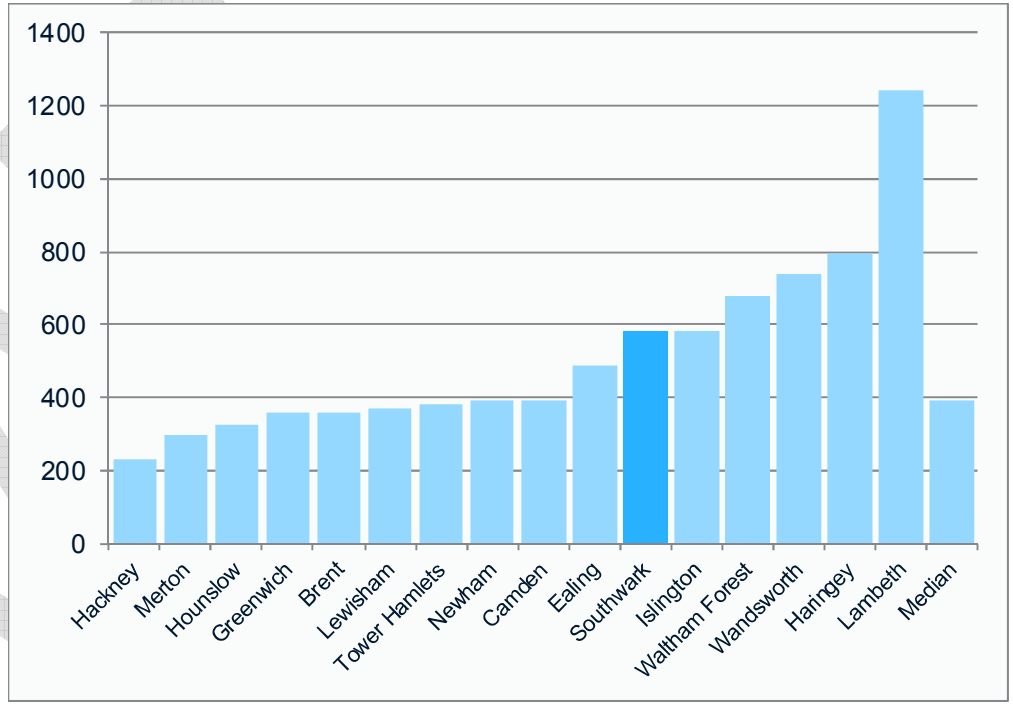
2.2 Of the concluded referrals, the percentage where the risk was identified as physical

Council (in rank order)	No
Lewisham	19
Ealing	19
Hackney	21
Greenwich	22
Islington	22
Newham	22
Haringey	23
Tower Hamlets	24
Merton	24
Southwark	25
Lambeth	26
Camden	27
Brent	28
Hounslow	28
Waltham Forest	28
Wandsworth	36
Median	24



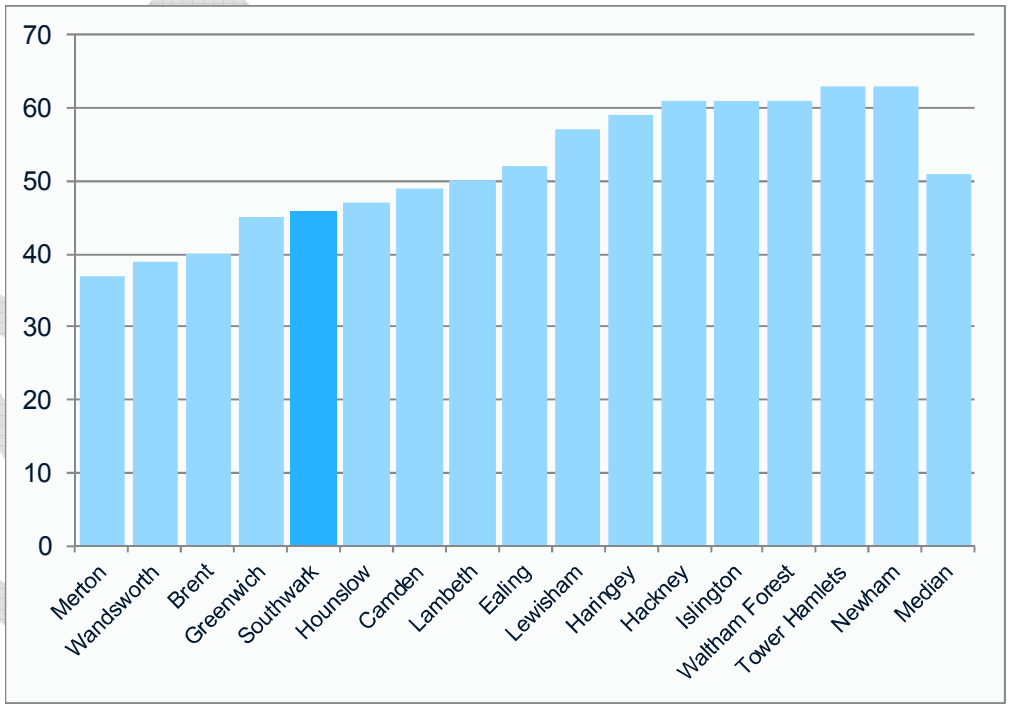
3. Total number of concluded referrals where location was identified

Council (in rank order)	No
Hackney	230
Merton	300
Hounslow	325
Greenwich	360
Brent	360
Lewisham	370
Tower Hamlets	380
Newham	390
Camden	395
Ealing	490
Southwark	580
Islington	585
Waltham Forest	675
Wandsworth	740
Haringey	795
Lambeth	1240
Median	392.5



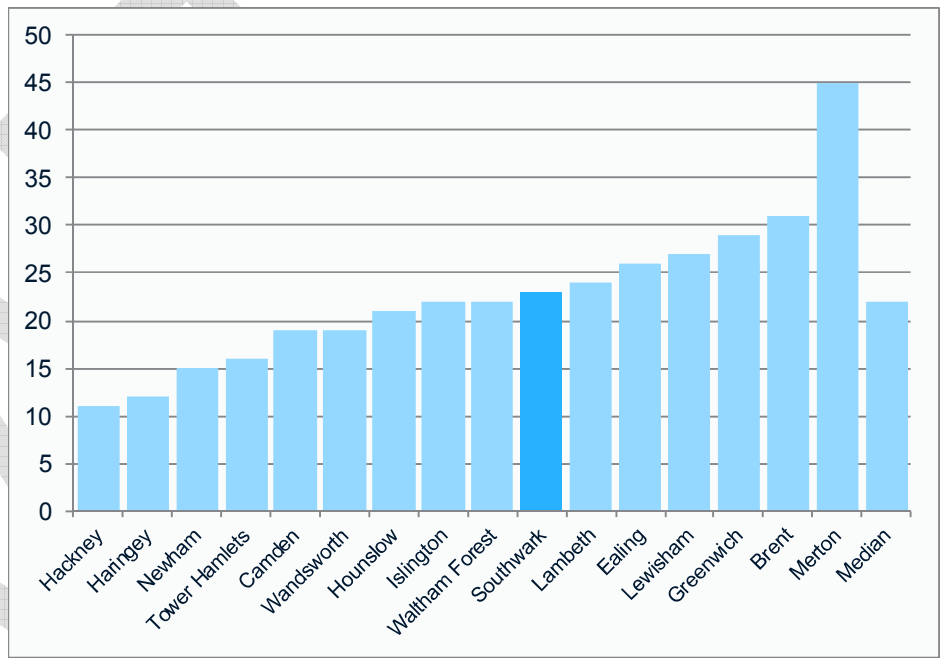
3.1 Of the concluded referrals with location identified, the percentage where the abuse took place in the victims own home

Council (in rank order)	No
Merton	37
Wandsworth	39
Brent	40
Greenwich	45
Southwark	46
Hounslow	47
Camden	49
Lambeth	50
Ealing	52
Lewisham	57
Haringey	59
Hackney	61
Islington	61
Waltham Forest	61
Tower Hamlets	63
Newham	63
Median	51



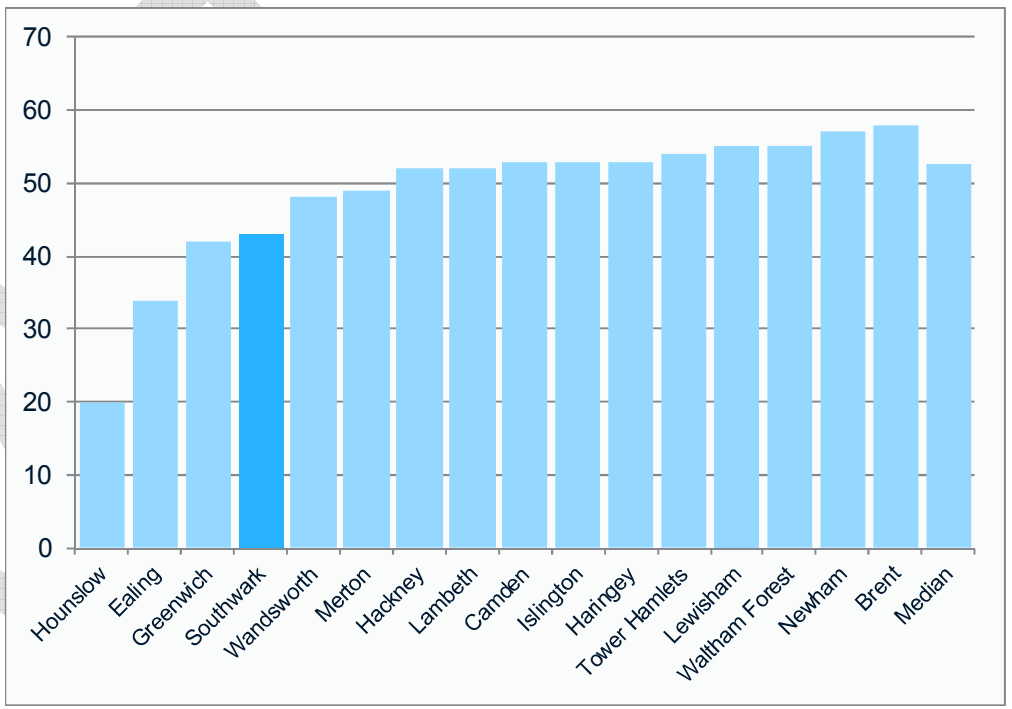
3.2 Of the concluded referrals with location identified, the percentage where the abuse took place in a care home

Council (in rank order)	No
Hackney	11
Haringey	12
Newham	15
Tower Hamlets	16
Camden	19
Wandsworth	19
Hounslow	21
Islington	22
Waltham Forest	22
Southwark	23
Lambeth	24
Ealing	26
Lewisham	27
Greenwich	29
Brent	31
Merton	45



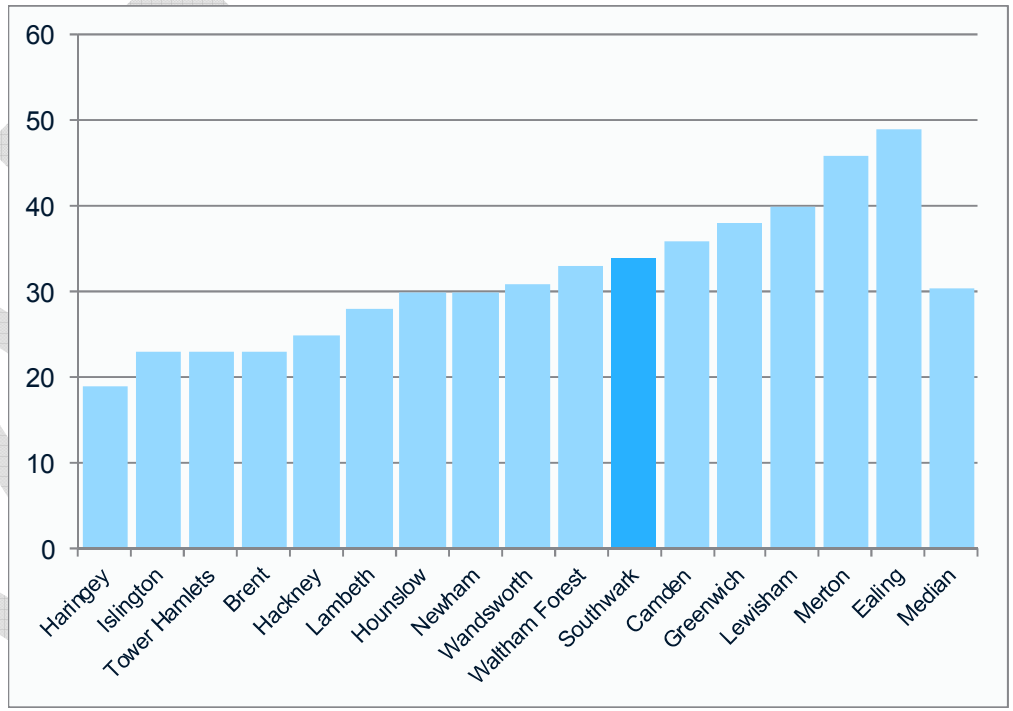
3.3 Of concluded referrals, the percentage where source of risk was known to the individual but not in a social care capacity

Council (in rank order)	No
Hounslow	20
Ealing	34
Greenwich	42
Southwark	43
Wandsworth	48
Merton	49
Hackney	52
Lambeth	52
Camden	53
Islington	53
Haringey	53
Tower Hamlets	54
Lewisham	55
Waltham Forest	55
Newham	57
Brent	58
Median	52.5



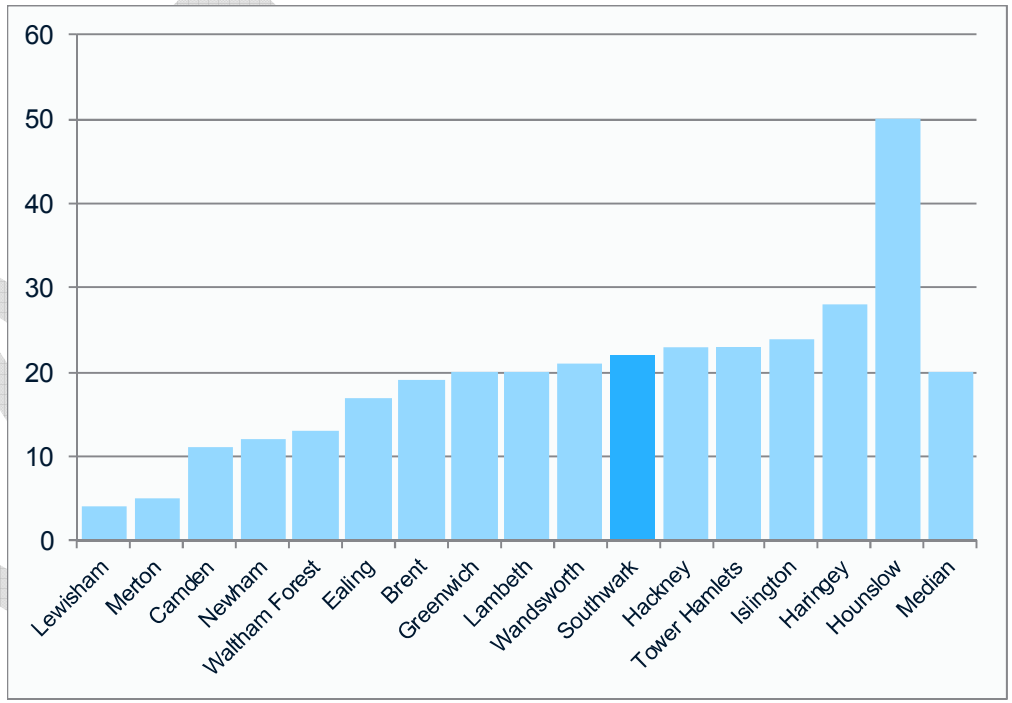
3.4 Of concluded referrals, the percentage where the source of risk was a social care employee

Council (in rank order)	No
Haringey	19
Islington	23
Tower Hamlets	23
Brent	23
Hackney	25
Lambeth	28
Hounslow	30
Newham	30
Wandsworth	31
Waltham Forest	33
Southwark	34
Camden	36
Greenwich	38
Lewisham	40
Merton	46
Ealing	49
Median	30.5



3.5 Of concluded referrals, the percentage where the source of risk was unknown to the individual

Council (in rank order)	No
Lewisham	4
Merton	5
Camden	11
Newham	12
Waltham Forest	13
Ealing	17
Brent	19
Greenwich	20
Lambeth	20
Wandsworth	21
Southwark	22
Hackney	23
Tower Hamlets	23
Islington	24
Haringey	28
Hounslow	50
Median	20



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Item No. To be completed	Classification: Open	Date: To be completed	Meeting Name: Healthy Communities Scrutiny Sub-Committee
Report title:		Personalisation: The number and proportion of people receiving cash Direct Payment and Direct Payments via a third party. Briefing Note	
Ward(s) or groups affected:		All wards	
From:		Jay Stickland Director of Adult Social Care	

RECOMMENDATION(S)

1. That the information in this report is noted.

BACKGROUND INFORMATION

2. At the October 2014 meeting of the Health Communities Scrutiny Committee Members received a report on "Personalisation in adult social care – an overview".

3. That report provided details of the ways in which people with adult social care needs and their carers may be supported to have maximum independence and choice by receiving payments to arrange services to meet their assessed needs. These payments are called Direct Payments, and they may be made direct to the person; to an authorised family member or friend; or to a 3rd party organisation designated as a Management Account Provider.

4. A question raised at the October 2014 meeting sought further information on the numbers of people who receive Direct Payments through these options. This report provides this supplementary information.

KEY ISSUES FOR CONSIDERATION

5. Appendix 1 provides the most recent available statistical data (end of Qtr 3) on the numbers and proportions of:
   - Clients using Direct Payments for the first time during the first three quarters of 2014-15
   - All clients using Direct Payments during the period

   In summary, the data shows that:

5.1 Since April 2014, there have been an average of 16 people starting Direct Payments per month – a total of 96 people.

5.2 The proportions of new DPs which are self-managed, managed by a 3rd party and managed through a MAP varies from month to month, reflecting users' choice.

5.3 Of the 96 new starters:
- 17% self-managed their Direct Payment
- 31% had their Direct Payment paid to a 3rd party
- 52% had their Direct Payment paid to a Managed Account Provider

5.4 The total number of clients using Direct Payments has increased from 877 in April 2014 to 991 at the end of September 2014.

5.5 Of the 991 clients receiving Direct Payments at the end of September 2014
- 47% self-managed their Direct Payment
- 35% had their Direct Payment paid to a 3rd party
- 18% had their Direct Payment paid to a Managed Account Provider

5.6 Southwark Council actively promotes the use of Direct Payments as a key way in which adults with social care needs and their carers can have maximum control and choice over the services that they need. Direct Payments support the Council's Personalisation agenda and the development of a pluralistic market support and care services, as described in the paper considered by the October 2014 meeting of the Healthy Communities Scrutiny Sub-Committee.

5.7 The national Adult Social Care Outcomes Framework measures the proportion of all Adult Social Care clients who receive Direct Payments. In 2013-14, the proportions of clients who received Direct Payments to arrange all or part of their support services were:

Southwark:	29.0%
England average:	19.1%
London average:	22.1%
Average of councils statistically similar to Southwark:	24.6%

Southwark's out-turn was better than the averages for England, London and for statistically similar councils.

BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
Personalisation in adult social care – an overview http://moderngov.southwark.gov.uk/documents/s49184/Personalisation%20report.pdf		Becki Hemming

APPENDICES

No.	Title
Appendix 1	Profile of payment arrangements for people receiving Direct Payments

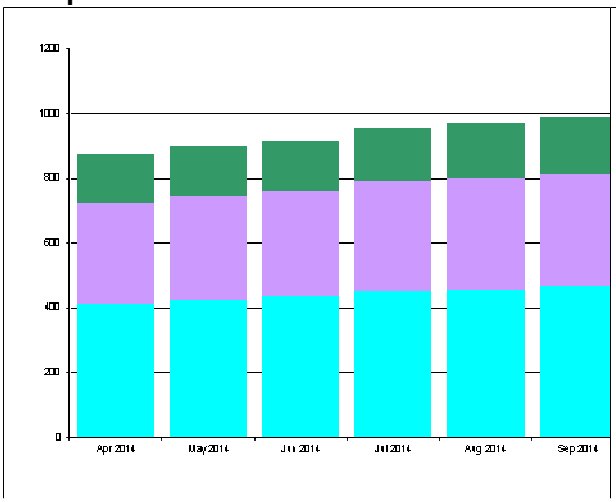
Appendix 1

Profile of payment arrangements for people using Direct Payments

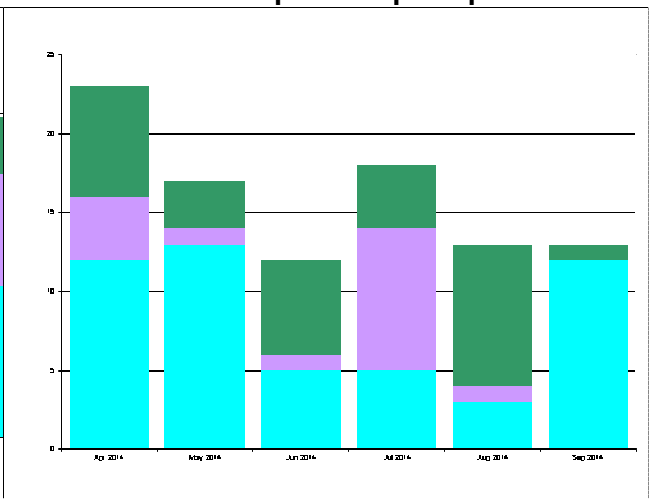
Month	MAP		Self managed		3rd Party		Total new DPs	
	New starters	All open cases	New starters	All open cases	New starters	All open cases	New starters	All open cases
Apr 2014	12	412	4	315	7	150	23	877
May 2014	13	426	1	320	3	153	17	899
Jun 2014	5	435	1	325	6	156	12	916
Jul 2014	5	454	9	337	4	164	18	955
Aug 2014	3	457	1	342	9	173	13	972
Sep 2014	12	468	0	345	1	178	13	991
Total new starters Apr-Sep 2014	50		16		30		96	

Graphs: Payment arrangements by month and by payment arrangement

All open DP users



New starters in the period Apr-Sep 2014



Pie-charts: Over the period April 2014 – September 2014, the proportions of DPs that are self-managed, paid to 3rd parties and managed via a MAP

All open DP users

New starters in the period Apr-Sep 2014

AUDIT TRAIL

Cabinet Member	Councillor Dora Dixon-Fyle, Adult Care, Arts and Culture
Lead Officer	Jay Stickland, Director of Adult Social Care, Children's and Adult's Services
Report Author	Jessica Slater, Interim Head of Adults Performance, Children's and Adult's Services
Version	Final
Dated	13 January 2015
Key Decision?	No

CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments Included**
Director of Legal Services	No	No
Strategic Director of Finance and Corporate Services	No	No
Cabinet Member	No	No
Date final report sent to Constitutional Team/Community Council/Scrutiny Team		

Agenda Item 8

King's College Hospital NHS
NHS Foundation Trust

Briefing

Briefing for: Southwark Healthy Communities Scrutiny Sub-Committee

Date January 2015

Subject Homeless emergency department attendance

Introduction

The Committee requested details on the number of people without homes that attend the King's Emergency Department at Denmark Hill, in addition to our links with homeless agencies.

Homeless emergency department attendance

King's holds data on the attendance of homeless people at our Denmark Hill Emergency Department collated as per the following categories:

- Attendances of people with no fixed abode
- Attendances of people who have attended from local hostels

A total of 317 attendances to our Emergency Department (ED) were made the last six months (Jul-Dec 2014) by people within the above categories. Almost 60% of these were from local hostels with the remaining of no fixed abode.

King's is host to a King's Health Partners Homeless Pathways Team (HPT). The team has been in situ for a year and is managed by a Senior Social Worker and comprises of a housing worker, a Nurse, a Social Worker and 4 GP sessions. The team provide the ED with a one stop shop service including advice about all local voluntary and statutory services, assisting with Homeless Persons Unit presentations and ensuring good ongoing coordinated healthcare.

The HPT received 178 referrals from ED and the Clinical Decision Unit in the last six months. Their annual report will be published shortly.

St Thomas' Hospital
Westminster Bridge Road
London SE1 7EH

Main switchboard: 020 7188 7188

Councillor Lury
Chairperson
Healthy Communities
Scrutiny Sub-Committee
160 Tooley Street,
London SE1 2QH

22nd January 2015

Dear Councillor Lury

People without homes that Guy's and St Thomas' Hospital provides care for in the Accident and Emergency Department .

At the Healthy Communities Scrutiny Sub-Committee meeting on November 11th 2014, we provided information on the access to emergency health services for people with mental health needs at Guy's and St Thomas Hospital. As requested by the committee, this paper provides supplementary information regarding the care provided for people without homes who attend our A&E department.

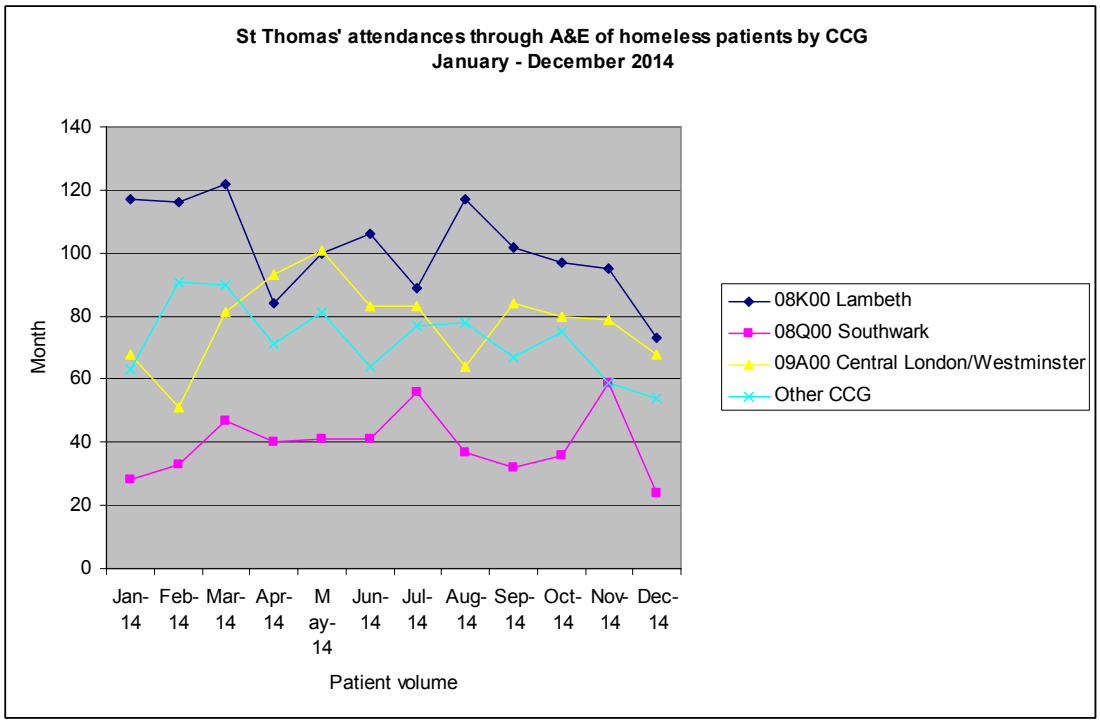
Background

It is recognised that nationally the annual cost of unscheduled care for homeless people is eight times that of the housed population and homeless people are overrepresented amongst frequent attenders in A&E. This is particularly true for Guys and St Thomas' Hospital as one of London's largest providers of unplanned secondary care to homeless people.

Prevalence

Recent data demonstrates that between January and December 2014 there were 3497 recordings of unhoused people treated through the Guys and St Thomas' A&E department, which remained consistent in distribution across the year, with a significant drop-off during December 2014. It is important to note that this figure is generally regarded as an under-representation with a further 800 patients offering address details suggestive of homelessness.

The graph below demonstrates the split by CCG, with a significantly higher proportion of homeless patients being recorded as Lambeth CCG (35%), as opposed to Southwark (14%) and Central London / Westminster (27%). Of particular note, is the high volume of other CCG approximately 25%, which represents a large split of geographical locations from across England and Wales.



Working with other Agencies

Kings Health Partners has recognised the need for a more coordinated approach to the care of unhoused people and is piloting a flag-ship service with the development of Pathway Nurse Homeless Health Practitioners who coordinate a multi-agency response across Lambeth and Southwark.

This team hosted by Guy's and St Thomas is working collaboratively with organisations such as The Passage, St Giles Trust, St Mungos Broadway and Groundswell, in order to provide this multi-agency approach. The team also liaises closely with a number of other agencies across the health and social care sector including: the Health Inclusion Team; Westminster Homeless Health Team; the START team; JHT (Westminster homeless mental health team); Lambeth, Southwark and Westminster outreach teams; Lambeth, Southwark and Westminster housing commissioners; Housing Options in each borough; Hostel managers and area managers such as Look Ahead; Mungos Broadway; Thamesreach; London Ambulance Services; Police day centres; and also data providers like CHAIN.

We would be happy to provide further information on this issue if that would be helpful.

Yours Sincerely,

Nicola Wise
General Manager
Acute Medicine Directorate

Agenda Item 9

King's College Hospital NHS
NHS Foundation Trust

Briefing: Trust update

Briefing for: Health Overview and Scrutiny – Southwark and Lambeth

Date January 2015

Subject Update on elective inpatient orthopaedic and gynaecology services at Orpington Hospital and the Princess Royal University Hospital

Contents

1. Introduction

It has now been some time since elective inpatient orthopaedic and gynaecology services began to be provided at Orpington Hospital and the Princess Royal University Hospital (PRUH) respectively.

The rationale for relocation of these services is still very relevant as demand for our services continues on an upward trajectory. Impact on the availability of beds in the key areas of general medicine and critical care remains impacted by emergency admissions levels. In putting our patients first it is important that we take measures to manage this pressure. We have already done this in a number of areas with these elective changes being a specific example.

An update on the progress following the move was last provided in October 2014. This report provides a further update of the current status and covers specific requests for information.

Overall the services are attracting a growing number of patients and the satisfaction scores remain high. Patients using the service at Orpington Hospital for example have not experienced any cancellations and the site has very recently been given a five star rating on NHS Choices.

2. Patient choice and numbers

The choice of using these services is discussed with patients during consultations including patient transport arrangements. We have now formalised these discussions with all our consultants now using a bespoke pro forma. Numbers of patients choosing to use the services are as follows. We do not currently hold data on patients who have chosen to remain at Denmark Hill but this is something we will work towards capturing for future reporting.

Elective inpatient orthopaedic

By the end of December 2014 we had seen 3,160 patients since the opening of the service at Orpington Hospital. Length of stay continues to be low with the maximum stay at three days. The service has grown steadily and we are now operating at full capacity with three operating theatres, 23 inpatient beds and around 12 procedures every day with plans to increase this to 14.

Southwark

A total of 195 Southwark elective, inpatient orthopaedic patients had their procedures at Orpington hospital.

Lambeth

A total of 249 Lambeth elective, inpatient orthopaedic patients had their procedures at Orpington hospital.

Elective inpatient gynaecology

The gynaecology service at the PRUH has seen 988 patients since opening.

Southwark

A total of 52 Southwark elective inpatient gynaecology patients have had their procedures at the Princess Royal University Hospital.

Lambeth

A total of 25 Lambeth elective inpatient gynaecology patients have had their procedures at the Princess Royal University Hospital.

3. Waiting times and cancellations at KCH, Denmark Hill

We have made progress in the reduction of waiting times for orthopaedic surgery at Denmark Hill, making more beds available on the site. When comparing 2014 with the previous year they are lower. The average waiting time in 2014 was 68 days compared to 103 days in 2013. This equates to a reduction of around four weeks. Additionally we have reduced the number of patients waiting over 18 weeks by more than half.

There has also been some reduction in cancelled procedures due to the availability of beds, down by 28 in 2014 compared to 2013.

4. Patient transport

King's provides transportation to Southwark and Lambeth patients who choose to attend Orpington Hospital and the PRUH. To date we have received not any formal complaints or had any issues raised with us regarding this transport.

5. Patient feedback

On 14 November 2014 King's attended a meeting convened by Healthwatch Lambeth, Southwark and Bromley for residents to ask us questions about the changes. The session was well attended with representation across the three boroughs and we were able to address a range of issues. See appendix 1 for an outline of the comments raised and our responses.

Orpington Hospital – Boddington, Orthopaedic ward

Friends and Family Test

The most recent Friends and Family test scores for the orthopaedic (Boddington) ward at Orpington Hospital are:

October:
95% would recommend their friends or family to have treatment on Boddington Ward
3% would not recommend their friends or family to have treatment on Boddington Ward

November:
97% would recommend their friends or family to have treatment on Boddington Ward
0% would not recommend their friends or family to have treatment on Boddington Ward

Princess Royal University Hospital - Surgical 8, Gynaecology ward

Friends and Family Test

The most recent Friends and Family test scores for the gynaecology (Surgical 8) ward at PRUH are:

October:
100% would recommend their friends or family to have treatment on Surgical 8
0% would not recommend their friends or family to have treatment on Surgical 8

November:
96% would recommend their friends or family to have treatment on Surgical 8
4% would not recommend their friends or family to have treatment on Surgical 8

Healthwatch Meeting re Service Change – 14th November 2014

Issues and responses:

1. **Issue / comment**: engagement regarding new model of care at Orpington should have happened earlier. **Response:** King's carried out engagement work with Health Overview and Scrutiny Committees for all three key boroughs, Commissioners and local Healthwatch. However, we acknowledge that there should have been more direct engagement with patients and the public about our proposals
2. **Issue / comment**: will Lambeth and Southwark patients continue to have a choice of where they have their elective orthopaedic surgery? **Response:** Yes
3. **Issue / comment**: Choice for mental health service users. **Response**: mental health service users will have the same choice as any patient as to where they have their surgery
4. **Issue / comment**: will carers / relatives of patients who have their surgery at the PRUH be provided with free transport in the same way as patients? **Response**: patient transport is being provided by private car so a family member / carer will be able to travel with the patient both on their way to Orpington for their surgery and on their way home at the end of their stay. Relatives / carers who wish to visit patients when they are in hospital will need to make their own travel arrangements
5. **Issue / comment**: will there be a reduction in orthopaedic procedures at the Denmark Hill site? **Response**: One of the aims of offering patients from Lambeth and Southwark the choice to have their elective orthopaedic surgery at Orpington is to free up capacity at the Denmark Hill site so that we can focus better on complex orthopaedic surgery, treating seriously ill patients referred to the trust's other specialties and looking after patients coming through the Emergency Department. . If a patient wishes to have their surgery at the DH site, they have the choice to do and, if a patient has complex needs, they will continue to be operated on at the DH site
6. **Issue / comment**: Have we taken on more clinical staff at Orpington. **Response**: Patients at Orpington will be operated on by surgeons working at both the PRUH and Denmark Hill. A patient's operation will be carried out by the surgeon the patient sees at their outpatient appointment. We have recruited extra nursing staff to run the wards at Orpington.
7. **Issue / comment**: patients are being told that they face longer waits and cancellations should they decide to remain at the DH site for their operation. Will they see the same consultants at Orpington as they would at the DH site? **Response: Yes**
8. **Issue / comment:** re King's designation as a Major Trauma Centre, if patients had known the impact of that becoming a MTC would have on capacity, they may have responded differently to the consultation **Response**: The emergency patients who are taking up beds booked for planned procedures are not Trauma patients. For the most part they are elderly and frail patients who have need of emergency treatment to stabilise their conditions.
9. **Issue / comment:** What's the cost of transporting patients to Orpington and how early will Lambeth and Southwark patients have to travel if they have an early operating slot? **Response:** The trust has made a commitment to provide transport for patients who choose to have their operation at Orpington. Usual pick up time would be 7 am for an 11 In terms of travel time, it is not envisaged that the journey to Orpington will necessitate an earlier pick up time by patient transport.

10. **Issue / Comment:** Pressure on the emergency department means that change is inevitable. The Trust should acknowledge this and be more transparent about its plans and proposals, avoiding management speak. Magazine @King's is all good news – need to be more realistic and talk about the challenges as well as the good news stories **Response**: The trust notes this
11. **Issue / Comment:** point size in trust Annual Report is too small for visually impaired people **Response:** The trust follows standard guidance on readability for people with visual impairment but we will look at this again
12. **Issue / Comment:** Discharge notifications need to be accurate and timely. **Response**: work is going on to improve these across all sites.
13. **Issue / Comment:** When is the option for having surgery at Orpington discussed with the patient and by whom? **Response:** A clinician will discuss the options for where to have surgery at the patient's outpatient appointment.
14. **Issue / Comment:** query on copying letters to patients Response: It is NHS policy to copy letters to patients and we do this routinely.

For further information, please contact:

Jessica Bush, 020 3299 4618 jessica.bush@nhs.net

Write report for Review 1 – Health of the Borough
4 March 2015
Review 1 Health of the Borough - draft final report. Review 2 Personalization – receive evidence from: • Hestia • Richmond Council good practice • Voluntary Day Centers • Service user survey Cabinet member interview and interview of the Leader on Public Health
Review 3 Hold Public Health scrutiny in a day and draft report Review 2 draft Personalization report
21 April 2015
Hospital Quality Accounts • hospital mortality and morbidity statistics. • hospital ward staff turnover and levels of ward staffing • summary of complaints Receive and consider Serious Incident Reports, including analysis of root causes. Complaints reports from CCG & NHS England Agree Review 3 Public Health scrutiny in a day – agree report Agree 2 Personalization – agree report

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HEALTHY COMMUNITIES SCRUTINY SUB-COMMITTEE
MUNICIPAL YEAR 2014-15

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Dated: January 2015	