Open Agenda

Health and Social Care Board

Thursday 17 February 2011
6.30 pm
160 Tooley Street, London SE1 2TZ

Cabinet Membership	Portfolio
Councillor Peter John	Leader of the Council
Councillor Ian Wingfield	Deputy Leader of the Council and Cabinet Member for Housing Management
Councillor Fiona Colley	Cabinet Member for Regeneration and Corporate Strategy
Councillor Dora Dixon-Fyle	Cabinet Member for Health and Adult Social Care
Councillor Barrie Hargrove	Cabinet Member for Environment, Transport and Recycling
Councillor Richard Livingstone	Cabinet Member for Finance, Resources and Community Safety
Councillor Catherine McDonald	Cabinet Member for Children's Services
Councillor Abdul Mohamed	Cabinet Member for Equalities and Community Engagement
Councillor Veronica Ward	Cabinet Member for Culture, Leisure, Sport and the Olympics

Southwark NHS Primary Care Trust Membership	
Mee Ling Ng	Chair & Non Executive Director
Susanna White	Chief Executive, Southwark PCT and Strategic Director of Health & Community Services
Malcolm Hines	Deputy Chief Executive and Director of Resources
Ann Marie Connolly	Director of Public Health
Dr Olufemi Osonuga	Professional Executive Committee Chair
Peta Caine	Vice Chair, Non Executive Director
Richard Gibbs	Vice Chair, Non Executive Director
Anne Montgomery	Non Executive Director
Robert Park	Non Executive Director
Edward Robinson	Non Executive Director

INFORMATION FOR MEMBERS OF THE PUBLIC

Access to information

You have the right to request to inspect copies of minutes and reports on this agenda as well as the background documents used in the preparation of these reports.

Contact

Everton Roberts, Southwark Constitutional Team 020 7525 7221
Vicky Bradding, Corporate Secretary, Primary Care Trust 020 7525 0408

Members of the committee are summoned to attend this meeting
Councillor Peter John, Leader of the Council
Mee Ling Ng, Chair of Southwark PCT Board
Date: 10 February 2011

Health and Social Care Board

Thursday 17 February 2011
6.30 pm
160 Tooley Street, London SE1 2TZ

Order of Business

Item No.	Title	Page No.
1.	**WELCOME AND INTRODUCTIONS**	
2.	**APOLOGIES** To receive any apologies for absence.	
3.	**NOTIFICATION OF ANY ITEMS OF BUSINESS THE CHAIR DEEMS URGENT** In special circumstances an item of business may be added to an agenda within five clear days of the meeting.	
4.	**DISCLOSURES OF INTERESTS AND DISPENSATIONS** All members present are required to declare at this point in the meeting (or as soon as possible thereafter), any personal interest(s) and dispensations (if any) in respect of any item or issue to be considered at this meeting.	
5.	**MINUTES** To agree as a correct record, the minutes of the meeting held on 15 July 2010.	1 - 4
6.	**MATTERS ARISING** To consider any matters arising from the minutes of the meeting held on 15 July 2010.	

Date: 10 February 2011

Agenda Item 5

Health and Social Care Board

MINUTES of the OPEN section of the Health and Social Care Board held on Thursday 15 July 2010 at 6.30 pm at Room G02c - 160 Tooley Street, Ground Floor

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PRESENT:

Councillor Peter John
Councillor Dora Dixon-Fyle
Councillor Richard Livingstone
Mee Ling Ng
Susanna White
Malcolm Hines
Ann Marie Connolly
Dr Olufemi Osonuga
Richard Gibbs
Robert Park
Edward Robinson

1. WELCOME AND INTRODUCTIONS

The joint chairs welcomed the members.

2. APOLOGIES

Apologies for absence were received from Peta Caine, Councillor Fiona Colley, Councillor John Friary, Councillor Barrie Hargrove, Councillor Catherine McDonald, Anne Montgomery, Councillor Veronica Ward and Councillor Ian Wingfield.

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

There were no late items.

4. DISCLOSURES OF INTERESTS AND DISPENSATIONS

There were no disclosures of interests or dispensations.

5. MINUTES

RESOLVED:

That the minutes of the meeting held on 18 February 2010 be agreed as a correct record.

6. MATTERS ARISING

There were no matters arising.

7. A FAIRER FUTURE FOR ALL IN SOUTHWARK - PRIMARY CARE TRUST COMMENTS

RESOLVED:

1. That the mission and commitments of the new administration as set out in 'A Fairer Future for All in Southwark' cabinet report 15 June 2010 be noted.

2. That the PCT recognises that the implementation of some of the commitments will be challenging in a time of financial restraint, however it also notes that many of the commitments will impact positively on the health of Southwark's population.

3. That it be noted that while there have been significant improvements in the overall health of the population of Southwark as shown by improved life expectancy, there are still considerable inequalities in health experience between different parts of the borough. In particular those living in the more deprived areas of the borough are more likely to become ill and die earlier. These inequalities relate not so much to health care access but to a complex mix of social, educational, economic and environmental conditions experienced by people living in Southwark.

4. That the evident commitment of the new administration to health issues is welcomed alongside the opportunities presented by the Council mission and commitments to collaborate with council colleagues and others to develop work that will contribute to health improvement. In the context of a recession with a decline in public spending it will be important to ensure that we work together as best as possible to ensure that health is protected.

8. PRIMARY CARE TRUST (PCT) STRATEGY PLAN 2010/11 - 2014/15

RESOLVED:

That the high level summary of the primary care trust strategy plan be noted.

9. STRENGTHENING NHS COMMISSIONING IN LONDON

RESOLVED:

That the report be noted.

10. FINANCE POOLED BUDGET

RESOLVED:

That the current financial position of Health and Social Care and the three operational pooled budgets set up under s75 of the National health Service Act 2006 be noted.

11. PERFORMANCE REPORT

RESOLVED:

That the latest performance with respect to the LAA targets relating to health and social care be noted.

12. PRESENTATION - CHILD OBESITY / FREE HEALTHY SCHOOL MEALS

The board received a presentation from Ann Marie Connolly, Director of Public Health on Southwark healthy weight and free school meals.

13. CABINET DECISIONS TAKEN SINCE THE LAST BOARD MEETING

RESOLVED:

That the decisions taken by the cabinet since the last meeting of the Board be noted.

14. PCT DECISIONS TAKEN SINCE THE LAST BOARD MEETING

RESOLVED:

That the decisions taken by the Primary Care Trust Board since the last meeting be noted.

15. OPPORTUNITIES FOR ESTATE SHARING

The board discussed issues relating to estate sharing.

The meeting ended at 8.22pm

CHAIR:

DATED:

Agenda Item 7

Item No. 7.	Classification: Open	Date: 17 February 2011	Meeting Name: Health & Social Care Board
Report title:		Changes in the NHS nationally and locally and implications for partnerships in Southwark	
Ward(s) or groups affected:		All	
From:		Chief Executive NHS Southwark and Strategic Director Health & Community Services	

1. RECOMMENDATIONS

1.1 The Board is asked to note:

i) The response of Southwark Council to the NHS changes as set out in the Cabinet report of 23 November 2010.

ii) The initial approach of NHS Southwark to the changes as set out in the PCT Board report of 18 November 2010.

iii) The implications of the national Operating Framework for the NHS, published in December 2010.

iv) The agreed process of due diligence between Southwark Council and NHS Southwark.

v) The joint work to develop the Health & Wellbeing Board

2. BACKGROUND INFORMATION

2.1 The White Paper *Excellence and Equity – Liberating the NHS* set out far reaching proposals affecting health services, including the abolition of PCTs in 2013, GP led commissioning , and a new Public Health role for councils.

2.2 The Cabinet of Southwark Council, at its meeting of 23 November 2010, agreed a report and recommendations on this issue. This report is attached at Appendix 1.

2.3 NHS Southwark is implementing a range of measures in response to Department of Health and NHS London guidance. These affect the long standing partnership arrangements between the two organisations.

2.4 The community health services of NHS Southwark – the "provider arm" are planned to merge with those of NHS Lambeth and move into Guy's & St Thomas's NHS Foundation Trust (GSTTFT). This is part of the separation of the commissioning and provider functions of PCTs required by the previous government and confirmed by the coalition government. The deadline for this is April 2011 and the work is on schedule. It affects many jointly provided services across adults and children's care.

2.5 Southwark Health Commissioning, the local GP Consortium was included in the 52 groups of GP practices selected by the Department of Health to be the first to take on commissioning responsibilities. The consortium is supported by the National Clinical Commissioning Network, the National Leadership Council and by national primary care bodies, such as the Royal College of GP's Centre for Commissioning.

3. MATTERS FOR CONSIDERATION

3.1 NHS Southwark has an obligation to deliver a management cost reduction of over 40% on baseline costs, in line with a target set by the DH (and passed on by NHS London through the SE London sector). The target is to reduce management cost spend from the 2009/10 outturn spend of £8.9m to no more than £5.3m. NHS London has brought the 2012/13 target forward and requires the PCT to deliver the target in full from April 2011. The target was calculated by the SE London sector on the basis that all 6 PCTs would move to an equal management cost figure per capita (based on unified weighted population, which is the basis for the NHS allocation formula). The 6 PCTs share the £29.4m Sector target envelope set by NHS London on this basis.

3.2 NHS London has required all PCTs to deliver the year 3 management costs reduction one year early, i.e. by March 2011 for a full year effect in 2011/12. A further staff consultation commenced on 22 November, and set out how the management cost reductions will be delivered. The workforce of NHS Southwark will have reduced from circa 900 in 2009, including community staff, to approximately 80 staff from April 2011, in the local Business Support Unit, supporting GP commissioners, and including Public Health staff.

3.3 The Department of Health consultation on Public Health funding and remit will run until 31 March 2011. There are early discussions as to the role of Public Health and how it will integrate into the Council. There is also concern that the funding mechanisms under discussion are adequate in providing a ring fenced grant for a range of activities to be managed locally, and nationally by the new Public Health Service.

3.4 Therefore, there has been a recent and rapid process to clarify how this would be achieved. NHS Southwark has been working with neighbouring PCTs in the SE London sector to share functions wherever appropriate. However, this has been in the clear context of preserving the local shared management and governance arrangements between the Council and the PCT.

3.5 On 15th December 2010, the Department of Health published the Operating Framework for the NHS in England 2011/12. The document states that PCTS will be grouped into clusters, to be in place by June 2011 with each cluster having a single Executive team and a single Accountable Officer with as much business as possible delegated to Borough based Business Support Units (BSUs). These units will be overseen by local committees operating as sub committees of each PCT Board.

3.6 On 31st January 2011, the Department of Health published the PCT Cluster Implementation Guidance which set out further guidance on the requirement to establish clusters by June 2011; accountability arrangements for clusters; HR guidance to support staff affected by the formation of clusters and advice, developed jointly with the Appointments Commission, on non-executive issues related to clusters.

3.7 The DH description of PCT Clusters means that NHS Southwark will not have a separate Board and will be part of the governance arrangements which will apply to the other PCTs in SE London sector. In line with the arrangements which apply to all PCTs, there will be only one Accountable Officer and one Director of Finance for the PCTs in SE London. Existing local Boards will cease from April 2011.

4. LOCAL ARRANGEMENTS

4.1 NHS Southwark has established a Clinical Commissioning Board (CCB) as a committee of the PCT Board. The CCB which consists predominately of local GPs will oversee the operation of the Southwark Business Support Unit and is chaired by a Clinical GP commissioner lead. There are 8 GP leads, two from each of the four localities in Southwark and they have been chosen by a process of selection/election.

4.2 Given the close working with the Council, and the rapid development of the GP consortium locally, the approach has been to build as much sustainability and continuity into the health/care system, at a time of major organisational upheaval.

4.3 The Southwark BSU which will carry out the responsibilities remaining at local level, including those being undertaken by the GP Consortium, is very small, consisting of approximately 50 posts. The structure has been designed with the GP commissioning leads and is intended to have the best mix of senior experienced specialist staff and supporting operational staff to deliver its objectives within available resources. The SBSU's remit will include Client Group Commissioning, which is part of the joint management arrangements that are currently in place. A SEL sector team will commission from the local Hospital services on behalf of all 6 Boroughs.

4.4 The transitional governance arrangements for SE London PCTs and Bexley Care Trust are still to be determined. However, it is clear that these could affect local partnership arrangements, though the recently published PCT Cluster implementation guidance stipulates that the establishment of PCT clusters should not lead to the dismantling of effective joint working arrangements.

4.5 The Council has initiated a Due Diligence review of the current partnership arrangements, which affect a number of senior posts, management arrangements, and pooled budget agreements. This will enable the Council and NHS Southwark to agree how best to take these issues forward and retain the significant learning and outcomes that have been achieved. The Council is also meeting with NHS London and SEL Sector senior colleagues to discuss these issues further.

4.6 Another key development of the changes will be to establish a Health and Wellbeing Board in each area. Discussions are underway, and an officer group has been established, overseen by the lead member, to take this work forward and make recommendations shortly. The Establishment of this new Board will potentially mean the demise of the current Health and Social Care Board with its functions being subsumed into new arrangements. This is still to be determined.

5. RISK FACTORS

5.1 The rapid change in the context of a tight financial position creates risk and uncertainty in the whole healthcare system. Mitigation of the risk is the key issue of this paper.

6. COMMUNITY INPUT

6.1 Many health gains have been achieved in Southwark in recent years through our joint arrangements and close working, although gaps between the richest and healthiest and the poorest communities remain large. Continued focus on this throughout a time of organisational upheaval is a big consideration. The Business Support Unit and GP Consortium have local engagement in services and their redesign, as one of their top priorities.

BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
White Paper	NHS Southwark	

APPENDICES

No.	Title
Appendix 1	Changes in the NHS and Implications for Southwark Council – Report to 23 November 2010 Cabinet

AUDIT TRAIL

Lead Officer	Susanna White, Chief Executive NHS Southwark and Strategic Director of Health & Community Services	
Report Author	Susanna White	
Version	Final	
Dated	9 February 2011	
Key Decision?	No	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / EXECUTIVE MEMBER		
Officer Title	**Comments Sought**	**Comments included**
Strategic Director of Communities, Law & Governance	No	No
Finance Director	No	No
Date final report sent to Constitutional Support Services/ PCT dispatch		10 February 2011

APPENDIX 1

Item No.	Classification: Open	Date: 23 November 2010	Meeting Name: Cabinet
Report title:		Changes in the NHS and Implications for Southwark Council	
Ward(s) or groups affected:		All wards	
Cabinet Member:		Councillor Dora Dixon-Fyle, Health and Adult Social Care	

FOREWORD - COUNCILLOR DORA DIXON-FYLE, CABINET MEMBER FOR HEALTH AND ADULT SOCIAL CARE

1. The changes currently mooted for the NHS by central government are amongst the largest and most significant for a decade. In addition, the decision to abolish NHS Southwark from April 2013 means that how primary healthcare is delivered and commissioned locally will change. What we don't know is how these changes will finally manifest itself as we are still keenly anticipating further White Papers and legislation from the Government.

2. What we do know is that the local authority will gain important new powers and that its role in health and health scrutiny will change, and that those changes will impact upon the residents of Southwark, one of the most diverse and poorest boroughs.

3. As one of the few local authorities in the country to have an integrated health and adult social care system how we react to those changes is critical. This report outlines how we will begin to prepare the council for its new role, it outlines some of the challenges that we face and how we propose to address them. This is the beginning of that journey.

RECOMMENDATIONS

Recommendations for the Cabinet

That the Cabinet:

4. notes the changes being planned and taking place in the NHS at national, regional and borough level and the continuing degree of uncertainty surrounding these developments.

5. notes the implications for the Council's arrangements for partnership working with the health sector in Southwark in both the shorter term transition period prior to the abolition of Southwark PCT in April 2013 and in the longer term.

6. welcomes the proposal from Southwark GPs to be considered as a GP consortium pathfinder and agrees to support them in this project.

7. agrees that the Council will undertake a due diligence exercise with the PCT to clarify all current joint and shared arrangements between the two organisations through which their accountabilities are currently delivered, in consideration of the changes that are taking place in the health system.

8. notes that a team in the Council is leading work on considering all of the implications that are taking place in the health system.

Recommendations for the Leader of the Council

That the Leader:

9. agrees that the Cabinet Member for Health and Adult Social Care will oversee a programme of work to implement the legislation that will follow the NHS White Paper and respond to the future government publications anticipated on public health and adult social care.

   In particular it is noted:

   - the abolition of all PCTs by April 2013
   - the establishment of consortia of GPs to commission local NHS services
   - the role of the Council at a local level, with new Health and Wellbeing Boards, to join up public health, GP consortia, childrens and adults social care

BACKGROUND INFORMATION

10. The Government published the NHS White Paper *Equity and Excellence: Liberating the NHS* on the 21st July. The paper includes proposals to transfer public health functions to local authorities by April 2012, to abolish NHS Primary Care Trusts (PCTs) by April 2013 and, in their place, to establish consortia of GPs, and to set up new Health and Wellbeing Boards that will join up the commissioning of local NHS services, social care and health improvement. Since the publication of the NHS White Paper there have been two significant further developments in the health system for Southwark:

    - The Strategic Health Authority, NHS London, have brought forward the requirement for London Primary Care Trusts (PCTs) to reduce their management costs by 54% by one year so that the whole reduction needs to be in place for April 2011.

    - The chair of Southwark's Clinical Commissioning Board (CCB), Doctor Amr Zeineldine, has written to NHS London expressing the wish of Southwark GPs to be considered for Early Adopter status for GP commissioning. This proposal has been welcomed by King's Health Partners.

11. These developments in the health system do not change Southwark Council's statutory duties and powers regarding: the provision of information regarding non-residential care services, the assessment of people who may need social care services, and the provision of support to people whose assessed needs meet local eligibility criteria. In Southwark services are provided to those whose assessed needs are critical or substantial. The Council is also required to co-ordinate multi-agency adult safeguarding arrangements.

12. The Council takes its statutory duties very seriously and it is partly for this reason that the Council has placed considerable focus on adult social care at this time. Adult social care in Southwark is currently being transformed.

13. The implementation of the personalisation agenda, the work towards meeting the Putting People First (PPF) milestones, and a new focus on both preventing people from needing to go into long term care, but also reabling people who have been in care to return to living independently in their own homes, is changing the role of clients, families, carers and social workers in this service. A new team has been set up in Older Person's South (OPS) to assess clients for personal care budgets which means that a greater number of individuals in Southwark, the majority for the first time, will be able to create and choose their own care packages rather than have these set by the Council. A new dedicated telephone line for all queries about help for older and vulnerable people is also being set up. These changes take place against a background of budget cuts as set out in the Comprehensive Spending Review (CSR), and the need to find considerable savings in this, as in other areas, of the Council's budget.

14. The Council is also considering Sir Ian Kennedy's review *Getting it right for children and young people: overcoming cultural barriers in the NHS so as to meet their needs* which was carried out in response to widespread concerns about services provided to children and young people by the NHS and other organisations following a series of high profile tragic deaths including the death of Peter Connelly (Baby P) in 2007. This report sets out how services are not always meeting the needs of children and young people, and outlines the barriers that exist which prevent this. In particular the report looks at the culture of the NHS and how this contributes to the current system. The report is an opportunity for the Council to improve joint working between childrens and adults services and to develop improved services that support people's needs throughout life, and not on the basis of how old they are.

KEY ISSUES FOR CONSIDERATION

Adult social care context

15. The changes that are taking place in the NHS are occurring in a context in which the Council continues to have statutory duties in adult social care. Through the coming period of transition, the Council will need to continue to deliver health and wellbeing outcomes, and to ensure that adults in Southwark are safe from financial, physical and other forms of abuse.

16. In addition to these duties, and in order to implement the People First (PPF) milestones and personalisation agenda, and to undertake other work to improve the customer journey in this area, the Council has established a transformational programme in adult social care.

17. The implications of personalisation on adult social care commissioning are considerable. At present, the joint Council-PCT adult commissioning service is the largest spend area of the Council. The service is accountable for some of the largest contracts let by the Council including Homecare, residential care (including the commissioning of care homes), assisted technology, mental health services, Supporting People (SP) and welfare catering. In line with a shift to a more preventative model, the division has undergone a review to develop an

increased focus on preventative services. However a model in which the Council largely commissions and provides and individuals largely take up and use services will become increasingly out-of-place at a time when more clients are utilising personal care budgets. The Council recognises that, increasingly, individuals will be taking up the opportunity to choose their own care packages, and, in light of this, that the Council will need to start taking a different role in this area.

18. The Council also aims to shift the balance of care in Southwark, that is, to move away from a system where there is more intensive nursing and residential care and towards one where people are supported to remain living in their own homes. Currently 72% of the department's total health and social care budget is spent on residential placements including nursing and care homes. However, through the transformation programme, the Council is taking action to prioritise services that help to prevent people needing to go into long-term care in the first place, but also to improve services that help those people leaving hospital or care return to living independently in their own homes.

19. A fundamental action that is being taken is the mainstreaming of the reablement service, which provides earlier, targeted interventions for older people within their own homes and communities. Of those people completing the reablement service, 71% required no further support from the Council or NHS. These changes are the beginning in a change in the Council's role, away from being a provider of care for older and vulnerable people, and towards one that enables people to live more independently for longer.

20. Whilst undertaking this significant transformation, the Council is also considering the implications of Sir Ian Kennedy's review *Getting it right for children and young people*. This review highlights a national challenge in which, on turning 16 or 18, young adults in care are moved from a children's service provider to an adult's service provider, regardless of the individual's needs.

Southwark PCT

21. The Strategic Health Authority (SHA) in London, NHS London, has set out a requirement for a reduction of PCT management costs by 54% by one year so that the whole reduction needs to be in place for the financial year commencing in April 2011. This action is being undertaken in light of a deteriorating financial situation in the NHS in London. The definition of management costs in the NHS is complex, but includes the cost of the PCT Board (Executive and Non-Executive Members), all managers who report to Executive Directors, all corporate support, including finance, but also the Provider Services arm of the PCT (that is, health visitors, district nurses and school nurses). In Southwark this reduction is around 42% as management costs have been lower generally than in London. This would require a reduction for Southwark PCT from a baseline of £8.9million to £3.6million by April 2011.

22. A number of possibilities are being considered in order for the PCT to manage this reduction. One possibility is for the Southwark PCT management team to be merged with neighbouring PCTs in order to establish one management team in the South East London sector (or possibly in two clusters). Another possibility, which does not necessarily preclude the first, is for the transfer of some PCT functions to Southwark Council to manage. A further possibility is for the transfer of some PCT functions to other parts of the NHS including the acute trusts. The

timescales to realise savings mean that there is a significant urgency in the undertaking of this work.

23. These significant changes are occurring prior to new health legislation being passed. The NHS White Paper sets out a timetable for the abolition of PCTs by April 2013 and the establishment, in their place, of consortia of GPs who will commission the majority of NHS services. It is recognised that, even without the current uncertainties that exist with the reduction in management costs in Southwark PCT, that the forthcoming changes being introduced by the Government will impact on the current health arrangements in Southwark.

24. This level of unprecedented change in the NHS contains risks for the Council. The Council will continue to prioritise the delivery of its transformation programme in adult social care, while still being required to meet its statutory accountabilities. These responsibilities will best be delivered through close working with partners in health. Southwark Council currently has joint management and commissioning arrangements with the PCT, and these arrangements are the vehicle for the Council in the carrying out of its adult social care responsibilities, that is, in the safeguarding of vulnerable adults, and in the provision of health and wellbeing outcomes in the borough.

25. In order to respond to the level of change in the health system, it is recommended that the Council commences discussions with the PCT regarding all arrangements that exist between the two organisations. This work will consider all arrangements, which will be subjected to due diligence on an "open book" basis, in order to provide clarity to the system at a time of uncertainty. The Chief Executive of the PCT is providing the Council with a "letter of comfort" which will set out the PCT's support for this exercise.

26. A team in the Council, comprising officers with expertise in adult social care, finance and corporate governance, is leading this work and will be undertaking a risk analysis of all arrangements.

<u>GP Consortium</u>

27. The NHS White Paper sets out proposals for the abolition of PCTs from April 2013. Local NHS commissioning will instead become the accountability of GP commissioning consortia, which it is envisaged will be placed on a statutory basis with powers and duties set out in primary and secondary legislation. The NHS White Paper sets out how GP consortia will be responsible for the commissioning of the great majority of NHS services.

28. Every GP practice will be a member of a GP consortium, and practices will have flexibility within the new legislative framework to form consortia in ways that they think will secure the best healthcare and health outcomes for their patients and locality.

29. On 21st October the Secretary of State for Health set out a programme to develop GP consortia pathfinders in order to support those GPs who wanted to develop consortia at the earliest possible stage. Even prior to this announcement, Doctor Amr Zeineldine, the chair of Southwark's GP Commissioning Board wrote to NHS London expressing the wish of Southwark GPs to be considered for the early adoption of GP consortia in Southwark. Doctor Zeineldine's proposal was welcomed by King's Health Partners.

30. There is a strong expectation that Southwark GPs will be accepted as an early adopter of GP consortia. NHS London have set out that any GP practices that wish to join the programme will be able to, should they be able to demonstrate:

- Evidence of strong GP leadership and support
- Evidence of Local Authority engagement or
- An ability to contribute to the delivery of the QIPP (Quality and Productivity) agenda in their locality

31. The development of a strategic relationship between the Council and GP Practices will be a new arrangement. There are a number of opportunities with this, not least the local knowledge and understanding that GP Practices will bring in the development of health and wellbeing strategies and the delivery of excellent health outcomes in the borough.

32. The Cabinet Member for Health and Adult Care met with Doctor Amr Zeineldine in October to commence a discussion on how the Council and GPs could better work together.

NHS White Paper, Equity and Excellence: Liberating the NHS

33. The NHS White Paper sets out the new coalition Government's strategy for creating a National Health Service which "achieves results that are amongst the best in the world" and, following the recent consultation on this, the Government plans to introduce a Health Bill in Parliament in late 2010.

34. The proposals outlined in the NHS White Paper are the commencement of a timetable of reform in the NHS and social care. Whilst these changes are significant, and the Council will have to undertake work to implement these, it is also important to set these proposals within the context of a number of additional publications and reforms which the Department of Health will announce over the course of this Parliament.

35. The following announcements and key dates are likely to be of particular relevance:

Department of Health Commitment	**Date**
Public Health White Paper published	December 2010
Health Bill introduced in Parliament	December 2010
Vision for Adult Social Care published	Spring 2011
Patient Strategy published	Spring 2011
Review of data returns published	Spring 2011
White Paper on Social Care Reform	2011

36. At present it would be speculative to comment on what the proposals in these publications might be. The White Paper on social care reform is likely to have particular impact, however, as it aims to set out a new funding framework for social care in the United Kingdom.

37. At a time when legislation has not yet been introduced, and in anticipation of these further Government publications, it would be premature for the Council to take action in implementing the proposals in the NHS White Paper. However there is an expectation that many of the changes will be implemented, and the

Council is therefore taking action to consider these and how these may be implemented in Southwark.

38. There are five key areas in the NHS White Paper for consideration by Southwark Council:

- The development of a new public health function
- The development of GP consortia
- The development of local HealthWatch
- The future role and functions of Monitor and the CQC
- Proposals relating to the health and wellbeing board

39. The following section summarises the proposals in the NHS White Paper for each of the five key areas. The Council has designated appropriate officers to consider each area and to, at the appropriate time, bring forward proposals and work to implement changes.

Public Health

40. The NHS White Paper sets out proposals for the establishment of a new National Public Health Service (PHS) with, at a local level, a Director of Public Health who will be jointly appointed and jointly accountable to both the PHS and to the local authority. It is proposed that the Director of Public Health will have a ring-fenced budget which would be set by the PHS. The allocation formula for these funds will include a "health premium" designed to promote action to improve population-wide health and reduce health inequalities.

41. The public health role of the London Mayor and Greater London Authority (GLA) will be a consideration in the development of a public health function in Southwark. At present there is a joint role in London of the Regional Director of Public Health (NHS London) and the Health Advisor to the Greater London Authority (GLA). One option for a newly defined Public Health Service in London would be to base this within the GLA. One possibility is that the public health budget and function in London will be split three ways, that is, between the PHS, the Mayor of London and the boroughs.

The development of GP consortia

42. The NHS White Paper sets out proposals for the abolition of PCTs. Local NHS commissioning will instead be the accountability of GP commissioning consortia, which it is envisaged will be placed on a statutory basis with powers and duties set out in primary and secondary legislation. The NHS White Paper sets out how GP consortia will be responsible for the commissioning of the great majority of NHS services.

43. Every GP practice will be a member of a GP consortium, and practices will have flexibility within the new legislative framework to form consortia in ways that they think will secure the best healthcare and health outcomes for their patients and locality. GP consortia will include an accountable officer and the NHS Commissioning Board will be responsible for holding consortia to account. GP consortia will be established in shadow form in 2011/12, and will be fully established in 2012. With the successful establishment of GP consortia, PCTs will be abolished from April 2013.

HealthWatch

44. The NHS White Paper sets out proposals which aim to strengthen the collective voice of patients with the development of HealthWatch England, a new independent body which will be located within the Care Quality Commission (CQC).

45. At a local level, Local Involvement Networks (LINks) will become local HealthWatch. The new organisations will provide advocacy and support, but will also undertake functions which are similar to that of the Patient Advice and Liaison Service (PALs) currently, with proposals, for instance, for local HealthWatch to consider complaints about GPs and NHS services and to support patients to choose their GP practices

Care Quality Commission (CQC) and Monitor

46. The NHS White Paper proposals set out a national inspectorate and economic regulatory framework for health and adult social care providers in the form of a refreshed mandate for the Care Quality Commission (CQC) and a new enhanced role for the Monitor organisation. As now, the CQC will act as a quality inspectorate across health and social care. It will operate a joint licensing regime with Monitor, and it will inspect providers against these standards to ensure compliance. The CQC will receive information to inform its inspection programme from a number of sources including HealthWatch (and HealthWatch England will be located in the CQC). Monitor will be transformed into the economic regulator for health and social care, and will promote competition, regulate prices and support the continuity of services.

Health and Wellbeing Board

47. The NHS White Paper sets out an aim to strengthen local democratic legitimacy in the NHS. One of the ways that it is envisaged that this will be achieved will be through the establishment of health and wellbeing boards, which it will be the responsibility of local authorities to coordinate. Health and wellbeing boards will take on the function of joining up the commissioning of local NHS services, adults and childrens social care, and health improvement.

48. The development of health and wellbeing boards, as set out in the NHS White Paper, will be a significant opportunity in Southwark. The boards are intended to provide a focus for strategic health decision-making. There are opportunities with this work to bring together a number of health organisations in Southwark that have not previously had an ongoing relationship, including GPs and the acute NHS trusts, in order to develop improved joined up health and social care services for the borough.

49. An additional opportunity with the development of a new Health and Wellbeing Board will be to ensure that a strong multi-agency approach exists within safeguarding. The Safeguarding Adults Partnership Board (SAPB) has recently been reviewed and an independent chair appointed. With the development of GP consortia there will be a particular opportunity to involve GPs in work to ensure that adults in Southwark are safe from financial, physical and other forms of abuse.

Community impact statement

50. There is a degree of uncertainty about how the level of change in the health system will impact on the population in Southwark. In the NHS White Paper, the Government sets out an aim "to empower professionals and providers, giving them more autonomy and, in return, making them more accountable for the results they achieve, accountable to patients through choice and accountable to the public at a local level."

51. There are opportunities with these changes, for instance, with the greater involvement of GPs in strategic health planning, and the local knowledge and expertise that GPs will bring in working with the Council and other organisations, including public health, to help improve the health and wellbeing of the people of Southwark.

52. With these changes, and in consideration of future legislation and other government publications, the Council will need to work with partners in order to ensure that, both during the coming transition period, and in the development of a new health and adult social care system in Southwark, that equalities and a respect for human rights is at the heart of the new health and adult social care system and that people who use services and their carers have fair access to services and are free from discrimination or harassment in their living environments or neighbourhoods .

SUPPLEMENTARY ADVICE FROM OTHER OFFICERS

Strategic Director of Communities, Law & Governance

53. The cabinet is being asked to:

    i) note the key issues arising from White Paper entitled "Liberating the NHS" and the likely implications of this change in the health and social care agenda and

    ii) welcome the proposal from Southwark GPs to be considered as a GP consortium pathfinder and agrees to support them in this project.

    iii) agree that the Council will undertake a due diligence exercise with the PCT to clarify all current joint and shared arrangements between the two organisations through which their accountabilities are currently delivered.

54. The Leader is being asked to agree that the Cabinet Member for Health and Adult Care will oversee a programme of work to implement the legislation that will follow the NHS White Paper and respond to the future government publications anticipated on public health and adult social care.

55. The White Paper proposes sweeping changes in the way that health services are delivered. As highlighted in the report already the White Paper it is proposed that PCTs are abolished and that GPs will take over commissioning. As an authority that has developed close ties with the PCT the decoupling of the Health & Social Care from the PCT will have significant implications for Southwark and the full extent of what this involves will need to be understood. The proposals therefore for a due diligence exercise to be pursued will be critical in informing the way forward.

56. The Health Bill is not yet before parliament but the White Paper expects it will be introduced this autumn.

Finance Director

57. The abolition of NHS Southwark has significant financial implications for the council; this is due to a number of Section 75 agreements between the council and the PCT. These arrangements set up pooled budgets – with different purposes, including joint commissioning, purchasing equipment and employing staff. The 3 biggest agreements accounted for a combined gross cost of approximately £88m in 2009/10. Another consideration is that PCT currently occupies council buildings.

58. In noting suggested ways forward, finance strongly supports a process of due diligence – whereby clarity of accountabilities is established and any transfer of accountabilities to the council is subject to appropriate checks. A stringent due diligence process is paramount to ensuring a proper evaluation of the financial risks resulting from the changes in Public Health and Adult Social Care.

BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
None		

APPENDICES

No.	Title
None	

AUDIT TRAIL

Cabinet Member	Councillor Dora Dixon-Fyle, Cabinet Member for Health and Adult Social Care
Lead Officer	Annie Shepperd, Chief Executive
Report Author	Graeme Gordon, Head of Corporate Strategy
Version	Final
Dated	12 November 2010
Key Decision?	Yes

CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments included**
Strategic Director of Communities, Law & Governance	Yes	Yes
Finance Director	Yes	Yes
Cabinet Member	Yes	Yes
Date final report sent to Constitutional Team		12 November 2010

Agenda Item 8

Item No. 8.	Classification: Open	Date: 17th February 2011	Meeting Name: Health and Social Care Board
Report title:		'Healthy Lives, Healthy People' – The Public Health White Paper	
Ward(s) or groups affected:		All wards	
From:		Dr Ann Marie Connolly	

RECOMMENDATION(S)

1. The Health and Social Care Board is asked to note the contents of the report and the implications of the implementation of the Public Health White Paper.

BACKGROUND INFORMATION

2. This paper presents the main aspects of the White Paper on Public Health, and its supporting documents, which are currently out for consultation.

3. While the White Paper is currently out for consultation, aspects relating to its implementation are already included in the Health and Social Care Bill currently going through parliament. The implementation of this White Paper, subject to the passage of the Bill, will have implications for the responsibilities of Southwark Council and transfer of responsibilities from NHS to local authority.

4. A summary of these implications in relation to the proposed new Health and Wellbeing Board has been considered at the recent Southwark Health and Wellbeing partnership board.

KEY ISSUES FOR CONSIDERATION

5. The Public Health White Paper proposes to transfer responsibilities for health improvement to local authorities. This will be supported by a ringfenced grant.

6. The council will be accountable for the achievement of a suite of Public Health Outcomes. A proposal for a Framework for these Public Health Outcomes is currently out for consultation. There is currently a potentially large number of outcomes being considered.

7. Councils will have a Director of Public Health who will be the principal adviser on health matters to the council and whose role is likely to include providing intelligence and evidence based advice, supporting and developing strategies that will improve health, and commissioning programmes and services that will help local populations to manage their own health.

8. The Council will be responsible for establishing and running the new Health and Wellbeing Boards for the local area. These boards will be responsible for strategic oversight in relation to health and wellbeing matters for all of the population including children.

9. Health and Wellbeing Boards will be responsible for producing a Joint Strategic Needs Assessment (JSNA) of the local population. This will inform the production of a Joint Health and Wellbeing strategy for the area that will be produced with the local GP commissioning consortium.

Policy implications

10. The change will mean that the existing Health and Wellbeing Board will no longer be appropriate in its scope, membership and accountability. The new Health and Wellbeing Board would most likely take over the responsibilities of the existing H&WB Board and the Health and Social Care Board. The relationship of the new Board with the LSP, Southwark Alliance and with the Children's Partnership, Young Southwark, will need to be considered.

11. The council will need to establish a Public Health function within the organisation. This will need to be in place by April 2013. However it is possible that some or all of the current functions might transfer to the council earlier using some form of jointly agreed arrangement with the PCT such as a Section 75 agreement.

12. There is much development work to be completed to establish the Health and Well Being Board in shadow form, to prepare the council for its new health responsibilities and to manage the transition period

13. While the transition is taking place the PCT remains accountable for health improvement targets and the budgets for public health are within the PCT allocation.

Community impact statement

14. There is no immediate impact on local communities. The impact will be on the council functions and accountabilities to start with. In the longer term it would be expected that this proposed approach will improve outcomes for local people through a greater focus on health improvement outcomes and through better joint planning and commissioning.

Resource implications

15. Full assessment of all the financial, resource and staffing implications in relation to the public health function transfer have yet to be carried and this is likely to take place over the next six months to a year. However this will all be subject to national legislation and transition planning at national, London and local level.

NOTE: Legal/Financial implications

16. There will be legal implications related to the transfer of accountabilities for health improvement to the council. There are also implications related to the establishment of the Health and Well-being Boards in 2013. Any possible future transfer of public health staff under a section 75 arrangement will have financial issues in relation to it.

Lead Officer	Dr Ann Marie Connolly
Report Author	Dr Ann Marie Connolly
Version	Final
Dated	February 2011
Key Decision?	No

The Public Health White Paper, new public health responsibilities of Councils and Health and Wellbeing boards

Introduction

1. HM Government launched the White Paper on Public Health '*Healthy Lives Healthy People* ' on 30th November 2010. This sets out the vision of the Secretary of State for Health for addressing key public health issues for the future. It focuses on the main health problems that the government considers important, indicates the principles that underpin an approach to improving health and sets out the structures and systems through which it plans to address these.

2. The White Paper includes a series of consultation questions to which the government is inviting responses until 8th March 2011. The document is not published by the Department of Health, rather by the Government as a whole indicating the direction of travel away from health being just an issue for the NHS and being a cross governmental issue instead. It is supported by two further consultation documents. The first sets out a proposal for the Public Health Outcomes Framework through which local government, and other bodies will be monitored on. The second consultation paper sets out proposals for how funding will flow though the public health structures and where will be the accountabilities for commissioning different elements of the system.

Health Issues in the White Paper

3. The White Paper highlights specific health issues as important. These includes the inequalities in mortality rates that are experienced by different populations across the country. It notes the influence of wider factors on health and wellbeing referencing in particular the review on health inequalities by Prof Sir Michael Marmot earlier in 2010. There is an emphasis on maternal and early child health and about developing good health for young people including issues on obesity, substance misuse and mental wellbeing. It identifies those lifestyle issues that impact on adults long term health prospects emphasizing obesity, alcohol and smoking. Mental health is included in the health issues.

4. There is a strong focus on child health and the Secretary of State wishes to increase numbers of health visitors and double the numbers of families being supported through Family Nurse Partnership.

5. There is a strong emphasis on the role of work to improve health, both getting people back into work and on engaging employers in their role of improving the health of their staff. The importance of local environment where people work, live and play is recognised, as is the sustainability agenda.

Approaches to the new public health system

6. It assumes a partnership approach to improving health and focuses on innovation in improving health and on empowering local government and local communities to reduce inequalities and improve health at key stages of life.

7. The paper outlines a Public Health Responsibility deal on food, alcohol, physical activity, health at work and behaviour change working with industry, business, employers, voluntary sector, as well as the statutory sector.

8. The principles underpinning the approach are to reach out and reach across to individuals, families, communities, workplaces business, voluntary sector and NHS as well as local government. Central government will act where it considers it relevant.

9. The approach will be to

- Strengthen self-esteem, confidence and personal responsibility
- Positively promote 'healthier' behaviours and lifestyles
- Adapt the environment to make healthier choices easier

10. The values will be to ensure that interventions happen at the right place. There is a recognition that there is a spectrum of approaches to intervention between two extremes of leaving it to the individual/ 'hands-off' or intrusive intervention. Therefore the government will recognise this spectrum and balance the freedoms of the individuals with the need to avoid serious harm and will consider different approaches for different groups of the population. The approach they propose is a ladder of interventions with 8 rungs between 'Doing Nothing' (complete freedom for the individual to choose), through providing information and on to 'Eliminate Choice' (legislative banning by government).

Local Authorities and Public Health

11. There will be a new public health system with localism at its heart with the local authority taking responsibility for health improvement of local populations. Local authorities will have new local freedoms and there will be an expectation to create local solutions that meet local needs. Council will receive a ring fenced budget to support local activity on health improvement with an expectation that the majority of services will be commissioned.

12. This will mean the transfer of functions and accountabilities for many health improvement outcomes from PCT to Local Authority. For these purposes the council will receive a ring fenced allocation or grant to support it in the achievement of its outcomes.

Directors of Public Health

13. Local authorities will have a Director of Public Health. It is proposed that they will be employed by local authorities and jointly appointed between the local authority and Public Health England (a new nationally created body). The White Paper sets out an expectation that they will be public health professionals with appropriate training and skills. Directors of Public Health will be the strategic leaders for public health and health inequalities in local communities, working in partnership with the local NHS and across the public, private and voluntary sectors. It is proposed that they will be the principal adviser on all health matters to the local authority, its elected members and officers on the health of the local population, health inequalities, developing and implementing local strategies. There is an expectation that they will also provide a high quality public health input to the NHS services and work closely with GP consortia to identify, prevent and manage a range of conditions. They will be expected to play an important role in emergency preparedness and response to major public health threats. They will contribute to Local Resilience Forums.

Public Health England (PHE)

14. There will be a dedicated and professional public health service, Public Health England with a mission across the whole of public health which will be a part of the Dept of Health accountable to the Secretary of State and not a separate legal entity. It will include elements of public health activity from DH and bring in Public Health Observatories, Health Protection Agency and the National Treatment Agency.

15. The role will include: public health advice and evidence to the Secretary of State, effective health protection services, commissioning national health improvement services including campaigns, jointly appointing Directors of Public Health with councils, allocating ring-fenced public health grants and commissioning some services from the NHS Commissioning Board

London-wide Issues

16. As there are two tiers of local democracy in London there has been debate about where the health improvement function should be placed and what are the roles of borough councils vis-a-vis the GLA. The White Paper expresses that LAs are free to take joint approaches. The Mayor of London has made a case for a city-wide approach and the Secretary of State has invited the Mayor and local authorities in London to develop proposals on how they can work collectively together to improve health in London. Prior to Christmas an agreement was reached whereby London Councils will allocate 3% of their Public Health grant for city wide work on specific health issues with potential for a further 3% depending on the success of the programme

Transition to the new Public Health system

17. With regard to the Southwark situation there will be a number of steps through a transition period before the public health function of the

council will be established. It may be a straightforward process of transferring the DPH and staff from PCT to the council, or it may turn into a more complicated process, recognising that the responsibilities of council will not be exactly the same as those of PCTs. PCTs will retain responsibilities until April 2013, albeit through some different structures, yet to be decided.

18. Further information about the process for transition will emerge nationally and London wide. This is subject to the passage of the Health and Social Care Bill through Parliament. Furthermore the proposed or shadow budgets for grants to local authorities will not be available until the 2012/13 meaning that it is not possible to be specific yet about the shape and size of the public health departments in the local authority.

19. The process for planning this transition has now commenced with the establishment of a Public Health Transition Advisory Group for London. This group has been meeting since summer 2010 and includes representatives from London Councils, GLA, Chief Executives of Local authorities, representatives of the Directors of Adults Social Services and Children's services as well as DsPH, and representatives from DH, HPA and London Health Observatory and voluntary sector. Until now there has been a considerable focus on the interrelationship between councils and the Mayors Office/GLA focussing on the Mayors duties in relation to Health Inequalities. This work culminated in an agreement in late December between councils and the Mayors office that councils will provide 3% of budget to the Mayors office to support city-wide work on Health Inequalities and Health Improvement.

20. The next stage of planning for transition is being led as a transition project at the DH level, with the project being mirrored at the London level. It is expected that there will be a project plan released shortly at national level for the establishment of Public Health England and this will inform the plans for development of all other aspects of the new public health system.

21. While this is proceeding there are a number of Councils across London which are taking a more proactive approach to the changes and are currently arranging for public health departments to transfer to the local authority with funding still through the PCT but a legal arrangement through a Section 75 agreement (of the NHS Act 2006) allowing for council management of staff and budgets. Three councils are in advanced stages of these arrangements while other areas are taking a more cautious approach to this, as they await the parliamentary processes and clarity about budgets. In Southwark with the integrated structures this has not been such a pressing issue but with the changes to the NHS structures will in time need to be resolved.

Funding and Resources for Public Health

22. There is currently a consultation document from the Department of Health on the proposals for how funding and commissioning will work for the future for public health. It identifies the main areas that the funding will need to cover and which organisation will be responsible for commissioning which service.

23. PHE will allocate ring-fenced budgets weighted for inequalities to upper tier and unitary local authorities. There will be scope to pool budgets locally in order to support local public health work. The Dept of Health is currently consulting on their proposed approach to funding and commissioning of services. Within this they are setting out the levels at which different elements of the public health service will be commissioned e.g PHE, NHS Commissioning Board or local authorities. Currently it is proposed that local authorities will be responsible for commissioning the following:

24.

Accident Prevention	Childrens Public Health aged 5-19
Sexual Health and contraception services	Public Mental Health
Physical activity interventions	Prevention and early presentation
Obesity Programmes	Dental Public Health
Substance Misuse	Community Safety
Alcohol Misuse	Social Exclusion
Tobacco Control	Health Intelligence
NHS Health Checks	Health Protections – with PHE
Health at Work	

25. There will be a new health premium which will apply to part of the budgets for health improvement. Local Authorities will receive a health premium that depends on progress made in improving health of the local population based using the outcomes framework. It will be funded from within the overall public health budget. Disadvantaged areas will receive more if they make progress , recognising that they face the greatest challenges. Payments will reflect achievement and not ability to negotiate a less demanding target.

26. The Local Authority Chief Executive will be the accountable officer. There will be shadow allocations in 2012/13 providing for planning for 2013/14.

Health and Well Being Boards

27. There will be a statutory duty on councils to establish Health and Well Being Boards for upper tier local authority and unitary authorities. The minimum membership will be local councillors, Directors of Public Health, Directors of Adult Social Services, Directors of Childrens services, GP consortia and Health Watch. There will be a duty on GP consortia to participate.

28. There will be a joint and equal responsibility on the GP consortia and local authorities to produce a Joint Strategic Needs Assessment (JSNA) of the health and wellbeing needs of the local population. This will in turn inform development of a Joint Health and Wellbeing strategy which all H&WB Boards will have a duty to create. This will be a high level overarching strategy which will then have other more detailed plans sitting under it addressing specific issues.

29. The emphasis is on encouraging coherent commissioning strategies promoting joined up commissioning across the NHS, social care, public health and other local partners. There will be an expectation to go beyond the existing joint integration of services for groups such as those with disability to move to join up with housing or criminal justice system.

30. There is an existing Health and Wellbeing Board for Southwark, which is a subgroup of the LSP. Initial discussions have taken place with the existing core membership about the creation of the new Board that would replace the existing one. These are, by necessity, preliminary discussions as the formal new Board does not need to be in place until 2013.

31. The membership of the new Board will need to be established and agreed. The role, terms of reference and modes of operating have yet to be determined. The establishment of the new Board will need to take cognisance of the likely statutory roles and membership, defining its relationship and links with Southwark Alliance. The issue of how the Board will intersect with the Young Southwark Board will need to be considered, because matters relating to health and wellbeing of young people will also be the responsibility of the Health and Wellbeing Board.

32. Plans are underway to establish the process to engage all relevant stakeholders to develop how this Board will function and agree the membership that will best meet both statutory obligation as well as being responsive to local needs of the population.

33. The Health and Wellbeing board should be the main body that informs and drives the joint commissioning agenda for health and social care activity between council and GP Commissioners. With the disappearance of the PCT (and with current significant restructuring of the PCTs across London to be implemented in 2011), the roles of both the existing Health and Social Care Board and the existing Health and Wellbeing Board will need to changed. It is proposed that they subsumed into the responsibilities new Health and Wellbeing Board. It is suggested that this new Board should be established in shadow or interim form in 2011, until such time as the formal statutory body needs to be in place (April 2013).

34. Southwark GP Commissioners have been recognised as a Pathfinder groups of commissioners by NHS London. There is also an invitation for councils to put themselves forward as pathfinder Health and Wellbeing Board. This is an option that it would be possible for the council to consider in discussion with its partners.

35. Across London many councils are establishing Health and Wellbeing Boards already, although many did not have the structures similar to what Southwark has had.

Public Health Outcomes

36. There will be a Public Health Outcome Framework by which the local authority and the Director of Public Health will be held to account. The consultation on the contents and scope this Framework was published in late December. This sets out a framework with five main domains and a set of proposed outcomes within each of these domains. For some domains a large number of indicators have been proposed but it is assumed that the final number will be reduced.

Domain 1 Health protection and resilience, protecting people from - major health emergencies and serious harm to health	Nos of Indicators 6
Domain 2 Tackling the wider determinants of ill health: tackling factors that affect health and wellbeing	21
Domain 3 Health Improvement; helping people to live healthy lifestyles and to make healthy choices	10
Domain 4 Prevention of ill health: reducing the number of people living with preventable ill health	7
Domain 5 Healthy life expectancy and preventable mortality: preventing people from dying prematurely	9

37. Some of the indicators are shared indicators with the NHS Outcome Framework and a few are shared with the Social Care Outcomes Framework. While the final number of proposed Public Health Indicators is not yet known, it will be necessary for the Health and Wellbeing Board to consider which indicators across Public Health, Social Care and NHS that it will monitor. It does not preclude other local indicators from being considered.

Timetable for implementation

Early 2011

- DH will provide more information with a detailed roadmap for the system as a whole - NHS, PHE and the DH with key milestones
- Further detail on PH following responses to the White Paper on the NHS
- Human resources framework for people moving between different organisations
- Health and Social Care Bill introduced to Parliament

2011/12

- Detailed policy and operational design
- Overarching HR framework for NHS, PH and arms length bodies
- Develop and consult on a PH workforce strategy
- Accountability for delivery in 2011/12 will continue to reset with SHAs and PCTs
- Shadow Health and Wellbeing Boards begin to be developed
- SHA will be responsible for transition of the PH systems during 2011/12 with RsDPH as the lead
- Public Health England (PHE) set up in shadow form
- Start work with local authorities on local arrangements including the matching of DsPH to local authority areas.

2012/13

- PHE will come into being in April 2012
- Publication of shadow ring fenced budgets for public health in local councils
- Local authorities have Health and Well Being boards operating although not on a statutory basis

2013 Onwards

- Public Health system in place
- Ring fenced public health allocations to local authorities
- Full Health and Wellbeing Boards operating

AMC 08.02.2011

Agenda Item 9

Item No.	Classification:	Date:	Meeting Name:
9.	Open	17 February 2011	Health & Social Care Board
Report title:		Southwark Safeguarding Adults Partnership Annual report 2009-2010	
Ward(s) or groups affected:		All	
From:		Susanna White Strategic Director Health and Community Services	

RECOMMENDATION

1. That the Safeguarding Adults Annual Report 2009-2010 is accepted and endorsed by members.

BACKGROUND INFORMATION

2. Safeguarding alerts regarding vulnerable adults have risen by 31% compared with 2008–2009. 59% of alerts concerned elderly people. 41% of alerts involved financial abuse of a vulnerable adult.

3. The report contains examples of safeguarding adults' interventions that workers across the Safeguarding Partnership have made during the year. These include a case study where the Council in conjunction with the Police and an NHS Trust undertook a joint investigation into allegations of abuse in a care home.

4. The report describes the changes in governance structures made to Safeguarding Adults Partnership Board and the appointment of an independent chair in order to strengthen the effectiveness of the Partnership.

RISK FACTORS

5. None.

Background Papers	Held At	Contact
Annual Safeguarding Report	As attached	John Emery 53314

AUDIT TRAIL

Lead Officer	Alison Ewens	
Report Author	John Emery	
Version	Final	
Dated	9 February 2011	
Key Decision?	No	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments included**
Strategic Director of Communities, Law & Governance	No	No
Finance Director	No	No
Cabinet Member	No	No
Date final report sent to Constitutional Support Services/ PCT dispatch		9 February 2011

Southwark Safeguarding Adults

Annual Report 2009-2010

Southwark Council

Southwark NHS Primary Care Trust

CONTENTS PAGE

Foreword by the Chair of the Southwark Safeguarding Adults Partnership Board

This will be the last time that I write a foreward to the annual safeguarding report as, following a number of changes to the governance structures within both Children's and Adult's safeguarding in Southwark, the Safeguarding Adults Partnership Board (SAPB) will now be chaired by an independent person.

This is the right change and provides a level of independent scrutiny to the SAPB which will provide a strong voice to those working to ensure that vulnerable people in Southwark are safeguarded. I am very pleased to announce that Terry Hutt has now been appointed to this post. Terry is an experienced adults social services manager, and has a background which includes inspectorate and safeguarding experience with the Commission for Social Care Inspection (CSCI). I am looking forward to working alongside Terry as we ensure that the changes we put in place in 2009-10 are embedded, and that we build on the enthusiasm and knowledge that was so apparent at the partnership stakeholders event in March 2010 to continue to ensure that people in Southwark are kept safe.

The annual safeguarding report contains but a few examples of the many safeguarding interventions and outcomes that those in the sector deal with every day. Many relate to financial abuse, which remains a key local issue. A number of the case studies in this report relate to people trying their best to manage their money, but - for whatever reason - having a friend or relative who is misusing that money. However we have also included a case study about a nursing home where the Council, in partnership with an NHS Trust and the Police undertook a priority safeguarding investigation following allegations of abuse and neglectful practices. It is hoped that this type of action will not be needed, however where it is necessary I am grateful to staff for the urgency and dedication with which they bring to often very difficult and challenging circumstances.

This report also sets out how it is only by working in partnership, social workers, housing officers, the voluntary sector, NHS trusts and others, that we are able to ensure that vulnerable people in Southwark are safeguarded. It is with this in mind that we continue to work together to improve our joint practices and processes, and I look forward to working with everyone involved in safeguarding to accomplish our shared vision of a Southwark that is excellent at safeguarding.

Yours sincerely

Susanna White
Strategic Director of Health and Community Services, Southwark Council and Chief Executive of Southwark Primary Care Trust (PCT)

Executive summary

1. Southwark is a borough where there is an increasing number of safeguarding alerts being raised, with an increasing number of alerts being raised by the vulnerable person on whom the abuse is alleged to have been committed, their friends or family.

2. With an increased number of alerts, there is also an increased number of safeguarding investigations. More people in Southwark have been kept safe.

3. The majority of safeguarding alerts in Southwark relate to financial abuse, usually committed within the victim's own home and often by members of their own family or by friends. It is within this particularly challenging and personal space that safeguarding investigations usually take place and social workers and others have to take actions to ensure that any abuse is stopped.

4. There has also been a major safeguarding investigation in 2009-10 related to institutional abuse within a nursing home. Whilst this type of investigation is unusual in Southwark, it demonstrated the strengths of partnership working in Southwark with a joint operation taking place between Southwark Council, Guy's and St Thomas's Hospital and the police.

5. With an additional number of safeguarding alerts, Southwark has also worked to refresh its governance arrangements. A new independent chair of the safeguarding and partnership board has been appointed, and the role and function of the sub-groups has been changed.

6. A partnership stakeholders event also took place in March 2010 which reaffirmed Southwark's vision to be excellent in safeguarding.

Introduction

1. During the last year in Southwark there has been a substantial increase in the levels of safeguarding activity. A changing context has also involved the review and implementation of an improved governance framework in safeguarding, with a refreshed board and sub-group structure and a new independent chair of adult safeguarding being appointed.

2. Many of these changes have been implemented following recommendations by the CQC Independence Wellbeing and Choice Assessment in April/May 2009. The report set out that Southwark had excellent safeguarding policies and procedures; however the report also noted a need to strengthen compliance at an operational level.

3. The CQC report also noted the strength of the Safeguarding Adults Partnership Board (SAPB) in achieving a strong level of inclusivity with carers, the voluntary sector and other stakeholders engaged in safeguarding work. The quality of the work that was jointly undertaken between the local authority and the local NHS Hospital Trusts was also highlighted. However the CQC recommended that the number and role of board sub-groups should be reviewed.

4. Following the inspection, the SAPB set in place a review to strengthen safeguarding governance arrangements and to improve the performance management and workings of teams involved in safeguarding.

5. This report describes the activities for adult safeguarding during 2009-10 in Southwark and highlights the changes to the governance arrangements, key outcomes achieved, and actions that are now being taken towards achieving an excellent service.

Governance Arrangements

6. The Care Quality Commission (CQC) made a number of recommendations related to safeguarding in May 2009. Whilst the SAPB was considered inclusive and included a wide range of representatives including carers and service users, it was suggested that the board's capacity for leading the safeguarding agenda in Southwark could be improved through a refocusing of efforts in a number of areas. The board considered proposals for change in the autumn of 2009 and, following a board awayday in February 2010, new safeguarding governance arrangements have been developed.

7. The refreshed framework includes a streamlined board which is chaired by an independent person who has now been appointed. The board was previously chaired by the Council's strategic director for health and community services and the appointment of an independent person provides an improved level of independent scrutiny and accountability over the adults safeguarding agenda. The new chair is an experienced adults social services manager, and has a background which includes inspectorate and safeguarding experience with the Commission for Social Care Inspection (CSCI). The board has also agreed new terms of reference which includes a commitment for more regular meetings.

8. The SAPB formally reports to the Health and Social Care Board, which is a joint leadership body comprising of the Council's Cabinet and the Southwark Primary Care Trust (PCT) Board. The Council and PCT have a history of close cooperation and joint working and this was developed into formal partnership arrangements between the two organisations. The Health and Social Care Board considers the Safeguarding Adults Annual Report each year, oversees implementation of the safeguarding action plan, and considers specific issues that may have an adverse impact on vulnerable adults.

9. The SAPB is also recognised as a thematic partnership group within Southwark's Local Strategic Partnership (LSP), with the Assistant Director, Adult Social Care meeting regularly with lead

officers from the other LSP partnership groups to address cross-cutting issues. Assistant Directors responsible for Community Safety and Adult Social Care attend both the SAPB and the Safer Southwark Partnership (SSP) thematic partnership group to ensure that the leadership of the safeguarding agenda is strongly led by organisations involved in crime prevention and community safety.

10. The SAPB receives safeguarding monitoring reports on a quarterly basis. These reports highlight the number of referrals received, updates on progress of current safeguarding investigations, and provides the board with information on the outcomes of completed investigations.

11. The refreshed board also has representation from a number of senior safeguarding practitioners whose role is to take forward work and drive forward safeguarding improvements on behalf of the board.

12. One of the strengths of the previous model was the enthusiasm and energy that was brought by the carer, voluntary sector and service user board representatives. Whilst the review aimed to rationalise membership of the board and the number of board sub groups that existed in order to have an improved governance system, it was important to ensure that the commitment of those involved in the system was maintained. The review therefore set out to improve clarity over the role of sub groups and the role of carer and other representatives on these.

13. The refreshed framework set up the following five sub-groups, and an additional "task and finish" financial fraud sub-group was also set up to oversee a short-term project. These groups were developed to take on specific safeguarding workstreams and to oversee the completion of these:

    - Practice Quality and Audit
      A sub-group to look at supporting improvements in safeguarding agencies and teams with the development of effective audit practices and other improvement measures. The group has a particular remit to embed processes, oversee the management of cases and to ensure that processes for the evidencing of work are in place. The Deputy Director of Adult Social Care chairs this sub-group.

    - Learning and Development
      A sub-group to support training and other development requirements in relevant organisations. The group has a specific project to take forward the development of core competencies across the partnership. The Council's Head of Organisational Development chairs this sub-group.

    - Human Resources
      This is a joint sub-group with the Children's Safeguarding Board to support recruitment and to maintain and embed workforce standards across partnership agencies. The Council's Head of Human Resources chairs this sub-group.

    - Stakeholders
      This group supports engagement and involvement by key stakeholders, including carers, service users and representatives from the voluntary sector. It is envisaged that the independent chair and a service user or voluntary sector representative will co-chair this group.

    - Health Providers
      This sub-group is currently taking forward a project looking at the prevention and treatment of pressure sores and the development of transfer of care protocols related to this.

    - Financial Fraud

This "task and finish" sub-group was set up to oversee a short term project which is undertaking work to improve understanding of the levels of financial fraud in the borough. This is particularly significant at this time as 2009-10 has seen an increase in the number of safeguarding alerts relating to financial abuse, which is already the highest are from which safeguarding alerts are raised in the borough.

14. In addition to regular attendance at the SAPB, statutory organisations such as Guy's and St Thomas's Foundation NHS Trust, King's Foundation NHS Trust, NHS Southwark provider services, and South London and Maudsley Mental Health Foundation Trust all have their own internal safeguarding boards to oversee compliance with the multi-agency policy and procedures and with CQC standards.

Partnership Stakeholders Event

15. In March 2010 over one hundred delegates representing the customers and agencies that form Southwark Safeguarding Adults Partnership attended a stakeholders' event to learn about, discuss and develop ideas about how excellent practice in safeguarding vulnerable adults can be achieved in Southwark.

16. Delegates were welcomed by Councillor David Noakes, the Executive Member for Health and Adult Care, who affirmed the Council's commitment to making Southwark a safer borough and its determination to safeguard vulnerable adults. Susanna White, Strategic Director of Health and Community Services and Chief Executive NHS Southwark, then spoke about the CQC Independence, Wellbeing and Choice Inspection that took place in 2009 and the improvements that have been put in place in response to the recommendations made by the inspectors. In particular, she outlined the developments to the SAPB that would make it a more focused and effective body. She also restated that it is Southwark's ambition to become excellent in safeguarding.

17. Excellence in safeguarding was the key theme developed in the presentations given by the main conference speakers. DC Maria Gray of the Metropolitan Police outlined the new standard operating procedures adopted by the police to ensure a consistent approach to investigations of alleged crimes against vulnerable adults. Jonathan Lillistone from Southwark Adult Care Commissioning Service also spoke about work to ensure robust safeguarding standards are maintained.

18. The stakeholders event was also provided with a presentation by Terry Hutt, an independent social care consultant, who provided delegates with an overview of how excellence in safeguarding is achieved and outlined ten steps that Southwark should take to achieve excellence. These included: ensuring that safeguarding and self directed support systems are integrated; regular audits of practice; strong partnership working; and an agreed work programme with accountability with the Safeguarding Board.

19. Throughout the day delegates were actively involved through question and answer sessions and table discussions and many suggestions were made for achieving excellence. These included further developing and maintaining strong audit processes, creating virtual safeguarding teams to progress investigations, everyone owning the safeguarding process, and regular information campaigns to keep the public aware of the safeguarding message. The SAPB has subsequently agreed to integrate these ideas into their work programme for the year forward.

20. Feedback from the event was extremely positive and many delegates mentioned how much they had learned. A number of people said they had found the conference inspirational and wanted additional events to raise awareness of abuse of vulnerable adults.

Statistical Overview

21. Safeguarding data and information is available in appendix 1.

Number of safeguarding alerts and investigations

22. In 2009/10 a total of 377 safeguarding alerts were received. This represents an increase of 31% on the previous year. 88% (332) of alerts led to safeguarding investigations compared with 86% (248) in the previous year. There has been an increase in the number of safeguarding alerts in each of the previous three years and, compared to 2007-08, there were an additional 35% (133) safeguarding alerts in Southwark.

Who is raising alerts of abuse?

23. In 2009-10 41% of safeguarding alerts originated with the vulnerable adult themselves, or a family or friend. This is particularly significant as it shows a rise of 11% in such alerts compared with 2008-2009 and is thought to be related to an increased awareness in recognising abuse and how to report it. Over the last three years whilst there has been a steady increase in the number of safeguarding alerts from the vulnerable person themselves, a family or friend, safeguarding alerts coming from social care workers and service providers has fallen by 14% compared to the previous year.

24. The increase in the number of alerts, and in the number of alerts originating from the vulnerable person themselves, or from their family or friends, follows the dissemination of refreshed multi-agency policy and procedures throughout Southwark. There has also been an ongoing training programme and publicity campaigns to support the embedding of these procedures, and the highlighting of safeguarding to relevant agencies and stakeholders.

25. Referrals from statutory agencies other than the local authority have increased in the past year with an 18% rise compared to 2009-10. A marked increase in referrals from the police must also be noted from 5 in 2008-9 to 17 in 2009-10. This is also reflected in an increasingly close working relationship between the police and other statutory agencies.

Who are the individuals who are having alleged abuse committed to them?

26. As in previous years, most safeguarding alerts progressing to investigation were for elderly people making 59% of the total (and a quarter of alerts were from those between the ages of 75-84). This is in line with national levels (AEA Prevalence Report 2007) that highlights that people over 75 years of age were most likely to be abused. 166 or 84% of investigations involved people in this age group.

27. Whilst the number of safeguarding alerts has increased overall, the proportion of alerts to gender has stayed relatively constant over the last three years (43% of alerts relating to a vulnerable adult who is male, 57% to a female person) with a nominal increase of the proportion of alerts relating to a vulnerable person who is male. The majority of safeguarding alerts at 68% related to a vulnerable person who had an ethnicity of being white. These figures are consistent with the demographics of the elderly people age group in Southwark, being predominantly white and with a greater proportion of female to male, which is the group where the majority of safeguarding alerts are raised.

28. 58 safeguarding alerts progressing to investigation related to people with a learning disability with a further 46 for people with sensory and physical disabilities. 9% or alerts progressing to investigation were for people with known to have mental health needs.

29. No safeguarding alerts were received for people whose major presenting problem was substance misuse. The SAPB recognises that this may not be an accurate reflection of the level of abuse

experienced by this group and that further work is required to understand the role of safeguarding in substance misuse cases in Southwark. One issue discussed by the SAPB related to the chaotic nature of the lifestyles of some service users in this group which may be reflected in lower safeguarding reporting of this type of abuse.

30. As with the previous year only one formal safeguarding alert was raised concerning someone regarded to be funding their own care. However during the year safeguarding investigations were undertaken regarding the care being received by older people in three local care homes, including five people who were funding their own care in the home. Individual safeguarding alerts were not raised for each resident, resulting in an under-reporting of safeguarding activity. This will be addressed in 2010/11. Nevertheless the need to ensure that people funding their own care know how to seek help about any possible abuse remains an area of concern that the SAPB will be taking forward.

Alerts not progressed to investigation

Type of abuse alleged	Number not progressed to investigation during 2009-10
Financial	13
Multiple	4 (1 x Physical and Financial, 2 x Neglect and Physical, 1 x Financial and Psychological)
Neglect	11
Other	1
Physical	11
Psychological	2
Sexual	3
Total	**45**

31. Further work is being undertaken to understand what actions were taken despite the decision not to progress the alert as a safeguarding inspection.

Types of abuse

32. In line with the previous years' data on safeguarding, the most common type of alleged abuse was financial with 136 investigations carried out. This represents 41% of all investigations. The SAPB is concerned about this volume of abuse relating to finance and also the slight proportionate increase. This will be a major area of work which the SAPB will take forward in the coming year.

33. The majority of safeguarding investigations at 58% related to alleged abuse that had taken place in the vulnerable person's own home. This is consistent with the levels of financial abuse that was reported as this type of abuse is generally perpetrated in the vulnerable adults own home.

Financial Abuse

34. An analysis of safeguarding alerts and investigations has determined that financial abuse is the most common form of abuse reported in Southwark. The Council's fraud team works closely with Adult Social Care and the police in conducting investigations, pursuing proven perpetrators and in putting effective protection plans in place. A police officer is seconded into the team to assist with this work. Where vulnerable adults are unable to manage their own money the Council provides both an appointee and a deputyship service. The number of people being supported in this way

has increased from 325 appointees and 55 deputyships at the end of 2008/09 to 380 appointees and 65 deputyships by the end of 2009/10.

Case Study 1

Mrs A is an elderly lady in her 80s and was living in Peckham with one of her sons, who was in his 50s. Mrs A had a physical disability and was receiving benefits that supported her to remain living in her own home. A safeguarding alert was raised by Mrs A though as she was upset and concerned about her son who would ask her for money which he would use to buy alcohol. It was later discovered that the son had an alcohol addiction problem. Mrs A felt disempowered and felt unable to stop providing her son with money however she was also aware that this meant that she was not able to access the support she required. Mrs A was also worried about approaching a social worker, however, as she understandably did not want her son to get into trouble, and talked about how she did not want him to end up homeless. She was keen to ensure that whatever happened her son was not prosecuted. Assuring Mrs A that she was there to help resolve the problems, the social worker organised a family conference at Mrs A's home. The meeting was very difficult for the family, as many of the issues raised had never been discussed before. A good outcome was produced though with all parties agreeing that Mrs A's money would be managed by her daughter and that her son would therefore no longer have access to it. The social worker has since checked to ensure that the agreed plan has been put in place and has found that Mrs A is able to use her money to access the support that she requires.

Case Study 2

Social workers received a referral from a housing officer in Peckham who was concerned about a tenant he worked with, Mr H. There were allegations that Mr H's brother had bullied him, both with physical assault and also through financial exploitation which he claimed had taken place on several occasions. The situation was difficult – as it was important to understand Mr H's situation and to provide a safe space where he could discuss the situation away from his brother. Social workers made arrangements with the police to be present when Mr H visited the housing office. Following the meeting, alternative accommodation was arranged immediately which was necessary due to the severity of the situation. Social workers and the police officers interviewed Mr H and deduced that he was clearly fearful of his brother. It transpired that he indeed did not want to return to the accommodation he currently resided in. Mr H was taken to alternative accommodation and requested possessions were collected on his behalf. Police are now investigating the brother, and Mr H is now happily living in a different one bedroom flat.

Physical abuse

35. Physical abuse with 90 investigations carried out represents approximately 27% of all cases investigated. 78 investigations were carried out which is a small reduction in overall incidence from the previous year.

Case Study 3

31 residents lived in a privately owned nursing home, 23 of whom were from Southwark. The home had a history of poor or patchy performance and had been rated by CQC inspectors as an adequate home at the time of the safeguarding investigation. In the summer of 2009 the safeguarding lead at Guy's and St. Thomas's Hospital was alerted to a number of serious concerns about practice at the home. This included allegations of assaults, neglectful practices and that records of members of staff had been falsified. An investigation was set up between Guy's and St Thomas's Hospital, Southwark Council and the police. The investigation involved an immediate visit to the home to check on the

safety and wellbeing of the residents and verify the claims that had been made. The investigation revealed a large number of serious issues which the team had to tackle. Following the investigation, the Council's adult social care service concluded that the home not providing the quality of care that Southwark's residents should expect to receive. The Council therefore decided to cease funding placements at the home and met with residents and their relatives to explain that they would be helped to find better homes to live in. There were some positive outcomes from this very difficult work. One resident, who wanted to be more independent, was helped to move into a flat of his own in an extra care sheltered scheme. After relocating to a new home, a resident who had been non-verbal whilst in the home, began to respond to questions with appropriate sentences and can now communicate to a degree with carers and other residents. This investigation into physical and institutional abuse demonstrated strong joint working between the Council, an NHS acute trust and the police.

Case Study 4

Ms G is a lady in her 50s with learning disabilities. She lives with her elderly mother and is her sole carer. Ms G attends a local day service. One Friday afternoon staff noticed she was visibly distressed. Upon questioning she remarked that her mother had been attacking her with a walking stick. Ms G appeared visibly concerned and did not want to go home to her mother. As this incident was reported as an assault, the police were contacted and this situation was flagged as a safeguarding alert. The police referred the case to social workers due to the situation. Duty social workers on call visited the same day for a discussion before Ms G returned home. The mother was evidently frail - and said that she was at the end of her tether due to what she called Ms G's attention seeking behaviour (i.e. knocking on the door to come in at 5am in the morning). Duty social workers facilitated a family conference that afternoon, and Ms G returned home to a tearful reunion. Ten days later, the situation was reviewed and Ms G was discovered to be calmer and much more positive. She was offered more support in the future if needed, but stated she was more than happy with the service provided.

Sexual abuse

36. The incidence of allegations of sexual abuse showed both an absolute fall in numbers and a corresponding relative fall in incidence with 15 cases investigated in 2009-2010 compared with 25 in 2008-2009 representing 10% and 4.5% of the totals respectively.

Outcomes of Investigations

37. During 2009-2010 252 cases were closed of which 51, approximately 20%, were substantiated with a further 26, approximately 10%, partially substantiated. This number includes cases that may have been referred in 2008-9 but not closed that year.

38. Whilst these figures for case conclusions may appear low they are typical for a London borough and reflect the difficulty in fully investigating allegations of adult abuse where the victim often lacks capacity to appreciate that they may have been abused and is unable to provide reliable information, or may feel intimidated or reluctant to provide information because the alleged perpetrator is a friend or family member. This situation is reflected in some of the challenging case studies cited in this report.

39. For 25% of cases, following a safeguarding investigation, no further action was required or the issue was resolved. This reflects often immediate issues which are alerted, can be resolved quickly and sometimes do not require further intervention. 22% of cases required some form of increased monitoring of the vulnerable adult. A number of the case studies in this report reflect

this type of situation in which the social worker remains in contact with the vulnerable adult and their family following a safeguarding intervention to ensure that there are no further issues or a repeat of the type of abuse that prompted the original safeguarding alert. 13% of investigations involved an outcome in which a different system was put in place for the management of the vulnerable adults finances. This is consistent with the levels of safeguarding investigations relating to financial abuse, and also an area of increased interest for the SAPB with the roll-out of personal budgets for a wider group of people in Southwark.

40. Prior to closing a safeguarding investigation the social worker completes a protection plan with the service user to determine what actions have been, or will continue to be taken in order to minimise future risks of abuse. This frequently includes the ongoing involvement of providers in monitoring the service user's well-being. Feedback from service users during subsequent reviews is that the protection plan and the post investigation support has helped them to feel safe.

41. As part of protection plans social workers inform people about the community alarm services available in the borough, including the Southwark monitoring and alarm response team (SMART), which provides community alarm and telecare services and a home visiting service 24 hours a day in response to emergencies.

Outcome for alleged perpetrator

42. In the majority of cases, at 57%, no further action was taken against the perpetrator of the alleged abuse following a safeguarding investigation.

43. This area remains a challenge for Southwark and is similar to other local authorities that have a comparable population and environment nationally. It has been notoriously difficult to prove allegations of abuse in cases and taking further action, including criminal action, can often be a challenge for the individuals, on whom the abuse has been committed, many of whom find it difficult to put forward their case without additional support.

44. With regard to perpetrators, when they are family members, as they often are in cases of financial abuse, the victims of abuse often do not want to bring forward prosecutions but rather wish for a resolution that does not unduly punish the perpetrator. This often results in a change in the way in which the vulnerable adult's finances are managed, either through management by the Council or by another family member, which resolves the situation without stigmatising the family member involved.

Deprivation of Liberty Safeguards

45. From 1st April 2009, Mental Capacity Act 2005 Deprivation of Liberty Safeguards (MCA DOLS) legislation was introduced for people who are unable to make decisions about their care or treatment. The European Court of Human Rights has said that the rights of people who cannot make these decisions and who may have their liberty taken away in hospitals and care homes must be strengthened. The MCA DOLS has been developed to protect these people.

46. Southwark Council has responded to this legislation by developing policies and procedures to ensure that the Council is capable of meeting the requirements dictated by the new Act.

47. Prior to implementation, training was arranged for provider organisations to identify service users who may require a potential DOLS assessment. For the period from April 2009 to March 2010 30 requests for DOLS assessments have been received with 17 authorised. This is comparable for figures across London.

48. The Safeguarding Adult Team now manages the Deprivation of Liberty Safeguards (DoLS) for both Adult Social care and Southwark PCT and close working with colleagues in commissioning

have aided the development and focus of the local advocacy provider Cambridge House to provide IMCA services. For 12 months up to March 2010 there have been a total of 8 IMCA referrals involving safeguarding concerns. Feedback has shown that people who have used the IMCA services felt that they were supported, listened to and their views were championed by their IMCA.

Working together – NHS Southwark

49. Southwark PCT established an adult safeguarding steering group in January 2010 to oversee the development of safeguarding adults work, make decisions in consultation with the Southwark NHS Provider Services (SPS) Board and operational Board, sign off safeguarding policy and move forward strategic objectives and priorities. The group operates under the auspices of Southwark's multiagency safeguarding adults partnership board.

50. The group membership includes clinicians and managers across health and social care and meetings take place 6 weekly.

51. The group has responsibility for ensuring that quality assurance arrangements are in place for the Safeguarding activity, and for the monitoring and development of procedures on the basis of lessons learnt.

52. The group workplan is in place and includes:

- Developing an adult safeguarding adults policy specific to community health services
- Ensuring staff have the required skills and competencies to safeguard adults, recognise potential safeguarding issues and undertake risk assessments
- Overseeing compliance with the requirement of core standards and CQC registration
- Developing systems for activity reporting
- Developing related practice guidelines

53. A comprehensive SPS adult safeguarding policy has been developed and is widely available. The policy was formally launched at the SPS nurse and Allied Health Profesionals leadership meeting in March 2010 and a safeguarding introduction and briefing undertaken with the 40 attendees from a range of services across the organisation.

Working Together - Community Safety

54. At the heart of Southwark's partnership approach are the principles of identifying and reducing the risk of harm and identifying and supporting vulnerable people. To support the clear links between the work of the Council's community safety team and other safeguarding agencies, the Head of Community Safety is a member of the SAPB and the Deputy Director of Adult Social Care is a member of the Safer Southwark Partnership (SSP) which includes representation from the police and fire service.

55. The Head of Community Safety is accountable for ensuring that the Safeguarding Adult Team and the adult social work services receive early notification of critical incidents that occur and may have impact on vulnerable adults.

56. All of the agencies working within the SSP are committed to these principles and the SSP recognises the strong links to both the adult and Children's Safeguarding Boards in Southwark

57. The SAPB also works very closely with Community Safety Partnership Services to address domestic abuse issues, including regular and active attendance by the Safeguarding Adults Co-

Ordinator at MARAC (Multi-Agency Risk Assessment Conferences), which ensures co-ordinated action by partner agencies to safeguard people at serious risk from domestic violence.

Working together – housing

58. Southwark Council is the largest local authority social landlord in London with 45,000 tenants and homeowners. With such a high level of social housing in the borough there is an additional importance to safeguarding in housing services.

59. Housing officers' visits to known vulnerable tenants have been a great success. Last year the housing service carried out over 5625 visits to check on known vulnerable tenants. The Council also has a tenancy check programme which helps to identify tenants whose vulnerability was previously unknown. This programme is ongoing and is aimed at making sure that tenants are receiving adequate help and support from either the Council or other agencies and are living free from abuse.

Building Safeguarding Capacity within Southwark

60. A range of Safeguarding Adults courses are commissioned and co-ordinated by the Council and are advertised on the Southwark website for council staff and are available for staff from partner organisations. The Alerter and Investigation Officer courses are provided regularly, with more specific courses being provided as required. These include courses on safeguarding for chairs of case conferences, investigation managers, commissioners, providers and case conference minute takers. During 2009/10 84% of Adult Social Care staff received safeguarding training, as did 75% of staff in independent sector registered care services.

61. Three half day workshops were arranged in January 2010 and attended by 45 Adult Social Care and PCT commissioners to improve their knowledge of safeguarding and improve their skills when working with providers and applying contract monitoring processes. Evaluation of the effectiveness of the training demonstrated a significant improvement in participants' knowledge of their commissioning role in relation to safeguarding and how to support providers to improve the quality of safeguarding.

62. Since January 2010 Safeguarding Awareness training has been incorporated into induction training for all staff joining the Council and NHS Southwark. During 2009/10 Safeguarding Alerters training was targeted at all service providers including housing, community safety and leisure. In addition during the year an e-learning training programme for safeguarding adults and children's awareness was introduced. This will be available for all council staff from early 2010/11 and rolled out to external partner agencies, including the voluntary sector during the year.

63. In addition to participating in the training commissioned by the Council, providers also organise their own internal safeguarding training based on the multi-agency policy and procedures and the safeguarding adults competency framework. For example in 2009/10 Kings College Foundation NHS Trust provided safeguarding training to 1756 staff whilst 3340 from Guys and St Thomas's Foundation NHS Trust received such training.

Quality Assurance

64. The established Adult Social Care safeguarding case file audit programme has three levels; monthly audits completed by social work team managers (two audits per team identified by the Safeguarding Adult Team); quarterly audits conducted by the Safeguarding Team, and (at least annually) an externally commissioned audit by an independent auditor. The findings of these audits are considered by the Adult Social Care Senior Management Team (SMT) in order to both recognise good work and outcomes and to identify further actions required to improve and standardise good practice. Following feedback from staff and managers, in 2009 the

safeguarding audit tool, that had been in use since November 2008, was reviewed and simplified. A revised audit tool was piloted in September 2009 and launched in November 2009. Further improvements to the Audit Tool have been identified with changes to be implemented from May 2010.

65. Findings from recent level one and two audits include:

- improvements in the standard of recorded management oversight of investigations
- improved recording of mental capacity and referrals to IMCAs
- a faster response to alerts with most cases being allocated from duty (which commences the initial investigation and protection planning) to social workers within 48 hours.

66. The variability in practice standards that was identified by the CQC inspection in April 2009 has been addressed. Specific experienced social workers have been identified and these conduct the majority of the safeguarding investigations and provide targeted safeguarding training for managers.

Safeguarding and Personalisation

67. The Putting People First agenda provides an opportunity to develop more personalised services and give service users and carers more choice and control. However, striking a balance between empowerment and protection poses challenges for local authorities and Safeguarding Adult Partnerships.

The recent Department of Health consultation on the review of no secrets highlighted these comments from Safeguarding Adult Partnerships about personalisation.

- A balance needs to be established between empowerment and protection and between the rights for self determination and the duty to ensure safety of people and safety of public money.
- We want to support people to be citizens and take risks that they understand.
- Empowerment in all aspects of life is a protective factor against abuse

68. The Personalisation Programme is well established, with lead officers and a project team implementing the programme plan to ensure that Southwark continues to meet the Putting People First milestones. Ensuring that people are safeguarded whilst exercising choice and control over how they live their lives is an integral part of the new operating model that was developed during 2009/10 and is currently being implemented.

69. A service user and carer panel was established in September 2009 and meets monthly to work with the personalisation team to co-produce the new operating model. As each stage of the new model, i.e. Access and Information, Re-ablement, Outcome Based Assessment and Support Planning has been developed, presentations have been made to the panel, workshops conducted providing the opportunity for challenge and questioning, and user and carer feedback incorporated into the model. Panel members advised about the wording of easy to read advice for users about personalisation assessment processes and their comments about ways to ensure that service users are enabled to manage their personal budgets were included in the staff guidance about managing risks.

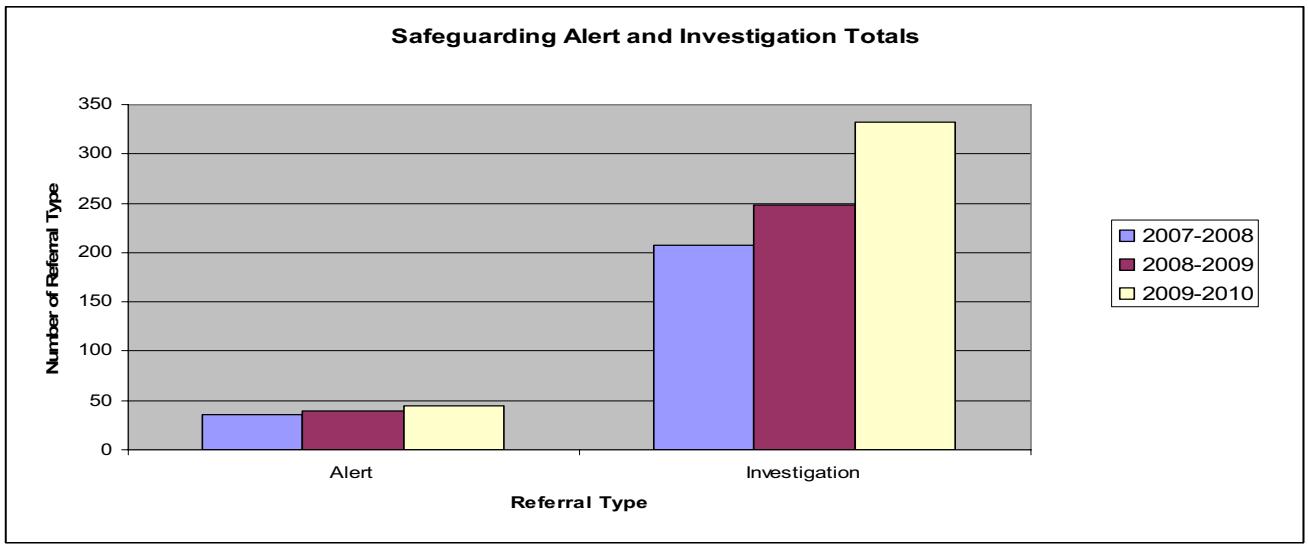
70. The Council is aware that there are concerns about how individuals will be safeguarded outside of regulated services and that there may a greater risk of financial abuse, in particular. But it is

already the case that many people who are referred for a safeguarding investigation are living in regulated, institutional care and for reasons of financial abuse.

71. Following the introduction of personal budgets more widely, the Council will retain its legal duty of care. But in agreeing the support plans the Council will need to be more open to people choosing to manage the risks in their lives differently, whilst also ensuring that individuals are safeguarded and that support is in place in areas of concern.

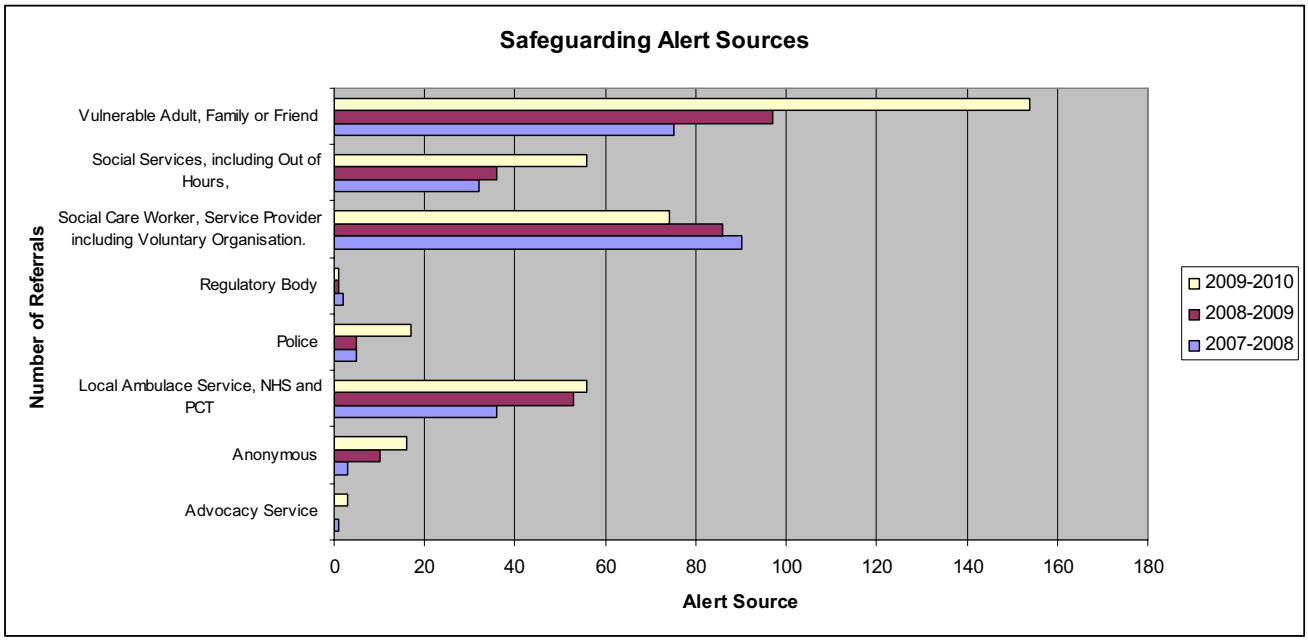
APPENDIX 1

Table 1. Number of Safeguarding Alerts and Investigations



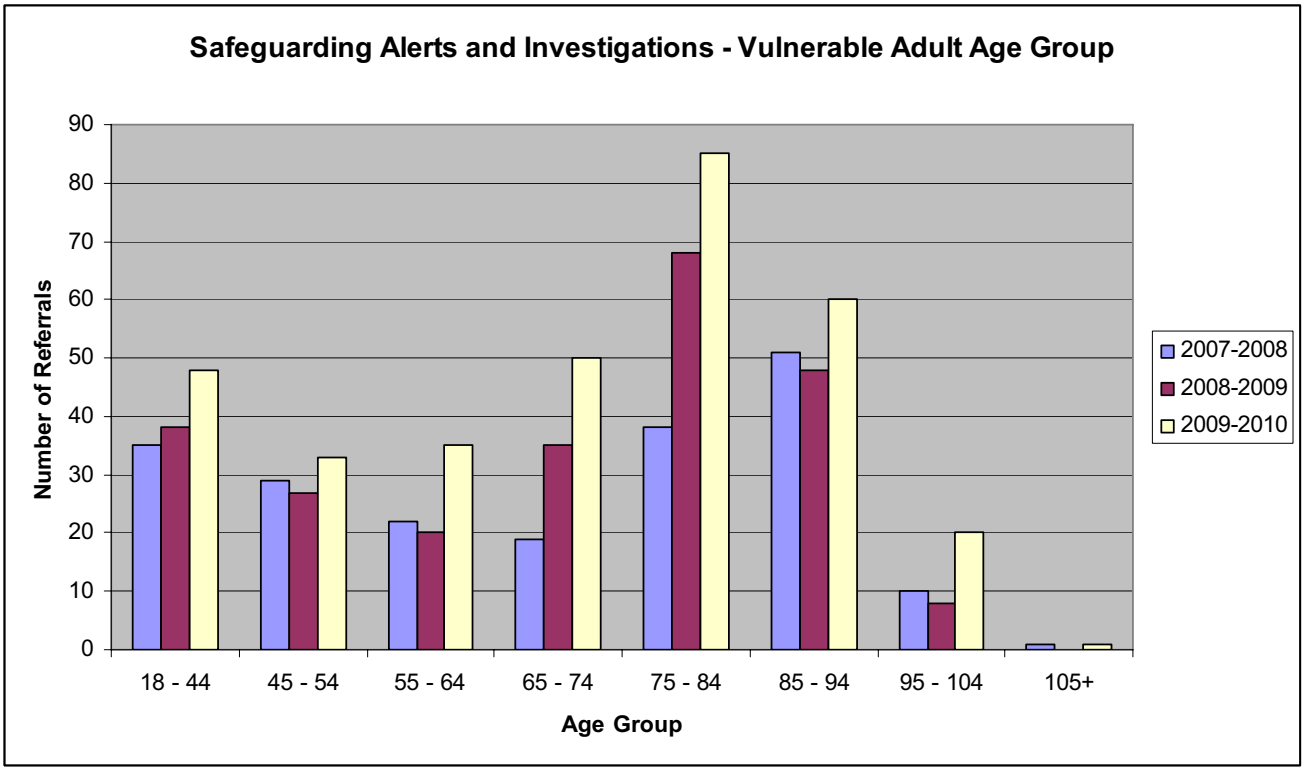
Safeguarding Alert and Investigation Totals			
	2007-08	**2008-09**	**2009-10**
Alert for which a safeguarding investigation is not required	36	40	45
Investigation	208	248	332
Total	**244**	**288**	**377**

Table 2. Safeguarding Alert Sources



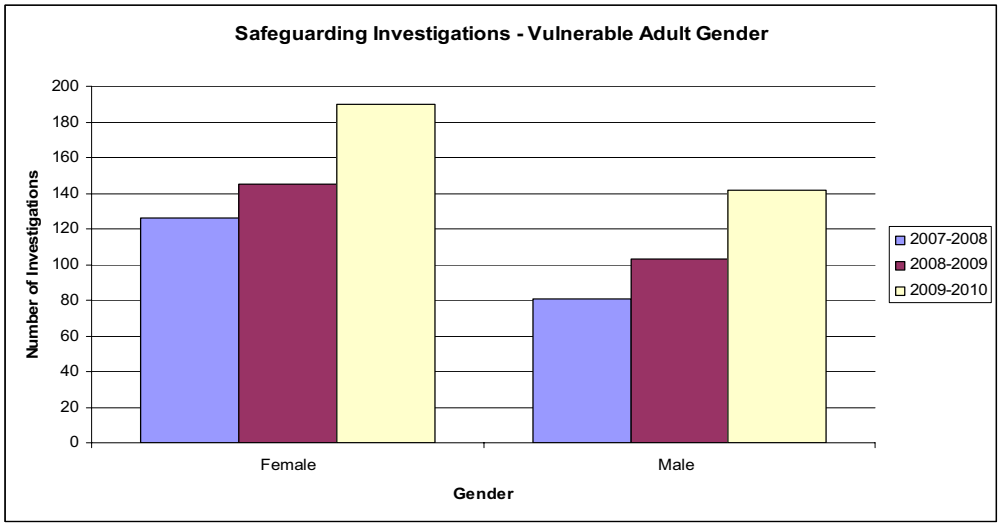
Safeguarding Alert Sources	2007-08	2008-09	2009-10
Advocacy Service	1	0	3
Anonymous	3	10	16
Local Ambulance Service, NHS and PCT	36	53	56
Police	5	5	17
Regulatory Body	2	1	1
Social Care Worker, Service Provider including Voluntary Organisation.	90	86	74
Social Services, including Out of Hours,	32	36	56
Vulnerable Adult, Family or Friend	75	97	154
Total	**244**	**288**	**377**

Table 3. Safeguarding Alerts by Vulnerable Adult Age Group



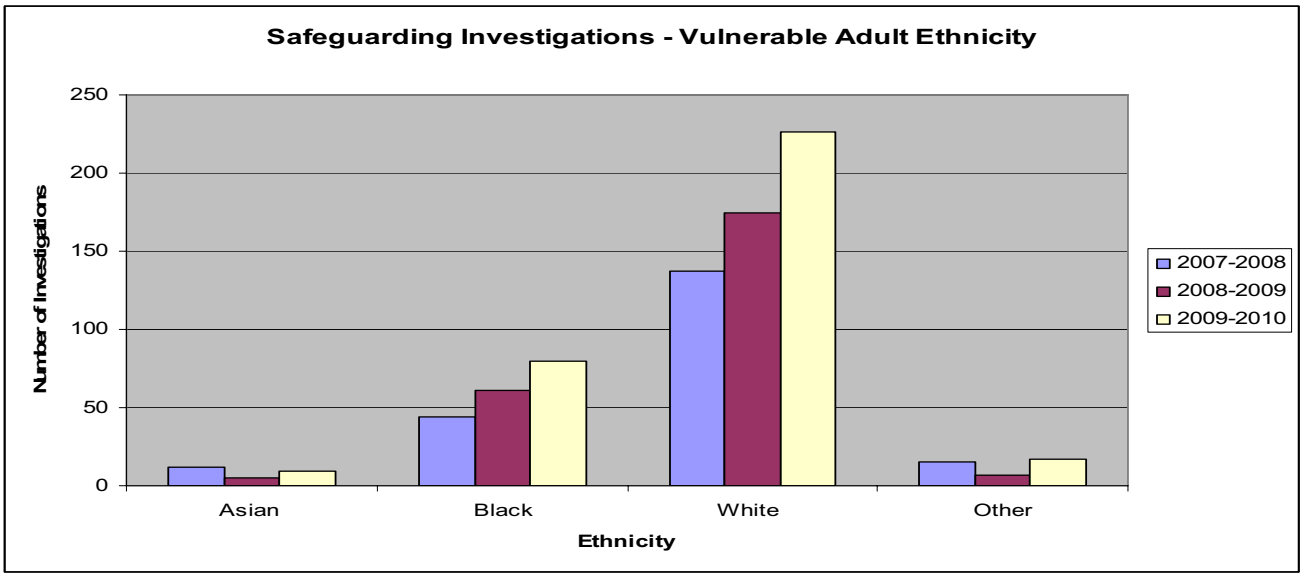
Safeguarding Alerts and Investigations - Vulnerable Adults Category			
	2007-08	**2008-09**	**2009-10**
18 - 44	35	38	48
45 - 54	29	27	33
55 - 64	22	20	35
65 - 74	19	35	50
75 - 84	38	68	85
85 - 94	51	48	60
95 - 104	10	8	20
105+	1	0	1
Total	**205**	**244**	**332**

Table 4. Safeguarding Investigations - Vulnerable Adult Gender:



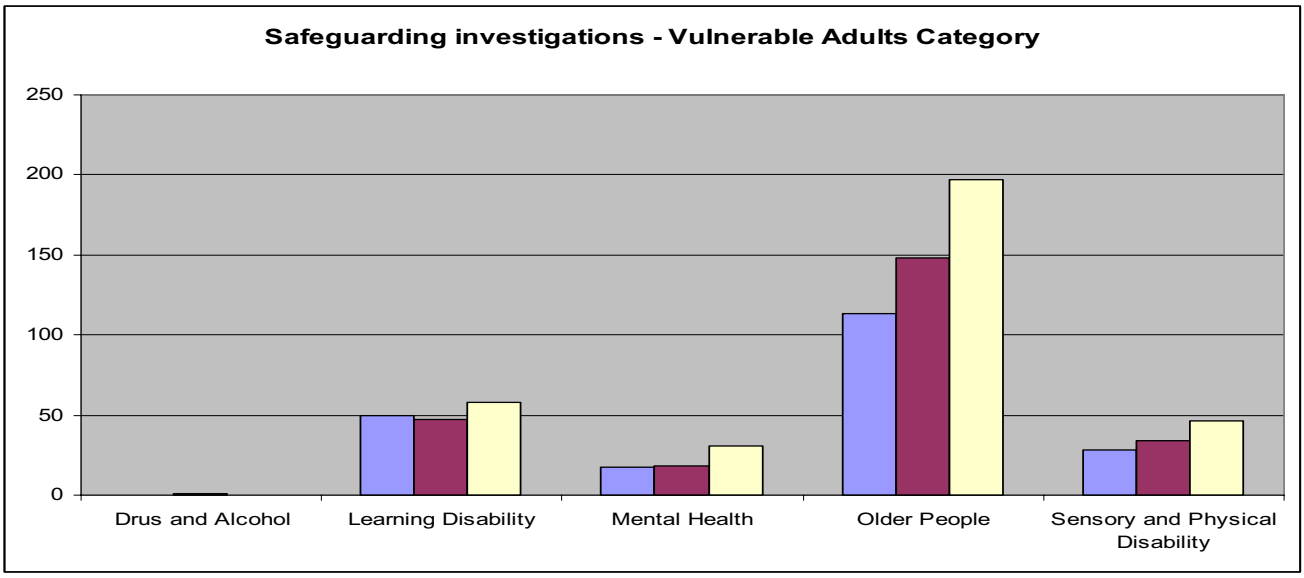
Safeguarding Investigations – Vulnerable Adults Gender			
	2007-08	**2008-09**	**2009-10**
Female	126	145	190
Male	81	103	142
Total	**208**	**248**	**332**

Table 5. Safeguarding Alerts raised by Ethnicity



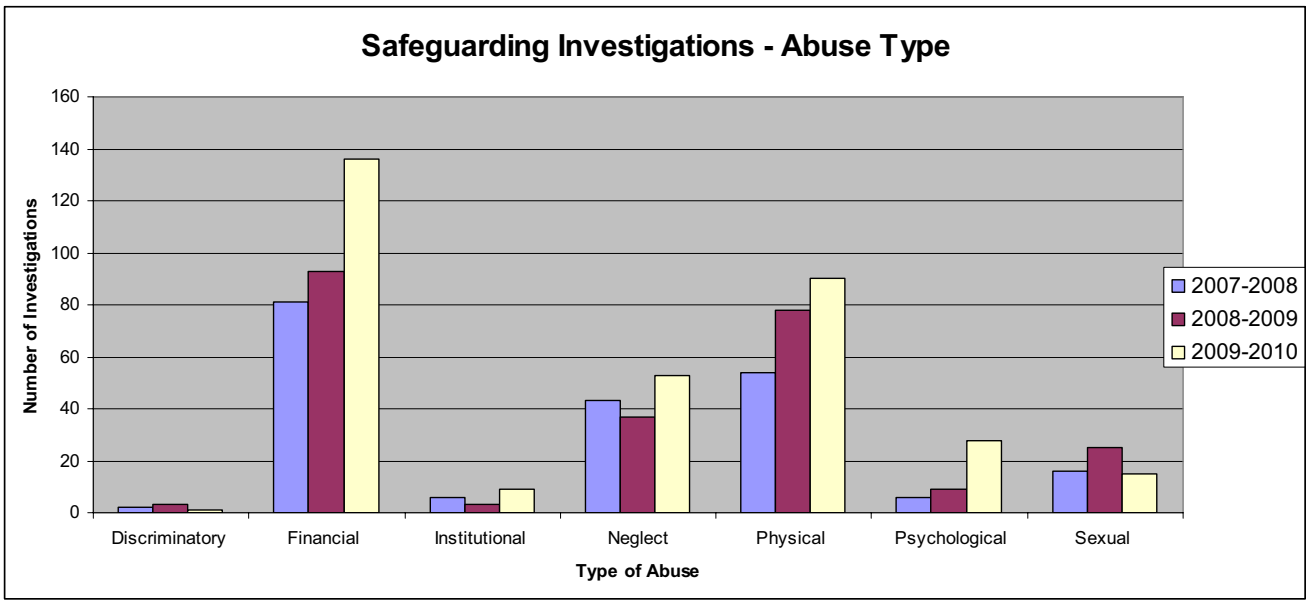
Safeguarding Investigations – Vulnerable Adult Ethnicity			
	2007-08	**2008-09**	**2009-10**
Asian	12	5	9
Black	44	61	80
White	137	175	226
Other	15	7	17
Total	**208**	**248**	**332**

Table 6. Safeguarding Alerts - Vulnerable Adults Category



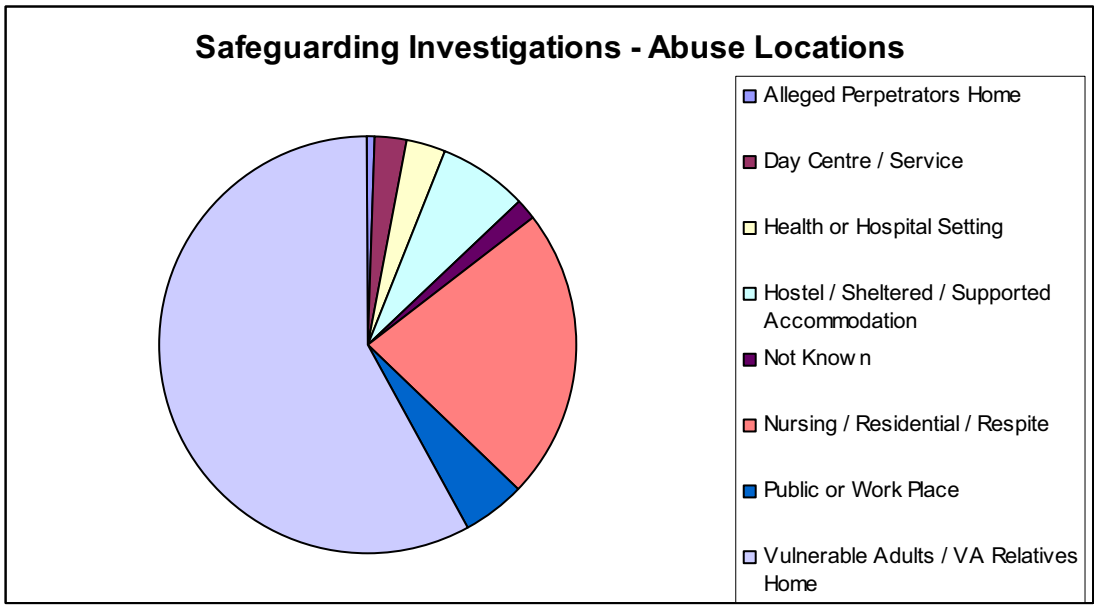
Safeguarding Investigations – Vulnerable Adults Category	2007-08	2008-09	2009-10
Drugs and Alcohol	0	1	0
Learning Disability	50	47	58
Mental Health	17	18	31
Older People	113	148	197
Sensory and Physical Disability	28	34	46
Total	**208**	**248**	**332**

Table 7. Types of Abuse Investigated



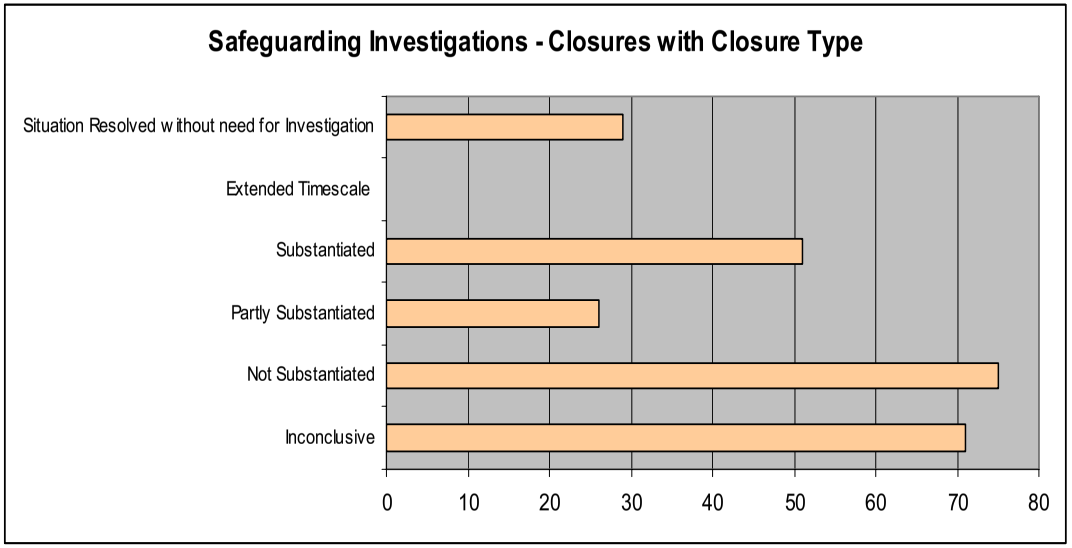
Safeguarding Investigations – Abuse Type	2007-08	2008-09	2009-10
Discriminatory	2	3	1
Financial	81	93	136
Institutional	6	3	9
Neglect	43	37	53
Physical	54	78	90
Psychological	6	9	28
Sexual	16	25	15
Total	**208**	**248**	**332**

Table 8. Location of Abuse



Safeguarding investigations – abuse locations	2009-10
Alleged Perpetrators Home	2
Day Centre / Service	8
Health or Hospital Setting	10
Hostel / Sheltered / Supported Accommodation	23
Not Known	6
Nursing / Residential / Respite	75
Public or Work Place	15
Vulnerable Adults / Vulnerable Adults Relatives Home	193
Total	**332**

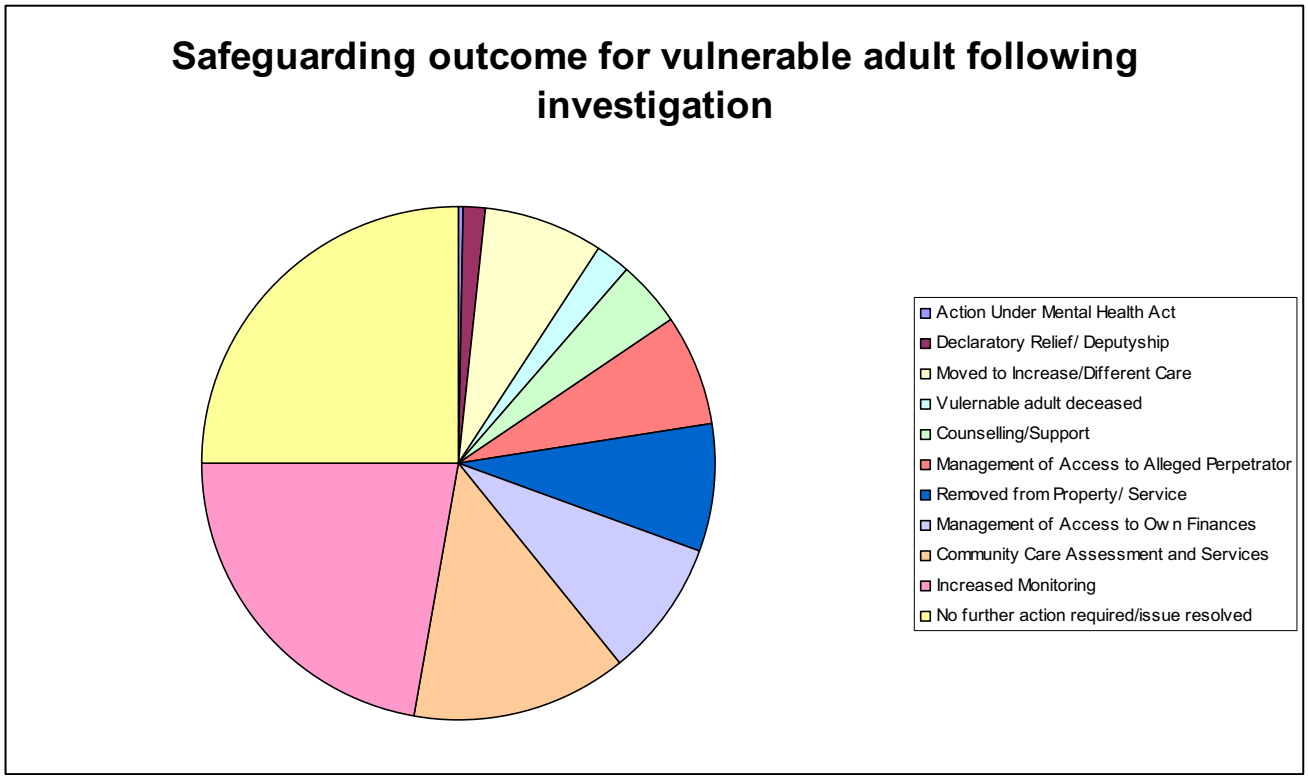
Table 9. Case Conclusions



Safeguarding investigations – closure with closure type	
	2009-10
Inconclusive	71
Not Substantiated	75
Partly Substantiated	26
Substantiated	51
Extended Timescale	0
Situation Resolved without need for Investigation	29
Total	**252**

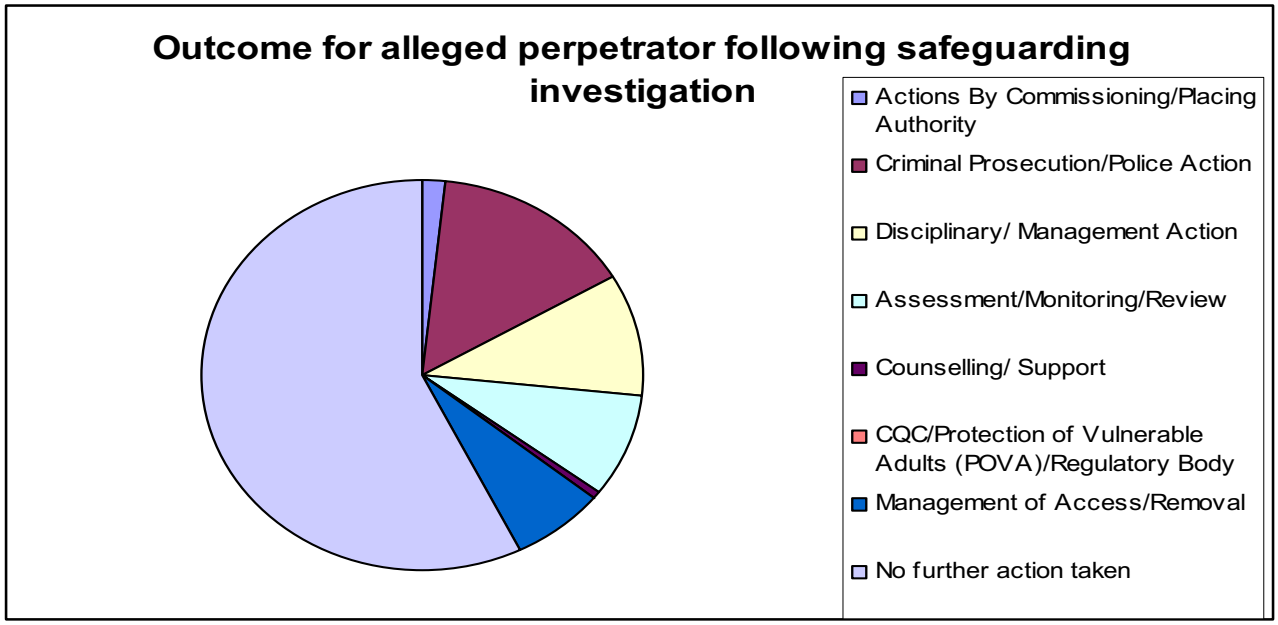
Item:	Conclusion:	Definition:
1.	Substantiated:	All of the allegations of abuse are substantiated on the balance of probabilities
2.	Partly Substantiated:	This would apply to cases where it has been possible to substantiate some but not all of the allegations made on the balance of probabilities. For example '*it was possible to substantiate the physical abuse but it was not possible to substantiate the allegation of financial abuse*'.
3.	Not Substantiated:	It is not possible to substantiate on the balance of probabilities any of the allegations of abuse made.
4.	Not Determined / Inconclusive:	This would apply to cases where it is not possible to record an outcome against any of the other categories.
5.	More Likely than not to have occurred:	

Table 10. Outcome for Vulnerable Adult:



Safeguarding outcome for vulnerable adult following investigation	2009-10
Action Under Mental Health Act	1
Declaratory Relief/ Deputyship	3
Moved to Increase/Different Care	19
Vulnerable Adult Deceased	6
Counselling/Support	10
Management of Access to Alleged Perpetrator	18
Removed from Property/ Service	20
Management of Access to Own Finances	22
Community Care Assessment and Services	34
Increased Monitoring	56
No further action required/issue resolved	63
Total	**252**

Table 11. Outcome for Alleged Perpetrator



Safeguarding outcome for vulnerable adult following investigation	2009-10
Actions By Commissioning/Placing Authority	4
Criminal Prosecution/Police Action	38
Disciplinary/ Management Action	25
Assessment/Monitoring/Review	22
Counselling/ Support	1
CQC/Protection of Vulnerable Adults (POVA)/Regulatory Body	0
Management of Access/Removal	18
No further action taken*	144
Total	**252**

Item No. 10.	Classification: Open	Date: 17 February 2011	Meeting Name: Health and Social Care Board
Report title:		Performance Update – Local Area Agreement Targets relating to Health and Social Care – 2010/11 Quarter 3	
Ward(s) or groups affected:		All	
From:		Adrian Ward, Head of Performance, Southwark Health and Social Care	

Recommendation

1. That this report is noted.

Background/context

2. In Southwark's Local Area Agreement (LAA) (2008/09 to 2010/11) 35 Improvement Targets were selected from the basket of 198 National Indicators. Of these, 10 targets were of direct relevance to the delivery of Health and Adult Social Care priorities. Separate targets were set for 2008/09, 2009/10 and 2010/11 in agreement with the Government Office for London.

3. The purpose of this report is to present a brief summary of these targets and latest performance against them as at Quarter 3 of 2010/11.

Note: LAA abolition

4. On 13th October the Communities Secretary Eric Pickles announced the withdrawal of the current system of national performance management of Local Area Agreements and the associated National Indicator set. This follows on from the Coalition Government's scrapping of the Comprehensive Area Assessment and reflects their approach to performance management of public bodies.

5. In a similar fashion the Care Quality Commission has abolished the annual assessment of PCTs and NHS trusts for 2009/10 and 2010/11. The annual assessment of Adult Social Care recently published (in which Southwark achieved an improved rating of 'performing well') will also be the last. The NHS World Class Commissioning framework has also been dismantled. These systems all supported the delivery of LAA priorities. The government's intention is that in future local government and its partners will have greater autonomy in selecting priorities and will not be subject to the same degree of top down performance management as previously. In the case of health and well-being this will be guided by a national Public Health outcomes framework for which a consultation document was publishedon 20th December 2010.

6. Whilst the LAA targets are clearly now of less significance in terms of any external assessment of performance, as a result of these changes, they remain

the set of locally agreed priorities. Clearly, there will be a new priority setting process under the new system but until that is in place the LAA reflects key local priorities.

7. It should be noted that the new proposed outcomes frameworks that will replace the LAA and NI system contain a number of key outcome measures that are the same as or very similar to those in Southwark's LAA. Childhood Obesity, Mortality rates, Teenage Pregnancy, Smoking, Personalisation numbers and employment of people with learning disabilities and mental health problems and drug treatment are all measures in the system.

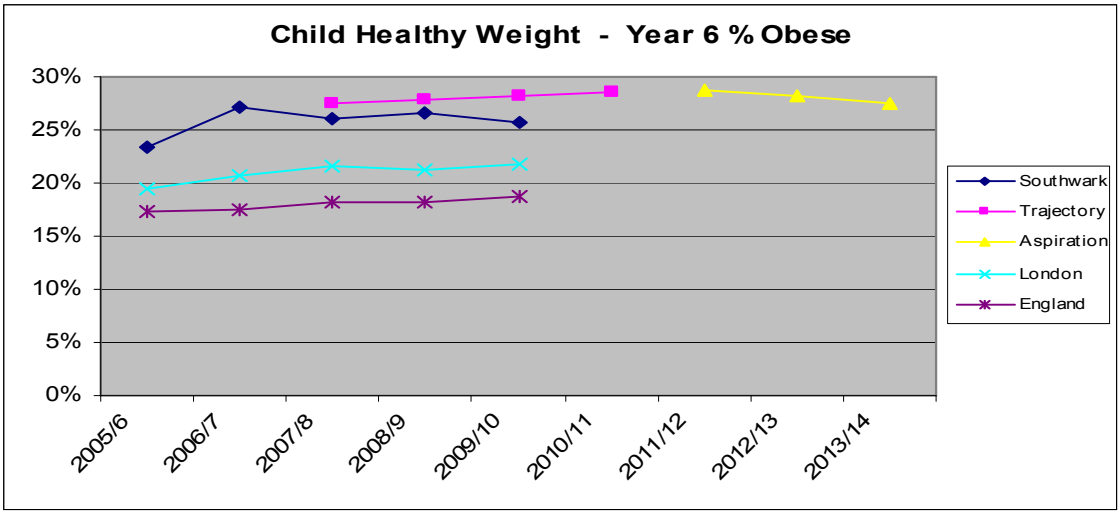
KEY ISSUES FOR CONSIDERATION

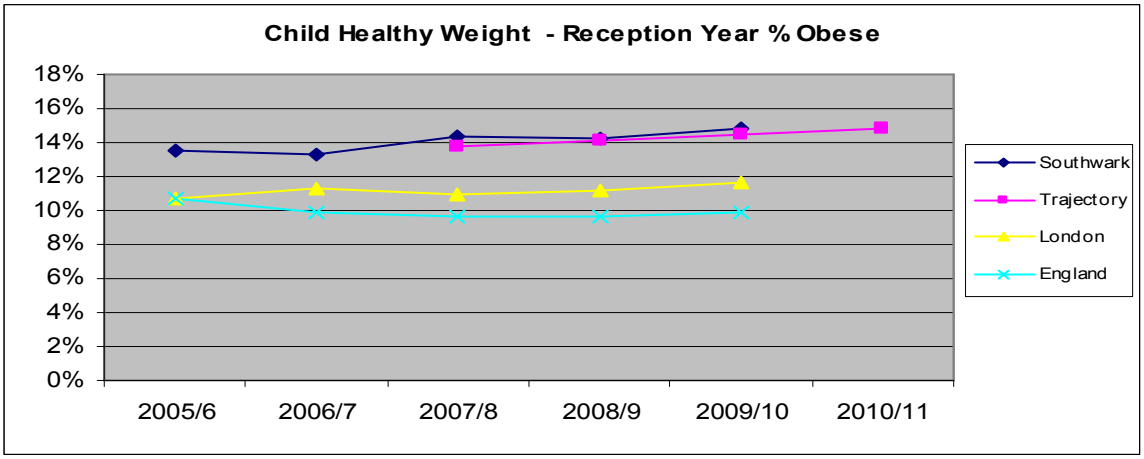
Healthy Weight of Children (Year 6) LAA indicator NI 56:

8. National data for the 2009/10 school year has now been released. The key points arising from this are:

Year 6: The % of children who are technically obese in Southwark schools has declined from 26.6% last year to 25.7% this year. This is below the LAA target figure, of 28.3%, as the LAA had assumed that the increasing trend would continue through to 2010/11 although with a reduced rate of increase. In comparative terms this is 4th highest nationally – compared to highest last year. The London average was 21.8%. See chart below.

Reception: The % of obese children increased from 14.2% last year to 14.8% this year. In comparative terms this is an increase from being the third highest nationally to being the highest. The London average was 11.6%. See chart below.





9. In response to the high levels of obesity in Southwark a Health Weight Strategy 2009-2012 was agreed and is being implemented across the borough by all partners, with a delivery plan focused on four strands:

Strand 1 - early intervention and prevention (with a particular focus on children)

Strand 2 - shifting the curve of overweight (focusing on increased activity and improved diet)

Strand 3 - targeting those at risk of an unhealthy weight (personalised advice, intervention and support, including children at risk of unhealthy weight, people with mental ill health, some BMR communities and people living in low income households)

Strand 4 - effective treatment of weight disorders (including pharmacological treatment and bariatric surgery)

10. These four strands are supported by:

- A programme of monitoring and evaluation, which will contribute to the obesity treatment and prevention evidence base.
- A programme of workforce training and development to build capacity throughout the borough.
- Effective governance arrangements to ensure that healthy weight strategy group and healthy weight strategy is fit for purpose.
- A commitment to developing and nurturing effective partnerships with statutory and third sector organisations.

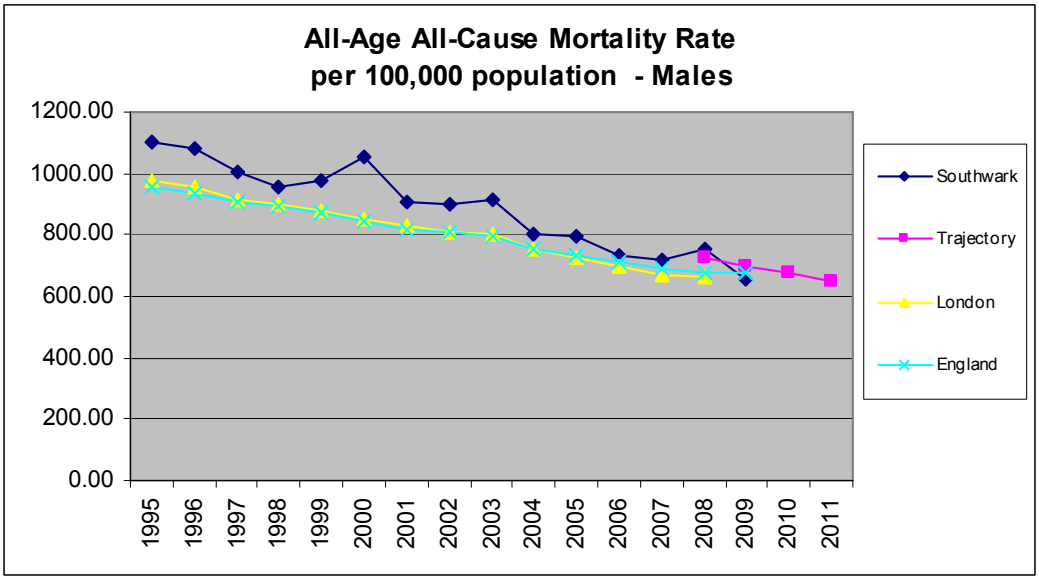
The policy of providing free school meals to all primary school children is designed to help improve the diet of children in the borough and hence help tackle the obesity problem.

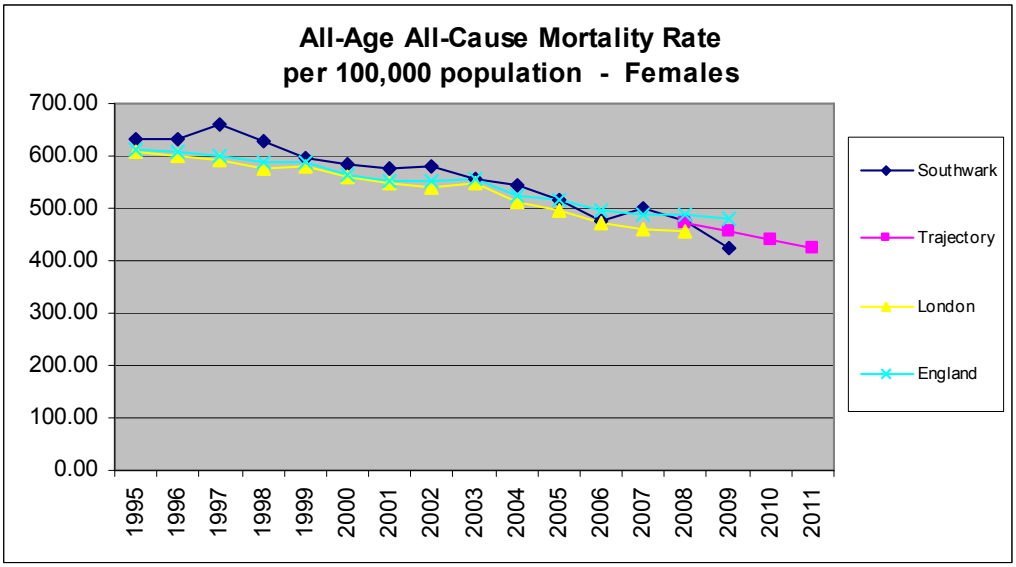
All-Age All-Cause Mortality (LAA target NI 120)

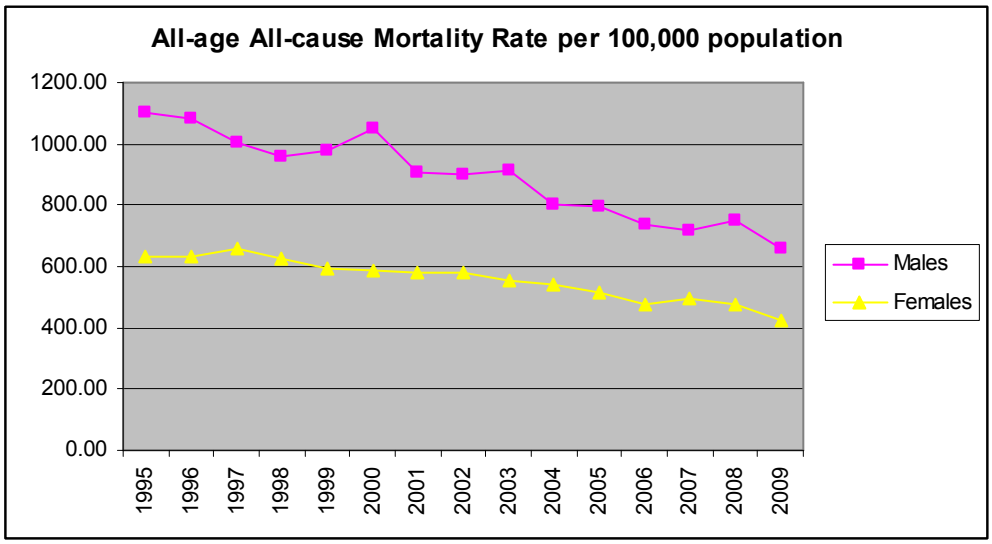
10. Unpublished provisional data for 2009 shows further significant reductions in the all-age all-cause mortality rate (per 100,000 population) for both males and females.

11. In 2008 Southwark became the first spearhead PCT in the country to have completely eradicated the inequality gap, for females, with a rate 2.6% below the national average. With the substantial further reduction in female mortality in 2009 the rate is now quite significantly below the national average and could well now be below the London average, although that figure is not yet available. Since the baseline period (1995-7) there has been 33% reduction in the female mortality rate, and the rate is now below the trajectory set for Southwark by the DH.

12. The male mortality rate is now also below the national average as well as the trajectory and there has now been a 39% reduction in the male mortality rate since the 1995-7 baseline. Therefore, Southwark has now completely closed the gap with the national rate which was a target for the spearhead areas and is a very considerable achievement.



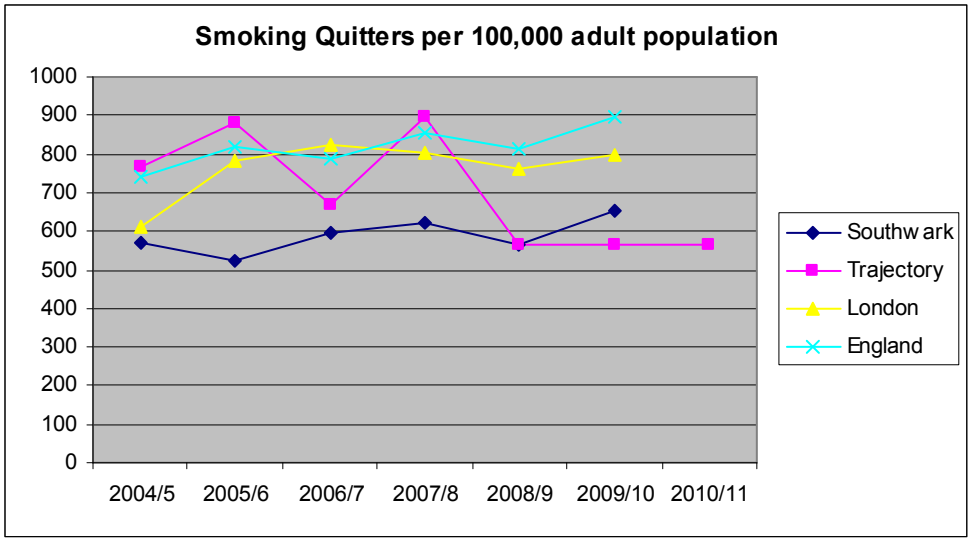




13. The gap between male and female mortality is less than in 1995 or 1996, but has not narrowed proportionately since then. The male mortality rate is 55% higher than the female rate, which is a very significant inequity. The Health Inequalities strategy aims to address these issues.

Smoking Quitters (LAA target NI 123)

14. The 2009/10 target was achieved, with 1510 people quitting smoking with support from NHS Stop smoking services, compared with the target of 1306. This is by a significant margin the highest number of quitters ever achieved. The rate of quitters per 100,000 population (of 647) was 21st highest in London and 19% lower than the London average. The revised Quarter 1 figure of 450 successful quitters is higher than the 332 in Quarter 1 last year, but the initial Quarter 2 return of 114 is disappointing, but expected to improve as final data comes in towards the year end. An area for further improvement is the success rate of those entering the service, which was 34% in 2009/10 compared with the London average of 46% quitting. In Quarter 1 the quit success rate improved to 42%, suggesting that the steps being taken are having an impact.



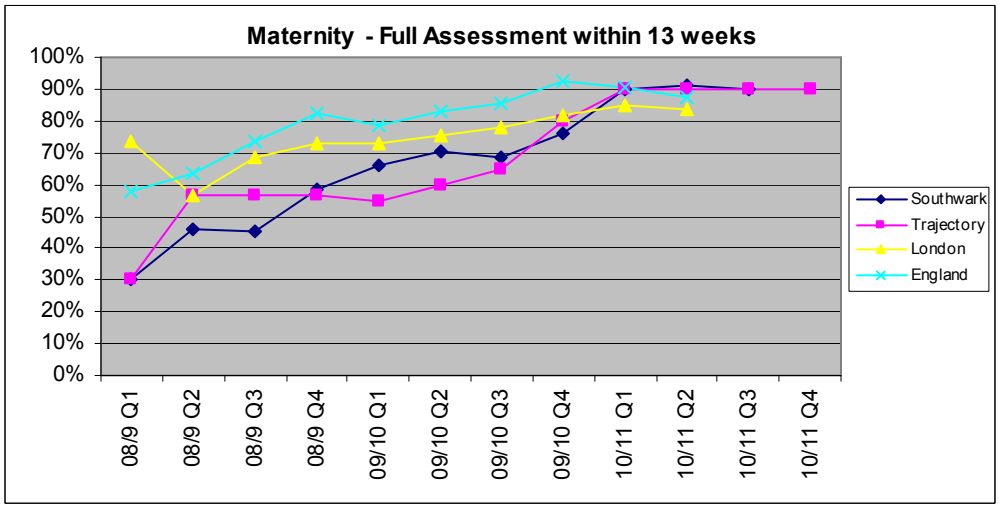
15. A stop smoking action plan is in place, which aims to :

- Increase the number of people who are aware of the service
- Increase the number of people seen and the number who set a quit date
- Ensure those who do attend are effectively supported and followed through to 4 weeks after their quit date

16. Support is available on one to one basis at most GP practices, some community pharmacists and some community dentists, at a clinic or at home if there are mobility issues. Six week group support is available at the specialist clinic.

Maternity Early Access (LAA target NI 126)

17. The target is to increase the percentage of women who have received a full assessment of their health and social care needs by a midwife or obstetrician within 13 weeks of pregnancy to 90% by 2010/11. This target was selected because access to maternity services has been identified as an issue locally, and is a possible contributory factor to higher than average infant mortality rates.



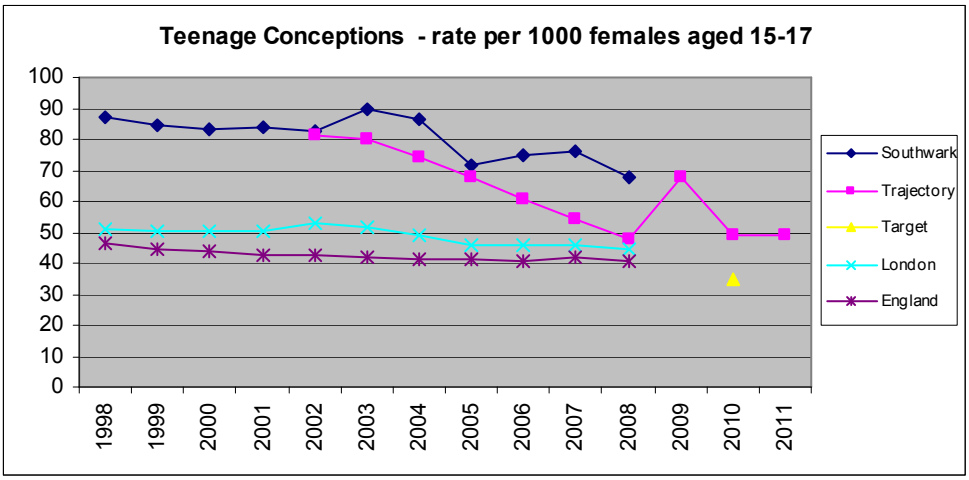
18. Progress in the year to date has been encouraging. Performance in Quarter 3 (provisional figure) shows that performance in the region of the 90% target has been sustained during they year with 89.8% achieved. asubstantial increase from 76% in Quarter 4. This is now better than the national average and the London average. The main action has been commissioning of enhanced midwife capacity and ensuring that the capacity of midwife teams matches the allocation of referrals, together with promoting the benefits of early ante natal care to all pregnant women.

Teenage Conceptions (LAA indicator NI 112)

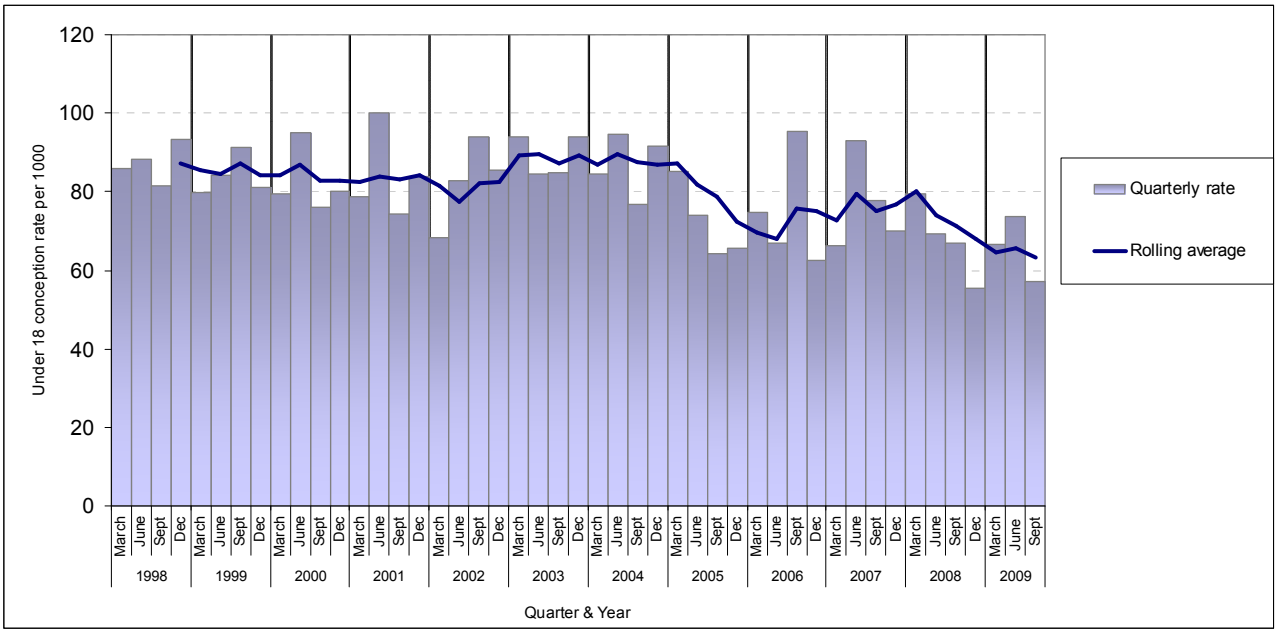
19. The latest published provisional data is for Quarter 3 (Jul-Sept) 2009 and shows a decrease on the previous two quarters, and a positive long term downward trend is being maintained (see chart below). During Quarter 3 there were 53 conceptions, and a 12 month rolling rate of 63.3 conceptions per 1000 females age 15-17 (the lowest rate yet). This represents a reduction of 27.4% on the 1998 baseline rate of 87.2 per 1,000, which is a higher reduction than the London average (19% reduction). Southwark was seventh best improved among the 32 London boroughs.

20. In absolute terms Southwark now has the 7th highest rate nationally and the highest in London, hence it remains an issue of major concern – however this is a comparative improvement from the position in 2007 when Southwark was highest nationally.

21. The latest published final data is for 2008 when the rate was 67.8 per 1000, a reduction of 22.2% on the 1998 baseline.



Rolling quarterly teenage conception rate and 12 month rolling average since 1998 (to Sept 2009):



Social Care Clients Receiving Self-Directed Support (NI 130)

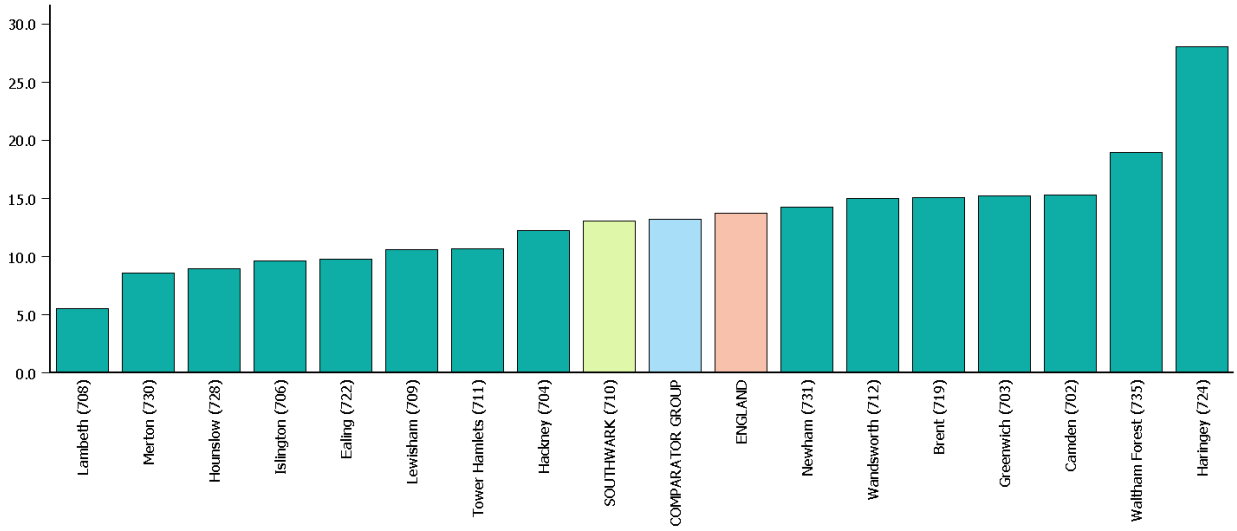
22. This target is for the proportion of social care clients receiving services through direct payments or personal budgets (self-directed support) to increase to 30% of all community-based service users by the end of April 2011. The performance for Qtr 3 was 596 clients receiving services through self-directed support, approximately 15.2%. This suggests that in terms of number there has not been a significant increase in the first 7 months of the year. (The year end figure achieved was 511 service users on some form of self-directed support, which was 13.7% of all community-based service users).

23. There are strong grounds for confidence that the 30% target can be achieved. Developing the infrastructure for the implementation of personal budgets has been prioritised and, along with other aspects of the personalisation and transformation agenda, is being subject to focused programme management. Specific developments that have now been implemented that will enable numbers to accelerate before April include:

- Rolling out a new review methodology that converts existing users onto Personal Budgets
- Rolling out revised procedures that ensure all new users are offered a personal budget
- Finalising a substantial cohort of indicative budgets that are in the system from the pilot stage
- Improving data capture, especially regarding Carers receiving personalised services directly from voluntary sector funded providers

24. Benchmarking data suggests that Southwark's 2009/10 performance was in line with the London average, which in comparative terms is an improvement as Southwark had been one of the lowest performers in 2008/09:

NI 130: Benchmarking 2009/10 - the % of community based service users on self-directed support (IPF comparator group)



Vulnerable People Achieving Independent Living (LAA indicator NI 141)

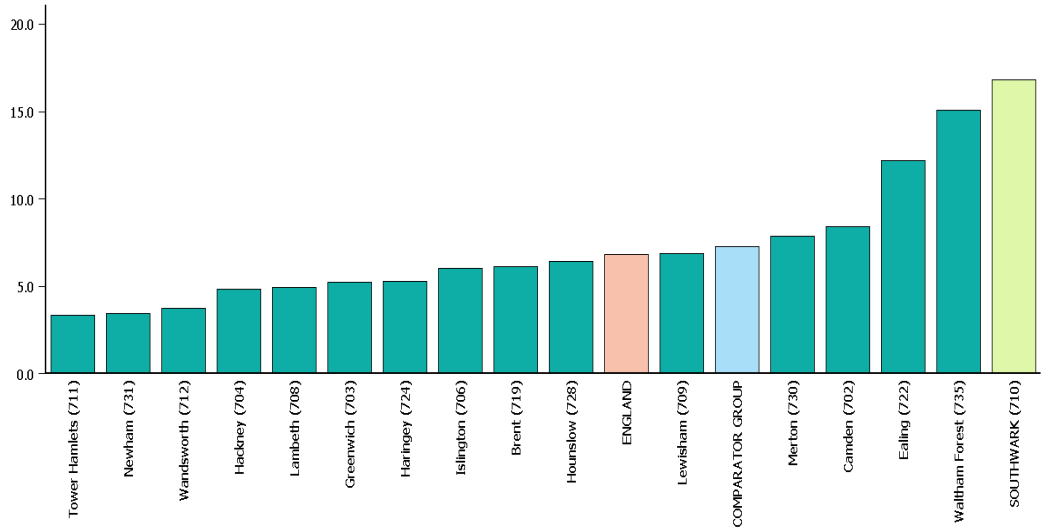
25. This target measures the % of people who are moving on in a planned way through Supporting People services into lower level services and independent living. It measures the performance of short term and temporary services such as temporary housing for the homeless. The performance for 2009/10 was 78.1%, exceeding the target of 77%.

26. This indicator no longer produced by DCLG and no benchmarking data is available.

Adults with Learning Disabilities in Employment (LAA indicator NI 146)

27. In 2009/10 16.8% of adults with Learning Disabilities were in paid employment (140 people out of 832), which is a very slight reduction on the 17.7% the previous year but strong performance overall. The chart below suggests Southwark has the strongest performance in its comparator group.

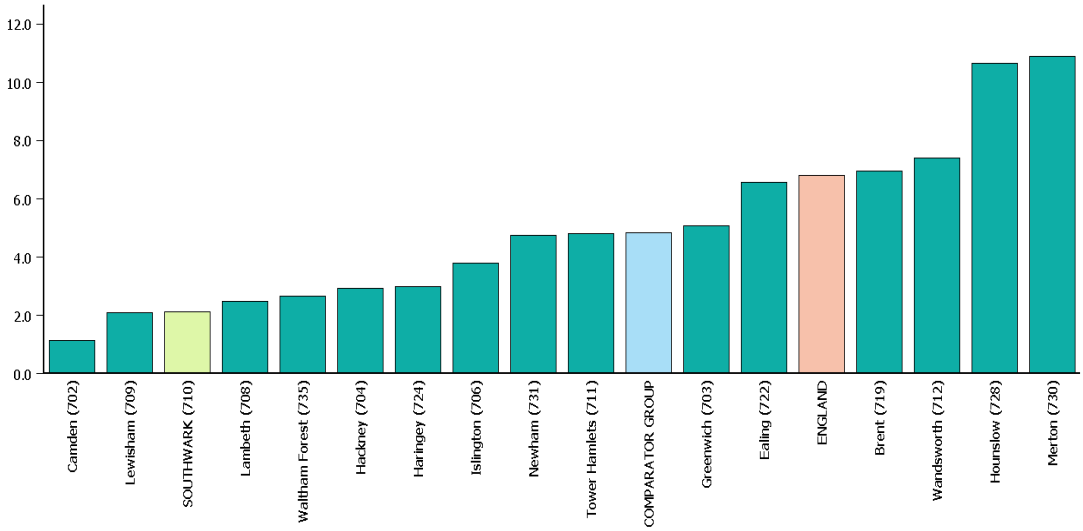
NI 146: % of people with learning disabilities in employment 2009/10 (IPF comparator group)



Adults with Mental Health problems in Employment (LAA indicator NI 150) -

28. The chart below shows performance on this indicator, which measures the proportion of people in contact with secondary mental health service on enhanced CPA who are in employment, is low.

NI150 - Adults in contact with secondary mental health services in employment (expressed as a percentage), 2009-10 (CIPFA comparator group)



29. The performance in 2009/10 was impacted on by the fact that a significant percentage of clients did not have their employment status recorded. During the current year there has been a substantial improvement in this area with recording now at 82%. However, only 3.8%, just 67 people, have been identified as employed. This is low, but not substantially below the comparator group or

national averages in absolute terms. The employment rate amongst those on enhanced CPA is likely to be very low given the intensive levels of needs of this group, and no specific target was set for the LAA.

Drugs Users in Effective Treatment (LAA NI 40) (withdrawn)

30. In the last LAA refresh the numbers in drug treatment target, which had been beset with data accuracy problems, was withdrawn from Southwark's LAA as agreement could not be reached on revising the growth target to reflect the more accurate baseline. Replacing the formal LAA target the council and PCT have focused on a more outcome focussed local LAA target on which data is reliable; the % retained in effective treatment for 12 weeks. Performance on this has increased during the year from 84% to 86% compared to the target for 2010/11 of 89%. This performance is above the London average of 83% and the national average of 85%.

RISK FACTORS

Financial costs: Not applicable. Note the LAA reward funding has been withdrawn by the Coalition Government.

Human resources: Not applicable

Legal: Not applicable

Community Impact

31. The LAA priorities and the associated targets were set taking into account those areas that will have the maximum impact on the community in line with our strategic goals. Delivery of these targets is therefore key to having an impact on community priorities. A number of these targets also have a strong health inequalities dimension and impact on more disadvantaged communities within the borough.

Background Papers	Held At	Contact
Performance documentation	Health and Social Care Performance Team	Adrian Ward 020 7525 3345

AUDIT TRAIL

Lead Officer	Malcolm Hines, Deputy Chief Executive and Director of Resources, Southwark Health and Social Care	
Report Author	Adrian Ward, Head of Performance, Southwark Health and Social Care	
Version	Final	
Dated	3 February 2011	
Key Decision?	No	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments included**
Strategic Director of Communities, Law and Governance	No	
Finance Director	No	
Cabinet Member	No	
Date final report sent to Constitutional Services/ PCT dispatch		9 February 2011

CABINET AGENDA DISTRIBUTION LIST **MUNICIPAL YEAR 2010/2011**
(Meeting held jointly with the Southwark NHS PCT)

NOTE: Original held by Constitutional Team; all amendments/queries to Everton Roberts Tel: 020 7525 7221

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Euan Cameron, Unison	1
Tony O'Brien, UCATT	1
Others	
Shahida Nasim, Audit Commission	1
Constitutional Team, Tooley Street	4
Vicky Bradding, Tooley Street	25
Total:	73

Dated: 6 February 2011