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DATE: 23 November 2016

To: Members of the
HEALTH AND WELLBEING BOARD

Councillor David Jefferys (Chairman)
Councillor Diane Smith (Vice-Chairman)
Councillors Ruth Bennett, Stephen Carr, Ian Dunn, Robert Evans, Colin Smith and Pauline Tunnicliffe

London Borough of Bromley Officers:

Stephen John	Assistant Director: Adult Social Care
Dr Nada Lemic	Director of Public Health
Kay Weiss	Interim Director: Children's Services

Clinical Commissioning Group:

Dr Angela Bhan	Chief Officer - Consultant in Public Health
Harvey Guntrip	Lay Member-Bromley CCG
Dr Andrew Parson	Clinical Chairman CCG

NHS England:

Matthew Trainer	South London NHS Area Team Lead - NHS England

Bromley Safeguarding Children Board:

Annie Callanan	Independent Chair - Bromley Safeguarding Children Board

Bromley Voluntary Sector:

Linda Gabriel	Healthwatch Bromley
Colin Maclean	Community Links Bromley

A meeting of the Health and Wellbeing Board will be held at Bromley Civic Centre on **THURSDAY 1 DECEMBER 2016 AT 1.30 PM**

MARK BOWEN
Director of Corporate Services

Copies of the documents referred to below can be obtained from http://cds.bromley.gov.uk/

AGENDA

1 APOLOGIES FOR ABSENCE

2 DECLARATIONS OF INTEREST

3 MINUTES OF THE MEETING HELD ON 6TH OCTOBER 2016 (Pages 1 - 12)

4 QUESTIONS FROM COUNCILLORS OR MEMBERS OF THE PUBLIC

In accordance with the Council's Constitution, questions to this Committee must be received in writing 4 working days before the date of the meeting. Therefore please ensure questions are received by the Democratic Services Team by 5.00pm on 25th November 2016.

5 INTEGRATED CARE NETWORK AND FRAILTY UNIT UPDATE (Pages 13 - 24)

6 PRIMARY CARE CO-COMMISSIONING UPDATE (Pages 25 - 34)

7 BETTER CARE FUND 2016/17 PERFORMANCE UPDATE (Pages 35 - 46)

8 JSNA UPDATE REPORT (Pages 47 - 50)

9 QUESTIONS ON THE DRAFT JSNA 2016 INFORMATION BRIEFING

The information briefing comprises the final draft of the 2016 JSNA.

The briefing is available on the Council's Website on the following link:

http://cds.bromley.gov.uk/ieListDocuments.aspx?CId=559&MId=5982&Ver=4

10 BROMLEY WINTER PLAN (Pages 51 - 74)

The report has been added to the agenda for noting. A report on performance against the plan will be provided at the next meeting.

11 PHLEBOTOMY UPDATE

12 ELECTIVE ORTHOPAEDIC CENTRES

13 HEALTHWATCH INEQUALITIES REPORT (Pages 75 - 92)

14 BROMLEY SAFEGUARDING ADULTS BOARD ANNUAL REPORT--2015-2016 (Pages 93 - 138)

It is intended that the report be provided for information and noting on this occasion, with a more detailed discussion to take place at the next meeting of the HWB in February 2017.

15 LETTER FROM HOME OFFICE AND DEPARTMENT OF HEALTH--COLLABORATION BETWEEN POLICING AND HEALTH PARTNERS (Pages 139 - 142)

A response to the letter will be provided at the meeting.

16 WORK PROGRAMME AND MATTERS ARISING (Pages 143 - 154)

17 ANY OTHER BUSINESS

18 DATE OF THE NEXT MEETING

The date of the next meeting is 2nd February 2017

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HEALTH AND WELLBEING BOARD

Minutes of the meeting held at 1.30 pm on 6 October 2016

Present:

Councillor David Jefferys (Chairman)
Councillor Diane Smith (Vice-Chairman)
Councillors Ruth Bennett, Stephen Carr, Ian Dunn, Robert Evans, Colin Smith and Pauline Tunnicliffe

Stephen John,(Assistant Director: Adult Social Care)
Dr Nada Lemic, (Director of Public Health)
Matthew Trainer, (South London NHS Area Team Lead - NHS England)
Dr Angela Bhan, (CCG Chief Officer - Consultant in Public Health)
Harvey Guntrip, (Lay Member-Bromley CCG)
Annie Callanan, (Independent Chair - Bromley Safeguarding Children Board)
Linda Gabriel, (Healthwatch Bromley)
Colin Maclean, (Community Links Bromley)

Also Present:

Agnes Marossy, Lorna Blackwood, Jackie Goad, Folake Segun, Rory Macfarlane, Dr Ruchira Panajape

74 APOLOGIES FOR ABSENCE

Apologies were received from Kay Weiss.

Apologies were also received from Dr Andrew Parson and Dr Ruchira Panajape attended as substitute.

75 DECLARATIONS OF INTEREST

There were no declarations of interest.

76 MINUTES OF THE HWB MEETING ON 2ND JUNE 2016

It was noted that the reference in the previous minutes to the 'Royal Voluntary Society in Bromley' (Minute 63) should be amended to 'Royal Voluntary **Service** in Bromley'.

Subject to this amendment the minutes were agreed as a correct record.

77 QUESTIONS FROM COUNCILLORS OR MEMBERS OF THE PUBLIC

No questions had been received.

78 UPDATE FROM THE CHILDREN'S SOCIAL CARE SERVICES IMPROVEMENT GOVERNANCE BOARD

The update concerning the Children's Social Care Services Improvement Governance Board was provided by the Council Leader, Councillor Stephen Carr.

The Board had been established immediately subsequent to the findings of the Ofsted report into Children's Services. The Board consisted of Members, Senior Officers, and representatives from the police, BSCB, the CCG and a Schools' Representative. The Board had met on a regular basis since its formation.

The Ofsted report had resulted in 22 recommendations. The Governance Board had drafted Terms of Reference and an Action Plan to ensure that all of the recommendations would be implemented. The Improvement Plan had been given high priority and so multiple drafts had been produced before the plan was finalised. The Action Plan was extended to cover the whole of Children's Services, and not just the areas highlighted by Ofsted. It was noted that there were two work streams identified by Ofsted as being good. The Board had initially met weekly, and this was subsequently changed to fortnightly meetings.

Members heard that the Action Plan had been scrutinised by the Care Services PDS Committee and the Executive & Resources PDS Committee before being approved by Executive. The Improvement Plan also went to Full Council for final approval and sign off. The Independent Commissioner for Children's Services had submitted her recommendations to the Minister, and LBB were awaiting a response. Additionally, a new Deputy Chief Executive and Executive Director of Education, Care and Health had been appointed.

The Leader felt strongly that the Governance Board should have an Independent Chairman and it was the case that a suitable candidate was being sought. The HWB would be informed of developments going forward. Improvements had been made to quality assurance, staff caseloads, improving staff numbers, and also with making improvements to the Court Team. It was also the case that more appropriate housing would need to be provided for those leaving care. The Leader stated that he welcomed scrutiny from partner organisations and scrutiny committees.

Cllr Ruth Bennett asked when the Commissioner's report to the Secretary of State would be published. It was responded that the report would be due sometime in October. It was noted that the Commissioner had been supportive, helpful, and that LBB were not expecting any surprises in the report; it was still the case however that LBB were unsure of what the final recommendations would be. Cllr Robert Evans commented that it would be the Minister who would make the final decisions.

Colin Maclean referenced the Borough Officers Strategic Partnership Forum which was chaired by the Leader and which discussed the new Building a Better Bromley vision and collaborative working; this meeting had been held the day prior to the HWB meeting. The membership of the Partnership Forum comprised the Leader, LBB Directors, Chief Officers from the MPS, LFB, CCG, DWP, Community Links and London South East Colleges. The Forum met to ensure that statutory requirements were being fulfilled, which included the proper functioning of Children's Services.

The Independent Chair of the Bromley Safeguarding Children's Board (BSCB) stated that they also had to develop an Action Plan and had significant ongoing work to do after Ofsted had stated that the BSCB required improvement. The BSCB Development Day this year (25th October 2016) would be used to look at how the BSCB could improve outcomes and be more effective in the future. As part of this, an Improvement Plan for the Board had been developed and BSCB had secured the support of Rory McCallum, the Professional Advisor to the Chair of the City and Hackney Safeguarding Children's Board as the facilitator for the Development Day.

Dr Bhan stated the CCG had been pleased with the responses to the Ofsted report, and with being part of the solution. On the positive side, an opportunity had arisen for various organisations to revise systems. The CCG were in the process of organising a mock CQC inspection of themselves and their partners.

Post meeting note:

The Statutory Direction issued to LBB from the Department for Education was published on the DFE and Bromley Council websites on 10th October 2016.

79 HEALTH AND SOCIAL CARE INTEGRATION UPDATE

It was suggested that this update may be better titled as 'Integrated Care Network Update'.

Dr Bhan made the point that the emphasis over the last two months for the CCG had been concentrating on work relating to children. However, it was still the case that the CCG and LBB had been working collaboratively on health and social care integration which was still being funded by the Better Care Fund (BCF). Lorna Blackwood had been leading this for LBB, and had been working closely with the CCG. Part of this work involved looking at social care implications.

It was noted that Dementia Hubs had been set up and financed by the BCF and that there had been a national drive to increase diagnosis rates for dementia. Access to the hubs was not only via GP's, but also via Oxleas and the third sector. It was felt that it would be a good idea if data concerning the dementia hubs could be brought back to the HWB, part of the data should relate to the discharge of patients. Various winter initiatives were being developed as well as the Transfer of Care Bureau.

Dr Bhan felt that good progress had been made concerning the development of the ICN's (Integrated Care Networks), and expressed her thanks for the support that had been received from the HWB and partners. It was now the case that standard ICN operational procedures and protocols were being written up.

Dr Bhan explained that in the future, GP's would have the option to refer complex cases to a Multi-Disciplinary Team (MDT). A pilot for this would be in place by the end of November 2016. The plan was for 3 MDT's to pick up 10 patients each at any given time, and that over the course of a year they would manage 1600 patients. At the time of writing, no significant extra burden was expected to be placed on LBB in terms of social care provision. Further development was required in terms of dealing with the housing needs of people in care homes. This was likely to take the form of an upgraded version of the Visiting Medical Officers Scheme, but was currently in an early stage of development.

Good progress had been made with developing the Frailty Unit in Orpington, including the provision of new geriatric services. Dr Bhan informed the Board that 1/3 new geriatricians had been recruited, but more were required. Care Navigators had been recruited to help the public 'navigate' the new system. The Frailty Unit (FU) would have 36 beds (and chairs) and would open in January 2017. It was anticipated that the size of the Unit would gradually expand, and would provide a step up service for people in the community. All parties involved were working very hard to make the new FU successful.

The Leader was pleased to hear of the progress made in developing the ICN's. He asked Dr Bhan what the impact would be on social care due to the increased volume of referrals, as this would have an impact on capital and resources. He also asked if the funding for any social care referrals would come from the BCF. Dr Bhan responded that she anticipated that currently there would be no extra demands on social care resources. However, she did mention that it remained to be seen if there were new needs that may need to be met. Dr Bhan stated that the objective of the FU was to reduce the number of hospital admissions, and also to reduce the need for packages of care from social care. It was anticipated that use would be made of the third sector to assist with reablement, and to counter the negative effect of isolation. Dr Bhan was confident that LBB had the relevant systems in place, and it was the case that BCF monies were available for another 3 years to assist.

Cllr Diane Smith expressed concern at what she perceived to be a limited number of beds in the FU, and asked what measures would be in place to ensure that enough step up beds would be available. Dr Panajape answered that the FU at Orpington would work differently, and that the FU was integral to a proactive frailty pathway. The plan was that under the new system, the focus would be on identifying patients that were escalating in need, and would therefore benefit from being cared for by the MDT. It had been proven that patients benefited from multi-disciplinary case management, and that referrals to the FU would need to come from a gerontologist.

Colin Maclean referenced the Bromley Third Sector Enterprise (BTSE). This was a new venture that had been established by some of Bromley's key charities.

The aims of BTSE were to:

- Provide a single point of access and signposting to the voluntary and community sector (VCS) health and social care provision in the London Borough of Bromley

- Enable the VCS to be a core provider of health and social care services in and around the London Borough of Bromley

It was also the case that Community Links were working on developing a social prescribing scheme.

Matthew Trainer was glad that the FU was not going to be treated as an extension to hospital treatment, and stated that care pathways had to change to reduce pressure that was building up in the system. He felt that too much care in previous models had been required to be given to those who were in a position of crisis; this was very detailed, costly and technical. Patients that spent too much time in hospital were in danger of developing muscle wastage and infections. He expressed the view that the current NHS model was unaffordable. The Chairman felt that it would be a good idea to have an FU update at the next meeting.

RESOLVED that the ICN update be noted, and that a further update be brought to the next meeting of the Board, which would include an update on the development of the Frailty Unit.

80 HEALTHIER SOUTH EAST LONDON PRE-CONSULTATION ENGAGEMENT FOR PLANNED ELECTIVE CARE REPORT

Dr Bhan provided the Elective Care update. She informed the Board that inpatient orthopaedic centres still existed on 7 sites, and that the associated rehabilitation services were working well. An Evaluation Panel had been set up to evaluate site options for the development of the new orthopaedic centres against the criteria developed by clinical and patient groups and signed off by the CCG Committee in Common (CiC). The task of the Evaluation Panel was to assess the suitability of potential sites against financial and non-financial criteria. It was hoped that the determination of the site would be by non-financial criteria if possible. It was intended that one site be located in inner London, and one in outer London.

The scores for each option against non-financial criteria were listed in the report:

- Guy's and Lewisham 1.15
- Guy's and Orpington 2.15
- Orpington and Lewisham 1.08

So based on non-financial criteria, the 2 favoured sites would be Guy's and Orpington. The CiC would meet again on 8th November, and it was anticipated that the Evaluation Panel would have completed its work by then, and this would have

included a financial evaluation of the proposals.

It was noted that for the orthopaedic centre proposal to go forward it would have to demonstrate the following criteria:

- that the proposal did not destabilise any hospital
- that trauma services could be maintained at A&E departments
- that the proposal was affordable and made a positive financial contribution

Cllr Ruth Bennett expressed the view that some of the objections from the public had been made on the basis of dis-information, and that this would need to be countered. Dr Bhan mentioned that some consultation had already been undertaken, but a full consultation was planned. It was anticipated that the implementation of the orthopaedic elective care centres would act as a prototype for similar centres of excellence in other disciplines.

Mr Trainer stated that it was not the case that the NHS were looking to strip resources, but that the aim was to facilitate an efficient consolidation of resources. It was important that people understood this, as demand was outstripping funding. Cllr Dunn referred to the conditions outlined in the report for an orthopaedic centre proposal to go forward. He asked how it could be demonstrated that '*trauma services can be maintained at our A&E departments'.* Dr Bhan responded that outpatients and day surgery still had to function as normal. Duty rotas would be maintained to ensure that trauma centres had the correct level of medical input.

Councillor Diane Smith asked how the financial arrangements would be handled when people had treatment in the Elective Care Centre from outside the borough. Dr Bhan assured that the correct lines of communication would be put in place between social services departments. It was the case that a model was already working in south west London. Mr Stephen John commented that under the Social Care Act, there was a statutory obligation for the responsible social services department to pick up costs. Dr Panajape explained that pre and post-operative arrangements, along with rehabilitation would remain unchanged.

81 STEPPING UP TO THE PLACE-INTEGRATION SELF ASSESSEMENT TOOL

A document had been allocated to the agenda entitled, 'Stepping up to the Place: Integration Self-Assessment Tool'. This was a document that had been drafted by The Association of Directors of Adult Social services (ADASS), the Local Government Association (LGA), NHS Clinical Commissioners and the NHS Confederation. The aim of the publication was to show what a fully integrated, transformed system should look like.

The self-assessment tool consisted of 2 core modules, and 2 optional modules.

The Core Modules were:

- Do you have the essentials for the integration journey?

- How ready for delivering integration is your health care system?

The Optional Modules were:

- Effective governance for delivering integration

- Effective programme management for delivering integration

Rory Macfarlane (London Councils) was in attendance to answer any questions concerning the self-assessment tool.

It was decided that the self-assessment tool be noted, but should be taken away and carried forward outside of the current meeting. It was noted that the LGA had a budget to assist in the implementation of the steps outlined in the tool. It was agreed that Mr Macfarlane and Lorna Blackwood would meet after the meeting to discuss the self-assessment tool further.

82 HEALTHWATCH ANNUAL REPORT

The presentation on the Healthwatch Annual Report 2015-2016 was given by Linda Gabriel.

Three broad areas of work were identified:

- Mental Health
- Children and Young People
- Access to Primary Care Services

Engagement with young people identified that children and young people needed to be given more information and an insight into mental health at a younger age.

In terms of signposting, roughly a third consisted of directing people to GP surgeries, followed by hospitals. A pie chart showing ‘positive stories by service type’ showed that people’s positive experiences were primarily with community health services.

The Board heard that during 2015/2016 Healthwatch used their powers to conduct ‘Enter and View’ visits to 6 Extra Care units, and made various recommendations subsequently.

Healthwatch undertook a project to gain better understanding and appreciation of Bromley residents’ attitudes towards pharmacies. Ten pharmacies across the borough were visited, focusing on topics such as dispensing; promotion of healthy lifestyles, signposting and patient feedback. From the views and experiences gathered, it was evident that patients and service users felt they received a high quality of service from local pharmacies.

Healthwatch explored attitudes towards mental health and service access in the borough. They gathered the views, opinions and experiences of 109 residents and

service users. The majority of respondents agreed that there was not enough mental health support in the community.

Healthwatch felt that they had made a difference in the community by:

- Publishing 5 reports that focused on priorities.
- Playing an active role in gathering the views and experiences of homeless people for the borough's Homeless Health Needs Audit.
- Facilitating consultation with local people who access HIV services.
- Holding an event to raise awareness about the importance of self-care.
- Providing intelligence to the CQC, prior to the inspection of King's College Hospital.
- Delivering public engagement as part of the IAPT and Mental Health Employment Service review.
- Involvement in the development of the 'Our Healthier South East London' Programme.
- Engagement with over 200 members of the public as part of the CCG's Phlebotomy Services consultation.

Ms Gabriel informed the Board that Healthwatch had decided to continue with the same priorities for 2016/17 which were:

- Mental Health
- Children and Young People's Wellbeing
- Access to Primary Care Services

Mr Trainer mentioned that he was aware of a GP surgery that was using its practice address to help homeless patients register for various services, and that processes needed to be improved for homeless people to get access to medication. The Chairman stated that the issue of homelessness was being looked at in the next Joint Strategic Needs Assessment (JSNA).

It had been noted that the issue of sexual health and gender identity was a project that Healthwatch were looking to explore in the near future. Councillor Pauline Tunnicliffe highlighted that the number of young people identifying themselves as 'bisexual' had increased by 45% in the last 3 years. She asked if there was any link between this and mental health. Ms Gabriel replied that the focus of Healthwatch had been on the ability to access services rather than on identifying medical correlations. This being the case, no correlation had yet been identified.

Cllr Tunnicliffe stated that she had been informed that anti-depressants did not work well for young people, so were they being prescribed less?

Dr Panajape responded to this query. She stated that she was not aware of any evidence that supported the claim that anti-depressants were less effective for young people. It was true that young people were more volatile, and that the risk factors may increase as a result. She expressed the view that a holistic approach was required along with occupational therapy.

Cllr Diane Smith enquired if Healthwatch had been looking into issues concerning access to primary care services, specifically new GP surgeries. Ms Gabriel responded that Healthwatch had been looking into existing service quality, and not at new service provision. It was resolved that this matter be added as a future agenda item.

RESOLVED that the matter of new GP service provision be added as an agenda item for the next meeting.

83 BRIEFING ON SMOKING AND MENTAL HEALTH

The Board looked at the briefing note on smoking and mental health written by Dr Agnes Marossy. The briefing had been drafted in response to the report produced by ASH (Action on Smoking and Health) entitled; 'The Stolen Years: The Mental Health and Smoking Action Report'. This report had been developed in collaboration with 27 leading mental and public health organisations.

It was noted that 40% of people with a mental health condition smoked; this figure increased to up to 70% for people that had been discharged from a psychiatric hospital.

Dr Marossy informed the Board that work on the JSNA for 2017 included data searches of GP surgeries to include the identification of patients with mental health conditions who smoked. It was also the case that Oxleas, with support from the 'Stop Smoking Service' had implemented smoke free sites for their acute services, and were working on making the long stay wards smoke free. The commissioned contract for the 'Stop Smoking Service' included the targeting of priority groups including pregnant smokers, routine and manual labour workers and smokes with mental health conditions.

The Specialist Stop Smoking Service had undertaken 'Stop Smoking' training with staff at Community Options (they were a charity who supported people with severe and enduring mental health problems, and were commissioned to provide services in Bromley).

The Stop Smoking Service was currently commissioned from Bromley Healthcare, and this contract was due to end on 31st March 2017. The service would be decommissioned as the Executive had made a decision to cut the budget for this service. Dr Bhan expressed concern about the effects of decommissioning the service, and felt that this would be a problem going forward, and that it would have an adverse effect on the health of many people.

Cllr Ruth Bennett asked if a person's mental health needs may in fact be made worse if they stopped smoking, and how was it possible to monitor if a person had

given up or not? Dr Lemic responded that there was no evidence to support the hypothesis that giving up smoking would worsen the mental health conditions of people with mental health needs. It was possible to test individuals to ascertain if they had given up smoking or not; a machine was used to test carbon monoxide levels.

84 MOU BETWEEN THE HEALTH AND WELLBEING BOARD, AND THE BROMLEY SAFEGUARDING CHILDREN'S BOARD

The Working Agreement between the HWB and the BSCB was well received by the Board.

The Chairman referred members to Appendix A, (Role and Responsibilities: S7). He recommended that the reference to the HWB as an 'executive' body be replaced with the word 'statutory' as the HWB was not an executive body.
With this adjustment, all parties were happy to approve the agreement.

Mr Stephen John felt that it would be beneficial if another MOU was drafted between the HWB and the Adult Safeguarding Board.

RESOLVED that subject to the adjustment detailed above, the MOU between the HWB and the BSCB be approved and signed off.

85 UPDATE FROM THE MENTAL HEALTH SUB GROUP INCLUDING CAMHS TRANSFORMATION PLANS

The update from the Mental Health sub group was provided by Mr Harvey Guntrip.

The sub group had met prior to the main meeting of the HWB, and Mr Guntrip summarised the meeting as follows:

The Chair introduced the following aims to members and sought general agreement on the terms and conditions under which the sub group would operate.

1: To understand the wider mental health needs for the population of Bromley.

2: To map existing and proposed provision across the Borough and cross borders.

3: To investigate key issues impacting on effective delivery of mental health services across the Borough and facilitating strong partnership working across all agencies.

4: To propose a joint LBB/CCG strategy for a cost effective mental health service across the Borough.

Discussion was held concerning these aims, and general agreement was reached, including a commitment from all present to aid in the facilitation of joint working across all agencies. The sub group agreed that the current membership was the

appropriate size and composition for the task, and that other invitees would be called as appropriate to items on the future agendas.

Daniel Taegtmeyer (CAMHS Transformation Plan Lead from Bromley CCG) introduced a paper:

'CAMHS Transformation and Mental Health of Children and Young People (CYP) in Bromley'.

A wide ranging discussion around the topic took place and general support of the aims of the plan was given. All members committed to working closely in the development of the plan and to ensure its long term success.

Stuart Thompson (Mental Health Interim Commissioner Bromley CCG) introduced a paper:

"Developing Mental Health and Wellbeing for Bromley"

Discussion around the broad range of topics contained in the paper took place and Stuart and Lorna confirmed they would work closely to ensure any commissioning intentions would be well rehearsed by both LBB and CCG to ensure maximum impact. Members agreed that a combination of the CAMHS and the Mental Health and Wellbeing plans would constitute the backbone of an overall Bromley Strategic Plan for Mental Health and the sub group would assist in developing this plan in future meetings. The sub group concluded that future meetings would run in tandem with Health and Wellbeing Committee dates and that ongoing conversations around the topics would continue outside the meetings as appropriate.

Mr Guntrip informed the HWB that it was the intention of the sub group to chart and print a strategy document with real time frames that would be presented to the Board for discussion. It was suggested that as the CAMHS Transformation Plans needed to be signed off by October 31st, that authority be delegated to the Chairman and Vice Chairman of the HWB for sign off.

Dr Bhan felt that the strategy of the Mental Health Sub Group should be clinically led, and that something else should be set in place to enable this. She felt that it was fundamental to have clinicians involved, and that a broader engagement was required.

Annie Callanan referenced school counsellors, and expressed the view that they should all be BACP (British Association for Counselling and Psychotherapy) trained and registered. This was not currently the case. A paper drafted by Jenny Selway would be presented to the Schools Partnership Board with this recommendation.

86 PHLEBOTOMY UPDATE

It was noted that procurement matters were being developed by the CCG.

87 WORK PROGRAMME AND MATTERS ARISING

The Work Programme and Matters Arising report was noted.

It was noted that a JSNA update would be provided to the Board in December.

The Board were informed that an agenda planning meeting had been scheduled for 31st October.

In terms of future agenda items it was agreed that access to GP services be added as an agenda item for the next meeting. Cllr Dunn suggested that an update from IMPOWER would be beneficial.

RESOLVED that

(1) A JSNA update be brought to the next meeting

(2) Access to GP services be added as an agenda item for the next meeting

88 OTHER BUSINESS

The Chairman asked members if they felt it was a good idea to have a 'Health and Wellbeing Week', with a possible exhibition at the reference library. Any thoughts around this should be emailed to the Committee Clerk with the Chairman copied in.

89 DATE OF NEXT MEETING

The date of the next meeting was confirmed as December 1st 2016.

The Meeting ended at 3.30 pm

Chairman

NHS
Bromley
Clinical Commissioning Group

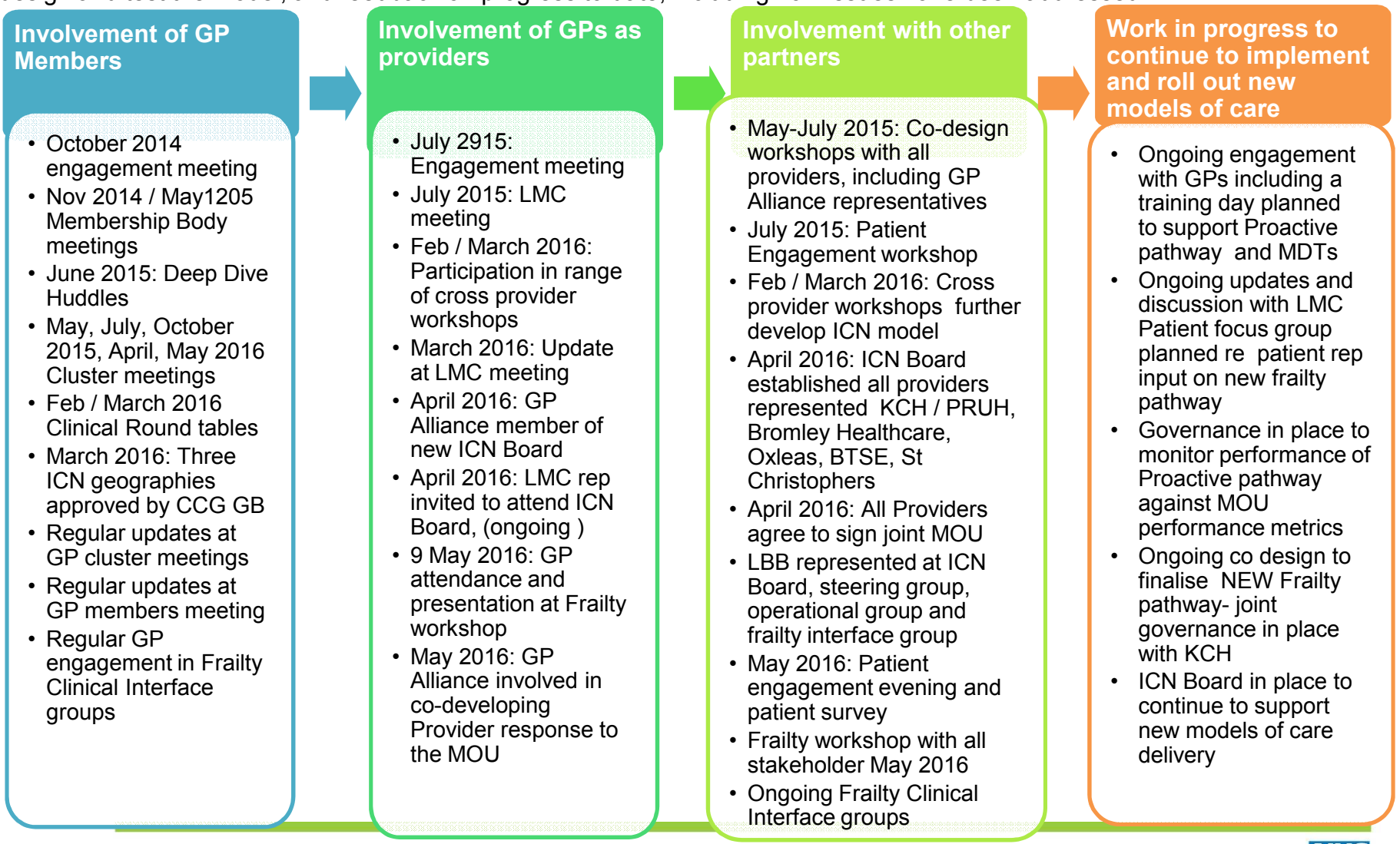
INTEGRATED CARE NETWORK UPDATE

FOR HEALTH & WELLBEING BOARD
December 2016

CONTENTS

HOW WERE STAKEHOLDERS INVOLVED?

Significant engagement has taken place with a wide range of stakeholders in order to identify issues, address concerns, co-design and test the model, and feedback on progress to date, including how issues have been addressed.



NHS Bromley Clinical Commissioning Group

PATIENT IDENTIFICATION

1

All **HEALTH AND CARE PROFESSIONALS** will case find and identify High Risk, High system users and provide their details to the **MDT LIAISON COORDINATOR** (via the Bromley Healthcare Single point of entry). *N.B. In Year 1 only GPs will be actively case finding*

The **MDT LIAISON COORDINATOR / CARE NAVIGATOR** provide **CARE NAVIGATION** and **CARE COORDINATION** support at an ICN level

PATIENT IDENTIFICATION AND CASE FINDING

2

The **MDT LIAISON COORDINATOR** support GPs in updating EMIS for any additional patient information, and where required a **NOMINATED GP CHAIR** will apply clinical judgement to non-GP identified cases to ensure consistency of assessment *(from Year 2 onwards)*;

If system capacity becomes an issue the **NOMINATED GP CHAIR** will prioritise who has the highest clinical and social priority for **INTEGRATED CASE MANAGEMENT**

CLINICAL GOVERNANCE AND DEMAND MANAGEMENT

3

Based on individual organisation consent policies, by this point the relevant **HEALTH AND CARE PROFESSIONAL** or the **MDT LIAISON / CARE NAVIGATOR** will have checked that the **PERSON** is happy to be put on the **PROACTIVE CARE PATHWAY**

PATIENTS IDENTIFIED AS REQUIRING PROACTIVE CARE PATHWAY will be placed on pathway for initial holistic assessment via a Community Matron, with the referral being managed by the **MDT LIAISON COORDINATOR**

PATIENT CONSENT

To ensure an intervention is most effective, resources must target the individuals at highest risk, and any case-finding method needs to be able to identify individuals at high risk of future emergency admission to hospital.

In practice, most programmes use a combination of a predictive case finding model and clinical judgement; the model is used to flag individuals who are at high risk, and the clinician then makes a judgement as to whether a person is likely to benefit from case management.

PROACTIVE CARE PATHWAY

4

An initial **HOLISTIC ASSESSMENT** (Guided conversation) is carried out with the patient by the most relevant person, who will usually be the Community Matron

INITIAL ASSESSMENT

5

An **INTEGRATED CARE AND SUPPORT PLAN** will be developed by the Community Matron with the patient, supported by the **CARE NAVIGATOR** role (when required)

INTEGRATED CARE PLAN

6

A **MULTI-DISCIPLINARY TEAM** carries out an initial review of the person, updates and ratifies the **INTEGRATED CARE PLAN**, and assigns a **CLINICAL LEAD** based on the agreed **PRIMARY NEED** of each person

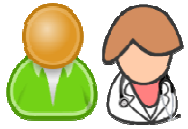
INITIAL MDT MEETING

7

The **NOMINATED GP CHAIR** will Chair the MDT meetings to ensure all the patient's needs are considered and actioned, ensuring that the best interests of the patient are considered and prioritised

CLINICAL GOVERNANCE

8



The **CLINICAL LEAD** is the first point of contact for the patient for their **PRIMARY NEED**, supported by the **MDT LIAISON COORDINATOR** who will be the main point of contact for all other needs (including self-management support)

POINT OF CONTACT

9

The updated **INTEGRATED CARE AND SUPPORT PLAN** is shared with the patient by the most relevant person and the care plan is implemented, overseen by the **CLINICAL LEAD** and coordinated by the **CARE NAVIGATOR** with support from the **MDT LIAISON COORDINATOR**

PATIENT INVOLVEMENT

10

The **MDT LIAISON / CARE NAVIGATOR** arrange **MDT** reviews at the intervals set out in the **INTEGRATED CARE AND SUPPORT PLAN** to review the care plan progress and make changes to the patient's care as required (70% of patients will require discussion at a 2nd MDT)

REGULAR REVIEW

11

When required an **HOLISTIC ASSESSMENT** (guided conversation) is carried out to re-assess the needs of the person, and where appropriate reduce the intensity of support they need

RE-ASSESSMENT

ICN MOBILISATION - RECENT PROGRESS

- Recruitment to new MDT roles is nearly complete

The first MDT was held on 18 October – Three (3) patients were referred via the Bromley Healthcare Single Point of Entry

Positive feedback was received from all professionals involved in the first MDT

More MDTs have been arranged for 24 and 28 November

Bromley Healthcare single point of entry form has been updated so GPs can select to refer a patient to the Proactive Care Pathway

RECRUITMENT TO NEW KEY ROLES

GP CHAIR	• Two Chairs appointed by the GP Alliance to provide governance to the MDT meetings • Due to start at end of November and December
MDT LIAISON COORDINATOR	• 3.6 WTEs recruited and starting in November / December • GPs will be informed of the named MDT Liaison Coordinator support for their ICN in coming weeks
CARE NAVIGATORS	• 3.6 WTEs Care Navigators recruited and starting at the beginning of December • Care Navigator Manager JD agreed and out to advert (This role also supports the Frailty Pathway)
INTERFACE GERIATRICIAN	• One of three Interface Geriatricians recruited and due to start in January 2017 • KCH are aiming to recruit a further two geriatricians
MENTAL HEALTH PROFESSIONAL	• Out to advert to provide MH input to MDTs
SOCIAL PRESCRIBING ADMINISTRATOR	• Out to advert to support the Social Prescribing Portal

Each provider organisation will cover the MDT meetings with existing staff whilst they are waiting for new appointments to start

FEEDBACK FROM FIRST MDT

"We achieved more for each of these patients in a 20 minute discussion than we would have done just spending 20 minutes alone with the patients"

"Had the practice not been looking for these patients for the ICN then we had no intention of doing anything particular over and above their management plan to date. Each patient now has multiple actions ongoing which without doubt will improve their conditions"

"It was crystal clear that everyone was very keen to help and to support those patients discussed, and it was nice to be able to contribute to this"

"It was helpful for actions to be taken away from the MDT without the need for formal referral"

"... the Community Matrons assessments were excellent and vital to ensuring an accurate action plan"

"... it was an incredibly worthwhile session and moving forwards we will really be able to transform some patient's lives"

WHAT TO EXPECT FROM A MDT MEETING

The **Community Matrons** will have done a comprehensive assessment including the patient's wishes/goals and will present this alongside your presentation of the patient

The **MDT Liaison Coordinator** will ensure relevant organisations, who should be helpful in formulating an action plan for this patient, will attend the MDT meeting

The role of the **GP Chair** is to ensure that the nature of the discussion and care plan are of good quality.

The **Care Navigators** are the point of contact into the voluntary sector e.g. Age UK/ MIND etc. and should therefore pick up these actions.

Mental health team and **Geriatricians** will be available depending on need and can pick up relevant actions.

If information is needed from **other community services** e.g. SALT/ podiatry you should expect that your Community Matron and MDT Liaison Coordinator will have accessed this information.

In the long run we will have a local care record available to help exchange information (we are looking into whether a multi-organisational care plan is feasible)

ELIGIBILITY CRITERIA FOR INTEGRATED STEP UP / DOWN FACILITY

KEY REQUIREMENTS

- Non-acute elderly care
- Patients whose condition is likely to require some medical input
- Level of Frailty: scoring at least 6-7 on the Rockwood Frailty Scale (age not deciding factor)
- Hours of decision making for referrals: proposed 8am-5pm based on availability of Geriatrician
- Patients with a Bromley GP (test impact after 2-3 months)
- Access – via step up or step down through Geriatrician gateway
- Unit is consultant led with a MDT approach - TBC
- 7 day access

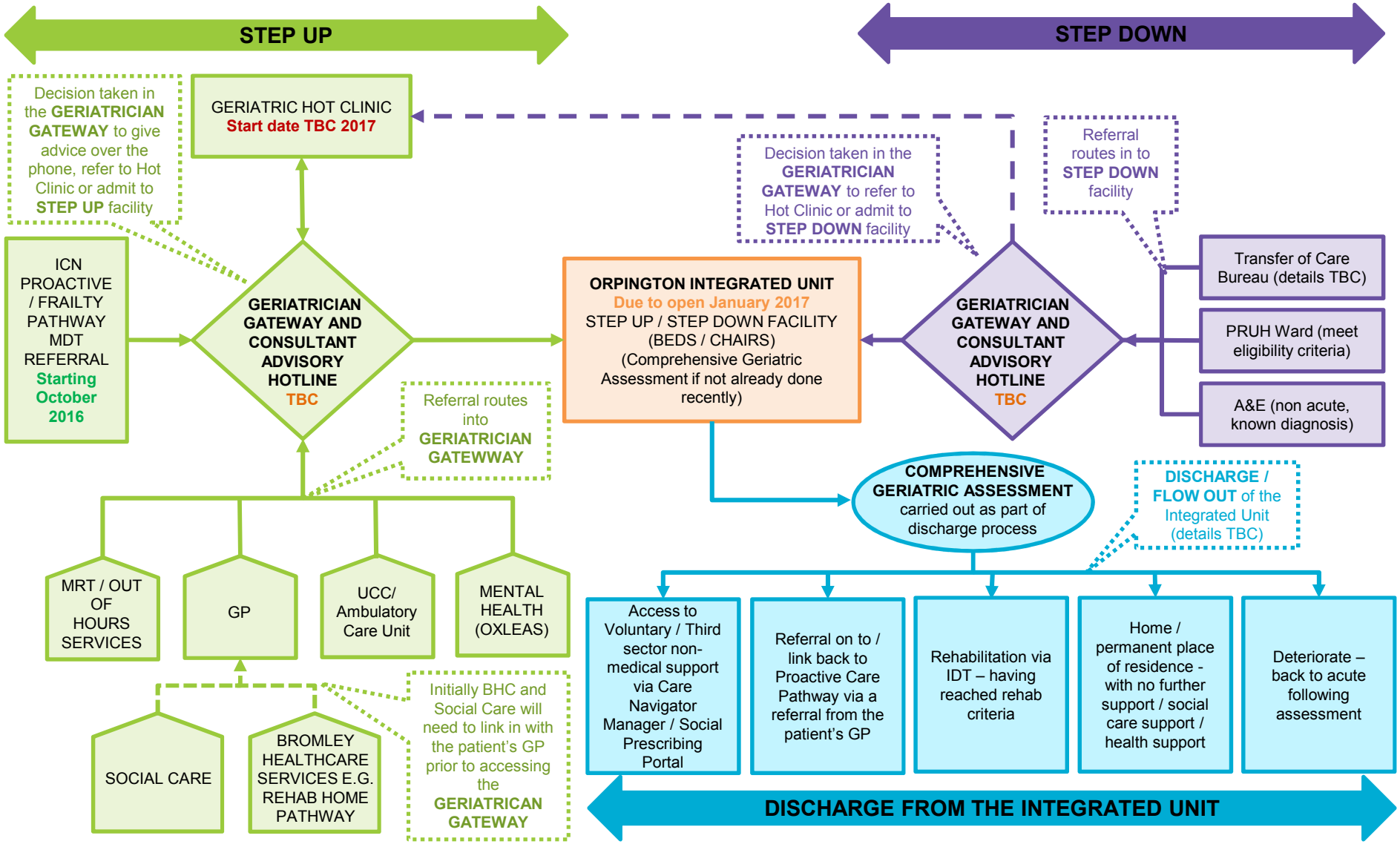
STEP UP

- Referral through one of the following Gerontology gateways:
  - Geriatrician hot clinic
  - MDT referral from Proactive Pathway
  - GP referral via geriatric hotline where patient has been suitability assessed as not requiring admission to acute site
- Patients with known diagnosis or ongoing needs but cannot be treated at home, requiring a stay of less than in the region of 7 days
- Patients with delirium or dementia who require non-acute support can be discussed and considered for this support
- Step up via Rehab Home Pathway or MRT for patients who are not safe to be supported at home and require inpatient rehabilitation
- Management of venous ulcers and patients with long term conditions that have been gradually failing with an identified cause e.g. increased leg oedema
- People discharged, where the package of care is inadequate or there was a non-acute reason for the package of care not being supportive (recurrent admissions)

STEP DOWN

- All step down patients will have had a Comprehensive Geriatric Assessment started before transfer
- Recuperation/rehabilitation for patients whose condition is not currently reaching Lauriston criteria (slow stream)
- People who are medically stable but require support because their carer has been admitted
- Minor illness and falls not covered by the current fracture pathway
- Resolving Delirium / Dementia (slow stream requiring longer length of stay) - TBC

FRAILTY PATHWAY OVERVIEW FOR INTEGRATED FACILITY



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Report No.

London Borough of Bromley

PART ONE - PUBLIC

HEALTH AND WELLBEING BOARD

Date: **Thursday 1st December 2016**

Report Title: **Delegated Primary Care Commissioning – update report**

Report Author: *Name: Jessica Arnold*
Department: Head of Primary and Community Care
Organisation: Bromley CCG
Tel: 01689 866544
E-mail: jessica.arnold1@nhs.net

1. SUMMARY

The attached paper is a copy of a report for Bromley CCG's Governing Body on 24 November which describes preparations to move to delegated Primary Care Commissioning in Bromley from April 2017 and the implications of the move.

2. REASON FOR REPORT GOING TO HEALTH & WELLBEING BOARD

To provide an update on the application process and summary of what the changes will mean

3. SPECIFIC ACTION REQUIRED BY HEALTH & WELLBEING BOARD AND ITS CONSTITUENT PARTNER ORGANISATIONS

The Health & Wellbeing Board is asked to note this report.

Health & Wellbeing Strategy

The programme relates to all the priorities in the Health & Wellbeing strategy: Diabetes, Hypertension, Obesity, Anxiety & Depression, Children with Complex Needs and Disabilities, Children with Mental & Emotional Health Problems, Children Referred to Children's Social Care, Dementia, Supporting Carers

4. COMMENTARY

See attached paper

5. FINANCIAL IMPLICATIONS

There are no costs associated with this paper.

LEGAL IMPLICATIONS

The decision to move to delegated commissioning was made by the CCG membership body and ratified by the CCG Governing Body in January 2015. It will require revisions to the CCG's constitution some of which have already been made.

6. IMPLICATIONS FOR OTHER GOVERNANCE ARRANGEMENTS, BOARDS AND PARTNERSHIP ARRANGEMENTS, INCLUDING ANY POLICY AND FINANCIAL CHANGES, REQUIRED TO PROGRESS THE ITEM

The programme is subject to the existing governance and decision making structures of the CCG and NHS England.

7. COMMENT FROM THE DIRECTOR OF AUTHOR ORGANISATION

Non-Applicable Sections:	[List non-applicable sections here]
Background Documents: (Access via Contact Officer)	[Title of document and date]

NHS
Bromley
Clinical Commissioning Group

A meeting of the Governing Body of Bromley Clinical Commissioning Group
24th November 2016

ENCLOSURE 14

APPLICATION FOR FULLY DELEGATED PRIMARY CARE COMMISSIONING IN BROMLEY

DIRECTOR RESPONSIBLE: Angela Bhan, Chief Officer

CLINICAL LEAD: Andrew Parson, Chair

AUTHOR: Jessica Arnold, Head of Primary and Community Care

SUMMARY

In September 2016, the governing body discussed the opportunity and process for Bromley CCG to apply for level 3 fully delegated responsibility for primary care commissioning. This came following a call from NHS England to ask all CCGs in London at level 2 co-commissioning status to take on further responsibility for commissioning of general practice from April 2017.

In Bromley, engagement with our GP membership in early 2015 identified an eagerness amongst practices to move towards level 3 delegated commissioning, with 68% of the vote favouring this option. Further engagement with our membership and other stakeholders in summer and autumn 2016 confirmed this appetite and ratified the earlier decision to apply. For information, all six CCGs in South East London have decided to apply for level 3 delegation.

The deadline for applying for level 3 delegation is Monday 5th December. Following this, CCGs will be assessed for their readiness to take fully delegated responsibility, which will include scrutiny of how we are preparing for changes to our governance, conflict of interest and risk management.

This paper asks the CCG governing body to:

A) Note the engagement and preparation to date for level 3 delegation, and planned next steps (supplementary to the information in the annex of this paper)
B) Agree to a Chair's action being taken in early December to approve the final application form for the 5th December deadline
C) Receive updates on the post-application assurance process between the CCG and NHS England up to April 2017, and any implications for CCG operations or finances that arise

Included as an annex to this paper is information that went to the September governing body about what is included at level 3 that will be different from the current level 2 arrangements; and a summary of the advantages, disadvantages, risks and 'unknowns' of moving to level 3 delegation, should this be useful for discussion.

ENGAGEMENT WITH CCG MEMBERSHIP

Further to the progress reported at the September governing body, please note that the following engagement has now been completed:

- ✓ Engagement with all three GP cluster meetings at the September round of clusters, including presentation of the background, benefits and risks, and 'Q&A' session to allow discussion of the opportunities
- ✓ Letter to all Bromley GP practices to let them know about the opportunity to apply for level 3 delegated commissioning of primary care, and give them an opportunity to give their comments and feedback (September)
- ✓ Update and discussion with most practices (71%) on an individual basis during the primary care team's quarterly practice visits between August and October
- ✓ Communication to the GP membership through the weekly GP e-bulletin and Practice Zone (intranet) in September
- ✓ Discussion with Bromley LMC in person (July and November) and by letter (October)

In addition, this item is planned to go to the 22nd November meeting of the CCG membership for information and discussion.

Please note that details of committee and public involvement are included later in this paper.

Also note that earlier engagement with the CCG membership on level 3 delegation in 2015 saw a vote that yielded 68% support for level 3 (26% voted for level 2 co-commissioning, which was since implemented; and 7% voted for level 1 involvement).

FURTHER WORK REQUIRED TO SUPPORT OUR APPLICATION

Bromley CCG is working closely with Bexley, Greenwich, Lambeth, Lewisham and Southwark CCGs to develop aligned applications for delegation of primary care commissioning from April 2017. Applications are due by 5th December 2016 and if successful, will require further assurance including:

- Governance arrangements (to include the impact of new conflict of interest guidance)
- Operational resource to support delegation (currently linked to the NHSE London Organisational Development review)
- Financial and related due diligence information

In addition, the CCG has been working with the other SEL CCGs to discuss the practical tasks and decisions required to support assurances required from each CCG by NHS England as part of our applications. In preparation for completion of applications, this joint work is primarily focussed on the following three areas:

i. Governance Arrangements and Conflicts of Interest Processes

Current arrangements for co-commissioning with NHS England include Joint Committees for Primary Care Commissioning formed by each CCG with NHS England which meet in common and in public on a bi-monthly basis. The location for the committee in common alternates between boroughs. In support of the committees, each CCG has a sub-committee including NHS England representation, held in advance of the public meeting, where agenda items are discussed. Decisions are reserved for the public meeting. The committees also make use of other local governance arrangements, for example management of conflicts of interest.

CCGs are currently reviewing the above approach in light of experience gained over the last 18 months of co-commissioning and lessons learned by other boroughs who already undertake delegated commissioning. This review aims to ensure that the governance approach included in the application is compatible with existing governance arrangements, and allows CCGs in south east London to discharge their local and joint responsibilities effectively and transparently.

Alongside the review of primary care commissioning governance arrangements, CCGs are also reviewing Conflicts of Interest processes in light of updated NHS England governance. A key outcome of this review is the ability of each Primary Care Commissioning Committee to demonstrate transparently that meetings have been conducted and decisions made without conflict.

ii. Operational Resource to Support Delegation

At the current time, the level of resource – both financial and human – that would come from NHS England if we move to delegated commissioning is under discussion. Delegation is being taken into account as part of the Organisational Development review of NHS England (London region) by Ernst and Young which has been ongoing since Spring 2016. South east London CCGs are directly inputting into this review to reflect our preferences and recommendations for what devolved support for south east London CCGs should look like in the context of a likely move towards full delegation of primary care.

iii. Financial and Related Due Diligence

As part of the co-commissioning arrangements over the last 18 months, south east London CCGs and NHS England have been operating with much more transparency relating to financial budgets and plans for primary care commissioning. With greater financial responsibility being placed on CCGs as part of delegation, due diligence work is currently underway including:

- Budget allocation for Primary Care from 2017/18
- Funds committed for ongoing programmes, including source of funds and responsibility for any under- or overspend

NEXT STEPS

Next steps in this process include:

- All SEL CCG governing bodies to endorse intent to apply for delegated primary care commissioning and aligned approach to completion of applications
- Develop proposed updates to local and joint south east London governance structures to enable move to full delegation including the assurance required after our applications are made
- Develop updated conflict of interest guidance, incorporating primary care commissioning requirements
- Identify and make any updates required to constitutions to support delegation. These will be limited as most changes made to support co-commissioning were made in a way that would enable a future move to delegation
- Develop aligned applications for submission to NHS England, including the application pro forma and supporting documentation and rationale

COMMITTEE INVOLVEMENT:

Delegated commissioning was discussed at the CCG governing body meetings of January and March 2015 and September 2016; and at the CCG Clinical Executive Group in June 2016. Related matters such as risk management and conflicts of interest have also been discussed at the Primary Care Programme Board in October 2016.

PUBLIC AND USER INVOLVEMENT:
No public engagement has been undertaken to date. A patient and public event on primary care transformation is going ahead on 13th December. This will allow the CCG to meaningfully engage with patients around primary care priorities and transformation to help shape our operations as we move towards full delegation.

IMPACT ASSESSMENT:
An impact assessment will be conducted as part of the application and assurance process. This will be updated as more information is released by NHS England regarding the level of resource and the governance requirements associated with moving to level 3.

RECOMMENDATIONS:
The CCG governing body is asked to:

A) Note the engagement and preparation to date for level 3 delegation, and planned next steps (supplementary to the information in the annex of this paper)
B) Agree to a Chair's action being taken in early December to approve the final application form for the 5th December deadline
C) Receive updates on the post-application assurance process between the CCG and NHS England up to April 2017, and any implications for CCG operations or finances that arise

ACRONYMS
CCG – Clinical Commissioning Group
CoI – Conflict of Interest
DES – Direct Enhanced Service
GP – General Practitioner
LMC – Local Medical Committee
NHS – National Health Service
QOF – Quality Outcomes Framework
SEL – South East London
STP – Sustainability and Transformation Plan
Also: PMS/GMS/APMS – different types of GP contracts

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Telephone: 01689 866 172

ANNEX A

a) DEFINITIONS – WHAT DOES LEVEL 3 FULL DELEGATION MEAN?

At level 3, the CCG would take responsibility for:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing breech/remedial notices and removing a contract)
- Newly designing enhanced services
- Design of local incentives schemes as an alternative to QOF
- Establishing new GP practices in an area as appropriate
- Approving practice mergers
- Making decisions about 'discretionary' payments (e.g. returner/retainer schemes)

The CCG would continue to discharge it's statutory duties, for example those relating to quality, financial balance and public participation.

The following responsibilities would remain with NHS England:

- Holding the medical performers' list
- Performers' appraisal and revalidation
- Pay and rations
- Complaints
- Commissioning of dental, community pharmacy and eye health services

NHS England would remain accountable for outcomes and therefore would continue it's assurance role of CCGs to ensure responsibilities are being adequately discharged and well managed to yield the intended outcomes.

b) ADVANTAGES AND DISADVANTAGES OF FULL DELEGATION

Delegated primary care commissioning enables commissioning budgets and plans to be formally delegated and therefore provides greater opportunity to deliver population wide commissioning beyond the services currently commissioned by the CCG, allowing services to be better integrated around the patient.

Delegation ensures that the allocated budget for general practice remains in the borough and empowers CCGs with greater control to make more optimal and locally responsive decisions about how primary care resources are deployed as well as greater consistency between outcome measures and incentives used in primary care services and wider out-of-hospital services.

High level summary of advantages of delegated commissioning:

- Empowers and enables CCGs to improve primary care services for the benefit (and with the input) of patients and local communities
- Enables clinically led, optimal local solutions to local needs
- Enables commissioning and service design across the whole patient pathway
- Allows greater control over local decisions affecting primary care informed by local knowledge of services, practices and challenges

- Enables CCGs to shift investment from acute to primary and community services
- Enables the ongoing development of seamless integrated out-of-hospital services and ICNs
- Offers an opportunity to design local incentive schemes as an alternative to QOF or DESs
- Offers an opportunity to drive outcomes based commissioning in primary care by aligning outcome measures and incentives used in primary care
- Offers more control locally to contract monitor and manage the new PMS contracts and GMS equalisation services
- Mitigates the risk around the status quo whereby NHS England 'local' teams cover a large geographical patch, manage all independent contractors (GP practices, dental, optometry, pharmacy) and face considerable staffing and financial challenges
- Adheres to national policy, trends and commentary which favours full delegation to CCGs

Potential disadvantages of delegated commissioning:

- Workload for the CCG will increase. For example, the CCG will need to provide assurance that it is discharging NHS England's statutory functions effectively. This could be onerous in terms of monitoring and intervention. It will be important to ensure that there are adequate resources (funding and staff), although this is currently an unknown factor
- The range and frequency of real and perceived conflicts of interest will increase, and governance rules about GPs making decisions where conflict of interest applies will need to be carefully adhered to. However, strengthened and transparent processes for decision-making are being considered and will be finalised during the transition process to mitigate this risk as far as possible
- There is a risk of inconsistency of approach amongst CCGs in matters where national consistency is desirable, e.g. 8-8 primary care access, 7 days a week. The CCG would need to continue to work with NHS England on national priorities and with other CCGs to learn from best practice and experience elsewhere

c) RISKS AND UNKNOWN FACTORS

Resources:
At the current time, the level of resource – both financial and human – that would come from NHS England if we move to delegated commissioning is unknown. Delegation is being taken into account as part of the Organisational Development review of NHS England (London region) by Ernst and Young which has been ongoing since Spring 2016. SEL CCGs are directly inputting into this review to reflect our preferences and recommendations for what devolved support for SEL CCGs should look like in the context of a likely move towards full delegation of primary care.
Risk status: High
Mitigation: Contribution to OD work and representation of existing resource and its focus

Financial risks
CCGs will take full responsibility for NHS England Primary Care QIPP requirements at level 3 delegation. CCGs will need to consider Primary Care commissioning priorities alongside other competing priorities, and factor this into prioritisation of the QIPP programme and staff resource for delivery.
Risk status: High
Mitigation: Development of an ambitious and deliverable QIPP programme will be important for managing this risk

Governance and operational risks
Moving to level 3 could present risks related to financial reporting; information and performance monitoring; and governance and conflict of interest. However, learning from CCGs that have already moved to level 3 shows that these risks can be mitigated successfully and we would seek to learn

from others' experience during the transition period. For example, recent conflict of interest guidance is already being analysed and implemented in Bromley through the lay member-chaired Conflict of Interest working group and plans for a Primary Care Commissioning Committee at local level are being actively discussed. The CCG is also beginning to play a greater role in information, performance and contract monitoring of GPs in anticipation of delegation, including through the structure of the proposed PMS/GMS commissioning intentions, work on GP information packs and a new Quality in Primary Care working group to look at practice resilience.

Risk status: Low

Mitigation: Preparation for changes to governance and C.o.I. are underway is good time and using best practice

South East London consistency

If all six CCGs opt for different levels of delegation, consistency and timescales for delivery across the patch will be more difficult. However, all six CCGs have engaged with their members and governing bodies to understand the opportunities and benefits of full delegation, and have since opted to apply for level 3.

Risk status: Low/nil

Mitigation: SE: CCGs' decisions to apply for level 3 are being ratified at November governing bodies

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Report No.

London Borough of Bromley

Decision Maker:	**HEALTH AND WELLBEING BOARD**
Date:	**Thursday 1 December 2016**
Decision Type:	Non-Urgent Non-Executive Non-Key
Title:	**BETTER CARE FUND 2016/17 PERFORMANCE UPDATE**
Contact Officer:	Jackie Goad, Executive Assistant Chief Executive's Tel: 020 8461 7685 E-mail: Jackie.Goad@bromley.gov.uk
Chief Officer:	Doug Patterson, Chief Executive, London Borough Bromley Angela Bhan, Chief Officer, NHS Bromley Clinical Commissioning Group
Ward:	All Wards

1. Summary

1.1 This report provides an overview of the first and second quarter performance of the Better Care Fund 2016/17 on both expenditure and activity levels up to the end of September 2016.

2. Reason for Report going to Health and Wellbeing Board

2.1 This is the first performance report on the Better Care Fund 2016/17 to keep the board informed on the position of the pooled fund and progress of the locally agreed Better Care Fund schemes.

3. SPECIFIC ACTION REQUIRED BY HEALTH AND WELLBEING BOARD AND ITS CONSTITUENT PARTNER ORGANISATIONS

3.1 That the Health & Wellbeing Board notes the latest financial position and the performance and progress of the Better Care Fund schemes.

Health & Wellbeing Strategy

1. Related priority:

General overarching regard to local health and care priorities.

Financial

1. Cost of proposal: £21,611,000

2. Ongoing costs:: £21,611,000

3. Total savings: Not Applicable:

4. Budget host organisation: Local Authority

5. Source of funding: Top slicing of existing budgets (primarily BCCG budgets) to create the BCF in 2015/16

6. Beneficiary/beneficiaries of any savings: n/a

Supporting Public Health Outcome Indicator(s)

Yes:

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4. COMMENTARY

Background information

4.1 Bromley's Better Care Fund 2016/17 local plan was formally agreed and endorsed by the Health & Wellbeing Board at its meeting on 21st April 2016. The plan was subsequently submitted to NHS England for approval in May 2016.

4.2 The Better Care Fund (BCF) grant is ring fenced for the purpose of pooling budgets and integrating services between Bromley Clinical Commissioning Group (BCCG) and the local authority. For 2016/17 the Better Care Fund grant allocation is £21,611k.

4.3 In order to ensure that local areas are meeting the standard conditions of the Fund it is a requirement to report back to NHS England on a quarterly basis progress against the agreed plan including expenditure.

4.4 The purpose of this report is to provide the Health & Wellbeing Board with an overview of the performance for Better Care Fund for Quarter 1 and Quarter 2.

Performance Metrics

4.5 Bromley is responding to the national metrics with the BCF. Under the BCF Policy Framework 2016/17 the national metrics which were set out for 2015/16 continue to be measured. In summary the metrics are:

a. Non-elective admissions

b. Delayed transfers of care (DTOCS) from hospital per 100,000 population.

c. Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population.

d. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services.

<u>Non-elective admissions (emergency admissions)</u>

4.5.1 There were 6,443 emergency admissions in Quarter 1 which was below the quarterly plan ceiling. However there has been an increase in admissions for Quarter 2 which means that there has been higher level of activity than forecast.

	NE Admissions	Actual Performance#	Quarterly Plan	Variance
Apr-16	2,155			
May-16	2,060			
Jun-16	2,228	6,443	6,604	**161**
Jul-16	2,184			
Aug-16	2,238			
Sep-16	2,211*	6,633	6,530	**-103**

Estimate

 # Actual performance derived from SUS activity

4.5.2. Based on April to September data (SUS & NHSE MAR) there has been no reduction in emergency admissions. The Integrated Care Network structure is now in implementation phase so the CCG is expecting to see the impact on emergency admissions in the latter half of the year.

Delayed transfers of care (DTOCS)

4.5.3 In compliance with the national 2016/17 BCF plan condition, a DTOC joint action plan has been developed which sets out Bromley's agreement to reduce delayed transfers of care.

4.5.4 The Transfer of Care Bureau (TOCB) which was established in November 2015 consists of an integrated discharge team who work together to manage effective, safe appropriate and timely discharges and the transfer of care for patients who have ongoing needs between agencies.

4.5.5 There were 1,356 delayed days in Quarter 1 and 1,460 delayed days in Quarter 2. Based on April to September data (NHSE) Bromley has not achieved the planned reduction in DTOCs in Quarter 2.

		16-17 plans			
		Q1 (Apr 16 - Jun 16)	**Q2 (Jul 16 - Sep 16)**	**Q3 (Oct 16 - Dec 16)**	**Q4 (Jan 17 - Mar 17)**
Delayed Transfers of Care (delayed days)	**Number**	1,017	967	918	872

		16-17 actuals	
		Q1 (Apr 16 - Jun 16)	**Q2 (Jul 16 - Sep 16)**
Delayed Transfers of Care (delayed days)	**Number**	**1,356**	**1,460**

4.5.6 The demand for early discharge places significant pressures on the social care market – this is recognised nationally as an issue for the health and social care economy and is particularly pronounced locally where there are high numbers of self funders and a competitive labour market. With regard to the discharges from the PRU, many of these rely on more intensive packages of support, e.g. double handed packages of care required by therapists or 1:1 support in a care home. These packages are more difficult to place and may result in a delay. The local authority has delegated responsibility for agreeing packages of care during the winter period to the Director of the Transfer of Care Bureau (TOCB) which will enable the Bureau to consider alternatives to standard services which should help to speed up the discharge process in complex cases.

4.5.7 The Council and Bromley CCG are working together to ensure that joint funding decisions are made as quickly as possible and that where decisions cannot be made locally within the TOCB the escalation processes are clear and timely.

Admissions to residential care

4.5.8 During Quarter 1 there were 44 admissions into residential care against the ceiling of 76.4 which means that the level of activity was lower than projected. In Quarter 2 there were 93 admissions to residential care.

		Planned 16/17	Qtr 1 Actual	Qtr 2 Actual	YTD Performance
Long term support of older people (aged 65 and over) met by admission to residential and nursing homes	**Number**	283	44	93	137

4.5.9 Whilst the actual performance for Quarter 2 is more than a quarter of the annual plan we are delivering year to date, however there is risk if performance continues at the Quarter 2 level.

Reablement

4.6 Based on local data the percentage of people still at home 91 days after discharge is slightly lower than planned for both Quarter 1 and Quarter 2. Further information regarding reablement is provided in the BCF Scheme delivery section below

		Planned 16/17	Qtr 1 Actual	Qtr 2 Actual	YTD Performance
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	**Annual %**	94%	**89%**	**89.3%**	TBC
	Number	80	112	TBC	TBC

BCF Scheme Delivery

4.7 The BCF programme has been aligned to the 'Out of Hospital Strategy' and the development of the Integrated Care Networks which aims to move care from an acute setting into the community. Table 1 below details both existing (agreed 2015/16) and new schemes, all community based services and spend allocated for each.

Table 1. BCF Schemes

	Scheme Name	2016/17 Expenditure (£)	New or Existing Scheme	Project Name
1	Reablement - Additional Capacity	838,000	**New**	
2	Winter Pressures - Discharge Support	1,643,000	Existing	
3	Integrated Care Records	425,000	Existing	
4	Intermediate Care Services inc. DTOC Team	465,000	Existing	
5	Community Equipment	415,000	Existing	
6	Dementia Universal Support Service*	511,000	**New**	Dementia Hub
7	Dementia Clinical Diagnosis	609,000	Existing	
8	Extra Care Housing	411,000	Existing	
9	Health Support into Care Homes	308,000	**New**	
10	Risk Share against acute over performance	1,323,000	Existing	
11	Self-Management & Early Intervention*	1,029,000	**New**	
12	Carers Support*	622,000	**New**	Carers Support Service
13	Protecting Social Care	4,404,000	Existing	
14	Disabled Facilities Grant	1,681,000	Existing	
15	Carers Funding	518,000	Existing	
16	Reablement Funds	1,244,000	Existing	
17	DoH Social Care Grant	4,415,000	Existing	
18	Intermediate Care - OT resource	150,000	Existing	
19	Integrated Discharge Team	600,000	**New**	Transfer of Care Bureau
	TOTAL	**21,611,000**		

* Now incorporated into the Primary and Secondary Intervention Fund. See Scheme 11.

4.7.1 Progress against schemes which are new and in the planning phase or being implemented in 2016/17 are detailed below.

Scheme 1: Reablement – Additional Capacity

4.8 Additional reablement capacity should enable more people to become independent on discharge from hospital, and in some cases reduce hospital admission. The effect of this should be a reduction in the number of residents requiring ongoing packages of care and enabled to live as independent as possible in the community.

Scheme Delivery

4.8.1 Recruitment to the post of reablement facilitators has proved problematic, however a rolling recruitment programme is in place for facilitators and a number of posts have been filled.

Metric Outcomes

Metric	Actual 2016/17	Planned 2016/17
Increase those reabled to 65 per month	50	65

4.9 **Scheme 6: Dementia Universal Support Service**

The Dementia Universal Support Service (Dementia Hub) was commissioned to establish a clear pathway for people and their carers immediately following diagnosis. A diagnosis itself does not immediately trigger eligibility for Council support in terms of social care as a person's needs are often not considered to be substantial or critical at that stage. This service supports people in those early stages to ensure that support planning is in place, which will allow people to remain independent for as long as possible and delay or prevent the need for social care or health crisis as far as possible. The service provides a 'one stop shop' in terms of information, advice, support and planning for people with dementia and their carers immediately following diagnosis.

Scheme Delivery

4.9.1 Bromley and Lewisham Mind are the lead provider with a consortium approach from other specialised organisations, which includes, Oxleas NHS Foundation, Age UK Bromley and Greenwich and Carers Bromley.

4.9.2 The services were phased in July 2016, with a go live date of October 2016.

During mobilisation in Quarter 1 the service received 308 referrals (176 service users and 132 carers) of which the majority came from the Memory Clinic, as designed. 90 clients have received 1:1 advisor support. A delay in receiving patient NHS numbers has meant that it is not possible to determine at this stage if there has been a reduction in acute activity. The submission of NHS numbers has been picked up as a contract monitoring issue and will be provided for Quarter 2. Generally it has been difficult to obtain NHS numbers as many people do not know that they have an NHS number.

4.9.3 Although in its infancy, the initial implementation and performance of the dementia hub is positive and close monitoring of the service will continue to ensure that provision is appropriately directly.

Scheme 7: Dementia Clinical Diagnosis

4.10 Although this service is an existing scheme information is being provided as it is linked to the memory clinic.

4.10.1 In 2015/16 Bromley CCG and the London Borough of Bromley agreed an investment plan of £1m per annum from the Better Care Fund towards integrated health and social care support for people with Dementia. This area of need was prioritised by the Bromley Health and Well Being Board based on the needs of the Bromley population and the Joint Strategic Health Needs Assessment.

4.10.2 As part of the investment programme, fund was committed to invest in Secondary care services offering specialist clinical skills to support early intervention through Local Care Networks, as well as the expansion of the memory clinic to offer NICE compliant services.

4.10.3 This investment is supplemented by other projects from the Better Care Fund, in particular increased resources for social care and the voluntary sector, including practical support to reduce carer breakdown, falls and illness that lead to preventable hospital admissions.

Scheme Delivery

4.10.4 Oxleas Foundation Trust provides the secondary care memory services in Bromley and additional capacity in the services was commissioned to ensure that people with memory problems can access early support, assessment and diagnosis in a sustainable and timely way that meets the escalating local demand.

4.10.5 This was negotiated into their existing contract in 2015/16 and the additional capacity is now fully operational and monitored through the existing contract management arrangements with the Trust. The additional investment has enabled Bromley to meet (and maintain) the National Dementia Diagnosis target.

Metric Outcomes

Metric	Actual 2016/17	Planned 2016/17
Dementia Diagnosis Rate	67.5% (Sept)	66.7%

Scheme 9: Health Support in to Care Homes

4.11 This project seeks to review and refresh our arrangements for medical support into Bromley's care homes and extra care housing units. This primarily includes support from local GPs as part of the Visiting Medical Officer (VMO) scheme, but also includes care home residents' access to community services and other health and social care partners.

Scheme Delivery

4.11.1 The CCG has led a process to better understand how the VMO scheme is currently working in terms of activity, quality outcomes and coverage, and to explore improved models of providing medical support. This has included some engagement with VMOs and care homes, but more engagement is needed to get a better understanding of the depth and breadth of challenges.

4.11.2 A joint project team between the CCG and the council has been identified and will shortly begin scoping the next steps to move the programme forward and tie in with other related joint priorities, e.g. care homes commissioning, domiciliary care, Integrated Care Networks and community service re-procurement.

Scheme 11: Self Management & Early Intervention

4.12 The proposal to set up a primary and secondary intervention fund work stream within the Better Care Fund for the future provision of primary and secondary intervention services was approved at Care Services PDS, Executive and Clinical Executive group in September 2016.

4.12.1 The strategy, jointly worked on by commissioners from both the local authority and Bromley Clinical Commissioning Group (BCCG) sets out a framework through which to design a set of Third Sector services that support people in the community to maintain their independence and delay and prevent the need for high cost care packages and early admissions to care homes and/or hospital.

4.12.2 The total fund is £2.7m and the services to be provided are:

- Single Point of Access
- Carers Support Services
- Services to Elderly Frail
- Services for Adults with Long Term Health Conditions
- Services for Adults with Physical Disabilities
- Services for Adults with Learning Disabilities
- Mental Health Services
- Support to the Sector

Scheme Delivery

4.12.3 A cross organisational project group has been set up and which meets regularly to ensure that the work is reflective of both the CCG and LBB and there has been strong engagement with the third sector to ensure that providers are prepared for the tendering process.

4.12.4 A Prior Information Notice (PIN) along with the tender documentation informing the market of intentions for the service is due to be released and a 'Meet the Provider' event will be arranged by commissioners for potential providers to understand the requirements of the proposed service.

Scheme 12: Carers Support

4.13 The Carers Support project is to commission a new Carers Service in line with the Joint Strategy for Carers 2016-2020 to commence in April 2017. The Carers Strategy was the joint response from the CCG and the local authority to the increased requirements for health and social support to carers as laid out in the Care Act 2014.

Scheme Delivery

4.13.1 The Carers Support Services are to be commissioned with the wider joint Primary and Secondary Intervention Services as outlined in Scheme 11 above.

4.13.2 A joint Carers Commissioner to lead on the Carers Support project was appointed in June 2016.

5. IMPACT ON VULNERABLE PEOPLE AND CHILDREN

All services are designed to avoid people who are vulnerable reaching the point of crisis where they would be seeking support of statutory services and/or requiring unplanned admission.

6. FINANCIAL IMPLICATIONS

6.1 The current budget and expenditure for the Better Care Fund is detailed in the table below

BCF 2016/17 - QUARTER 2

	Description	2016/17 budget £'000	Year to date £'000	Forecast Oct to Dec £'000	Forecast Jan to March £'000	Forecast Outturn £'000	Diff bud/act £'000
LBB	Reablement capacity	838	200	319	319	838	0
CCG	Winter Pressures Discharge	634	0	316	318	634	0
LBB	Winter Pressures Discharge (LBB)	1,009	312	348	349	1,009	0
CCG	Integrated care record	425	85	130	210	425	0
CCG	Intermediate care cost pressures	465	232	116	117	465	0
LBB	Community Equipment cost pressures	415	208	104	103	415	0
LBB	Dementia universal support service	511	153	133	133	419	-92
CCG	Dementia diagnosis	609	304	152	153	609	0
LBB	Extra Care Housing cost pressures	411	206	103	102	411	0
CCG	Health support into care homes	254	0	0	64	64	-190
CCG	Health support into extra care housing	54	0	0	14	14	-40
CCG	Self management and early intervention (inc Vol sector)	1,029	0	257	257	514	-515
CCG	Carers support - new strategy	622	13	30	203	246	-376
CCG	Risk against acute performance	2,073	338	849	886	2,073	0
LBB	Protecting Social Care	4,404	2,202	1,101	1,101	4,404	0
LBB	Disabled Facilities Grants - CAPITAL	1,681	334	676	671	1,681	0
CCG	Carers Funding	518	0	0	130	130	-388
CCG	Reablement Funds	935	468	234	233	935	0
LBB	Reablement Funds	309	155	77	77	309	0
LBB	DoH Social Care grant	4,415	2,206	1,103	1,106	4,415	0
	Total Recurrent Budget	**21,611**	**7,416**	**6,048**	**6,546**	**20,010**	**-1,601**

13,993	13,993	5,976	3,964	3,961	13,901	-92
7,618	7,618	1,440	2,084	2,585	6,109	-1,509
21,611						

6.2 From the table above it can be seen that there is still a sum of £1.6m which it is expected will be allocated in year.

7. LEGAL IMPLICATIONS

7.1 The Care Act 2014 amended the NHS Act 2006 to provide the legislative basis for the Better Care Fund. It provides the mandate to NHS England to include specific requirements relating to the establishment and use of an integration fund. NHS England and the Government allocate the Better Care Fund to local areas based on a framework agreed with Ministers. For 2016-17 the allocation is based on a mixture of the existing Clinical Commissioning Group allocations formula, the social care formula and a specific distribution formula for the Disabled Facilities Grant element of the Better Care Fund.

7.2 The amended NHS Act 2006 gives NHS England the powers to attach conditions to the payment of the Better Care Fund. In 2016-17 NHS England set the following conditions to access the funding:

- The requirement that the Better Care Fund is transferred into one or more pooled funds established under Section 75 of the NHS Act 2006.
- The requirement that Health & Wellbeing Boards jointly agree plans for how the money will be spent with plans signed off by the relevant local authority and clinical commissioning group(s).
- The requirement that plans are approved by NHS England in consultation with DoH and DCLG.
- The requirement that a proportion of the areas allocation will be subject to a new condition around NHS commissioned out of hospital services which may include a wide range of services including social care.

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Report No.

London Borough of Bromley

PART ONE - PUBLIC

HEALTH AND WELLBEING BOARD

Date:	**Thursday 1st December 2016**
Report Title:	**Approval of the 2016 JSNA**
Report Author:	Dr Agnes Marossy, Consultant in Public Health, ECHS Tel: 020 8461 7531 E-mail: agnes.marossy@bromley.gov.uk
Chief Officer:	Dr Nada Lemic, Director of Public Health

1. SUMMARY

1.1 Joint Strategic Needs Assessment (JSNA) has been a statutory requirement of local authorities and NHS primary care trusts since 1 April 2008.[1] Original guidance set out an expectation that the JSNA be carried out jointly by the director of public health, director of adult social services and director of children's services.

1.2 The aim of the JSNA is to deliver an understanding of the current and future health and wellbeing needs of the population over both the short term (three to five years), and the longer term future (five to ten years) to inform strategic planning commissioning services and interventions that will achieve better health and wellbeing outcomes and reduce inequalities.

1.4 The JSNA is an evidence based document highlighting need, as such it is distinct from the Health & Wellbeing Strategy which it informs.

2. REASON FOR REPORT GOING TO HEALTH & WELLBEING BOARD

At previous meetings the Health and Wellbeing Board (HWB) agreed that it would receive regular updates on the progress in completing the annual JSNA to increase knowledge which will assist in informing the HWB priorities. This report asks the Health & Wellbeing Board members to approve the 2016 JSNA and to consider the proposed structure of the 2017 JSNA.

3. SPECIFIC ACTION REQUIRED BY HEALTH & WELLBEING BOARD AND ITS CONSITUTENT PARTNER ORGANISATIONS

3.1 Whilst the Public Health Team within the LB Bromley have the lead responsibility for completing the JSNA a project steering group has been established with representatives from

- Education & Care Services
- Adult Social Care

- CCG Clinical Lead
- Children's Services
- Community Links Bromley
- Healthwatch Bromley
- LA Housing
- LA Planning
- Voluntary Sector Strategic Network

Health & Wellbeing Strategy

The JSNA is an evidence based document highlighting need, as such it is distinct from the Health & Wellbeing Strategy which it informs. The Health & Wellbeing Strategy outlines the priorities (based on the JSNA) agreed by the Health & Wellbeing Board together with the proposed actions and expected outcomes.

Financial

1. Cost of proposal:
2. Ongoing costs:
3. Total savings (if applicable):
4. Budget host organisation:
5. Source of funding:
6. Beneficiary/beneficiaries of any savings:

Supporting Public Health Outcome Indicator(s)

The JSNA will record progress against the Public Health Outcome Indicators.

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4. COMMENTARY

4.1 2016 JSNA

The final draft of the 2016 JSNA has been circulated to members of the Health & Wellbeing Board so that final approval can be discussed at this meeting.
The final document and Executive Summary will be published on the My Life website.

4.2 2017 JSNA

It was agreed at a previous Health & Wellbeing Board meeting that the 2017 JSNA would be the second part of a two year JSNA (2016 being the first part). It is proposed that in 2017 there will be a separate JSNA for Children and Young People. An outline of the proposed structure for the 2017 JSNA is included in the Appendix.

5. FINANCIAL IMPLICATIONS

6. LEGAL IMPLICATIONS

Joint Strategic Needs Assessment (JSNA) has been a statutory requirement of local authorities and NHS primary care trusts since 1 April 2008.

7. IMPLICATIONS FOR OTHER GOVERNANCE ARRANGEMENTS, BOARDS AND PARTNERSHIP ARRANGEMENTS, INCLUDING ANY POLICY AND FINANCIAL CHANGES, REQUIRED TO PROGRESS THE ITEM

8. COMMENT FROM THE DIRECTOR OF PUBLIC HEALTH

Non-Applicable Sections:	[List non-applicable sections here]
Background Documents: (Access via Contact Officer)	[Title of document and date]

Appendix

Proposed Structure for 2017 JSNA

JSNA Section		2017
Demography		✓
Life Expectancy & Burden of Disease		✓
In Depth Areas		Learning Disability
		Carers
Integrated Care Network Profiles		✓
Updates on Populations of Interest	Older People	✓
	Mental Health	✓
	Substance Misuse	✓
	Useful References	✓
	Executive Summary	✓

Bromley A&E Delivery Board

2016/17 Escalation Meeting Plan

Table of Contents

1. Overview

This report contains subsets of the Bromley Winter Plan 2016/17 and incorporates information from the PRUH Urgent Care Improvement Plan. The report is separated into three sections for clarity and ease of read, these areas are;

Section A – Performance. This includes information on the:

1) A recovery trajectory
2) An action plan to deliver against this.
3) The resources required to implement the plan

Section B - Delivery against 5 national initiatives

4) Progress to date

Section C – Winter surges

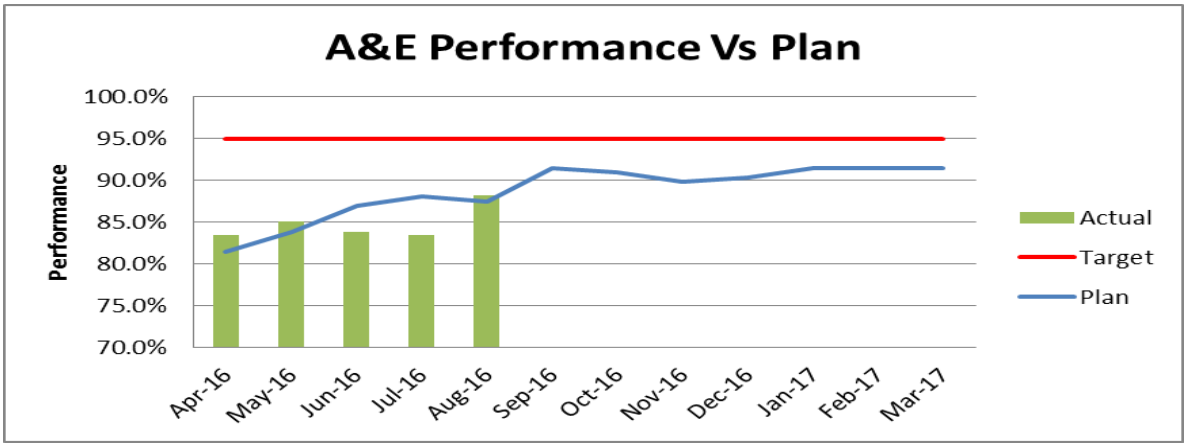
5) Winter schemes identified
6) Escalation procedures

The report has been written with the contribution and support from key partners in the Bromley Urgent Care system and Local A&E Delivery Board.

2. Section A - Performance

2.1 Performance

The performance at the PRUH has been varied over the last 6 months, and has not met the planned trajectory or the 4 hour 95% A&E target consistently.



In April 2016 Transformation Nous was commissioned to help identify through a robust and comprehensive diagnostic, reasons for poor performance.

The results showed there was not one key reason for failure but several smaller areas that required addressing. One of the areas assessed and identified were breaches and time to be seen.

The following table showing breach analysis over a 5 week period

		Week ending					
		11/09/2016	18/09/2016	25/09/2016	02/10/2016	09/10/2016	16/10/2016
Bed Management		150	83	125	167	149	125
Waiting for Diagnostics		16	10	8	8	18	11
Waiting for Specialist	Acute Trust	69	63	100	85	85	69
	MH Trust	13	11	7	7	12	7
Wait for First Clinician (not triage)		105	91	82	91	69	49
A&E Triage		1	0	2	2	0	0
Clinical		23	10	19	15	13	12
UCC breach		55	64	71	56	69	57
Transport (hospital Provided)		2	3	2	0	0	3
Others		17	38	19	13	10	14
Total Breaches		451	373	435	444	425	347
Total Attendances		2334	2373	2480	2361	2439	2420

The highest attributor to breaches consistently is the bed management and waits for first clinician, both areas have been allocated as key workstreams in the Urgent Care Improvement Plan (see Appendix 1). Work has undertaken with the UCC provider to address late handovers and ensure appropriate referrals into ED or bypass ED through alternative pathways.

2.2 Key actions identified to deliver the trajectory with timelines

2.2.1 Capacity

the Trust undertook a bed modelling exercise to assess the Trust's bed gap by site, based on historic seasonality and bed occupancy information, assumed growth, a do nothing productivity and efficiency assumption and a range of a range of bed occupancy scenarios.

2.2.2 Bed Management

40 beds additional beds have been commissioned in Orpington Hospital, 20 of the beds will be utilised to close the PRUH bed gap and 20 to provide elective capacity for the Denmark Hill service moves

2.2.3 Frailty Pathway

40 bed Frailty Unit at Orpington as part of overall frailty pathway development - the Orpington unit will act as a catalyst for overall pathway and outcome improvement, noting the very significant current frailty workload at the PRUH. It is anticipated this unit will open in January 2017

2.2.4 Discharge

Continued development of the Transfer of Care Bureau - enhanced leadership and capacity to drive and optimise impact and benefits, pending procurement of the service and the development of new longer term contractual arrangements to underpin an integrated, multi agency transfer of care bureau. More detailed actions can be found in the section B (Progress against 5 national initiatives)

2.2.5 Front Door Improvements

- Action to address and optimise the pathway from ED to assessment and admission, differentiating between admitted and non-admitted pathways and between adult and children's services – a key focus is improving flow in and out of AMU and ASU

- Review of rota's to match demand including redesign of hospital at night team
- Action to improve LAS handover delays and queues.
- Clean sheet redesign to focus on first 72 hours processes and pathways - key focus is ambulatory care offer, including new ambulatory care pathways and hot clinics

2.2.6 In-Hospital Plan

- Action to improve and maximise in-hospital ward based processes – to improve length of stay, reduce MFFD patients and improve discharge planning
- Implementation of a 23/12 surgical unit
- Improved bed allocation policy and bed management processes
- Improved infection control planning to mitigate norovirus risks

2.3 Resources required, and key risks and issues identified

Significant resource, in terms of both management and clinical capacity and transformation funding has been focused on the short and medium term work taking place on the emergency care pathway, recognising that the Clean Sheet Redesign Programme represents a three year emergency pathway transformation programme and the Recovery Plan a range of more immediate short term recovery actions.

KCH is in the process of a significant internal reorganisation – this will provide enhanced site based leadership and capacity and introduce a streamlined directorate structure, with clear clinical, nursing and operational leadership in place for each directorate. The corporate performance and planning functions have also been strengthened. These changes have not yet come in to effect but will do so over the remainder of Q3 and 4. They will take time to embed.

3. Section B – Delivery against 5 national initiatives

In August 2015 new guidance was issued by NHS Improvement and NHS England on a series of 'must dos' in relation to A&E performance improvement. This guidance was split into 5 domains which are:

3.1 Progress on delivering ED streaming

A&E Streaming at the Front Door:

A&E departments need to be able to access the most appropriate services for patients in a timely fashion to prevent delays and crowding of the department. This can be achieved by identifying the main services required and designing them around patient needs. There are several streaming paths for patients including primary care, ambulatory emergency care, out-patient referral, transfer to an assessment unit and transfer to a frailty service.

KCH operate a range of specialty advice lines for primary care including general medicine, paediatrics and geriatrics. These advice lines offer support, guidance and advice to primary care and help avoid unnecessary ED attendances, allow patients to be streamed to hot clinics and ensure that referrals are made appropriately. ED also has access to all specialties 24 hours a day.

A well designed streaming service delivered by Greenbrooks Urgent Care Centre (UCC) is supported by the availability of each of the streams during periods of high demand can reduce crowding and pressure on ED staff leading to an improved patient experience. The UCC operates 24 hours and day, 7 days a week.

Psychiatric liaison services are in place 24 hours a day 7 days a week at the PRUH

As part of winter management Greenbrook will need to assure the CCG they are able to fill all required GP slots. To provide assurance we have met with Greenbrook to evaluate their rota filling procedure. Recruitment for winter was circulated to their current GP list in August 2016 to obtain early take up. Slots that remain outstanding are then sourced through their internal staff bank across other Greenbrook sites. If slots are still unable to be filled they will offer an incentivized rate for those currently already on shift.

Greenbrook also have a contingency GP that works between several sites as additional capacity.

The final contingency is being outlined with the ED through a standard operating procedure that allows ED to pull patients from the UCC into the ED department at an early stage of the process.

3.2 NHS 111 calls transferred to clinicians

111 – Increasing the percentage of calls transferred to a clinical advisor

The Integrated Urgent Care Commissioning Standards outline a new model of care which will result in improved outcomes for patients. A key part of this new model is to increase the amount of clinical input into calls to the NHS 111 number thereby enhancing patient assessment and ensuring the patient is directed or referred to the most appropriate point of care. The IUC model has 8 key elements which commissioners are expected to achieve, these elements will to greater and lesser degrees contribute to increasing clinical input and ensure patients are directed appropriately.

Call volumes are predicted as a result of analysis of both historic and recent patterns of demand. Rotas are planned in line with the predicted call volumes, taking account of known activity peaks. LAS have a rolling recruitment programme to ensure sufficient staff to fill the rotas throughout the year.

Additionally LAS have in place a demand management plan that can be enacted when demand goes beyond predicted levels and mutual aid arrangements in place with SEL GPOOH providers.

It is anticipated that national timescales will be met; LAS 111 intend to take a pan-CCG approach initially and incorporate the following actions - Enhanced Clinical Assessment of Green Ambulance dispositions - increase transfer to clinician rate. Critical thinking and Probing skills workshops for Clinical Advisors - extend roll out to all Clinical Advisors. Identify referral outliers (Call Handlers and Clinical Advisors) and support to improve clinical outcomes. Frequent Callers - work has commenced - cross reference to 999 database, additional activity to review call activity and referral patterns (objective to increase SPN and appropriate supporting information to reduce 999 referrals where appropriate). Review data for Care homes with highest LAS 999 incidents (3 of top 4 are in Bexley CCG) to identify trends to 111 contacts and any potential interventions to support.

3.3 Ambulance Response Programme

The Ambulance Response Programme (ARP) is a national programme led by NHS England to improve the outcomes and experience of patients contacting the 999 ambulance service. The ARP aims to achieve:

- a more equitable and clinically focussed response from the ambulance service, that meets patient needs in an appropriate time frame
- Better allocation and distribution of resources in the face of rising demand
- Response standards that encourage the best possible patient outcomes
- An improved experience for all patients

Regular meetings are taking place between LAS and the ED department to address the handover issues that are occurring – Additional details of this can be found in the Urgent Care Improvement Plan – Appendix 1

There are a number of initiatives in place to support LAS across Bromley including:

3.3.1 Care Homes

The following is in place to reduce calls to LAS from Care Homes:

By pass numbers have been given to care home managers in order that they can directly access the GP.

- GP surgeries have joint protocols in place with the homes for management of UTIs & falls.
- A new VMO and care homes scheme is being developed and introduced in care homes across Bromley where gaps of provision have been identified. This will be procured substantively in the longer term but a pilot will run over this coming winter.
- Providers with large care homes have been asked to review their policy on when to call an ambulance.
- All care homes complete falls risk assessments and have fall prevention plans in place.
- A single Bromley wide policy has been developed and agreed in BROMLEY. For people who are at end of life, DNARS are in place and where appropriate the palliative team is involved.

3.3.2 Community Treatment Scheme

- Bromley Healthcare are focusing specifically on care home which have been identified as high users of both A&E and ambulances
- Bromley Healthcare are re-promoting the current ACP in place to help reduce ambulance callouts and admissions
- Discharge to Assess programme is being developed in the Transfer of Care Bureau to allow patients to be discharged into their place of residence whilst awaiting ongoing assessment

3.3.3 Frequent Users Forum

- There is an established forum covering PRUH, the current membership is being reviewed
- In addition Bromley CCG review frequent attenders at the Local A&E Delivery Board

3.4 Improving Patient Flow

SAFER bundle:

KCH has embedded the SAFER bundle to help improve flow, in line with ECIP best practice guidance. They currently use the SAFER bundle on acute admissions and medical wards, and plan to roll out across all wards. A programme to embed within all remaining wards is underway, alongside KCH's ward accreditation programme. They currently use ward round checklists as standard.

Baseline assessments of EDDs and Clinical Criteria for Discharge:

KCH – As part of a local CQUIN KCH have significantly increased the percentage of patients that have an EDD set, with in excess of 90% of patients in Q2 having an EDD set within 24 hours of admission. Further improvements are expected by the end of the year. KCH are also implementing a Clinical Utilisation Review system as part of the national CQUIN. The CUR supports clinicians to make evidence based decisions and improve operational efficiency by ensuring that discharges can be better targeted and length of stay reduced. A Project Manager has been engaged who is overseeing the implementation over Q3 and Q4.

3.5 Improving Discharge Processes

3.5.1 Transfer of Care Bureau

We have implemented elements of the safer bundle as part of the Kings way and this includes green days, red days, daily ward and board rounds etc.

Over the past 12 months the TOCB has reviewed its practices and developed new ways of working by **creating a multi-agency team based approach** with colleagues including Therapy, TOCB, Medics and Nurses - final agreement regarding the overall management of this team will be agreed and the performance monitored as a KPI will be set to reflect a minimum of 3 patients being discharged per day with this teams involvement.

This was agreed the Urgent Care Improvement Group.

Extensive conversations have already taken place about this team based approach and it has been agreed that (Community Matron) will be based within the TOCB and will utilise the existing resources and skills of the TOCB team that include LBB and Discharge co- ordinations to ensure that we are maximising the opportunities that the additional winter monies provide.

This work is mirroring the work on the wards to create a single list of patients with a team based approach on the wards

This will be linked to **new ways of working within the ED department** that have recently started in the PRUH,
We will have a senior SW supervising and supporting the work of two other social workers to ensure that rapid decision making can take place

LBB have agreed in principle that additional POC can be purchased and will be available via the TOCB to facilitate rapid decision making and expedite discharge.

The TOCB have recently completed a piece of pathway work with London Borough of Bexley around rapid response services and Bexley now has Social Workers on site and located in the Bureau to help facilitate the patients identified for Bexley borough.

4. Section C – Winter surges

Bromley Urgent Care providers met as a system to develop a collaborated approach for the management of surges over winter. An initial mapping exercise took place to:

- Evaluate last year's winter plan
- Identify and gaps in provision
- Develop scheme to address those gaps

Partners that met were Bromley Healthcare, Oxleas, Bromley Alliance, London Borough of Bromley, Kings College Hospital, Bromley CCG, and London Ambulance Service, all key contributors to the Local A&E Delivery Board.

Areas identified for addressing were

- Admission avoidance – pre-front door and inappropriate attendances
- Expedited discharges – from the PRUH into community services
- Improved discharge processes – between providers
- Additional capacity in primary care – to manage discharge or prevent admissions

4.1 Admission avoidance

The following admission avoidance schemes will be implemented as part of winter:

- BHC Medical Response In-reach
- Rapid Response ACP for care homes
- Social Care Manager at the front door
- Increase of Mental Health Patient Liaison Nurses

Working with community providers to avoid admission into an acute setting. Bromley Health Care (BHC) currently provides a step up admissions avoidance service for Primary Care, Care homes and LAS via ACP to access via its MRT service.

This was very successful last winter and BHC was routinely providing additional clinical support to patients referred from the other services with a view to preventing admission. The number of referrals significantly increased over the months of December to March (see below.)

Average	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Average number of referrals received (weekdays)	100	107	124	118	128	138
Average number of referrals	42	40	49	62	43	59

received (weekend)							

Number of Referrals	Column Labels						
Row Labels	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Grand Total
Monday	83	128	97	128	143	120	699
Tuesday	99	86	144	127	112	149	717
Wednesday	89	103	152	109	120	140	713
Thursday	107	88	125	94	110	143	667
Friday	124	131	103	133	159	141	791
Saturday	58	43	53	65	48	71	338
Sunday	26	37	45	59	38	47	252
Grand Total	**586**	**616**	**719**	**715**	**730**	**811**	**4177**

The scheme will also link with the emerging ICN network based in the three ICN hubs - the ICN networks aim is to provide proactive care to those frail and risk stratified pts via a hub with GP and Geriatrician support. This will provide links into the hospitals frailty pathway relating to the provision of additional beds on the Orpington Hospital site.

BHC provided a Medical Response Team In-reach service at the front door last year. Over the months of November 2015 – March 2016 In-reach assessed 701 patients and expedited and supports the discharge of 392 patients from ED, AMU and front end wards by assessing patient needs and ensuring that services were co-ordinated to facilitate the discharge as soon as possible.

Approximately 40% of patients identified and accepted were taken out by the team within 24 hrs with a further 38% within 48hrs and 12% within 72hrs.

For patients who were not suitable, for example if those patients lived outside Bromley, the in reach team signposted patients to other services and offered advice to the PRUH staff to assist navigating them to the right service. Tracking patients who could not be discharged straight from ED enabled the team to form a relationship with the patient, family and hospital staff to make sure the discharge happened as soon as possible once the patient was fit to go home.

It was challenging to discharge patients within 4 hours from ED or UCC. There were few patients identified/referred from ED or UCC. Patients were often awaiting investigations that medical staff required to enable them to declare the patient medically safe for discharge and these could not be undertaken within a 4hr timeframe, hence patients were admitted to CDU or AMU. Even when patients were identified within ED/UCC it was often not possible to discharge them straight from ED/UCC. BHC have undertaken

analysis of this and identified the following themes of explanations for delays:

- Faller with head injury needs CT head not able to be done within 4 hours
- Acute Coronary Syndrome needed monitoring and troponin result not achievable in 4 hours
- Dehydrated needing IV fluids - not achievable in 4 hours – BHC are exploring how to offer more rehydration in community
- Attended late evening or overnight to ED and were not seen by in reach until ANP came on duty,COPD needing therapy and stabilisation

To enable a multi-disciplinary approach at the front door, additional funding was given to Oxleas to provide 24 hours 7 day week coverage for mental health assessment. Additional social care staff was also employed to access social care services quicker at the hospital front door.

4.2 Redirection

Part of admission avoidance will also include patient redirection; we have commissioned as part of winter the following schemes to manage this:

- UCC champion
- Dressing's service
- Additional appointments in Primary Care Hubs

The UCC champion will redirect patients (after an initial stream) to a more appropriate place of treatment. For those minor illnesses or injuries that can be best seen in primary care, additional appointments have been secured to absorb this activity.

A dressing's service has also been commissioned following an audit by the UCC which reported between 5-10 dressing requests a day, particularly at the weekend. These patients will be redirected to these additional clinics.

The UCC champion will help manage throughout the winter surge on both UCC sites in Bromley and will work as part of the wider front door team.

4.2.1 Discharges

To enable quicker discharge process between providers and out of the hospital we have commissioned over winter an additional

- Discharge Co-coordinator
- Community Matron
- GP based in the Transfer of Care Bureau

- Day and Night Sitting

The additional resources will be managed and located in the Transfer of Care Bureau.

The TOCB has recently refreshed its role and has identified a number of key priorities for the winter period including:

- Clarity about the role and scope of the Bureau
- Governance arrangements to the TOCB board and System Leaders group
- Creation of new SOP and pathways
- Creation of new metrics for performance improvement
- Development of system wide metrics
- Three times weekly MFFD teleconference calls to reduce DTOCs and MFD delays and has seen a rapid reduction in delays, this has been mirrored by the following on the wards
- LOS work per ward
- Creation of one list per ward with oversight from Matron, TOCB and
- Therapy to drive through improvements in patient flow

We are utilising winter funding to purchase the skills of community matrons 5 days per week and GP 5 days per week (4 hrs per day) based within the TOCB and pulling patients from the "back end" of the hospital as part of an initiate to facilitate earlier discharges.
This is a new development at the PRUH and will help develop stronger links into the community, create additional support within the Frailty pathway and link into the ICN network.

It was identified that patients with relative small needs and support through day or night sitting could leave hospital sooner or avoids an admission all together. This will be done in partnership with the Geriatricians

4.2 Outcomes

The progress of the winter schemes will be monitored monthly at an operational meeting with key providers. These meetings will be in addition to the Local A&E Delivery Board.

Operational dates are;

- 23 November 2016
- 7st December 2016
- 8th February 2017

- 1st March 2017

Providers attending

- Bromley Healthcare – Operation Director
- PRUH – Managing Director
- GP Alliance- Director
- Bromley CCG, Clinical Lead (Chair) and Head of Contracts
- Greenbrooks UCC – Service Director
- Transfer of Care Bureau – Director
- London Borough of Bromley – Director, Health Integration Programme

Schemes will be monitored by outcomes and a set of key performance indicators and will be aligned to the PRUH Urgent Care Improvement Plan to measure the impact on the 4 hour target.

4.3 Escalation

Escalation and Winter Plans

Escalation in Bromley will be in-line with SE London escalation plans which have been co-created by, shared with and acted upon by all stakeholders within SE London including CCGs, Acute Trusts, Community Services, Social Services and Mental Health providers.

Below are the pre-defined triggers for, and actions in response to, each level of operational escalation in response to winter pressures. These levels mirror many of the systems already in use around the country, as well as the system that National Ambulance Resilience Unit (NARU) has recently developed.

In general, it is envisaged that local A&E Delivery Board areas will operate Operational Pressures Escalation Level (OPEL) One when operating within normal conditions.

OPEL One	Low levels of pressure across A&E Delivery Board area, relevant actions taken in response if deemed necessary,

	no support required
OPEL Two	Moderate pressure across A&E Delivery Board area, performance deterioration, escalation actions taken in response, support required
OPEL Three	Severe pressure across A&E Delivery Board area, significant deterioration in performance and quality, majority of escalation actions available are taken in response, increased support required
OPEL Four	Extreme pressure across A&E Delivery Board area, risk of service failure, all available escalation actions taken and potentially exhausted, extensive support and intervention required

Escalation Level	Acute Trusts	Community Care	Social Care	Primary Care	Other issues
OPEL One	• Demand for services above the established 'normal' level but capacity available to meet expected demand • Good patient flow through ED and other access points • Anticipated pressure on maintaining ED 4 hour target	Community capacity available across system. Patterns of service and acceptable levels of capacity are for local determination	Social services able to facilitate placements, care packages and discharges from acute care and other hospital and community based settings	• Out of Hours (OOH) service demand within expected levels • GP attendances within expected levels with appointment availability sufficient to meet demand	NHS 111 call volume within expected levels
OPEL Two	• Anticipated pressure in facilitating ambulance handovers • within 15 minutes • Discharges below expected norm • Slow patient flow through ED • Infection control issues emerging • Lack of beds across the Trust • Predicted discharges < expected admissions • ED patients with DTAs and no plan • Capacity pressures on PICU, NICU, and other intensive • Weather warnings suggest a significant care and specialist beds (possibly including ECMO)	• Patients in community and / or acute settings waiting for community care capacity • Lack of medical cover for community beds • Infection control issues Emerging	• Patients in community and / or acute settings waiting for social services capacity • Some unexpected reduced staffing numbers (due to e.g. sickness, weather conditions)	• GP attendances higher than expected levels • OOH service demand is above expected levels • Some unexpected reduced staffing numbers (due to e.g. sickness, weather conditions)	Rising NHS 111 call volume above normal levels Surveillance information suggests an increase in demand Weather warnings suggest a significant increase in demand

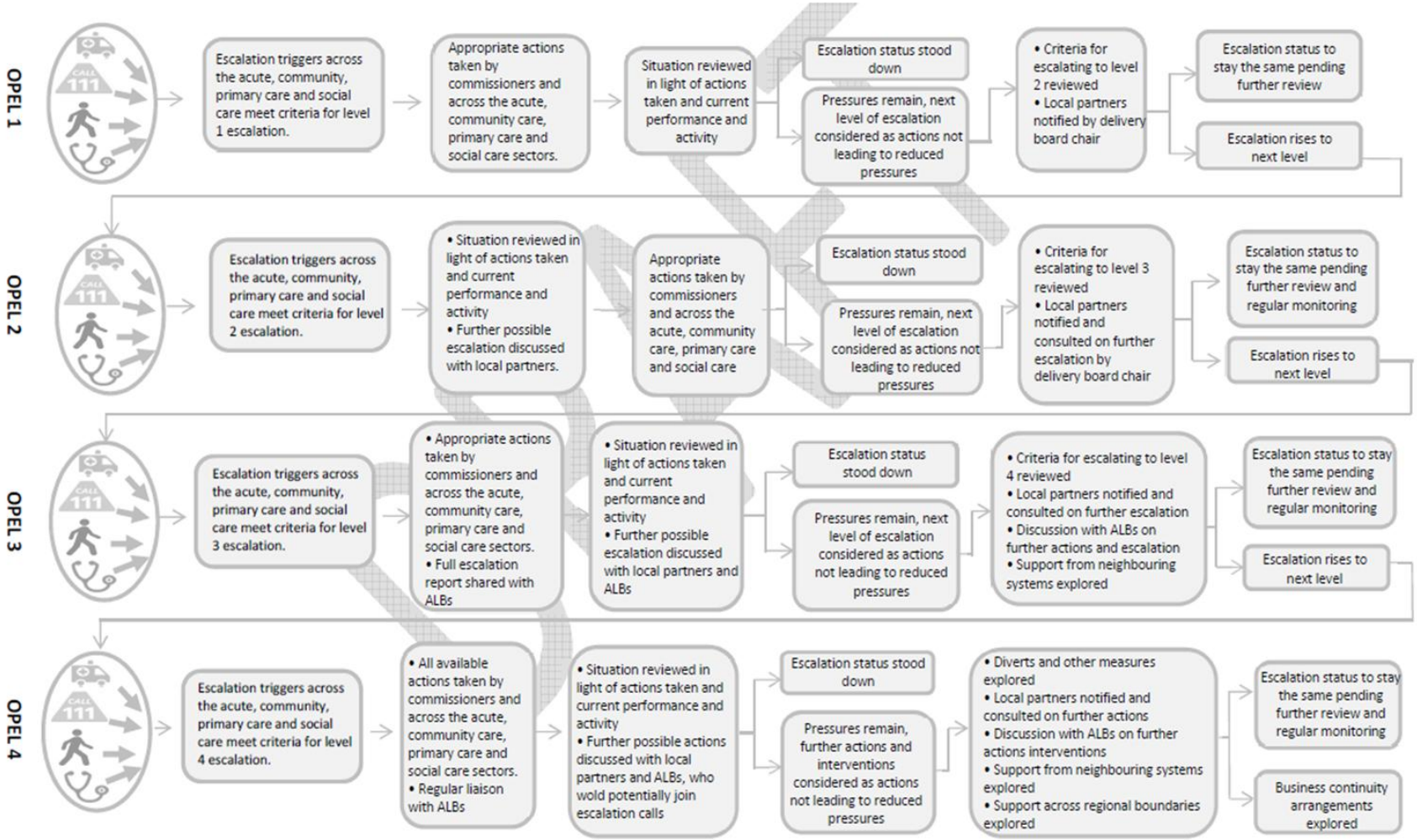
OPEL Three	• Actions at level 2 failed to deliver capacity • Significant failure of ED 4 hour target • Significant ambulance handover delays • Patients awaiting handover from ambulance service within 15 minutes significantly compromised • Patient flow significantly compromised • Significant unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow • Reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow • Weather warnings suggest a significant care and specialist beds (possibly including ECMO)	• Community capacity full • Significant unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow	• Social services unable to facilitate care packages, discharges etc. • Significant unexpected reduced staffing numbers to under 50%(due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow	• Pressure on OOH/GP services resulting in pressure on acute sector • Significant unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow	• Surveillance information suggests an significant increase in demand • NHS111 call volume significantly raised with normal or increased acuity of referrals • Weather conditions resulting in significant pressure on services Infection control issues resulting in significant pressure on services
OPEL Four	• Actions at level 3 failed to deliver capacity • No capacity across the Trust • Severe ambulance handover delays • Emergency care pathway significantly compromised • Unable to offload ambulances within 30 minutes • ED patients with DTAs >8 hrs. • Unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow is at a level that compromises service provision / patient safety • Severe capacity pressures on PICU, NICU, and other intensive care and specialist beds including ECMO	• No capacity in community services • Unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow is at a level that compromises service provision / patient safety	• Social services unable to facilitate care packages, discharges etc. • Significant unexpected reduced staffing numbers to under 50% (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow	• Acute trust unable to admit GP referrals • Inability to see all OOH/GP urgent patients • Unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow is at a level that compromises service provision	• Surveillance information suggests an significant increase in demand • NHS111 call volume significantly raised with normal or increased acuity of referrals • Weather conditions resulting in significant pressure on services Infection control issues resulting in significant pressure on services

Escalation Level	Whole System	Acute Trusts	Commissioner	Community Care	Social Care	Primary Care	Other issues
OPEL One	Business as usual – actions determined locally in response to operational pressures, which should be in line with expectations at this level						
OPEL Two	Undertake information gathering and whole system monitoring as necessary to enable timely de-escalation or further escalation as appropriate	• Undertake additional ward rounds to maximise rapid discharge of patients • Clinicians to prioritise discharges and accept outliers from any ward as appropriate implement measures in line with trust Ambulance Service Handover Plan • Ensure patient navigation in ED is underway if not already in place • Notify CCG on-call Director to ensure that appropriate operational • actions are taken to • Maximise use of nurse led wards and nurse led discharges	• Expedite additional available capacity in primary care, out of hours, independent sector and community capacity • Co-ordinate the redirection of patients towards alternative care pathways as appropriate • Co-ordinate communication of escalation across the local health economy (including independent sector, social care and mental health providers)	• Escalation information to be cascaded to all community providers with the intention of avoiding pressure wherever possible. • Maximise use of re-ablement/interme diate care beds • Task community hospitals to bring forward discharges to allow transfers in as appropriate. • Community hospitals to liaise with Social and Healthcare providers to expedite discharge from community hospitals.	• Expedite care packages and nursing / Elderly Mentally Infirm (EMI) / care home placements • Ensure all patients waiting within another service are provided with appropriate service • Where possible, increase support and/or communication to patients at home to prevent admission. • Maximise use of reablement/interm ediate care beds	• Community matrons to support district nurses/hospital at home in supporting higher acuity patients in the community • In reach activity to ED departments to be maximised • Alert GPs to escalation and request alternatives to ED referral be made where feasible	• Expedite rapid assessment for patients waiting within another service • Where possible, increase support and/or communicatio n to patients at home to prevent admission
OPEL 3	• All actions above done or considered	• ED consultant to be present in ED department 24/7, where possible • Contact on-take and ED	• Local regional office notified of alert status and involved in	• Community providers to continue to undertake	• Social Services on-call managers to expedite care packages	• OOH services to Recommend alternative care pathways	• To review all discharges currently referred and

	• Utilise all actions from local escalation plans • CEOs / Lead Directors have been involved in discussion and agree with escalation to black if needed	on-call Consultants to offer support to staff and to ensure emergency patients are assessed rapidly • Enact process of cancelling day cases and staffing day beds overnight if appropriate. • Open additional beds on specific wards, where staffing allows. • ED to open an overflow area for emergency referrals, where staffing allows • Notify CCG on-call Director so that appropriate operational actions can be taken to relieve the pressure. • Alert Social Services on-call managers to expedite care packages	discussions • CCG to co-ordinate communication and co- ordinate escalation response across the whole system including chairing the daily teleconferences • Notify CCG on-call Director who ensures appropriate operational actions are taken to relieve the pressure • Notify local DoS Lead and ensure NHS111 Provider is informed. • Cascade current system- wide status to GPs and OOH providers and advise	additional ward rounds and review admission and treatment thresholds to create capacity where possible • Community providers to expand capacity wherever possible through additional staffing and services, including primary care	• Increase domiciliary support to service users at home in order to prevent admission. • Ensure close communication with Acute Trust, including on site presence where possible	• In hours GP services to recommend alternative care pathways • Review staffing level of GP OOH service	assist within whole systems agreed actions to accelerate discharges from acute and non-acute facilities wherever possible • Increase support to service users at home in order to prevent admission
OPEL Four	• Contribute to system-wide communications to update	• All actions from previous levels stood up • ED consultant to be present in ED department 24/7, where possible • Contact on-take and ED	• Local regional office notified of alert status and involved in decisions around support from	• Ensure all actions from previous stages enacted and all other options explored and utilised	• Senior Management team and cabinet member involved in decision making regarding use of	• Ensure all actions from previous stages enacted and all other options explored and	• Ensure all actions from previous stages enacted and all other options

	regularly on status of organisations (as per local communications plans) Provide mutual aid of staff and services across the local health economy • Stand-down of level 4 once review suggests pressure is alleviating • Post escalation: Contribute to the Root Cause Analysis and lessons learnt process through the SI investigation	on-call Consultants to offer support to staff and to ensure emergency patients are assessed rapidly • Surgical consultants to be present on wards in theatre and in ED department 24/7, where possible • Executive director to provide support to site 24/7, where possible • An Acute Trust wishing to divert patients from ED must have exhausted all internal support options before contacting the CCG to request authorisation to explore a divert to neighbouring trusts whether these are in or out of the region.	beyond local boundaries • The CCGs will act as the hub of communication for all parties involved • Post escalation: Complete Root Cause Analysis and lessons learnt process in accordance with SI process	• Ensure all possible capacity has been freed and redeployed to ease systems pressures	additional resources from out of county if necessary • Hospital service manager, linking closely with Deputy Director Adult Social Care, & teams will prioritise quick wins to achieve maximum flow, including supporting ED re prevention of admission & turn around. Identification via board rounds and links with Discharge team &therapists. • Hospital Service Manager/Deputy Director to monitor escalation status, taking part in teleconferences as required.	utilised • Ensure all possible actions are being taken on-going to alleviate system pressures	explored and utilised • Continue to expedite discharges, increase capacity and lower access thresholds to prevent admission where possible

Local Escalation Diagram



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healthwatch Lewisham

healthwatch Bromley

Banking on a Meal …

1. Introduction

What is Healthwatch Bromley and Healthwatch Lewisham?

Healthwatch Bromley and Healthwatch Lewisham are two of 152 local Healthwatch organisations that were established throughout England in 2013, under the provisions of the Health and Social Care Act 2012. The dual role of local Healthwatch is to champion the rights of users of health and social care services and to hold the system to account for how well it engages with the public.

The remit of Healthwatch is as an independent health and social care organisation is to be the voice of local people and ensure that health and social care services are safe, effective and designed to meet the needs of patients, social care users and carers.

Healthwatch gives children, young people and adults in Bromley a stronger voice to influence and challenge how health and social care services are purchased, provided and reviewed within the borough.

Healthwatch's core functions are:

1. Gathering the views and experiences of service users, carers, and the wider community,
2. Making people's views known,
3. Involving locals in the commissioning process for health and social care services, and process for their continual scrutiny,
4. Referring providers of concern to Healthwatch England, or the CQC, to investigate,
5. Providing information about which services are available to access and signposting,
6. Collecting views and experiences and communicating them to Healthwatch England,
7. Work with the Health and Wellbeing board in Bromley and Lewisham on the Joint Strategic Needs Assessment and
8. Joint Health and Wellbeing strategy (which will influence the commissioning process).

2. Strategic Drivers

Healthwatch Bromley and Healthwatch Lewisham's role is to ensure the voices and views of the local community are expressed and to ensure their opinions are taken into account when services are commissioned. Healthwatch's routine engagement often includes feedback around patient registration and access to health and social care. This included a visit to the Living Well Project in Penge, an initiative that supports the growing number of people in Penge seeking support and help. The project offers a food bank, drop in lunches and a community garden, amongst other

services. Struck by the huge numbers in attendance, Healthwatch launched a research project focusing on the health needs of those who are at risk economically or identify as vulnerable, as well as any particular challenges they may face in accessing health and social care services. It is worth noting that for those interviewed who identified as homeless, borough boundaries had no influence on accessing services.

Healthwatch explored services across both the London Borough of Bromley and the London Borough of Lewisham. This report outlines the findings of the research, which took place from February to April 2016. This report highlights the areas of success in the current community and clinical services offered and identify areas for improvement in service access for those who are most vulnerable.

This report will be shared with the Bromley and Lewisham Health and Wellbeing Boards, participating General Practices, the Voluntary and Community Sector, the Bromley Clinical Commissioning Group (CCG), the Care Quality Commission (CQC), NHS England and Healthwatch England, and other Health subgroups.

3. Health inequalities in Bromley and Lewisham boroughs

The Joint Strategic Needs Assessment for Bromley (2015) states that "housing is a fundamental need for good health and wellbeing, and inequalities in a range of health issues can be tracked back to the quality of housing … For many already deprived communities, the only housing available is substandard, thus worsening pre-existing health conditions and making vulnerable individuals more housebound and at risk of homelessness. The threat of homelessness remains an issue for an increasing number of people."[1] Furthermore, for those who identify as homeless, the depth of exclusion is amplified as "traditional approaches to measuring health inequalities will struggle to explore the experiences of homeless people. For example, studies based on Indices of Multiple Deprivation are often based on the postcode of an individual which clearly excludes those without a fixed address".[2]

Furthermore, a report carried out by Kings College London, looked into the resettlement of homeless people and the ongoing challenges still faced by those who had managed to secure stable accommodation. For those, "living independently and establishing a home created several financial demands on the participants, and many were struggling financially five years after being resettled. The majority were reliant on social security benefits, had low incomes and found it hard to meet everyday living expenses."[3] Of the 297 participants involved in the research project, "fifty six per cent said that they ran short of money for food at times, and 44 per cent sometimes

[1] "The Joint Strategic Needs Assessment for Bromley 2015", London Borough of Bromley
[2] "Room to Breathe, A Peer-led health audit on the respiratory health of people experiencing homelessness"; *Trust for London* - Tackling Poverty and Inequality, *Groundswell* - Inclusive solutions to homelessness
[3] Maureen Crane, Louise Joly and Jill Manthorpe. "Rebuilding Lives Formerly homeless people's experiences of independent living and their longer-term outcomes"; Kings College London; January 2016

did not have enough money to heat their home. Overall, 65 per cent had an income below the UK poverty threshold."[4] The study clearly demonstrates that some homeless people are still vulnerable after they are resettled, and require ongoing support from housing and social care services in order to prevent further homelessness.

Further research suggests that for those whom housing or finance is an area of concern, health inequalities are significantly higher. Those who are economically deprived are often more prone to poly-morbidities, loneliness and isolation, and are at higher risk for developing mental illness. National research conducted by Homeless Link states that of those who are classified as homeless or in between homes "73% of participants reported a physical health problem and 80% a mental health issue."[5]

Similarly, a recent audit carried out by Groundswell and Trust for London, found that of 23 emergency departments in areas with large homeless populations, only 12 had a system for identifying and recording homeless patients, suggesting a lack of integration and communication between health and social care services and increasing concern around their standard of care and general wellbeing. Most notably, it is reported that for this demographic, "as well as the human cost of these issues, the costs to the NHS for secondary care have been estimated as 8 times that of treating the general population."[6] Ultimately suggesting that economic inequalities not only affect the health and wealth of the individual but have a detrimental effect on the local health economy.

4. Methodology

This study was conducted by Healthwatch's Community Engagement Officer, who visited 5 food banks across the boroughs of Bromley and Lewisham. Those in attendance were informally interviewed about their experiences of accessing health and social care services and the circumstances which has caused them to access community services in the borough. The community providers of food banks were also engaged, regarding information around numbers and their front line experiences. Engagement consisted of informal questions around the need and cause for community support, as well as the mental and physical wellbeing of their clients. Combining their experiences and voices helped Healthwatch to form a comprehensive picture of the state of services for those most at risk.

[4] "Rebuilding Lives Formerly homeless people's experiences of independent living and their longer-term outcomes"
[5] "The Unhealthy State of Homelessness – Health Audit Results 2014"; *Homeless Link*
[6] "Room to Breathe"; *Groundswell* - Inclusive solutions to homelessness

5. Summary of Findings

Overall, Healthwatch's research suggests that:

- Those suffering from financial hardship are more likely to suffer from lower standards of physical health and mental wellbeing.
- Zero hour contracts and unsecure employment often leaves people without sufficient resources to support themselves and their families, and thus become dependent on local support, such as food banks.
- Lack of communication between services means people are susceptible to falling through the gaps. This was most evident with benefit processing and a delay in payments, often for reasons unknown to the claimant.
- GP registration and access to primary care was severely restricted by a lack of permanent address, despite legislation stating that it is not a necessary requirement.
- Those who were already at risk were unable to support themselves in day to day life and as a result remained susceptible to further health complications.

6. Case studies

Living Well Project

Healthwatch's Community Engagement Officer visited the **Living Well Project at Holy Trinity Church**, **Penge** to speak to those accessing the food bank and community service. There were over a 100 people present at one session. The project offers all attendees a hot meal, shower, food parcel, as well as art and music sessions. Bromley Drug and Alcohol team were also present for those who wanted advice. It is worth noting that many present suffered from mental health challenges and lacked any form of clinical or familial support in dealing with the day to day realities of this.

To cite one example, Healthwatch spoke to a gentleman, who identified as homeless, who had previously visited a local drop in clinic for a prescription. He had been recommended a certain course of treatment, yet had been unable to ultimately access the treatment as he was not registered with a GP.

The gentleman had previously been **turned down by a local GP as he did not have a permanent address**. Healthwatch offered to support him but was met with the same response, despite it not being a legal requirement for registration. It was later agreed that the church address could act as a temporary address for the client. However, this was not accepted initially by the practice and Healthwatch had to escalate the query to both Bromley CCG and NHS England before the situation was finally resolved. The case required significant intervention to secure medical treatment, when in fact the medical need had already been established.

The challenges faced in registering this one patient is indicative of the **extensive barriers faced by some people trying to access health and social care** and the subsequent health inequalities within our community.

> *"This was more than a little victory and has sown a seed for the future."*
>
> **Christine Stone, Living Well Project**

Whitefoot and Downham

Whitefoot and Downham Community Food + Project (wdcfplus) offers a range of services to combat deprivation within their local ward. As well as providing food parcels for those in need, the project offers support from Citizens Advice Bureau, parent and family services, the local housing association and spiritual guidance. Clients are not required to have a letter of referral or food tokens to access services but records are kept of everyone who accesses the service.

Healthwatch spoke to several clients during the visit and for many brief bouts of ill health had left them unable to support themselves. It was commented that the project had been a real lifeline when times had been difficult. Not only were clients provided with nutritional support, they were also offered additional services and guidance around housing.

The wdcfplus project is an excellent example of a **comprehensive community based service tackling local deprivation**.

Bromley Food Bank

Bromley Food Bank, at the United Reform Church, operate on a referral basis, with those eligible for food support being referred by local services, such as the Job Centre or Citizens Advice Bureau. It is part of The Trussell trust and is organised by the local authority.

One participant Healthwatch spoke to, who had clear poor physical health and mental health issues, was having difficulties accessing his **disability benefits**. He had **conflicting information from social services and the job centre**, and as a result he was left without financial support for weeks at a time. Consequently, he was left with no choice but to seek support from local food banks. However, there is a total limit on how many times an individual can access this support, with it being capped at three visits. On the day of Healthwatch's visit, this was the last time he was eligible for support. The individual was concerned about how he was going to support himself in the following weeks and had no indication how long it would be until his benefit situation would be resolved.

It is evident in this case that **poor communication between social care and health services**, resulted in a local resident being left isolated and without support at his time of need. If local services are allowed to continue to operate disjointedly and in silo, it is likely more and more people will be left without support, with the increased chance of growing health inequalities.

Lewisham Food Bank

Also overseen by the Trussell Trust, **Lewisham food bank** offer a comprehensive signposting service including housing advice and domestic violence support, as well as food parcels. It was noted that any leftover food packages parcels are distributed to the homeless by the police at night. The community service even offer a **short term crisis loan** in the case of delayed benefit allowance. The reasons for accessing the food bank are recorded by staff at the point of referral. One of the main reasons for accessing the service is due to a **delay in benefits**, with clients often forgetting to inform the local authority of a change of address and subsequently missing letters and appointments. The total number of referrals to the project, in 2015, stands at **4664**. Low income clients made up the largest group accessing the food bank. The following table highlights the key reasons for deprivation within Lewisham. Please note that the table lists only the top reasons for accessing the services, not all.

REASON GIVEN	VOUCHERS	ADULTS	CHILDREN	TOTAL
Benefit Changes	307	411	259	670
Benefit Delays	624	816	373	1189
Debt	94	136	74	210
Delayed Wages	17	21	11	32
Homeless	89	98	56	154
Low Income	470	677	364	1041
Unemployed	167	241	144	385

The Hope Foundation

The Hope Foundation at Bromley Christian Centre provides food parcels for people in the London Borough of Bromley. Operating independently from the local council, the service offers support to any local resident who is in need. There is no limit to the number of parcels individuals can access, but if support is needed for a sustained amount of time, a review and assessment of individual circumstances will take place to see how the client can be further supported.

Healthwatch spoke to a retired individual who had been visiting the food bank weekly for an extended period of time. **Financial hardship**, due to taking on an unexpected family mortgage, had left this older couple financially unstable. As a result, they were unable to support themselves independently. They had become increasingly **socially isolated** as a couple, with the wife no longer able to leave the house. The food bank had proved a vital lifeline and support system for them at this time.

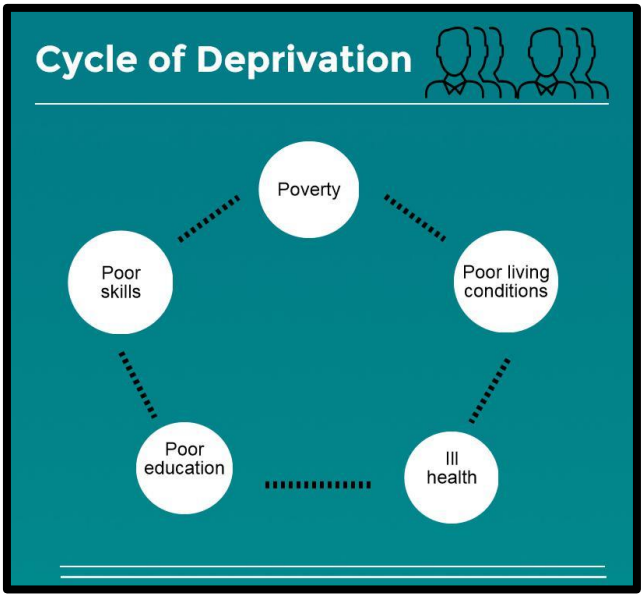
7. Impact on health inequalities

The causes of homelessness and economic deprivation included: "personal circumstances such as relationship breakdown, family unwilling to accommodate, debt, addiction and substance misuse."[7] Healthwatch's research confirms that there is clear evidence to link poor health and poor housing conditions. Furthermore, "the location, type of housing and access to amenities also contributes to the health inequalities. Those most susceptible are children, older people and those with chronic health problems."[8] Ultimately, everyone is potentially at risk from the effect of poor housing conditions.

The Centre for Social Justice writes that for those who are economically deprived, financial struggles are:

> *"exacerbated by the suspension or stopping of social security benefits, due to their non-compliance with benefit requirements, or to their lack of understanding of what to do when time limited benefits ended. In many instances, this had led to their housing benefit payments being stopped, rent arrears and threats of eviction. People who were employed casually or under 'zero-hours' contracts experienced the greatest financial difficulties. Their working hours and income were irregular. Most would have preferred to work more hours but were not given the opportunity."*[9]

This sentiment was echoed by the service users and providers we spoke to during our research.



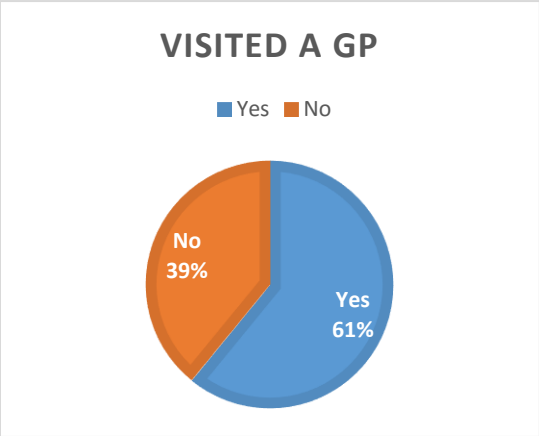
People are increasingly at risk of health inequalities due to external environmental factors, such as a lack of affordable housing, a strained economic climate, and policy reforms with knock on effects on welfare, poverty and unemployment. Furthermore, for those who regularly rely on food banks as their main source of nutrition, there are dangers of malnutrition. They are also less likely to seek medical help and as a result, conditions can often go undiagnosed for longer.

Ultimately, lack of access to primary care services has a huge impact on individual's physical wellbeing and emotional health.

[7] "Joint Strategic Needs Assessment", Bromley 2015, *The London Borough of Bromley*
[8] "Environment and Health Risks: a review of the influences and effects of social inequalities"; *World Health Organisation,* Europe
[9] "Rebuilding Lives"; Kings College London

8. Homeless Health Needs Audit

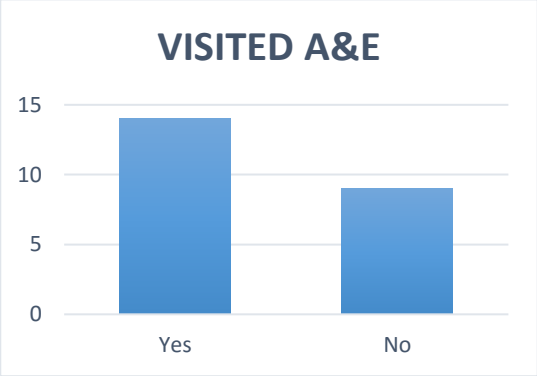
As part of a London wide homeless audit, Healthwatch interviewed a small sample of the single homeless population in the London Borough of Bromley. In total, there were 23 participants interviewed, who were asked about the key challenges and difficulties they face. The main results are shown below:

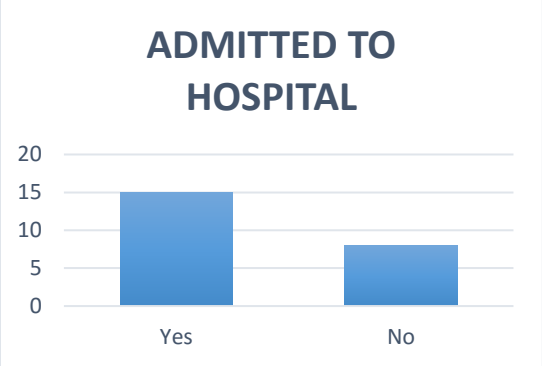


Of those surveyed, only 39% had been able to access a GP service

Over half had been admitted to hospital in the last 12 months

61% had visited A&E recently





57% of those spoken to had suffered some form of sexual, physical or domestic violence prior to becoming homeless

16 people had slept rough

15 participants had not used the homeless healthcare services

These figures clearly indicate that compared to the general population, the health statistics and admittance to emergency care for those who identify as homeless, are much higher. There are also issues around the high levels of abuse prior to becoming homeless. This small sample is suggestive of the health inequalities within the local population and supports the findings put forward by the Trust for London research previously referenced.

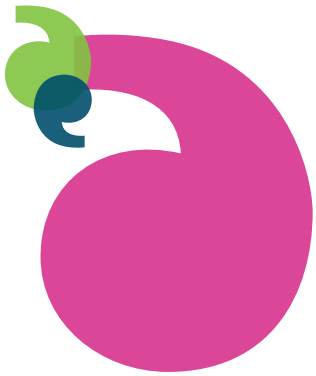
9. Conclusions and Recommendations

Following Healthwatch's research into health inequalities within the boroughs of Bromley and Lewisham, we recommend:

1. Increased promotion and awareness of community support services and food banks.
2. Further support and advocacy for those who are suffering financial hardship as a result of benefit delays or difficulties in benefit processing.
3. Additional council support and advice for those who are struggling to live independently to prevent people from entering the cycle of deprivation.
4. Increased awareness around the knock on effects of zero hour contracts and the unstable nature of many resident's financial position.
5. If not already in place, it would be advisable for the local authority and Clinical Commissioning Group to offer Equality and Safeguarding training which includes the homeless as a group at risk.
6. There would be mileage in operating a clinic type arrangement at local homeless facilities or food banks to capture those who are not registered with a GP, and to allow for a basic health review and health education.
7. A scheme that works across the borough, potentially a specific or nominated practice for those who are homeless or do not have a fixed address, would be hugely beneficial to the local population.
8. Promotion of 111 as a free, accessible route to health care for patients who are unsure of how to access local services or who are not registered with a GP.
9. Further work around hospital discharge and re-admittance for those without a stable living situation.
10. Open and equal access to primary care, especially for those who are most at risk. It is essential that residents have equal access to high quality local services and that they are supported to register and access the appropriate service.
11. Improved awareness and education among clinicians regarding the difficulty for many in accessing their services.

10. Acknowledgements

Healthwatch Bromley and Healthwatch Lewisham would like to express gratitude to all those who contributed and participated in this research project and allowed us to gather a comprehensive picture of health inequalities within the borough.



Responses from providors and commisioners:

Bromley Clinical Commissionning Group

"Thank you for sending the report to the CCG. We note that the report has a few recommendations for the CCG to consider. Following initial reading there are other aspects that we also feel we should consider such as ensuring there is clarity of GP registration process for the homeless.

Your report will be taken to the to Primary Care Board by the Head of Primary and Community Care for discussion of next steps."

London Borough of Bromley – Public Health

"This report covers two important issues: the use of food banks and the health needs of the homeless. It links in with work being carried out across SE London (Homeless Health Needs Audit).The report raises the important issue of the difficulties in homeless people accessing healthcare services.

The report would have benefited from a more clear demarcation between the issues causing food bank use and the issue of hardship related to homelessness."

Whitefoot and Downham Community Food Plus Project

"It is a very good read, definitely highlighting some of the main issues people are facing today. Hopefully this will be the start of things being put in place to eliminate the need for food banks altogether!"

Appendix: Food Bank Contact Information

Living Well Project, Penge

Holy Trinity Beckenham

66 Lennard Road

London SE20 7LX

020 8778 7258

Whitefoot and Downham Community Food Plus Project

480 Whitefoot Lane

Downham BR1 5SF

Bromley Borough Food Bank

Duncanson Room

United Reform Church

20 Widmore Road and Glades Place

Bromley

Kent, BR1 1RY

Lewisham Food Bank

Hope Centre

118 Malham Road

Forest Hill, SE23 1AN

Bromley Community Church

2 Masons Hill, Bromley

Kent BR2 9HA

020 8464 3101

Responses to Banking on a Meal

Bromley Clinical Commissioning Group

Jessica Arnold – Head of Primary and Community Care

Bromley CCG greatly welcomes the report, *Banking on a Meal*, from Healthwatch Bromley and Healthwatch Lewisham in June 2016. As well as the insight provided by the report into the general health and wellbeing challenges faced by people accessing food banks, the report highlights some particular concerns for general practice and CCG commissioned services. For this reason, the report was presented to a meeting of the Bromley Primary Care Programme Board on Tuesday 9th August 2016.

Key points of discussion, and corresponding actions that the CCG pledge to take, were:

- The difficulties experienced by homeless patients in registering with a GP identified in the report tally with the CCG's experience. We have had several calls in recent months from homeless patients and one from a practice unsure about what to do. We acknowledge that some practices are not aware that they can register a patient without proof of address, using a friend's house, a public building such as a church, or the GP practice itself as a temporary address

ACTION #1: The CCG will communicate to all Bromley GP practices about their obligations to register homeless patients, how they would do this and what support is available in managing complex patients. This will be in the form of an article in the widely read, weekly GP e-bulletin and as a memorandum at the next bi-monthly 'cluster' meetings of GPs on a locality basis.

- Training would be beneficial to help some GPs to manage homeless patients with more confidence

ACTION #2: The CCG will assess the likely need and uptake of a training opportunity amongst Bromley GP practices. If demand is sufficient to warrant organising training, this will be delivered by a suitable speaker.

- Some practices will be deterred from registering homeless patients due to an actual or perceived greater demand and complexity of caring for these patients

ACTION #3: We will scope the numbers of Bromley patients who are homeless who are not registered with a GP. If demand is sufficient, we will seek to establish one 'hub' GP practice in each of the borough's three localities that is incentivised to take homeless patients. This will not prevent patients from registering elsewhere, but will be a named practice where they can be registered without difficulty and with

GPs who are suitably trained and confident in caring for homeless people. If there is not sufficient demand in numbers, we would hope that action #1 will improve the ease of registering at any GP practice.

- As well as support from primary care, we questioned whether GPs and practice staff would know where to signpost patients who are homeless or in financial hardship in the voluntary sector. The offer from the voluntary sector is heterogeneous and information is not clearly available for signposting. Social prescribing might be of benefit to these patients

ACTION #4: As part of the CCG's transformation of the health and social care system into 'Integrated Care Networks' (our version of multispecialty community providers), a robust directory of voluntary sector services is being developed as well as creation of four Care Coordinator roles covering the borough. Care coordinators will be on hand via GPs and other health providers to support the care management of vulnerable patients, which would include homeless people and those experiencing financial hardship. Part of the Care Coordination role will be signposting to financial advice such as benefit claims and housing advice, as well as health care advice.

- The CCG needs to consider how we support frequent attenders at Urgent Care Centres and A&E who are homeless or in financial hardship and who might not be registered with a GP. Support from primary care may help to reduce or cease frequent attendance at urgent care settings by improving health outcomes for this cohort

ACTION: The CCG will follow up with our providers of urgent care services to assess the numbers and nature of presentations at urgent care settings by homeless patients. We will work on this as part of our wider approach to frequent attendance, a particular priority going into winter.

Finally, the Board raised that despite these actions that we will take as a CCG, there are wider determinants of homelessness and reliance on food banks that need to be considered in the round as preventative measures. These include poor mental health prevention; drug and alcohol abuse prevention; greater support for ex-offenders leaving prison/young offender institutions; and greater support for ex-Armed Forces personnel especially veterans. The CCG therefore urges Healthwatch to continue working with partners, including through the Bromley Safeguarding Adults Board, to holistically address the challenges identified in *Banking on a Meal*.

London Borough of Bromley

Dr. Nada Lemic – Director of Public Health

This report covers two important issues: the use of food banks and the health needs of the homeless. It links in with work being carried out across SE London (Homeless Health Needs Audit). The report raises the important issue of the difficulties in homeless people accessing healthcare services. The report would have benefited from a more clear demarcation between the issues causing food bank use and the issue of hardship related to homelessness.

Healthwatch Bromley is still awaiting responses from the London Borough of Lewisham and Lewisham Clinical Commissioning Group.

Banking on a Meal …

London Borough of Bromley and the London Borough of Lewisham

Healthwatch Bromley has been commissioned by the London Borough of Lewisham to deliver Healthwatch Lewisham.

Any enquiries regarding this publication should be sent to us at admin@healthwatchbromley.co.uk.

You can download this publication from www.healthwatchbromley.co.uk

Annual Report 2015-2016

Bromley Safeguarding Adults Board

"Bromley is a place where preventing abuse and neglect is everybody's business"

https://bromley.mylifeportal.co.uk/bsab

Foreword from the Independent Chair

As the Independent Chair of the Bromley Adults Safeguarding Board I am pleased and privileged to introduce our Annual Report for 2015-2016.

Safeguarding arrangements for adults in Bromley continues to be a key priority for the Board's partners. I am proud to have been part of the many achievements of the Board over the past year as it has continued to work on behalf of people at risk of harm and neglect during a year which has seen it taking on new responsibilities under the Care Act 2014 and respond to the complex and ever changing safeguarding agenda. There are areas where work is still needed and the future priorities of the Board which are incorporated in the Board's new Strategy will shape its work over the next three years.

A key part of the chair's role is to drive forward the continuous development of the Board and ensure local organisations work effectively together. The Board has responded to its new statutory duties and it has made great strides in delivering on these throughout the year.

I have been impressed by the strong partnership arrangements in Bromley and the consistent commitment shown to the work of the Board and its sub-groups. In particular there have been a number of innovative developments such as the close working relationship between the Council's Trading Standards, the London Fire Brigade and Victim Support our domestic abuse services provider. This has resulted in people being referred for home fire safety visits to reduce their risk from fires as well as more referrals to care management from local fire officers.

One of the highlights of the year is the Board's highly successful Annual Conference which enables local organisations and front-line staff to benefit from speakers and presenters from national and regional organisations addressing key issues in safeguarding. This year's conference, 'Six Months after the Care Act', proved to be extremely well received by those in attendance.

Finally, and on behalf of the Board, I would like to thank all staff for their continued dedication to safeguarding adults in Bromley. It is not easy to work with families of those who have been abused. Whilst it is important to be proud of what has been achieved, we must take time to reflect on our own priorities for the coming year and ensure we are equipped to deal with these challenges. We must continue to improve our own practice and therefore improve the outcomes for those in our community who have been abused or who are at risk of abuse. We must also continue to consider new ways of working together to address the issues that are faced in Bromley.

I would like to acknowledge the commitment of all our partners who have helped us achieve a great deal in the past 12 months and who continue to contribute to improving the way we all work together to protect some of our most vulnerable people in society, our adults with care and support needs. In particular, the contribution of Lynne Powrie as Chair of the Policy, Protocols and Procedures Sub-Group for many years, has been greatly valued and her hard work will be missed as she has stepped down from that post.

Annie Callanan
Independent Chair

Contents

Executive Summary

The Care Act 2014 moved the Safeguarding Adults Board onto a statutory footing. At a time of major organisational and legislative change the safeguarding adults agenda has never been more important.

Nationally, in light of a number of abuse scandals in recent years, there has been a focus on the quality of service delivery and monitoring, particularly for those adults who rely on others to help them in their daily lives. Therefore, the Board has responded by taking steps to assure itself that such incidents cannot be repeated for Bromley residents.

During the year it has continued with strong strategic leadership and operational arrangements which have enabled the Board member organisations to improve standards, evidence robust safeguarding arrangements and delivered sustained professional improvement.

The Board has focused on six priority areas during the year to ensure that it meets its duties under the Care Act 2014. Much of this work has taken place in partnership through its sub-groups.

A wide-ranging multi-agency training programme aimed at professionals and volunteers in the statutory, private, voluntary and independent sectors has been designed and delivered. This aims to ensure a greater understanding and awareness of safeguarding as well as improving practice by front-line officers and volunteers. The highly praised Safeguarding Conference, Six Months after the Care Act, the largest training event of the year, was attended by over 140 delegates from local health and social care providers.

All of the Board's safeguarding policies, protocols and procedures were reviewed to ensure that they are compliant with the Care Act 2014 and the London Multi-Agency Adult Safeguarding Policy and Procedures. Where necessary new policies were developed during the year.

The Board completed its robust programme of quality assurance of safeguarding practice through audits and reviews of individual cases. A number of specific audits and reviews of individual agencies were also carried out. The Care Act Compliant Toolkit, which was a self assessment of partner organisations, was completed and from this developed an action plan with those partner organisations. Bromley Clinical Commissioning Group also took part in a 'Deep Dive', focused on safeguarding, during the year for CCGs within London. Additionally, Adult Social Care was the subject of a Peer Review on safeguarding. The results of both these external processes will be received during 2016-2017 and their recommendations will be implemented.

Making Safeguarding Personal continued to be a focus by ensuring that person centred outcomes are at the centre of safeguarding work.

As part of the Board's Communication Strategy its website was relaunched and targeted awareness campaigns carried out - visit https://bromley.mylifeportal.co.uk/bsab.

The Board completed the year by developing its new Strategy for 2016-2019.

Partnership working has driven some of the more successful projects such as the collaboration between the Council and the London Fire Brigade. This has resulted in more people being referred for home fire safety visits to reduce their risk from fires as well as more referrals to care management from local fire officers. Specifically work between Trading Standards, the London Fire Brigade and the local provider of domestic violence services has enabled staff to be able to recognise evidence of

abuse and signs of risk.

Information gathered by the Board has allowed themes and trends of abuse and risk to be identified. Work continues to reduce the number of incidents of abuse: the most common of which are neglect and failing to provide needed care as well as physical abuse. There has also been focused work around hoarding, fire safety, domestic violence and doorstep crime and scams in order to safeguard individuals. Close collaboration between the Council, the police and local banks continues to resolve instances of financial abuse which, although not frequent, do have a large impact on individuals and families.

National Context

The Care Act was passed by Parliament in May 2014 and became effective in April 2015. This is a major legislative change which has affected adult safeguarding and put it on a legal footing.

Nationally there is a growing population of elderly people. Many of these individuals can become increasingly isolated socially as they outlive family members and friends and increasing geographical mobility leaves them far away from younger family members. This has been highlighted by research and campaigns led by the Campaign to End Loneliness and Age UK. As this social isolation is often to be found together with increased levels of health and social care support needs it leaves them at an increased risk of harm and abuse, particularly neglect.

At the other end of the age spectrum many more people with learning disabilities and complex needs are living into adulthood. They can be vulnerable due to their long-term conditions and health and social care needs as evidenced by the abuse revealed at Winterbourne View, a private hospital where physical and psychological abuse was revealed by the BBC's Panorama programme.

Nationally there has been increasing recognition of discriminatory abuse of the disabled, domestic abuse (particularly of the elderly) and modern day slavery as identified within the Care Act 2014.

In December 2015 the Mazars Review into the deaths of people with a learning disability and mental ill-health who had been receiving services from Southern Health NHS Foundation Trust during 2011 to 2015 was published. Prompted by the preventable death of Connor Sparrowhawk in July 2013 the review looked at the deaths of all people within these groups and identified themes, patterns or issues of concern. The report found that there was no effective systematic management and oversight of the reporting of deaths and the investigations that followed nor an approach to learning from these deaths. One of the main recommendations was that such deaths should be investigated properly throughout England.

Local Context

In response to the national safeguarding context, Bromley is learning the lessons from other parts of the country. Regular monitoring is taking place with health colleagues for people in treatment centres and private hospitals in response to abuse uncovered at Winterbourne View. Following the Mazars Report the Board is also monitoring steps to ensure that deaths of people with learning disabilities and mental ill-health, who are in receipt of services from local health providers, are being investigated properly.

The Care Act (2014) brought adult safeguarding onto a statutory footing from 1 April 2015 and CCGs and other NHS partners now have a range of new duties and responsibilities which are being fulfilled locally. Safeguarding Adults Boards have also been placed on a statutory footing. 2015–2016 has been a year of ensuring that individual agencies and the Bromley Safeguarding Adults Board meet these statutory duties.

Within Bromley there is an increasing number of older people who are living longer as well as an increasing number of younger people with complex needs who are living into adulthood. These groups of people as well as those with mental ill-health, physical disabilities and sensory impairments are particularly at risk of abuse and harm due to their health and care needs. Whilst not all social care is provided through the Council, there were 1,027 people aged between 18-64 years and 2,819 people aged 65+ receiving long-term care during 2015-2016.

Older People

Locally it is estimated that there are 57,200 older people, of whom 8,700 older people are aged 85+ and the proportion of older people in the population is expected to increase. As these numbers increase so the number of people with health and social care needs who may be vulnerable to abuse will continue to increase. This will be particularly true of those aged 85 and over: Bromley is unique in London because it has the most people aged over 85. In addition to those who are frail and have physical ill-health there are over 4,000 people with dementia in Bromley: this number is expected to rise by over 400 particularly for those aged over 85. Those with this condition are often placed at even higher risk of abuse.

There are 67 nursing and residential care homes in Bromley and many vulnerable older people live in these homes. Bromley also has 300 people living in extra care housing which helps individuals to live independently for longer.

Ensuring that residents are not at risk of harm and abuse, whether intentional or due to poor practice and lack of training, is a major concern of the Board and is tracked by safeguarding officers from health and social care agencies which commission services from private and voluntary providers.

Older people within Bromley can be at risk of being neglected or receiving poor care, particularly if they are over 75 years, whilst those over 85 years may also be at risk of being physically abused.

For people living in their own homes being socially isolated, ie rarely interacting with family, friends or neighbours or having the opportunity to leave their own home, is an issue in Bromley. 158 people, answering the National Adult Social Care Survey for people receiving social care support, said they didn't have enough social contact with people or felt socially isolated.

Another risk that older people in Bromley are particularly vulnerable to is financial or material abuse, especially through doorstep crime or scams. Such instances can have a significant

impact on life savings or make their homes at potential risk of loss.

Working age adults

As well as the types of abuse that affect people of all ages, people with health and support needs within this age group are also particularly at risk due to their disability or health condition.

- 4,700 adults with learning disabilities live in Bromley;
- Over 2,600 people in Bromley (almost 1% of the adult population) have been identified by GPs as experiencing serious mental illness;
- 4,500 adults have a serious physical disability;
- over 1,200 adults live with visual impairments;
- over 700 adults live with profound hearing impairments.

Carers

Another group of residents who may be at risk of harm or abuse are the 31,000 unpaid carers in Bromley. This risk can come from the person they are caring for. Carers may also be at risk by neglecting their own health needs if support services are not available to enable carers to attend hospital/GP appointments. Of 271 carers surveyed in 2013, two-thirds said their health had been affected by their caring role and 76 said their health needs were not being met.

Some may also being causing harm or abuse. This will mostly be unintentional, due to lack of training to carry out caring tasks or as a consequence of the stress of their role.

Arrangements of the Bromley Safeguarding Adults Board

Arrangements of the Safeguarding Adults Board are in place to ensure local partnerships are effective. It does this by:

- assuring itself that local safeguarding arrangements are in place;
- assuring itself that safeguarding practice is person-centred and outcome-focused, that it is continuously improving and enhancing the quality of life of adults living and working in Bromley;
- working collaboratively to prevent abuse and neglect where possible;
- ensuring agencies and individuals give timely and proportionate responses when abuse or neglect have occurred.

The structure of the Board and its sub-groups

The Board is organised in the following way (Appendix 1):

Bromley Safeguarding Adults Board: the strategic multi-agency steering group, made up of senior officers of local partners, with statutory responsibility for the oversight and co-ordination of safeguarding activity.

Executive: a group of managers from partners which ensures that the Business Plan of the Board is achieved by partner agencies through the work activity of its sub-groups. Officers from partners are invited to sit on each sub-group.

Performance Audit and Quality Sub-Group: The sub-group is responsible for the production of effective management information and performance challenge to the Board. It ensures that quality assurance arrangements are in place across Adult Social Care and Health sector partners to gather information on: the safeguarding casework; service user feedback and data on the outcomes achieved for people using services.

Training and Awareness Sub-Group: The sub-group is responsible for the implementation of the Training Strategy including the development, planning and coordination of multi-agency safeguarding adults training provision. This includes making recommendations regarding the facilitation and commissioning of appropriate training resources and the regular review and evaluation of the training provision in line with the Board's Business Plan. The sub-group is also responsible for delivering the Board's Communication Strategy.

Policy, Protocols and Procedures Sub-Group: The sub-group is responsible for ensuring there are up to date policies and procedures for practitioners and the Board to follow.

Funding of the Bromley Safeguarding Adults Board comes from the statutory partners and other members (Appendix 2).

Statutory members of the Board in Bromley are: London Borough of Bromley; Bromley Clinical Commissioning Group and the Metropolitan Police Service Bromley (Appendix 3).

Priority Areas

The Board identified six priority areas for 2015-2016:

1. **Training:** ensuring safeguarding understanding and awareness and practice in the statutory, private, voluntary and independent sectors through developing and delivering a robust training programme in line with the Care Act 2014;
2. **Policies:** ensuring that all current and new Board and individual agency policies and procedures are Care Act compliant;
3. **Quality Assurance:** monitoring the service provided to the public by using a robust audit process and performance framework;
4. **Practice:** developing safeguarding practice by front-line professionals to ensure that it is person-centred and follows the principles of Making Safeguarding Personal (MSP);
5. **Communications:** building community awareness of safeguarding by delivering the Board's Communication Strategy;
6. **Partnership Working:** joint working between member agencies with individuals at high risk of harm.

Board Activity, Achievements and Progress in 2015-2016

The Board's main achievements during 2015-2016 were:

- developing a 3 year strategy with statutory and voluntary sector partners;
- developing a communication strategy;
- holding a Development Day with partners to review the Board;
- revising the Board's training strategy and training programme;
- holding the Board's Annual Conference, a major training event, in October 2015 attended by over 140 people;
- supporting a comprehensive project which developed Board safeguarding policies and procedures compliant with the Care Act and London Multi-Agency Adult Safeguarding Policy and Procedures.

In addition, the Board has also undertaken a number of developments and projects to achieve its priorities during the year.

The Board commissioned additional e-learning programmes in Safeguarding Adults, Modern Day Slavery and Female Genital Mutilation.

Lunchtime learning sessions with expert speakers were introduced: one in particular was the Home Office presenting on Modern Day Slavery.

As part of quality assurance, safeguarding case work was audited and case studies evaluated with partner agencies.

The Board took part in designing Making Safeguarding Personal and evaluating the programme as part of the national network enabling access to good practice throughout the country.

The Board's website was reviewed and re-launched for both professionals and residents.

Sprinkler Project: Five people were identified as at high risk of fatality in the case of fire because of immobility due to disabilities. Four clients were Affinity Sutton tenants and, following

agreement with Affinity Sutton, two water misting systems were installed in two of the four premises in order to compare these with more traditional types of fire detection in the other two.

Hoarding Panel Project: The multi-agency Hoarding Panel was established to share information on complex cases. It also provided a training event for front-line staff involved with people affected by hoarding and chronic disorganisation.

Strategic and operational planning support and protection was improved for victims of domestic abuse through the Domestic Abuse Strategy Group and training for professionals on referring individuals to MARAC (Multi-Agency Risk Assessment Conference) was provided.

A Pressure Ulcer Passport was trialled which documents an individual's pressure ulcers so that root cause analysis is not repeated unnecessarily and resources are not wasted in this way.

Care Home Project: Bromley Clinical Commissioning Group commissioned Bromley Healthcare to work with three care homes to improve practices in relation to wound care management and develop practice and confidence through training and mentoring.

Performance, Audit and Quality Sub-Group

Chair: Ann Hamlet: Head of Safeguarding Adults, King's College Hospital NHS

Focus continued on auditing of safeguarding cases at all stages of the safeguarding process from initial to concluded enquiries considering the quality of multi-agency practitioners' work. 40 safeguarding case audits were carried out as well as 160 audits of generic care management cases: the latter to identify any safeguarding issues which had not been addressed.

The findings were that there had been an improvement in practice and that the adult at risk was central to the process and involved in decision making. Partnership working, combining skills and expertise was good. One example of learning was that there should be greater liaison between adult and children's services to highlight potential concerns about family carers.

Commissioned Services Intelligence Group (CSIG) reports to the group regularly on their work with representatives from commissioners, providers, partners and the Care Quality Commission (CQC) looking at concerns arising in domiciliary care, care home and private mental health providers which are regulated by the CQC.

Performance information for the Board arising out of data analysis is regularly scrutinised.

What we will do during 2016-2017:

- Set quality standards for the Board;
- Evaluate the responses to the Care Act Compliance checklist to ensure good practice is being carried out throughout the borough;
- Undertake a Safeguarding Adults at Risk Audit Tool (SARAT) Challenge and Support Event for health providers and Bromley Council which will review these self-assessments and suggest improvements for each agency;
- Undertake case file audits of safeguarding cases within LBB and Oxleas NHS Foundation Trust;
- Review cases in order to identify best practice as well as gaps in practice and circulate this to partner organisations;
- Deliver the Business Plan resulting from the new Prevention Strategy.

Policy, Protocols and Procedures Sub-Group

Chair: Lynne Powrie, Chief Executive, Carers Bromley

Focus was on completing the procedures in light of the Care Act 2014. The Safeguarding Adults in Bromley Multi-Agency Practitioner Toolkit was published with policies on:

- Advocacy for people at risk of harm
- Choking for people with dysphagia – the Hampshire policy was used while the local policy was being developed
- Managing Pressure Sores
- Female Genital Mutilation policy in partnership with the Bromley Children Safeguarding Board
- Modern Day Slavery policy
- Domestic Violence policy.

The safeguarding policies of the following organisations were reviewed

- The Priory
- Westmeria Healthcare Ltd

What we will do during 2016-2017:

- Update the Board's polices (Practitioner Toolkit) on a regular basis as new policies are approved by the Editorial Board and ratified by the Sub-Group;
- Review new and updated policies, protocols and procedures of the Board and partner agencies;
- Develop a protocol for the Private/Voluntary/ Independent sector regarding the quality assurance of their safeguarding policies;
- Deliver the Business Plan resulting from the new Prevention Strategy.

Communication Strategy:

- Review membership to deliver on the Communications Strategy Action Plan;
- Further develop the Board's website, including creating a member only area for Board papers;
- Ensure service user engagement and the values of Making Safeguarding Personal are at the centre of communications.

Training and Awareness Sub-Group

Chair: Antoinette Thorne, Workforce Development Manager, LBB

Focus has been the development of the safeguarding training programme for health and social care staff. The Multi-Agency Safeguarding Adults Training Strategy for 2016-2019 has been developed and a revised training programme has been reviewed, evaluated and commissioned.

Other achievements are: revised the Alerters Guide with information to carers, families and community groups on how to access safeguarding advice and help; produced safeguarding posters for Care Homes; improved the Board's safeguarding website; published on line safeguarding policy and procedures and participated in local networking events.

Training Activity

- 1,946 health and social care staff received training through a variety of means: facilitated training, lunchtime learning briefings and e-learning;
- Over 140 people attended the Board's Safeguarding Conference and received training from national organisations on a wide variety of subjects;
- 10 staff members were trained to deliver the Home Office Prevent training and there have been 12 sessions attended by 207 staff from the Council's Adult and Children's services, 7 foster carers and 77 from Education Services;
- 1,084 e-learning sessions were completed;

- 5 Best Interest Assessors refresher training places were funded.

What we will do during 2016-2017:

- Review the Board's group learning and development offer, revising the training strategy and competency framework to comply with Care Act 2014 requirements and Making Safeguarding Personal;
- Measure and report on the effectiveness of multi-agency safeguarding training and other training that helps make people feel safe;
- Develop a multi-agency Violence against Women and Girls (VAWG) training strategy for the Safeguarding Children and Adults Boards in partnership with Bromley Community Safety Partnership;
- Support the private/voluntary/independent sector to deliver safeguarding training to service users, families and carers;
- Support the implementation of the Bournemouth Competency Framework so all care management professionals can develop their competence in safeguarding adults. Formal training, including vocational or professional awards, will form a part of this development as well as informal day to day training.

Training Activity and Feedback

Satisfaction with all training sessions held in 2015-2016, based upon 457 evaluations, resulted in:

- 326 people rated their course as Excellent
- 114 people rated their course as Good
- 15 people rated their course as Satisfactory
- 2 people rated their course as Poor

Comment on Level 1 Awareness and Alerting:

"Will be better equipped when attending safeguarding meetings"

Comment on Level 3 Managing Complex Cases:

"Better understanding of safeguarding process and time scales, expectation under the Care Act 2014 around Safeguarding Adults."

Actions as a result of the course – Level 5 Safeguarding Adults for Managers Role

"I will read Bromley's Toolkit and then refresh periodically"

"I will be able to develop better links with other Safeguarding Managers as a result of this training"

"I will be able to update team's knowledge when I return to base"

Table 1: Training Sessions attended by partner organisations 2015-2016

Training Course	LBB	Private Voluntary	Oxleas	BHC	MPS	Other	Total
Level 1							
Awareness & Alerting *	53	104		2		3	**162**
Level 2							
Risk Assessment & Protection	18		9	1			**28**
Financial Abuse	11		2				**13**
Provider Manager's Role	1	43		1			**45**
Risk Assessment and Risk	11		1		1		**13**
Safeguarding and Care Act Training	10		3				**13**
Mediation Training – Best Interest	14		1	1		3	**19**
Mental Capacity Assessment in	36	8	8				**52**
Level 3							
Managing Complex Cases	16		9	1			**26**
Chairing Safeguarding Meetings	12						**12**
Level 5							
Safeguarding Adults for Managers	13		12				**25**
Training sessions							
Modern Day Slavery & Trafficking	16						**16**
Scams and Doorstep Crimes	31	24	1	1			**57**
Hoarding Behaviours	24	1	1			2	**28**
Domestic Abuse	14	3					**17**
MARAC	7	1	2				**10**
Adult Safeguarding Behind the	23	16		6		1	**46**
Deprivation of Liberty Safeguards							
Deprivation of Liberty Safeguards	8						**8**
Quality Assuring Mental Capacity Assessments	13		6				**19**
Total	**331**	**200**	**55**	**13**	**1**	**9**	**609**

* E-learning courses also available October 2015

Further details about the Board's Annual Conference showing the range of subjects, speakers and presenters which made the conference such a success with attendees can be seen below.

Bromley Safeguarding Adults Conference – October 2015

'Six Months after the Care Act'

The Board organises a multi-agency training event annually.

The Conference was attended by over 140 delegates from partners and health and social care providers from the private and voluntary sector. An over 90% satisfaction rate was given by attendees.

The Conference focus was:

- Organisational abuse and concerns for the individual and family members
- Impact of the Care Act implementation April 2015
- Mental Capacity Act and Deprivation of Liberty Safeguards

Speakers included:

- Niall Fry, Department of Health speaking on the changes and updates to the Mental Capacity Act and Deprivation of Liberty Safeguards;
- David Connolly, Law Commission speaking on Deprivation of Liberty Safeguards – The Review;
- Belinda Schwehr, Care & Law Health speaking on Multi Agency Safeguarding within the Care Act;
- Liz Onslow and Susan Lowson, Parliamentary & Health Ombudsman speaking on Dying without Dignity;
- Dan Scorer, Mencap speaking on Four Years on from Winterbourne View;
- Lesley Lincoln speaking on Orchard View: Living with the Trauma of Organisation Abuse – a Family's Story;
- Lynne Phair, Expert Witness speaking on Prevention is Better than Cure.

Workshops included:

- Ombudsman and Disclosure and Barring Service – changes and updates given by Jan Cuthbert, Assistant Ombudsman and Lyn Gavin, Disclosure and Barring Service;
- Multi-agency working under the Care Act – the role of the Police by Maria Gray, Central Safeguarding Team, MPS;
- The role of the Court of Protection by Annabel Lee, 39 Essex Chambers;
- Domestic Abuse and Older People by Asat Owens and Monsura Mahmud, Solace Women's Aid;
- CQC, regulator for health and social care and the London Mental Health Inspection Team by Lee Alexander, CQC;
- What can we learn from Serious Case Reviews by Sam Bushby and Nicky Kentell, West Sussex County Council;
- Dementia – Impact and consequences of our involvement by Brenda Bowe, Associate of Dementia Trainers;
- Drug and Alcohol Use – Assessment, Treatment and Managing Risk by Jonathan Williams, Bromley Drug and Alcohol Service;
- Pressure Ulcers and Adult Safeguarding – Risk Factors, Prevention and Principles of Healing by Gill Harman, Bromley Healthcare;
- Modern Day Slavery by Anne Read, Salvation Army.

Safeguarding Adults Case Studies

To understand the impact that safeguarding work can have on individual lives three case studies, representing the work of Board partners, are included in this section. Personal details have been anonymised to retain confidentiality.

Case Study 1

Mrs Smith

Mrs Smith is a 91 year old widow living in her own house with her son and daughter living locally. Mrs Smith has advanced dementia with a history of depression and hypertension. She is immobile and needs assistance with all aspects of living and personal care. She lacks capacity and is at high risk of pressure sores.

Mrs Smith had been receiving four daytime visits from two care workers arranged by the family. Her daughter had previously agreed to arrange 24 hour care.

A safeguarding alert was received from the London Ambulance Service when Mrs Smith was taken to hospital following a fall from her chair causing a head injury when she was alone. This was despite her having been tied to the chair reportedly by a 'luggage strap'.

It was concluded that she had been subject to neglect and physical abuse by her son and daughter. If she suffered harm it would become a criminal matter and would be referred to the police. Additionally an application to the Court of Protection would be made if she was not given immediate 24 hour care: the family moved her into a nursing home the next day.

Mrs Smith has subsequently gained weight and is reported to be doing well.

Case Study 2

Mrs Todd

Mrs Todd is 65 years old living with her husband and adult daughter. She has cognitive impairment as well as physical disability. Mrs Todd does not have mental capacity to decide how her care needs are met.

She has a package of care of four visits per day to assist with personal care and all aspects of daily living.

A safeguarding referral was received after Mr Todd refused for her to be cared for downstairs as it was not safe for his wife to use the stairs in the property. She was prone to falls and had suffered a fracture from a previous fall. There were also concerns of her diet placing her at risk of choking. The concerns were that Mr Todd was not making decisions in his wife's best interest placing her at risk of neglect and harm and could be potentially life threatening.

An Independent Mental Capacity Act Advocate was appointed to represent Mrs Todd's best interests.

The use of safeguarding procedures, the involvement of the police and negotiation with the family led to Mrs Todd receiving appropriate care in accordance with professional advice. Mrs Todd continues to be successfully cared for at home.

Case 3

Mr Jones

In March 2013 a trader from Lincolnshire knocked on the door of a 78 year old man who lived alone in Orpington. The caller claimed to be a builder and offered his services.

Mr Jones wanted some work done on his property but he didn't have the money to pay for it. The trader said he could arrange a deal whereby he could effectively do the work for free. Mr Jones thought the deal meant he would not have to pay any money up front but the debt would be settled when he died or if he sold the property. He was pressured into signing an agreement which gave the house to the trader.

In September 2013 concerns were raised about the situation and the whereabouts of the resident as Mr Jones had been removed from the house and into a caravan in the north of the country. Trading standards, housing and adult social care officers rehoused him as his home was in no fit state for him to return to and legally it was no longer his property.

The trader was found guilty of fraud in January 2016 and was sentenced to 5 years imprisonment. The house, worth over £250,000 was returned to the victim. He chose to stay where he was re-housed as he says he feels safe and is now very settled.

Mr Jones' niece later wrote to thank the team saying "I cannot express how grateful we are as a family for everything you and your supporting teams have done. I have never had to deal with Bromley Council before this, but everyone and every department has been fantastic, from Housing and Adult Safeguarding to yourselves in Trading Standards and Legal. You are all a credit to your departments."

Board Members' Reports

The agencies that make up the Bromley Safeguarding Adults Board are all committed to improving their ability to prevent harm as well as to identify and react to allegations of abuse towards the people they work with. Every year, we ask our partners to produce their Board partner statements which highlight their key achievements throughout the year and outline their plans for the coming year.

London Borough of Bromley

As the lead agency the London Borough of Bromley is responsible for receiving all safeguarding initial enquiries and either investigating themselves or asking another agency to make enquiries, if they are best placed to do so. The Strategic and Business Support Division has provided support to the Board structure, maintained its website and produced its safeguarding literature. Additionally, the Council also provides support to safeguarding through quality assurance and statistical analysis. The Council's Learning and Development Team commissions and supports the Board's training programme.

Care Management

The Care Management service is one of the key teams in the borough in regards to safeguarding as its staff will usually carry out enquiries into abuse or risk of abuse or harm. Working within the principles of Making Safeguarding Personal officers will work with individuals, their families and friends, as appropriate, to remove or reduce any identified risk.

Key Achievements: April 2015-March 2016

- Re-organised its front line service, the Adult Early Intervention Team, to receive safeguarding alerts and carry out preliminary safeguarding work reducing the number of alerts being investigated unnecessarily;
- Ensured all forms within CareFirst, (Adult Social Care Information database), were updated in line with the revised London Multi-Agency Adult Safeguarding Policy and Procedures and the revised NHS Information Centre's Information and Guidance on the Safeguarding Adults Collection (SAC);
- Trained its care management staff in line with changes to safeguarding in line with the Care Act;
- Specialist Care Managers, Consultant Lead Practitioners, supported staff to deal with safeguarding investigations providing continuing professional development sessions to teams;
- Project managed the Editorial Board which was funded by the Council to update policies and procedures in line with the Care Act.

Safeguarding Adults work planned for 2016-2017

- Strengthen links between Bromley Safeguarding Adults Board and Bromley Safeguarding Children Board. A task and finish group will been set up to help support the completion of actions which will benefit the safety of children, young people and adults at risk;
- Assure the Board that partners are appropriately flagging domestic violence where there is an adult at risk, with appropriate outcomes recorded;
- Undertake further analysis on safeguarding notifications that increase the Board's understanding of trends and prevalence of abuse and neglect locally;
- Improve service user experience and engagement through a feedback form gathering their views;

- Promote greater awareness of safeguarding adults with people who use services, the public and partner organisations;
- Appoint a Principal Social Worker to oversee front line practice;
- Embed the National Safeguarding Bournemouth Competencies into a supervisory and appraisal framework.

Tricia Wennell
Head of Assessment and Care Management

Trading Standards

A long term objective for trading standards is to raise the profile of scams and doorstep crime and its impact on older residents, which has historically been a grossly underreported crime. Nationally, the reporting levels are estimated at between 5% and 10%. Following the launch of an awareness campaign in November 2014, a significant increase in referrals of scams and doorstep crime incidents to trading standards from key partners were received.

Key Achievements: January 2015-December 2015

- Delivered scam and doorstep crime awareness sessions to 2,896 people - an increase of just under 1,000 people compared to the previous year. This included:
  - scam and doorstep crime awareness information to 64 community groups, 26 more than in 2014;
  - half day training for safeguarding practitioners and partners, such as London Fire Brigade and Victim Support, to recognise the signs of scams and doorstep crime and encourage referrals. This training was given to 48 groups of professionals in partner organisations.
- Received 246 calls to the Rapid Response number to enable action to prevent or disrupt crime from taking place, including 42 alerts from banks and 27 alerts from safeguarding partners. It is estimated that this saved residents £233,000;
- Received 227 reports of mass market frauds and scams perpetrated through letters, emails, texts and phone calls;
- Although prosecutions of offenders are rare due to the nature of the crime, victim vulnerability and issues of tracking down perpetrators, criminals are investigated.

Safeguarding Adults work planned for 2016-2017

- Continue with the key priority of protecting vulnerable residents;
- Offer more adult safeguarding professionals training in scams and doorstep crime in all sectors to raise awareness of such crimes and how to make referrals;
- Develop training/awareness presentations for adults with learning disabilities and engage with all appropriate groups in the borough;
- Continue to review data to further identify the needs of Bromley residents in relationship to scams and doorstep crimes.

Rob Vale
Head of Trading Standards

Domestic Violence and Adult Safeguarding

The Council commissions services to support adults in domestic violence situations through mitigating or removing the risk. There is a close working relationship with the police and other agencies, as appropriate.

Key Achievements: April 2015-March 2016

- In response to legislative change in the Care Act 2014 the Violence Against Women and Girls (VAWG) Commissioner post was bought across to Education, Care and Health

Services in October 2015 with the intention to support Board partners to understand VAWG in the context of adult safeguarding;

- Delivered a series of lunchtime briefings on Domestic Violence for partner agencies;
- Improved recording processes for care management officers to record safeguarding concerns for domestic and sexual violence;
- Care management staff have received training by Victim Support, the provider of domestic violence services, on risk assessment and referral procedures for MARAC (Multi-Agency Risk Assessment Conference).

Safeguarding Adults work planned for 2016-2017

- Develop the Bromley Community Safety Partnership Violence against Women and Girls Strategy, in partnership with the public sector, including Bromley Police, and the community and voluntary sector;
- Continue to raise awareness of domestic and sexual abuse across the partnership, improve pathways for both staff and service users who disclose experiencing and perpetrating domestic and/or sexual violence and establish an environment where both staff and service users are confident about making enquiries and making appropriate referrals for support;
- Develop and deliver a multi-agency VAWG training strategy on behalf of both the Safeguarding Children and Safeguarding Adults Boards.

Victoria Roberts
Violence against Women and Girls Interim Commissioner

Mental Capacity Act and Deprivation of Liberty Safeguards

The Board works to safeguard the rights of people who lack the mental capacity to make decisions for themselves. These rights are set out in the Mental Capacity Act 2005. The Act requires decisions to always be made in a person's best interests. The Board works to promote the safeguards of the Mental Capacity Act and Deprivation of Liberty Safeguards throughout Bromley. This work is reported to the Board as part of governance arrangements.

In response to the Supreme Court ruling in 2014 to extend the remit of Deprivation of Liberty Safeguards beyond residential homes and hospitals, the Council set up a dedicated team of Best Interest Assessors to carry out the assessments evaluating these applications.

The table below shows how the ruling has impacted the number of DoLs applications in Bromley which have dramatically increased.

Amit Malik
Group Manager, Deprivation of Liberty Safeguards Team

Table 2: Deprivation of Liberty Safeguards (DoLs) Applications – 2013-2016

DoLs Applications Received	2013/14		2014/15		2015/16	
	No.	%	No.	%	No.	%
Referrals Received	14		388		1,180	
Granted	6	43%	351	90%	999	85%
Not Granted	8	57%	31	8%	91	8%
Withdrawn	-	-	6	2%	6	1%
Standard Authorisations	3	21%	383	99%	1,154	98%
Urgent Authorisations	11	79%	5	1%	26	2%

Bromley Clinical Commissioning Group (BCCG)

BCCG commissions health services in Bromley. During 2015-2016 BCCG has demonstrated strong commitment and engagement with the Board by providing on-going CCG representation at all Board meetings. BCCG also works closely with its Board partners, including those whose services it commissions, to raise the profile of safeguarding and ensure that best practice is implemented in Bromley. BCCG also works closely with NHS England (London) and the Care Quality Commission on safeguarding concerns.

Key Achievements: April 2015–March 2016

- Internal Structures: BCCG has reviewed its internal structures, safeguarding policies and reporting systems to meet its duties under the Care Act;
- Commissioning Role: BCCG has reviewed its commissioning documentation and practice to ensure that safeguarding plays a key role in the performance of providers which is monitored regularly. A Safeguarding Dashboard of safeguarding performance by commissioned providers provides assurance on training and referrals as well as the ability to spot issues arising;
- Domestic Abuse: Provided additional funding to Victim Support for implementation of the IRIS programme (Identification and Referral to Improve Safety) for victims of Domestic Abuse;
- Training: Mental Capacity Act/Deprivation of Liberty Safeguards and Prevent training for BCCG and Primary Care staff including GPs as well as MCA/ DoLs awareness sessions for the public and staff working in the Community Services Provider;
- Awareness Raising: Producing and cascading a "Safeguarding Overview Booklet" and leaflets for Prevent, including key documents on the BCCG Intranet and GP Practice Zone and developing an Mental Capacity Act awareness training tool for people with Learning Disabilities;
- Nationally/Regionally: Participation and successful outcome from NHS England's Adult Safeguarding Deep Dive, established South East London Clinical Commissioning Group's Designated Safeguarding Adults leads' peer group supervision meetings and initiated peer group supervision for commissioned service providers' named safeguarding adult leads.

Safeguarding Adults work planned for 2016-2017

- Commissioned service providers will be monitored through their Safeguarding Adults Risk Assessment Tool (SARAT) action plans to provide assurance that risks are being monitored and services are safe;
- Arrangements that are in place to gain assurance from commissioned service providers about the Home Office Prevent and the Mental Capacity Act 2005 will be strengthened;
- Ensuring, via a Training Needs Analysis, that the existing safeguarding training programme for BCCG Staff is compliant with the new intercollegiate document for safeguarding adults aligned with the Board's staff training competency framework;
- To work in partnership with key stakeholders to implement Bromley Domestic Homicide Review action plan;
- To ensure that systems and processes are in place to facilitate timely collection and analysis of safeguarding data;
- To follow through the actions identified from the recent NHSE safeguarding Deep Dive such as recruiting a Named GP Adult Safeguarding Lead as a member of the Board.

Claire Lewin
Designated Nurse, Adult Safeguarding

Metropolitan Police Service - Bromley

The role of the MPS is the prevention, identification, risk management and detection of criminal offences. As a statutory member of the Board, MPS is committed to working in partnership in an open and transparent way with its partners. This is achieved through partnership working in the following areas: Multi-Agency Safeguarding Hub, MARAC (Multi-Agency Risk Assessment Conference) for people at high risk of domestic abuse and MAPPA (Multi-Agency Public Protection Arrangements) working with offenders in the community.

Key Achievements: April 2015–March 2016

- Implementation of the new MPS Missing Person Protocols leading to smoother initial response, more consistent risk assessment and improved resource allocation in the first critical 48 hours to support vulnerable adults;
- Ongoing joint discussions re meeting the Adult Social Care thresholds to reduce referrals and manage risk;
- Working with partners in risk assessment, prevention and disruption. There have been no murders, no domestic homicides or matters for a Serious Adults Review;
- Strengthened membership of MARAC (Multi-Agency Risk Assessment Conference) meetings.

Safeguarding Adults work planned for 2016-2017

- More cohesion on case work with vulnerable adults;
- To continue work on MPS response to reports of missing persons;
- To review and monitor all hate crime;
- Implement a (Multi-Agency Risk Assessment Conference) MARAC steering panel;
- Review current referral protocols.

Detective Chief Inspector Dave Yarranton,
Metropolitan Police Service Bromley

King's College Hospital, NHS Foundation Trust (KCH)

KCH is the acute health provider which, since 2013, has included the two hospitals in the borough, the Princess Royal University Hospital and Orpington Hospital.

Key Achievements: April 2015–March 2016

- The Safeguarding Team was strengthened and access to safeguarding information across the Trust improved;
- Instituted an annual audit reviewing deaths of people with learning disabilities which considered the application of Mental Capacity Act;
- Improved the flow of information and assurance by re-establishing the Safeguarding Adults, Learning Disabilities and Mental Capacity Act Group to provide updates re ongoing cases and training compliance.

Ann Hamlet
Head of Safeguarding Adults

Oxleas NHS Foundation Trust

Oxleas is the main provider of specialist mental health care in Bromley as well as providing health care for people with learning disabilities. Oxleas provides representation to the Board and its sub-groups and contributes to the statistical information received by the Board.

Key Achievements: April 2015–March 2016

- Ensured the Trust has Care Act compliant policies;
- A trust wide strategy for MARAC (Multi-Agency Risk Assessment Conference) referrals has been developed to support and assist practitioners in working with Domestic Violence and to improve the rate of referrals.

Safeguarding Adults work planned for 2016-2017

- Improve the collection and recording of safeguarding actions and its statistical database. Work will be undertaken with Bromley, Bexley and Greenwich Councils to introduce improved methods of collecting this information whilst aligning forms for all boroughs. This will align information for the Board's statistical reports.

Barbara Godfrey
Head of Social Care for Bromley (Adults)

Bromley Healthcare (BHC)

Bromley Healthcare is the community health care provider commissioned by Bromley Clinical Commissioning Group which provides a wide range of services across Bromley and it contributes to the work of the Board and its sub-groups through participation of relevant officers.

Key Achievements: April 2015–March 2016

- Ratified its internal prevention of choking policy;
- Worked with partners to improve outcomes for people with pressure ulcers:
  - Provided support to a specific group of three care homes;
  - Provided training to staff through the Care Homes Training Consortium;
  - Trialled the Pressure Ulcer Protocol which had been produced by King's College Hospital and Bromley Healthcare to document the history of an individual's pressure ulcer which patients can take between providers so helping to prevent or remove pressure ulcers;
  - Implemented a Root Cause Analysis form for use when a pressure ulcer is deemed avoidable.

Safeguarding Adults work planned for 2016-2017

- Audit programme to be completed between September and December 2016 including quality of mental capacity assessments and best interest decisions;
- Deliver a training programme on awareness, recognition and identification of domestic violence;
- Introduce improvements for safeguarding adults case supervision to community teams by the safeguarding lead;
- Ensuring the patient's wishes and what matters to them are clearly documented in the patient record.

Natalie Warman
Director of Nursing, Therapies and Quality

London Fire Brigade Bromley (LFBB)

LFBB is committed to working to safeguard vulnerable people in the borough by working closely with partners to identify high risk individuals and then remove or reduce risk.

Key Achievements: April 2015–March 2016

- LFBB were set a target to complete 2,880 Home Fire Safety Visits (HFSVs) for vulnerable householders in 2015/2016. Fire crews actually managed to complete 3,161 HFSVs, an increase of 158 (5%) on 2013/14 figures;
- LFBB worked closely with Bromley Council making 43 Safeguarding referrals. LFBB responded to 12 fire retardant bedding requests received from the Council for vulnerable residents;
- LFBB implemented a six monthly return from LBB housing providers reporting on fire safety issues to reduce fires in sheltered housing – this has been extended to include referrals to Trading Standards and Victim Support;

- LFBB supported the portable misting system project with the Council and Affinity Sutton;
- LFBB supported the Hoarding Panel;
- A joint working protocol was agreed with Trading Standards, MPS and Victim Support, a domestic violence services provider, to identify and safeguard victims of crime and vulnerable residents in Bromley. Rogue traders and scams, burglary and domestic violence awareness training was provided to station crews. Fire Safety training was delivered to Social Care, Trading Standards, MPS and Victim Support staff to identify vulnerable residents in the borough at risk from fire.

Safeguarding Adults work planned for 2016-2017

- Maintain close partner links and the system of referring safeguarding concerns;
- Review referral processes and recording of high risk residents;
- Review processes to install additional fire protection in the most high risk premises in Bromley;
- Provide an on-going programme of Fire Safety awareness training to LBB Trading Standards, MPS and Victim Support personnel to identify vulnerable residents at risk from fire and refer to LFBB;
- LBB Trading Standards, MPS and Victim Support to provide on-going rogue traders/ scam, burglary and domestic violence awareness training to LFBB personnel to identify vulnerable residents at risk from fraud, crime and abuse.

Daniel Cartwright
Borough Commander

Advocacy for All

Advocacy for All provides a number of one to one advocacy services in Bromley. This includes providing Independent Mental Capacity Advocates, Community Advocacy for adults with learning disabilities or autism who do not receive services and support for self-advocacy. Advocacy for All works with Board partners to improve awareness of safeguarding, recognise abuse and empower people to report abuse among the learning disability community.

Key Achievements: April 2015–March 2016

- Funding was secured from Awards for All and the 'People's Project' Big Lottery/ITV News competition to support the 'A Team' which is a group of people with a learning disability who are trained as trainers for other disabled young people and adults to ensure they are aware of and can recognise abuse. Free training is provided to people with a disability with costed sessions for professionals. People have felt comfortable and confident enough to disclose situations that have happened to them;
- Written an easy read 'Hate Crime' booklet.

Safeguarding Adults work planned for 2016-2017

- Continue to raise awareness of Hate and Mate Crime. Bromley Sparks will participate with Green Goose Theatre, Bromley College and the Bromley Disability Hate Crime Group in April 2016 to explore the challenges that some members of the community face in terms of mate crime;
- Identify and share trends in safeguarding particularly among people with a learning disability.

Vivienne Lester
Chief Executive

Age UK Bromley and Greenwich

Age UK Bromley and Greenwich promotes the wellbeing of all older people in the community and is the leading voluntary sector provider of services for older. Age UK Bromley and Greenwich works with Board partners in the voluntary sector, Bromley Council and the police to promote safeguarding among older people in Bromley.

Key Achievements: April 2015–March 2016

- Ensuring that all staff and volunteers are trained regularly in safeguarding and that safeguarding is part of all supervision;
- Senior staff attended the annual Safeguarding Conference.

Safeguarding Adults work planned for 2016-2017

- As part of the new Dementia Support Hub, safeguarding will be a key factor in the support of people with dementia and their carers;
- We will continue to work with Trading Standards and the police to prevent older people being victims of scams, rogue builders and financial abuse.

Maureen Falloon
Chief Executive

Alzheimer's Society Bromley

Alzheimer's Society Bromley provides services for people with dementia and their carers. It is committed to working with local safeguarding partners, in line with multi-agency policy, to uphold the Care Act principle of partnership working and safeguarding people in Bromley.

Key Achievements: April 2015–March 2016

- The Society supports employees and volunteers to ensure good quality safeguarding practice within the organisation and to respond in a proportionate and timely way to safeguarding concerns.

Safeguarding Adults work planned for 2016-2017

- Continue to implement the Society's Adult Safeguarding policy and procedures as outlined in the Locality Business Plan of the Bromley branch.

Mashhood Ahmed
Services Manager, Bromley

Bromley & Lewisham Mind

Bromley & Lewisham Mind works alongside people with mental health needs and dementia to improve their quality of life. As a member of the Board it works with partners to identify safeguarding issues and works with Bromley Council in providing information and reports relating to safeguarding issues.

Key Achievements: April 2015–March 2016

- Developed new Mental Capacity Act and Deprivation of Liberty Safeguards Policy and provided training to MindCare Dementia Support staff in its application.

Safeguarding Adults work planned for 2016-2017

- Review of Adult Safeguarding Policy and subsequent roll out to staff;
- Ensuring Adult Safeguarding awareness is embedded in new services from the outset, in particular the new Bromley Dementia Support Hub.

Ben Taylor
Chief Executive

Bromley Mencap

Bromley Mencap has a longstanding partnership with Bromley Safeguarding Adults Board providing services to disabled adults living in the borough as well as their carers and families.

Key Achievements: April 2015–March 2016

- Delivered disability awareness training, which covers safeguarding, to 21 employers/ local businesses;
- Continued to work with the Borough-wide consortium on Disability Hate Crime to raise awareness of this type of abuse.

Safeguarding Adults work planned for 2016-2017

- Campaigning with employers and service providers to raise the level of Disability Awareness across the Borough including safeguarding;
- The Welfare Benefits Service will raise awareness of financial abuse amongst its disabled clients. Last year clients were helped on 13 occasions to avoid unscrupulous "friends" extracting money from them;
- The monthly drop-in service will hold regular sessions around safeguarding and budgeting to ensure disabled adults have an awareness of these issues;
- The Day Opportunities Programme will deliver a series of activities and sessions around keeping safe;
- The Carers' Lunch Club will provide guest speakers on rogue traders and how to avoid them. In the past 23 people have been encouraged and assisted to subscribe to the Telephone Preference Service to ensure they don't fall victim to unscrupulous cold calling.

Eddie Lynch
Chief Executive

Carers Bromley

Carers Bromley supports over 5,000 carers in their caring role. Carers Bromley continues to make regular safeguarding referrals and have ensured its policies and procedures are current and up-to-date. It always aims to offer a multi-agency approach, focussing on trying to problem solve where possible. Carers Bromley ensures staff are trained regularly and that the organisational focus on safeguarding remains a priority.

Part of its work is enabling carers to protect themselves from the risk of becoming vulnerable, but also equips them to acknowledge and recognise potential risks of stress on them and the person(s) for whom they care.

Lynne Powrie
Chief Executive

Healthwatch Bromley

Healthwatch Bromley is an independent champion for service users and holds commissioners and providers to account for how well they engage with the public. Healthwatch Bromley has engaged with individuals, groups and communities across the Borough through public events, visits, consultations, surveys and social media and shares its findings with the Board as appropriate.

Key Achievements: April 2015–March 2016

- All staff and volunteers have undertaken adult safeguarding training and are able to recognise signs of harm or risk when working with the public, especially during Enter and View visits;
- Enter and View visits were made to six Extra Care Housing Schemes and reports were made to commissioners, providers and CQC.

Margaret Whittington
Trustee

Looking Ahead…

During 2016-2017 the Board will continue a number of actions started in 2015-2016:

- Finalising the Practitioner Toolkit of policies and procedures and further developing the Board website for use by partners, professionals and residents;
- Launching its Strategy 2016-2019 following consultation with service users, carers, professionals and residents of Bromley on its principles and aims;
- Continuing to quality assure partners by holding a Challenge and Support Event for the Council's and health providers' Safeguarding Adults at Risk Audit Tool (SARAT);
- Continuing to work with professionals to ensure that Making Safeguarding Personal is at the fore-front of their practice.

In addition, the Board will undertake the following actions:

- Monitoring the Learning Disability Mortality review which is an outcome of the Mazars review into Southern Health NHS Foundation Trust;
- Focus on the risk of harm of older people from domestic violence;
- Raise awareness of safeguarding in the community through a series of publicity campaigns;
- Continue to raise the risk of scamming and doorstep crime through training of professionals and focus awareness raising on community groups for people with learning disabilities;
- Continue to reduce the occurrence of fire-related harm through partnership working and targeted Home Safety Visits.

Safeguarding Adults Reviews

The Care Act 2014 introduced statutory Safeguarding Adults Reviews (previously known as Serious Case Reviews) and gives Boards the flexibility to choose a proportionate methodology.

The purpose of a SAR must be to learn lessons and improve practice and inter-agency working. It defines the circumstances under which a Board must conduct a SAR as "there is reasonable cause for concern about how the Board, members of it or others worked together to safeguard the adult and death or serious harm arose from actual or suspected abuse." It expects agencies to cooperate with the review but also gives Boards the power to require information from relevant agencies.

The Board may also commission a SAR in other circumstances where it feels it would be useful, including learning from “near misses” and situations where the arrangements worked especially well

There were no Safeguarding Adult Reviews during 2015-16.

Safeguarding Activity and Trends

This section details a range of data to demonstrate safeguarding activity in Bromley from many agencies. The majority of data included is collected by the Council's Performance and Information Team as the lead agency for safeguarding adults, but also includes data from other agencies to demonstrate their commitment to safeguarding adults.

All data is scrutinised and used to inform prevention work and reviews of guidance and policy. Bromley's data collection meets the requirements of the Health and Social Care Information Centre (HSCIC) Safeguarding Adults Collection. HSCIC is the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care.

In this year's data the client group categories have been changed to more closely reflect those used locally.

'Alerts' are expressions of concern that an adult may be at risk of or experiencing abuse or neglect, not all of which need investigating as safeguarding adult referrals.

A 'referral' is the pathway taken to support the person where abuse may occur (or has already occurred).

A 'concluded enquiry' is one where the investigation has been completed in 2015-2016, although the safeguarding investigation may have begun in 2014-2015.

In 2015-16 there was a significant increase in the number of alerts received with the number doubling from 517 to 1,155 which may be a consequence of the Care Act 2014, an increase in police 'Merlins' or better recording procedures. The number of alerts that became referrals has increased over the previous year, but, as a percentage of the number of alerts received, it has decreased which raises questions about the quality of the alerts being received.

Just over half of concluded enquiries related to abuse occurring in a person's own home. Just over half were alleged to have been carried out by someone known to the person. The most common combinations are in the victim's own home by a person known to them (a third), or by a care worker in a care home or the victim's own home (nearly a fifth in each case).

The prevalence of the location of alleged abuse has remained unchanged since last year, with 53% of safeguarding incidents investigated taking place in the person's own home. However, this appears to be part of a downwards trend over three years. An increasing proportion of alleged abuse is taking place in a care home. Nearly a third of concluded enquiries are related to abuse taking place in care homes.

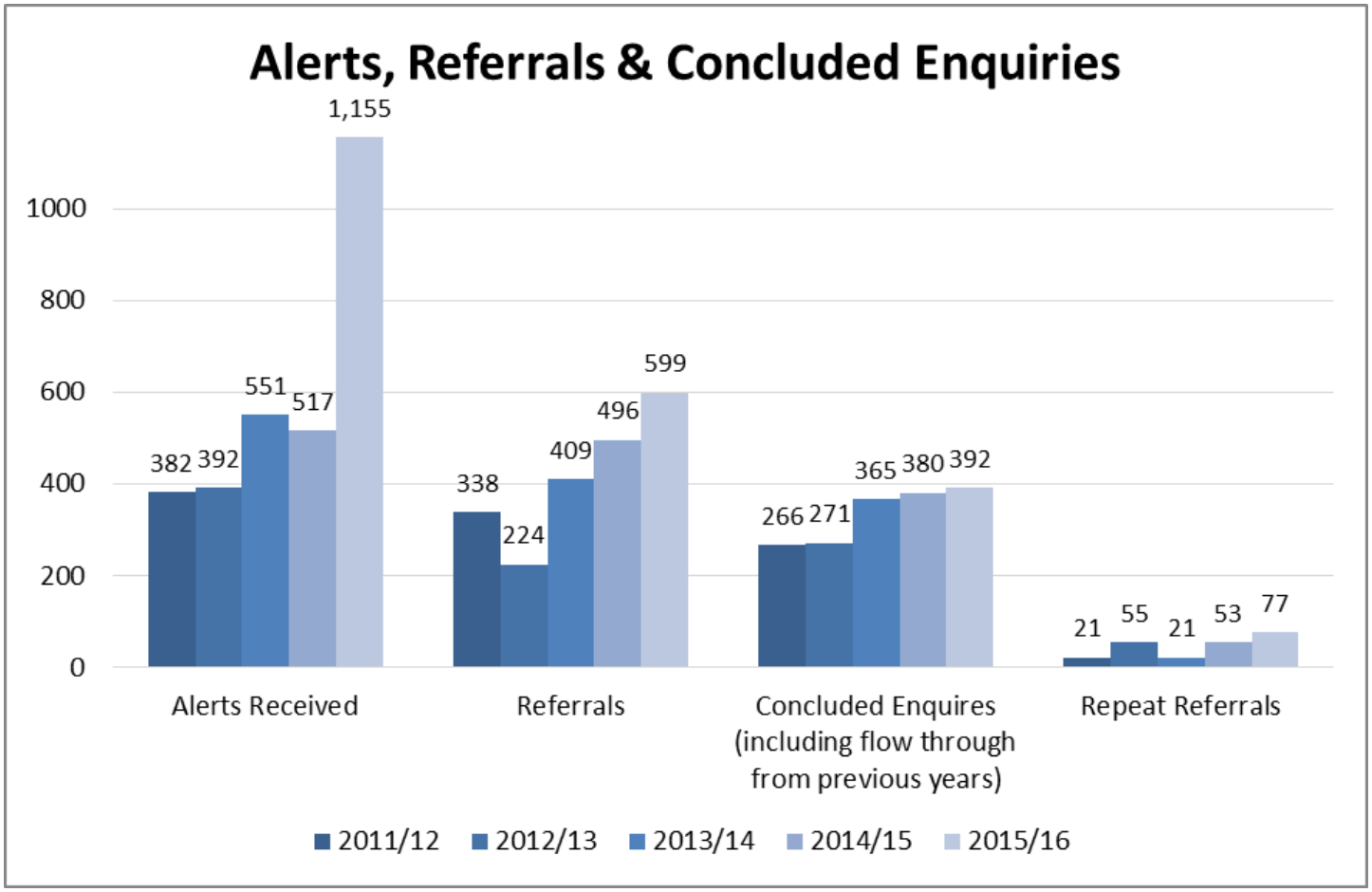
Neglect and failing to provide needed care (referred to as 'acts of omission') as well as physical abuse are the most prevalent types of abuse.

About a third of completed enquiries have the outcome of 'Fully substantiated', whilst a fifth had an outcome of 'Not substantiated' and 'Not investigated'. The percentage of 'Not Substantiated' concluded enquiries shows a fall of 6% over three years. There has been an overall rise in the percentage of cases 'Not being investigated' of 5%. This is possibly due to the threshold tool not having been applied appropriately, and therefore cases were closed after preliminary enquiries.

About one third of allegations against care workers are 'Fully substantiated', whilst a quarter are 'Not substantiated' and just under a fifth are 'Inconclusive'. In those cases where the alleged perpetrator is known to the client, just under a third are 'Fully substantiated' and a fifth

Alerts, Referrals and Concluded Enquiries

Chart 1: Comparison of Alerts, Referrals and Concluded Enquiries 2011-16



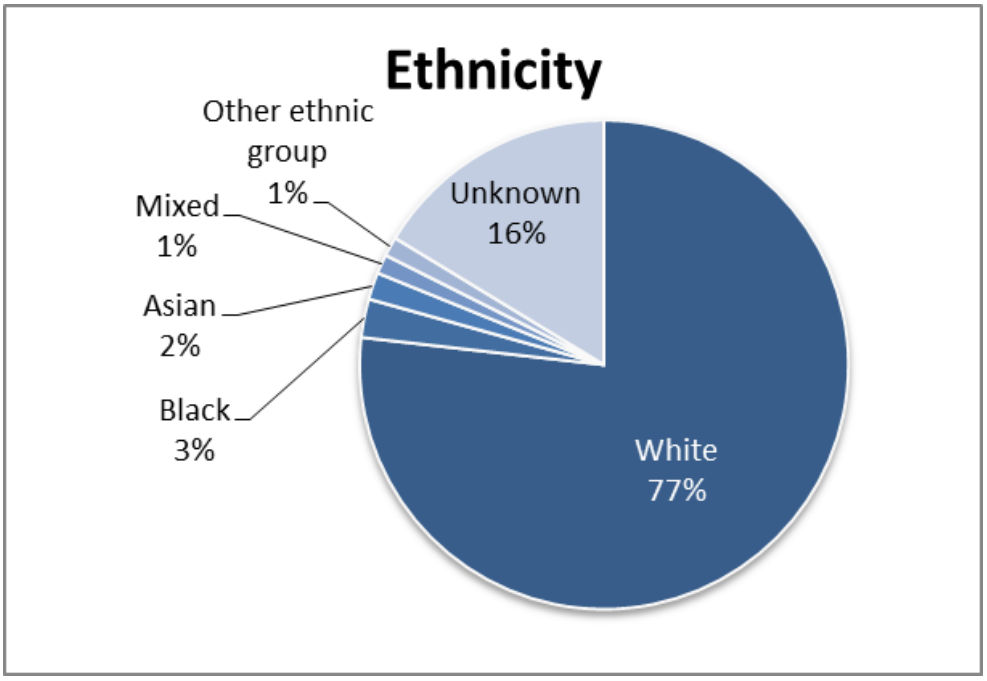
This year has seen a substantial increase in the number of alerts received during 2015-2016 which has more than doubled since 2014-2015. During this year there has been an increase in the number of Police 'Merlin' alerts. These alerts are made when police officers come in contact with a vulnerable adult and there are concerns for their safety. Such alerts are now being recorded more efficiently. The number of referrals has also increased to 599, an increase of 103 over the previous year, presumably as a consequence of the increase in alerts.

Concluded enquiries for 2015-2016 stands at 392, a slight increase on the number from the previous year (380).

Concluded Enquiries

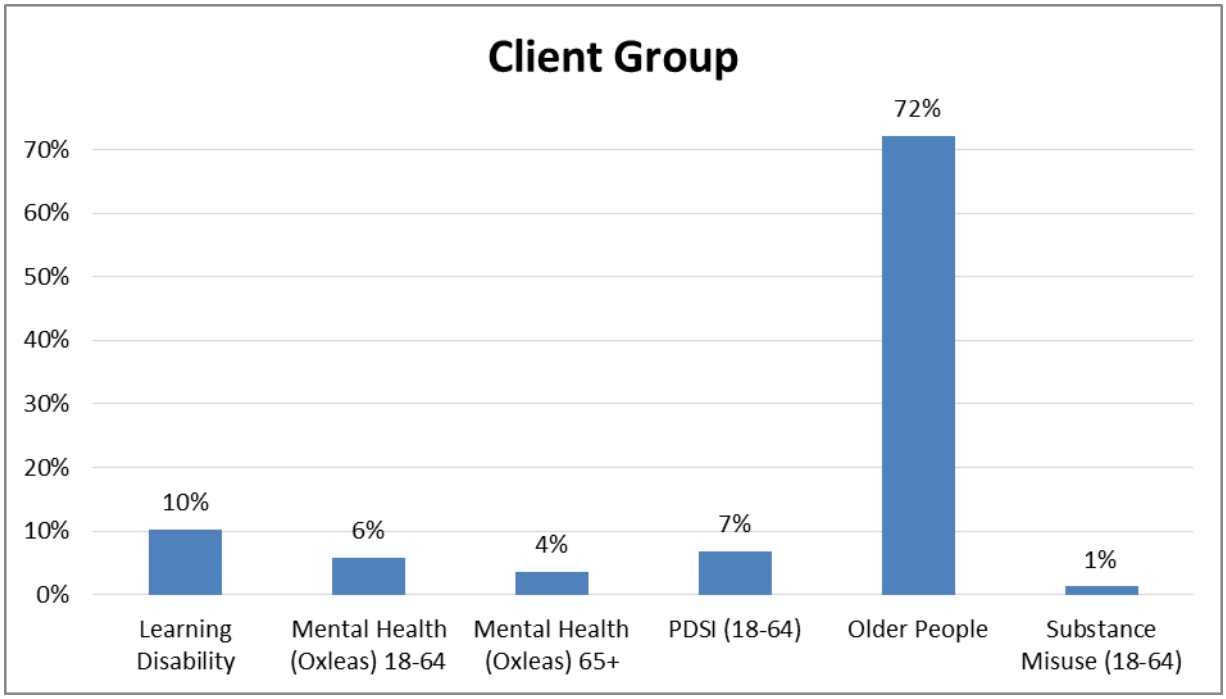
Concluded enquiries reported in this section are those enquiries completed in 2015-2016. They may have been carried over from 2014-2015 or newly begun in 2015-2016.

Chart 2: Concluded Enquiries by Ethnicity 2015-2016



In line with the overall ethnicity in Bromley, the largest number of individuals for whom a concluded enquiry has been carried out are white (77%). This compares to 80% in the previous year. This fall may be due to the increase in individuals for whom there is no recorded ethnicity from 3% in 2014-2015 to 16% in 2015-2016.

Chart 3: Concluded Enquiries by Client Group 2015-2016



The chart above shows quite clearly that the largest percentage of concluded enquiries is for older people (72%). The second highest, people with learning disabilities, is considerably lower at 10%.

Table 3: Concluded Enquiries – Source of Referrals by Age 2015-2016

Source of Referrals	Age Range Of Adults Subject To Abuse		No of Completed Referrals
	18-64	65+	
Care Quality Commission	0	11	11
Day Care Staff	1	4	5
Domiciliary Staff	3	17	20
Education/Training/Workplace Establishment	1	0	1
Family Member	6	27	33
Friend/Neighbour	2	7	9
Housing (including supporting people)	8	5	13
Mental Health Staff	14	12	26
Other (including probation, anonymous, contract staff, MAPPA*, MARAC**)	5	20	25
Other (Social Care Professional)	15	32	47
Police	5	18	23
Primary Health/Community Health Staff	11	63	74
Residential Care Staff***	5	44	49
Secondary Health Staff	3	9	12
Self-Referral	5	3	8
Social Worker/Care Manager	7	27	34
Unknown	0	2	2
Total	**91**	**301**	**392**

* MAPPA – Multi-Agency Public Protection Arrangements

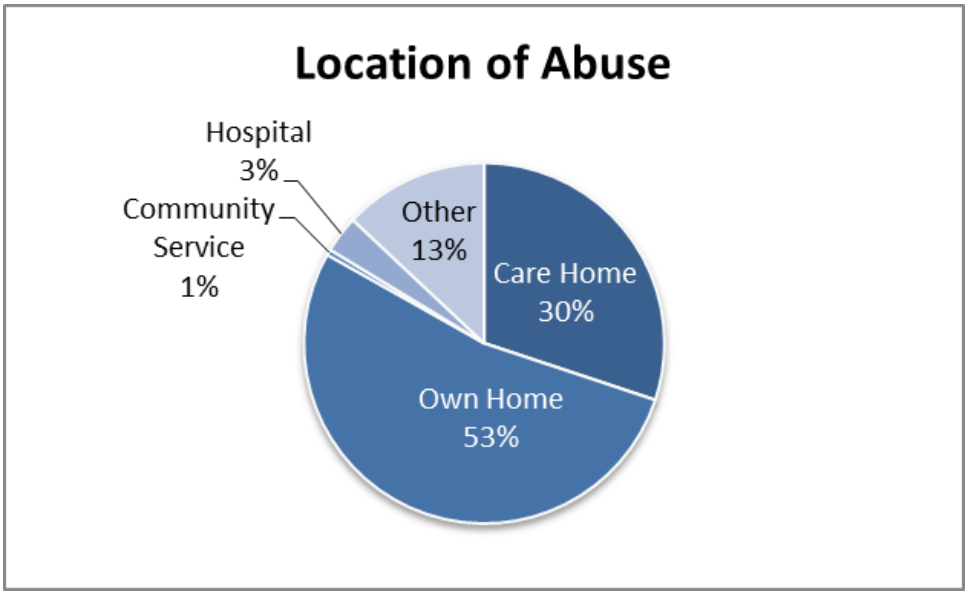
** MARAC - Multi-Agency Risk Assessment Conference (for people at high risk of domestic violence)

*** Residential Care Staff are those working with people who may be in care homes, residential homes or live in supported living ie their own home where staff are present to support them with everyday tasks.

Table 3 shows that there was a wide variety of sources for referrals of concluded enquiries with the greatest number coming from primary and community health professionals (77). This was followed by those from residential care home staff (49) and referrals from other social care professionals (47). Referrals from residential care home staff include concerns about incidents happening before a person entered a care home, between people living in the same home or by visitors as well as incidents caused by staff themselves.

Location of Abuse

Chart 4: Location of Abuse 2015-2016



This chart indicates that for concluded enquiries over half of alleged abuse takes place in a person's own home (53%), whilst 30% are in care homes.

Type of Abuse

Chart 5: Type of Abuse 2015-2016

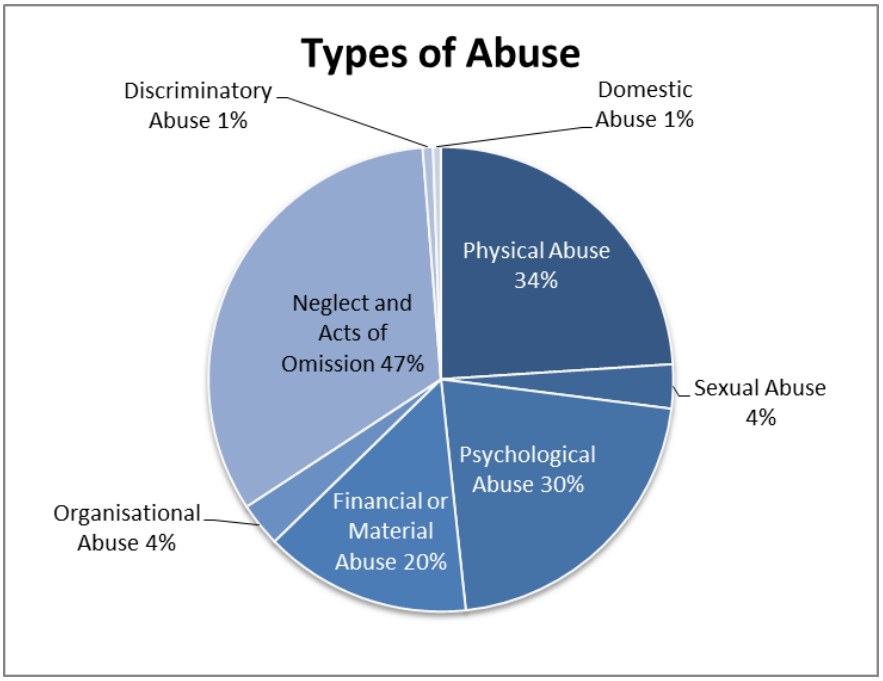
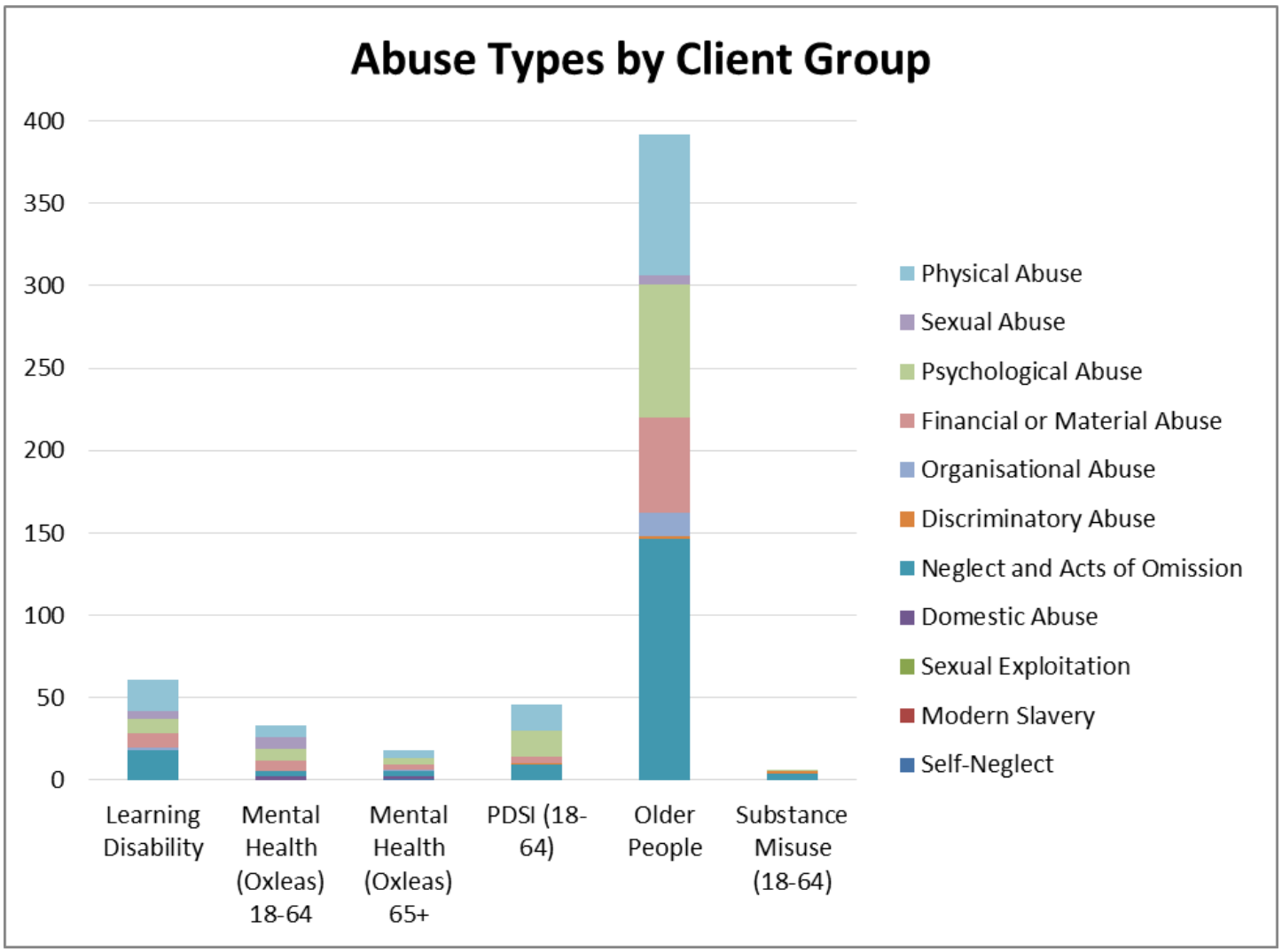


Chart 5 shows the different types of abuse that have been recorded for the concluded enquiries. As there may be more than one type of abuse for each concluded enquiry, figures add up to more than 100%. It shows that nearly half (47%) of people are alleged to be experiencing neglect and acts of omission. This continues the trend that was seen last year when it overtook physical abuse as the most prevalent type of abuse. The second highest is physical abuse (34%) followed by psychological abuse (30%). The other main type of abuse seen in these cases is financial or material abuse (20%).

Other categories of abuse, such as modern day slavery, sexual exploitation and self-neglect have been omitted from the chart as they are registering 0%.

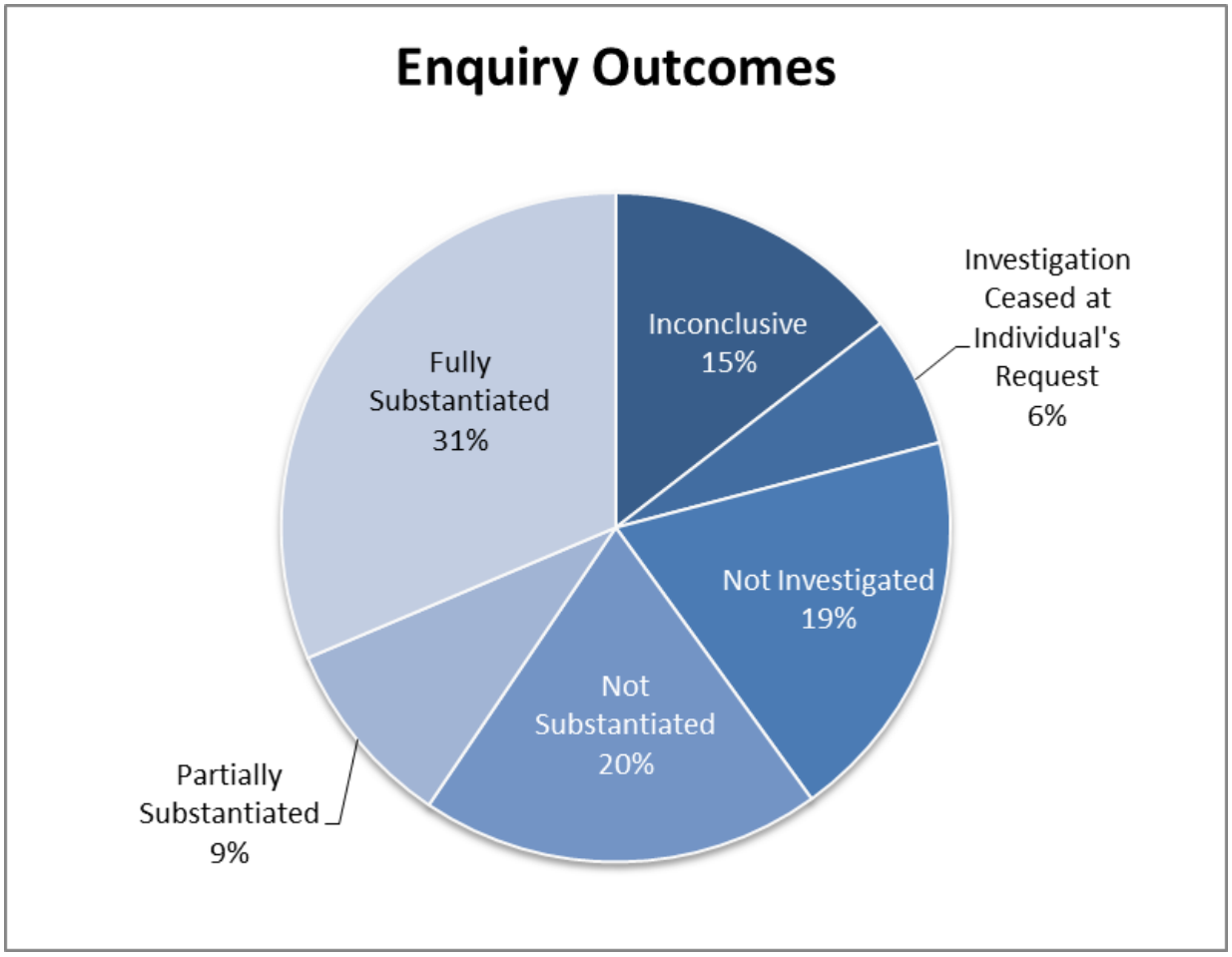
Chart 6: Types of Abuse Experienced by Client Group 2015-2016



From Chart 6 it can be seen that the types of abuse that older people are allegedly subject to are in line with the overall picture. For other client group types there is some variation on this. For people with learning disabilities physical abuse just outweighs neglect and acts of omission. People with physical disabilities and/or sensory impairments have physical and psychological abuse equally as the highest category.

Outcomes of Concluded Enquiries

Chart 7: Enquiry Outcomes 2015-2016



31% of concluded enquiries had an outcome of fully substantiated which continues the overall trend of this category rising over the past two years from 27% in 2013–2014. An additional 9% were partially substantiated in line with previous years. The percentage of those in the not substantiated category has been falling over the past two years and is now down to 20%. However those that have been categorised as not investigated is 19%: this shows an increase since 2013-2014 of 5%.

Person experiencing harm

Table 4: Outcome of Concluded Enquiries for person experiencing harm

Outcomes of Completed investigations	2013/14		2014/15		2015/16		Overall Trends in %
	No.	%	No.	%	No.	%	
Increased Monitoring	54	**15**	78	**21**	59	**15**	⇨
Community Care Assessment & Services	33	**9**	61	**16**	32	**8**	⇩
Application to Court of Protection	3	**1**	3	**1**	0	**0**	⇩
Application to change appointee-ship	2	**1**	3	**1**	2	**1**	⇨
Referral to advocacy scheme	3	**1**	7	**2**	0	**0**	⇩
Referral to counselling/training	7	**2**	14	**4**	9	**2**	⇨
Moved to increase/different care	25	**7**	44	**12**	43	**11**	⇧
Management of access to finances	1	**0**	16	**4**	20	**5**	⇧
Guardianship/use of Mental Health Act	5	**1**	11	**3**	5	**1**	⇨
Restriction/management of access to alleged PACH	13	**4**	18	**5**	15	**4**	⇨
Referral to MARAC	3	**1**	0	**0**	0	**0**	⇩
Other	40	**11**	66	**17**	93	**24**	⇧
No Further Action	162	**44**	233	**61**	261	**67**	⇧
Total Concluded Enquiries	**365**		**380**		**392**		

Table 4 shows both the number and percentage of totals as trends are being compared by percentage. There may be more than one outcome for each concluded enquiry. Where there have been specified outcomes for the person who has experienced harm the most common continue to be 'increased monitoring' over the past three years, followed by 'moved to increased/different care' and 'community care assessment and services'.

Over the past three years there are two categories which have increased overall by more than 3%, these are 'moved to increased/different care' and 'management of access to finances'.

'Other' types of outcome have also been increasing over the past three years. Possibly there are other outcomes which could be categorised individually.

Person alleged to have caused harm

Chart 8: Person alleged to have caused harm 2015-2016

Only 14% of alleged abuse was carried out by someone unknown to the victim. In a third of cases (32%) the abuse was alleged to have been carried out by a professional providing social care, whilst over half (54%) was someone that the victim knew who was not providing care.

Table 5: Person alleged to have caused harm by location of risk 2015-2016

Person alleged to have caused harm	Care Home	Own Home	Community Service	Hospital	Other	Total
Social Care Worker	60	55	1	2	7	**125**
Other - Known to Individual	37	130	1	8	34	**210**
Other - Unknown to Individual	21	23	0	3	10	**57**
Total	118	208	2	13	51	392

The largest combination of person causing harm and location occurs in abuse taking place in the person's home by someone known to them who is not a social care worker – there are 130 individuals in this category. This is followed by harm by a social care professional in both care homes and in the person's own home.

Table 6: Person alleged to have caused harm by type of abuse 2015-2016

Person alleged to have caused harm	Physical Abuse	Sexual Abuse	Psychological Abuse	Financial or Material abuse	Organisational Abuse	Neglect and Acts of Omission	Discriminatory Abuse	Total Cases
Social Care Workers	33	1	23	14	9	84	1	125
Other - Known to Individual	84	12	79	45	4	80	2	210
Other - Unknown to Individual	16	4	16	21	4	19	1	57
Total	133	17	118	80	17	183	4	392

Table 6 shows that the most common type of abuse alleged to have been caused by a social care worker is 'neglect and acts of omission'. There may be more than one type of abuse recorded for each concluded enquiry. For other people known to the victim the types of abuse most commonly alleged are 'physical', 'neglect and acts of omission' and 'psychological' abuse. The most common type of abuse which is alleged to be carried out by strangers is 'financial or material abuse'.

Table 7: Outcomes of concluded enquiries for person alleged to have caused harm – 2014-2016

Outcome for Person Alleged to have caused harm	2014/15		2015/16		Overall Trends
	No.	%	No.	%	
Exoneration	3	**1**	3	**1**	⇨
Action by Care Quality Commission (for registered care providers)	15	**4**	14	**4**	⇨
Action by London Borough Bromley Contract Compliance Team (against care providers in Bromley)	9	**2**	10	**3**	⇧
Action by Commissioning/Placing authority (for care providers in other Boroughs)	6	**2**	3	**1**	⇩
Criminal Prosecution	6	**2**	4	**1**	⇩
Police Action	14	**4**	19	**5**	⇧
Referral to Independent Safeguarding Authority (for paid carers)	3	**1**	5	**1**	⇨
Referral to registration body (for registered professionals such as GPs, Nurses)	4	**1**	5	**1**	⇨
Removal of the PACH from the Property/Service	6	**2**	14	**4**	⇧
Action under Mental Health Act	12	**3**	5	**1**	⇩
Carer's Assessment Offered	17	**4**	14	**4**	⇨
Community Care Assessment and Service	15	**4**	13	**3**	⇩
Counselling/Support/training/treatment provided	19	**5**	21	**5**	⇨
Continued monitoring	50	**13**	62	**16**	⇧
Management Action - Disciplinary, Supervision etc.	22	**6**	31	**8**	⇧
Management of access to Vulnerable Adult	14	**4**	15	**4**	⇨
No Further Action	233	**61**	265	**68**	⇧
Not Known / Not Recorded	31	**8**	0	**0**	-
Total	**380**		**392**		

Table 7 shows both the number and percentage of totals as trends are being compared by percentage. More than one outcome may be recorded for each concluded enquiry. For the person alleged to have caused harm the most common outcome continues to be 'continued monitoring', which has increased over the previous year. All other specified categories have not changed significantly. In over two-thirds of cases (68%) there has been no further action.

Domestic Abuse – Cases reported for over 65's in 2014-2015

The following information shows that 150 domestic abuse cases where the victim was over 65 years were recorded by the MPS in Bromley during 2014-2015. Older victims of domestic violence experience abuse for twice as long as those aged 61 and under and nearly half have a disability.

It shows that the most reported crime is that of Violence against the Person (75%) followed by Criminal Damage (14%). Approximately two-thirds of cases involve people aged 65-74 years (101) and women (91).

Table 8: Types of Domestic Abuse by Age Group and Gender of the Victim

Type of Crime	Age Group						Gender				Total	
	65-74		75-84		85+		Male		Female			
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Burglary	0	**0**	1	**3**	0	**0**	1	**2**	0	**0**	1	**1**
Criminal Damage	16	**16**	5	**13**	0	**0**	12	**20**	9	**10**	21	**14**
Robbery	0	**0**	1	**3**	0	**0**	0	**0**	1	**1**	1	**1**
Sexual Offences	0	**0**	0	**0**	1	**9**	0	**0**	1	**1**	1	**1**
Theft and Handling	7	**7**	5	**13**	2	**18**	4	**7**	10	**11**	14	**9**
Violence Against the	78	**77**	26	**68**	8	**73**	42	**71**	70	**77**	112	**75**
Total	**101**		**38**		**11**		**59**		**91**		**150**	**100**

Blue Light Data

The local police, London Ambulance Service and London Fire Brigade send referrals to London Borough Bromley whenever they find a person who may require support to meet their needs, or where potential abuse has been recognised. Although very few referrals meet the threshold to be opened as a safeguarding enquiry, every referral is followed up by the relevant teams.

Table 9: London Ambulance Service Referrals 2011 - 2016

	2011/12	2012/13	2013/14	2014/15	2015/16
Alerts Received from LAS	353	677	1,152	1,061	503
Alerts Processed as Safeguarding	16	32	27	18	9
Percentage of Alerts Processed as Safeguarding	4.53%	4.73%	2.34%	1.70%	2%

It can be seen that there has been a fluctuation in the number of alerts received from the LAS with a peak between 2013-2015, which reduced again in 2015-2016. This is due to specific work undertaken by the London Boroughs in conjunction with the LAS. However, the percentage of alerts processed as safeguarding over the past three years has remained steady around 2%. This is a decrease on the percentage of alerts processed as safeguarding from 2011-2012 and 2012-2013.

Table 10: Metropolitan Police Service Referrals 2011 - 2016

	2011/12	2012/13	2013/14	2014/15	2015/16
Merlins Received from Police	536	449	893	1,274	2,248
Merlins Processed as Safeguarding	18	20	22	28	17
Percentage of Merlins Processed as Safeguarding	3.36%	4.45%	2.46%	2.20%	1%
Referrals sent from LBB to police public protection	-	-	65	74	39
Percentage of referrals responded to within 3 days	-	-	94%	87%	91%

There has been a significant increase in police referrals over the past four years with over four times as many in 2015-2016 than there were in 2011-2012. These 'Merlin' alerts are made when police officers come in contact with a vulnerable adult and there are concerns for their safety. This system of alerts is the result of a London–wide initiative led by Bromley. However the percentage of referrals which are safeguarding issues has decreased over this time period to 1%.

The number of referrals from the Council to the police has decreased over the past year from the previous two years.

Table 11: London Fire Brigade Referrals 2013-2016

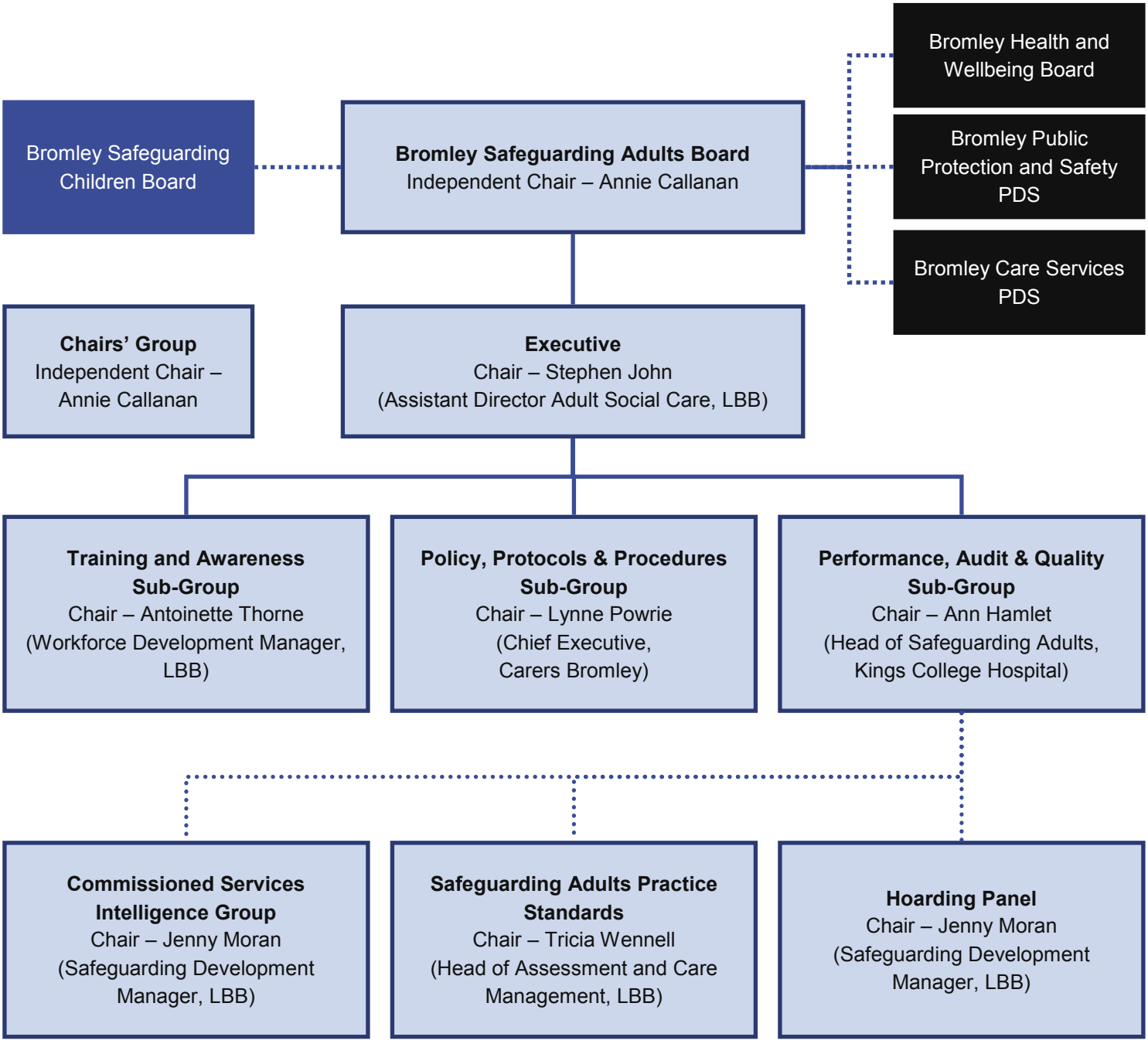
	2013/14	2014/15	2015/16
Home Fire Safety Visits	2,290	3,003	3,161
Home Fire Safety Initiative referrals sent from LBB to LFB	81	125	87
Safeguarding Referrals received from LFB	20	-	43

The London Fire Brigade has worked to increase the number of Home Fire Safety Visits over the past two years as a preventative measure to reduce the number of fires, and possible fatalities, in Bromley. Front-line staff in the Council make referrals to the Fire Brigade if they assess that there may be a fire risk to their clients.

Officers continue to make safeguarding referrals to the Council for individuals they come in contact with and this number has doubled over the past three years. No data is available for 2014/2015.

Appendices

Appendix 1 – Board Structure – March 2016



Appendix 2 - Funding Arrangements

Description	Budget	Expenditure	Variance
Temporary/Agency Staff	0	8,362.15	8,362.15
Training Expenses	31,420	28,526.50	-2,893.50
Training Equipment & Materials	1,500	85.24	-1,414.76
Printing & Stationery	2,500	0.00	-2,500.00
Other Office Expenses	6,000	144.00	-5,856.00
Other Hired & Contracted Services	10,500	10,185.00	-315.00
Agency/Consultancy Fees	8,000	0.00	-8,000.00
Conference Expenses	6,000	4,001.44	-1,998.56
Grants & Subscriptions	100	0.00	-100.00
Publicity	2,500	1,103.88	-1,396.12
Miscellaneous Expenses	20,280	451.29	-19,828.71
Total Planned Expenditure	£88,800	£52,859.50	-£35,940.50
Balance Brought Forward from 13/14	46,300	46,305.65	5.65
Home Office Grant - Community Safety Fund	0	5,000.00	5,000.00
Contribution from Health	20,000	21,000.00	1,000.00
Contribution from Metropolitan Police Service	5,000	5,000.00	0.00
Contributions from Other LBB Departments	12,000	37,000.00	25,000.00
Fees/Charges for Conference	1,500	2,470.00	970.00
Miscellaneous Income	4,000	4,000.00	0.00
Total Planned Income	£88,800	£120,775.65	£31,975.65
Balance Carried Forward to 16/17		£67,916.15	

Appendix 3 - Membership of the Board

Bromley Safeguarding Adults Board		
Name	**Organisation**	**Job Title**
Annie Callanan		Independent Chair
LEAD STATUTORY PARTNERS		
Stephen John	London Borough of Bromley	Primary Social Worker Asst Director – Adult Social Care
Sonia Colwill	Bromley Clinical Commissioning Group	Director of Governance, Quality and Patient Safety
Dave Yarranton	Metropolitan Police Service	Detective Chief Inspector
STATUTORY PARTNER MEMBERS		
Claire Lewin	Bromley Clinical Commissioning Group	Designated Nurse, Adult Safeguarding
Aileen Stamate	London Borough of Bromley	Quality Assurance Manager
Jenny Moran	London Borough of Bromley	Adult Safeguarding Development Manager
Antoinette Thorne	London Borough of Bromley	Workforce Development Manager
Tricia Wennell	London Borough of Bromley	Head of Assessment and Care Management
Paula Morrison	London Borough of Bromley	Assistant Director, Public Health
Rob Vale	London Borough of Bromley	Head of Trading Standards & Community Safety
Sara Bowrey	London Borough of Bromley	Head of Housing Needs
Claire Elcombe-Webber	London Borough of Bromley	Domestic Abuse Strategy Co-ordinator
PARTNER MEMBERS		
Ann Hamlet	Kings College Hospital NHS Foundation Trust	Head of Safeguarding Adults
Natalie Warman	Bromley Healthcare	Director of Nursing, Therapies and Quality Assurance
Amanda Mayo	Bromley Healthcare	Lead Nurse Adult Safeguarding
Daniel Cartwright	London Fire Brigade	Bromley Borough Fire Commander
Peter Curtin	London Fire Brigade	Station Manager, Bromley Fire Station
Darren Farmer	London Ambulance Service	Local Safeguarding Lead
Barbara Godfrey	Oxleas NHS Foundation Trust	Head of Social Care
Helen Jones	Oxleas NHS Foundation Trust	Service Manager for Older Adults
Segun Oladokun	Care Quality Commission	Head of Inspection, London South Care Quality Commission
Cllr Robert Evans	London Borough of Bromley	Portfolio Holder, Care Services
Cllr David Jefferys	London Borough of Bromley	Chair, Health and Wellbeing Board

Cont'd on next page

VOLUNTARY SECTOR MEMBERS		
Derec Craig	Victim Support	Senior Service Delivery Manager
Maureen Falloon	Age UK Bromley & Greenwich	Chief Executive
Eddie Lynch	Bromley Mencap	Chief Executive
Lynne Powrie	Carers Bromley	Chief Executive
Dominic Parkinson	Bromley and Lewisham Mind	Adult Services Manager
Elaine Gardiner	Kent Association for the Blind	Service Team Leader
Margaret Whittington	Bromley Healthwatch	Trustee - Healthwatch Board
PRIVATE SECTOR MEMBERS		
Rosemarie Duncan	Caremark	Representative - Domiciliary Care Forum
Izabela Szluinska	Antokol Care Home	Representative - Care Home Provider Forum
Ann Hinds	Ashcroft Nursing Home	Representative - Care Home Provider Forum
Susan Clinton	Affinity Sutton	Representing Registered Social Landlords
Ruth Sheridan	St Christopher's Hospice	Director of Supportive Care
TBC	Local Medical Council	Representing General Practitioners
Gary Stephen	BMI Healthcare	Director of Clinical Services

Bromley Safeguarding Adults Board

Civic Centre, Stockwell Close, Bromley, BR1 3UH

https://bromley.mylifeportal.co.uk/bsab

Home Office

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London SW1P 4DF
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Department of Health

Secretary of State for Health
Richmond House
79 Whitehall
SW1A 2NS
Follow us on Twitter @DHgovuk

TO:
Chairs of Health and Wellbeing Boards
Chief Constables
Police and Crime Commissioners

15 November 2016

Dear All

Police and Crime Commissioners and Health and Wellbeing Boards

We are writing to highlight and support some of the important benefits that can be realised through closer collaboration between policing and health partners.

The interface between crime and public health is well-documented – in the Department of Health's public health outcomes framework, for example, which contains a number of indicators that recognise the links, including: entry to the youth justice system, people in prison with a mental illness, domestic abuse, violent crime, re-offending, drug treatment outcomes and perception of community safety.

In many areas of the country, police and health and care partners, in both the NHS and Local Government, are working collaboratively to deliver better outcomes for individuals, including the most vulnerable and local communities and there is potential for further joint working. For example, local authorities, the NHS and the police are required members of Safeguarding Adult Boards which help ensure a collaborative, inter-agency approach to the responses and prevention of abuse or neglect.

In addition, many health and wellbeing boards already include amongst their membership either their Police and Crime Commissioner (PCC) or representatives from their local police force or criminal justice agencies. This has enabled boards to take a broader strategic view of their area beyond health and social care, and through Joint Strategic Needs Assessments (JSNAs) provides boards with the opportunity to better understand the nature of public needs and demands on local services – which can in turn influence local commissioning strategies.

There are already a number of areas where greater collaboration has had positive outcomes including:

- Every area in England is now working to implement their local Mental Health Crisis Care Concordat action plans, involving NHS services, police forces and local authorities, and many of these local partnerships are using their Boards to ratify their plans and support progress. Local action plans and other helpful information on the Concordat can be found here: http://www.crisiscareconcordat.org.uk/

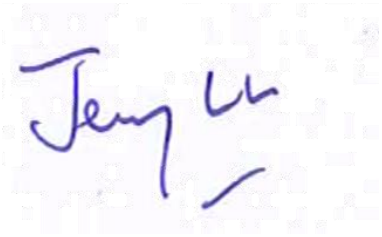
- In addition, around 30 police forces now have some form of street triage in operation. These models, often jointly commissioned by the PCC and Clinical Commissioning Groups, ensure mental health nurses staff support and advise police officers in their responses to people in mental health crisis. In some forces mental health workers and police officers provide joint responses in the community; in others mental health professionals work in emergency call centres in order to provide real time advice and support to frontline officers. The evaluation of nine initial pilot sites evidenced that the schemes contributed towards large reductions in the use of police custody as a place of safety for those vulnerable people detained under section 136 of the Mental Health Act.

- Around 25 police forces operate a drug intervention initiative which involves policing and health partners working together to identify, assess and refer users into appropriate treatment pathways. Investment in treatment is proven to reduce reoffending, with every £1 spent saving £2.50 for the Criminal Justice System, and with access to treatment reducing the impact of wider health harms including the spread of blood borne viruses and drug related mortality.

- A recent Home Office and Public Health England initiative in Middlesbrough brought together senior partners in policing, health and probation to consider the impact of heroin misusing offenders in their area and the wider implications this was having on individuals and the community. This has galvanised further collaborative working, including the development of a joint strategy to address their local needs and consider opportunities for developing a multi-agency commissioning approach for treatment services.

- The first phase of the local alcohol action areas programme, which ran until March 2015, saw police and health partners work closely together to reduce a range of alcohol-related harms. For example, Gravesham began a one-year pilot of a Make Every Adult Matter approach to street drinkers. An operational group is led by the area's alcohol and drug treatment provider with members including the police, third sector organisations, primary care providers, Jobcentre Plus and the Prison Service. Early indications are that the project is working well and that links between partner agencies are much improved and that better coordinated services for individuals with multiple needs are emerging. Invitations to apply to take part in the second phase of the programme were sent to PCCs, chief constables and all local authorities in England and Wales last month. The programme will begin in January and will again encourage active partnerships between local agencies to reduce alcohol harms.

Given the benefits outlined above, and the pressures on health and care services and police forces, we would like to ask Health and Wellbeing Boards and PCCs to consider how they can better work together by ensuring appropriate representation from both sectors on Health and Wellbeing Boards.



The Rt Hon Amber Rudd MP

The Rt Hon Jeremy Hunt MP

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CSD16160

London Borough of Bromley

Decision Maker:	**HEALTH AND WELL BEING BOARD**
Date:	**1st December 2016**
Decision Type:	Non Urgent Non-Executive Non-Key
Title:	**Health and Wellbeing Board Matters Arising and Work Programme**
Contact Officer:	Stephen Wood, Democratic Services Officer Tel: 0208 313 4316 E-mail Stephen.wood@bromley.gov.uk
Chief Officer:	Mark Bowen, Director of Corporate Services
Ward:	N/A

1. Reason for report

1.1 Board Members are asked to review the Health and Wellbeing Board's current Work Programme and to consider progress on matters arising from previous meetings of the Board.

1.2 The Action List (Matters Arising) and Glossary of Terms are attached.

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2. RECOMMENDATION

2.1 The Board is asked to review its Work Programme and progress on matters arising from previous meetings.

2.2 The Board is asked to consider what items (if any) need to be removed from "Outstanding Items for Possible Consideration".

2.3 The Board is encouraged to suggest new items for the Work Programme and for the next meeting.

Non-Applicable Sections:	Policy/Financial/Legal/Personnel
Background Documents:	Previous matters arising reports and minutes of meetings.

Corporate Policy

1. Policy Status: Existing Policy:

2. BBB Priority: Excellent Council; Supporting our Children and Young People; Supporting Independence; Healthy Bromley

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Financial

1. Cost of proposal: No Cost for providing this report

2. Ongoing costs: N/A

3. Budget head/performance centre: Democratic Services

4. Total current budget for this head: **£335,590**

5. Source of funding: 2015/16 revenue budget

Staff

1. Number of staff (current and additional): There are 8 posts (7.27) in the Democratic Services Team

2. If from existing staff resources, number of staff hours: Maintaining the Board's work programme takes less than an hour per meeting

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Legal

1. Legal Requirement: Matters Arising and the Work Programme should be actioned in accordance with statutory obligations.

2. Call-in: Not Applicable

Customer Impact

1. Estimated number of users/beneficiaries (current and projected): This report is intended primarily for Members of the Health and Well Being Board.

Ward Councillor Views

1. Have Ward Councillors been asked for comments? No

2. Summary of Ward Councillors comments: N/A

3. COMMENTARY

3.1 The Matters Arising table is attached at **Appendix 1.** This report updates Members on matters arising from previous meetings which are ongoing.

3.2 The current Work Programme is attached as **Appendix 2.** The Work Programme is fluid and evolving. Meetings are scheduled so that generally speaking they will be held approximately two weeks after CCG Board meetings which will facilitate more current feedback from the CCG to the HWB.

In approving the Work Programme members of the Board will need to be satisfied that priority issues are being addressed, in line with the priorities set out in the Board's Health and Wellbeing Strategy and Terms of Reference which were approved by Council in April 2013.

3.4 The Chairman proposes to reduce the frequency of Board meetings, given the establishment of Task and Finish Groups around Health & Wellbeing priorities and the related work and time commitment to attend meetings for all Board Members in between.

3.5 For Information, **Appendix 3** shows dates of Meetings and report deadline dates.

3.6 For Information, **Appendix 4** outlines the Constitution of the Health and Well Being Board.

3.7 **Appendix 5** is the updated Glossary.

APPENDIX 1

Health and Wellbeing Board

Matters Arising/Action List

Agenda Item	Action	Officer	Notes	Status
Minute 65 02/06/16 **HWB Strategy Update**	Resolved that the existing HWB Strategy be maintained for the present time, and that the Strategy be reviewed after fresh JSNA data is available.	**Dr Lemic and Dr Marossy**	The HWB Strategy will be updated in due course. It needs to be decided at which meeting the matter will be reviewed.	**Ongoing**
Minute 65 02/06/16 **HWB Strategy**	Resolved that the issue of Falls be discussed at a future meeting.	**TBC**	Speaker to be identified and asked to attend a future meeting to update the Board.	**Ongoing**
Minute 79 06/10/16 **Health and Social Care Integration Update**	Resolved that the ICN update be noted and that a further update be brought to the next meeting of the Board, which would include an update on the development of the Frailty Unit.	**Dr Bhan**	Item has been added to the December Agenda	**New**

Appendix 2

HEALTH AND WELLBEING BOARD
WORK PROGRAMME 2015/16

Title	Notes
Health and Wellbeing Board—December 1st 2016	
ICN and Frailty Unit Update	Mark Cheung
Primary Care Co-Commissioning Update	Mark Cheung
Work Programme and Matters Arising	Steve Wood
JSNA Update Report	Agnes Marossy
Phlebotomy Update	Mark Cheung or Dr Parson
Elective Orthopaedic Centres	Mark Cheung or Dr Parson
Healthwatch Inequalities Report	Healthwatch-Linda Gabriel
Other Business	N/A
Letter from Home Office and DoH concerning Police and Crime Commissioners and Health and Wellbeing Boards	For consideration
Quarter 2 BCF Update	Jackie Goad
Winter Plan System Performance	Lorna Blackwood (report for noting)
Bromley Safeguarding Adults Annual Report-2015-2016	Annie Callanan (report for noting)
Health and Wellbeing Board—February 2nd 2017	
ICN and Frailty Unit Update	Dr Bhan/Mark Cheung
Update from Mental Health Sub Group	Harvey Guntrip
Work Programme and Matters Arising	Steve Wood
Revised HWB Strategy	Dr Lemic
Phlebotomy Update	Dr Bhan
Elective Orthopaedic Centres	Dr Bhan or Dr Parson
GP Access	Dr Bhan
Other Business	
Development of the Transfer of Care Bureau	Dr Bhan
Bromley Safeguarding Adults Annual report-2015-2016	(For Discussion) Annie Callan
Primary Care Commissioning Update	Dr Bhan
IRIS System (TBC)	
CAHMS Co-Production Report	
Review of the General Practice Forward View Document and the role of HWBs in developing partnerships between primary care and wider local services.	Jessica Arnold
Health and Wellbeing Board—30th March 2017	
ICN and Frailty Unit Update	Dr Bhan
Update from Mental Health Sub Group	Harvey Guntrip
Work Programme and Matters Arising	Steve Wood
Phlebotomy Update	Dr Bhan
Elective Orthopaedic Centres	Dr Bhan or Dr Parson
Other Business	
TOCB Developments	
Primary Care Commissioning Update	

Outstanding Items for Possible Consideration:
IMPOWER to feed back to the Board concerning Health and Social Care Integration in Manchester
Promoting Exercise
NHS Self-Care Programme

Falls
Monitoring of Dementia Hubs
Health and Social Care Integration and the Self-Assessment Tool
Presentation from Community Links
Mental Health Strategy Document (From the Mental Health Sub Group)
BSCB Action Plan Update (subsequent to Ofsted Report)
Results of 'Mock' CQC Inspection of CCG
Update on Bromley Third Sector Enterprise
Healthwatch Annual Report for 2016-2017
Healthwatch Project to Explore Sexual Health and Gender Identity
MOU between BSCB and the LBB Adult Safeguarding Board
CAMHS Transformation Plans
Asylum Seekers
Ofsted Report Action Plan
End of Life Care
Annual Updates on the CAMHS Transformation Plan

Appendix 3

Dates of Meetings and Report Deadline Dates

The Agenda for meetings MUST be published five clear days before the meeting. Agendas are only dispatched on a Tuesday.

Report Deadlines are the final date by which the report can be submitted to Democratic Services. Report Authors will need to ensure that their report has been signed off by the relevant chief officers before submission.

Date of Meeting	Report Deadline	Agenda Published
1st December 2016	November 22nd 1.00pm	November 23rd 2016
2nd February 2017	January 24th 1.00pm	January 25th 2017
30th March 2017	March 21st 1.00pm	March 22nd 2017

A link to the agenda is emailed to the Board on the publication date. Hard copies are available on request.

Questions
Questions from members of the public to the meeting will be referred directly to the relevant policy development and scrutiny (PDS) committee of the Council, or to other meetings as appropriate, at the next available opportunity unless they relate directly to the work of the Board.

A list of the questions and answers will be appended to the corresponding minutes.

Minutes
The minutes are drafted as soon as possible after the meeting has finished. They are then sent to officers for checking. Once any amendments have been made, they are sent to the Chairman, and once he has cleared them, they are sent, in draft format, to Members of the board. Please note that this process can take up to two weeks.

The draft minutes are then incorporated on the agenda for the following meeting and are confirmed. Following this approval they are published on the web.

London Borough of Bromley

Constitution

Health & Wellbeing Board

(11 Elected Members, including one representative from each of the two Opposition Parties; the two statutory Chief Officers (without voting rights); two representatives from the Clinical Commissioning Group (with voting rights); a Health Watch representative (with voting rights) and a representative from the Voluntary Sector (with voting rights). The Chairman of the Board will be an Elected Member appointed by the Leader. The quorum is one-third of Members of the Board providing that elected Members represent at least one half of those present. Substitution is permitted. Other members without voting rights can be co-opted as necessary.

1. Providing borough-wide strategic leadership to public health, health commissioning and adults and children's social care commissioning, acting as a focal point for determining and agreeing health and wellbeing outcomes and resolving any related conflicts.

2. Commissioning and publishing the Joint Strategic Needs Assessment (JSNA) under the Health and Social Care Act.

3. Commissioning and publishing a Joint Health & Wellbeing Strategy (JHWS) – a high level strategic plan that identifies, from the JSNA and the national outcomes frameworks, needs and priority outcomes across the local population, which it will expect to see, reflected in local commissioning plans.

4. Receiving the annual CCG commissioning plan for comment, with the reserved powers to refer the CCG commissioning plan to the NHS Commissioning Board should it not address sufficiently the priorities given by the JSNA.

5. Holding to account all areas of the Council, and other stakeholders as appropriate, to ensure their annual plans reflect the priorities identified within the JSNA.

6. Supporting joint commissioning and pooled budget arrangements where it is agreed by the Board that this is appropriate.

7. Promoting integration and joint working in health and social care across the borough.

8. Involving users and the public, including to communicate and explain the JHWS to local organisations and residents.

9. Monitor the outcomes and goals set out in the JHWS and use its authority to ensure that the public health, health commissioning and adults and children's commissioning and delivery plans of member organisations accurately reflect the Strategy and are integrated across the Borough.

10. Undertaking and overseeing mandatory duties on behalf of the Secretary of State for Health and given to Health and Wellbeing Boards as required by Parliament.

11. Other such functions as may be delegated to the Board by the Council or Executive as appropriate.

Appendix 5

GLOSSARY:

Glossary of Abbreviations – Health & Wellbeing Board

Acute Treatment Unit	(ATU)
Antiretroviral therapy	(ART)
Any Qualified Provider	(AQP)
Autistic Spectrum Disorders	(ASD)
Behaviour, Attitude, Skills and Knowledge	(BASK)
Better Care Fund	(BCF)
Black African	(BA)
Body Mass Index	(BMI)
British HIV Association	(BHIVA)
Bromley Clinical Commissioning Group	(BCCG)
Bromley Safeguarding Children Board	(BSCB)
Cardiovascular Disease	(CVD)
Care Programme Approach	(CPA)
Care Quality Commission	(CQC)
Children & Adolescent Mental Health Service	(CAMHS)
Child Sexual Exploitation	(CSE)
Chlamydia Testing Activity Dataset	(CTAD)
Clinical Commissioning Group	(CCG)
Clinical Decision Unit	(CDU)
Clinical Executive Group	(CEG)
Clinical Leadership Groups	(CLG)
Common Assessment Framework	(CAF)
Community Learning Disability Team	(CLDT)
Community Psychological Services	(CPS)
Delayed Transfer of Care	(DTOC)
Director of Adult Social Services	(DASS)
Director of Children's Services	(DCS)
Disability Discrimination Act 1995	(DDA)
Dispensing Appliance Contractors	(DAC)
Emergency Hormonal Contraception	(EHC)
Essential Small Pharmacy Local Pharmaceutical Services	(ESPLPS)
Female Genital Mutilation	(FGM)
Florence – telehealth system using SMS messaging	(FLO)

Health & Wellbeing Board	(HWB)
Health & Wellbeing Strategy	(HWS)
Health of the Nation Outcome Scales	(HoNOS)
Hypertension Action Group	(HAG)
Improving Access to Psychological Therapies programme	(IAPT)
In Depth Review	(IDR)
Integrated Care Network	(ICN)
Integration Transformation Fund	(ITF)
Intensive Support Unit	(ISU)
Joint Health & Wellbeing Strategy	(JHWS)
Joint Integrated Commissioning Executive	(JICE)
Joint Strategic Needs Assessment	(JSNA)
Kings College Hospital	(KCH)
Local Medical Committee	(LMC)
Local Pharmaceutical Committee	(LPC)
Local Pharmaceutical Services	(LPS)
Local Safeguarding Children's Boards	(LSCB)
Long Acting Reversible Contraception	(LARC)
Mental Health Champion	(MHC)
Multi Agency Planning	(MAP)
Medicines Adherence Support Service	(MASS)
Medicines Adherence Support Team	(MAST)
Medium Super Output Areas	(MSOAs)
Men infected through sex with men	(MSM)
Mother to child transmission	(MTCT)
Multi-Agency Safeguarding Hubs	(MASH)
Multi-Agency Sexual Exploitation	(MASE)
National Chlamydia Screening Programme	(NCSP)
National Institute for Clinical Excellence	(NICE)
Nicotine Replacement Therapies	(NRT)
National Reporting and Learning Service	(NRLS)
Nucleic acid amplification tests	(NATTS)
Patient Liaison Officer	(PLO)
People living with HIV	(PLHIV)
Pharmaceutical Needs Assessment	(PNA)
Policy Development & Scrutiny committee	(PDS)

Primary Care Trust	(PCT)
Princess Royal University Hospital	(PRUH)
Proactive Management of Integrated Services for the Elderly	(ProMISE)
Public Health England	(PHE)
Public Health Outcome Framework	(PHOF)
Quality and Outcomes Framework	(QOF)
Quality, Innovation, Productivity and Prevention programme	(QIPP)
Queen Mary's, Sidcup	(QMS)
Secure Treatment Unit	(STU)
Serious Case Review	(SCR)
Sex and Relationship Education	(SRE)
Sexually transmitted infections	(STIs)
South London Healthcare Trust	(SLHT)
Special Educational Needs	(SEN)
Summary Care Record	(SCR)
Supported Improvement Adviser	(SIA)
Sustainability and Transformation Plans	(STP)
Tailored Dispensing Service	(TDS)
Unitary Tract Infections	(UTI)
Urgent Care Centre	(UCC)
Voluntary Sector Strategic network	(VSSN)
Winterbourne View Joint Improvement Programme	(WVJIP)

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