# Meeting of the Health and Adult Social Care Scrutiny Committee

**Wednesday 21st November, 2018 at 6.00pm**
**In Committee Room 2 at the Council House, Priory Road, Dudley**

## Agenda - Public Session

**(Meeting open to the public and press)**

1. Apologies for absence.

2. To report the appointment of any substitute members serving for this meeting of the Committee.

3. To receive any declarations of interest under the Members' Code of Conduct.

4. To confirm and sign the minutes of the meeting held on 25th September, 2018 as a correct record.

5. Public Forum

6. Medium Term Financial Strategy (Pages 1 - 23)

7. Dudley Safeguarding Adults Board Annual Report 2017/18 and Deprivation of Liberty Safeguards (Pages 24 - 47)

8. Quality of Maternity Care in Dudley (Pages 48 - 74)

9. The Development of Dudley Group Foundation Trust Strategy for 2019-2021 (Pages 75 - 78)

10. Clinical Commissioning Group Policy on NHS Continuing Healthcare (Pages 79 - 108)

11. Feedback from the Health and Adult Social Care Scrutiny Committee (Scrutiny Development) Working Groups (Pages 109 - 111)

12. To consider any questions from Members to the Chair where two clear days notice has been given to the Monitoring Officer (Council Procedure Rule 11.8).

**Chief Executive**
**Dated: 13th November, 2018**

**Distribution:**

**Members of the Health and Adult Social Care Scrutiny Committee**:
Councillor M Mottram (Chair)
Councillor P Miller (Vice-Chair)
Councillors J Baines, R Body, B Gentle, A Goddard, A Hopwood, L Johnson, C Perks, H Rogers and D Stanley; P Bradbury (Co-opted Member)

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# Minutes of the Health and Adult Social Care Scrutiny Committee

## Tuesday 25th September, 2018 at 6.00 p.m.
## in Committee Room 2 at the Council House, Dudley

**Present**:

Councillor M Mottram (Chair)
Councillor P Miller (Vice-Chair)
Councillors J Baines, R Body, B Gentle, A Goddard, A Hopwood, C Perks and D Stanley; P Bradbury (Co-opted Member)

**Dudley MBC Officers**

M Samuels – Strategic Director People, M Bowsher – Chief Officer Adult and Social Care, D Harkins – Chief Officer Health and Wellbeing (People Directorate) and H Shepherd – Democratic Services Officer (Chief Executive's Directorate)

**Also in Attendance**

Dudley Clinical Commissioning Group (CCG): L Broster, C Brunt and M Hartland
Dudley Group NHS Trust: J Dietrich, J Hobbs and D Wake (Agenda Item No. 6)
Sustainability and Transformation Partnership: Dr H Hibbs and J Fellows (Agenda Item No. 7)

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13 **Apology for Absence**

An apology for absence from the meeting was submitted on behalf of Councillor J Martin.

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14 **Declarations of Interest**

No member made a declaration of interest in accordance with the Members' Code of Conduct.

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15 **Minutes**

**Resolved**

That the minutes of the meeting held on 23rd July, 2018, be approved as a correct record and signed.

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16 **Public Forum**

No issues were raised under this agenda item.

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17 **The Dudley Group NHS Foundation Trust's Emergency Department Quality Improvement Update**

The Committee received a report of the Chief Executive (The Dudley Group NHS Foundation Trust) on the Quality Improvement Journey within the Emergency Department following the Care Quality Commission rating of inadequate in January, 2018.

The Chief Executive (The Dudley Group NHS Foundation Trust) was in attendance at the meeting and provided Members with an update position following the publication of the report submitted. It was emphasised that the Emergency Department formed only part of the whole Care Quality Commission inspection and although it was recognised that this service had been rated as inadequate, there were a number of other service areas that were performing well and had been rated 'Good'.

The Committee noted that the Care Quality Commission had undertaken further inspections of the Emergency Department in March and August, 2018 and it was anticipated that the latest findings would be reported and published in October, 2018. The Chief Executive (The Dudley Group NHS Foundation Trust) reassured Members that the Trust were committed in improving the service and quality of care provided to patients.

The key areas identified for improvement by the Care Quality Commission and the steps that had been taken by the Trust to alleviate concerns were referred to in detail.

In responding to a question raised by a Member with regards to the failings in recognising and in the treatment for patients with Sepsis, the Chief Executive (The Dudley Group NHS Foundation Trust) stated that there had been a national drive in raising awareness of Sepsis as it was recognised that early detection saved lives. It was noted that Sepsis 6, the national adopted tool for monitoring screening and treatment of patients, was fully implemented and the hospital was fully compliant. Members welcomed the improvements made in diagnosing and treating Sepsis, but were extremely concerned that this had not been addressed in subsequent years.

Arising from a question raised by a Member, the Chief Executive (The Dudley Group NHS Foundation Trust) confirmed that the Care Quality Commission inspections were conducted unannounced and at different times of the day.

In response to a question raised concerning the trajectory improvement for the triage service, it was confirmed that both the quality of care and time performance would be measured, in accordance with set parameters for each category. The Chief Executive (The Dudley Group NHS Foundation Trust) advised that the Emergency Care Improvement Support Team had provided support and had worked closely with the Emergency Department during August and would continue to provide support for three days a week over a six month period to help develop a safer, faster and better care for patients. It was also stated that Dudley NHS Trust had been 'buddied' with The Royal Wolverhampton NHS Trust to look at different pathways of care and to share best practices.

Members expressed concerns in respect to the poor and inadequate care that had been provided to patients previously, but commented positively on the interventions that had been actioned to date and fully supported the continued commitment for service improvement.

**Resolved**

(1) That the information contained in the report submitted and presented at the meeting in respect of the Quality Improvement Journey within the Emergency Department following the Care Quality Commission rating of inadequate in January, 2018, be noted.

(2) That a further report providing an update on the progress of improvements and development at the hospital be submitted to the Scrutiny Committee in six months.

(3) That a copy of the presentation slides to be circulated to all Members of the Health and Adult Social Care Scrutiny Committee, by the Democratic Services Officer.

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18 **The Black Country and West Birmingham Sustainability and Transformation Partnership**

The Scrutiny Committee received a presentation on the Black Country and West Birmingham Sustainability and Transformation Partnership.

Arising from the presentation and in response to a question raised it was confirmed that the geographical area referred to as West Birmingham consisted of the catchment area for Birmingham City Hospital rather than the Local Authority boundary.

In responding to a further question raised the Senior Responsible Officer stated that the Sustainability and Transformation Plan had been operational since 2015, however it was considered by some, that progress had been slow and therefore partners were now working more closely together to provide place based integrated care systems and overall stability in finances and quality improvement.

A member expressed concern in the lack of patient and community engagement in the development of the partnership. Reassurance was provided that community engagement would be undertaken and Health Watch organisations would be contacted shortly to promote the partnership.

**Resolved**

That the information contained in the presentation on the Black Country and West Birmingham Sustainability and Transformation Partnership, be noted.

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19 **Update on the Multi-Specialty Community Provider (MCP)**

A report of the Strategic Director People was submitted to provide Scrutiny Committee Members with an update on the process of commissioning and establishing Dudley Multi-Specialty Community Provider (MCP) and to highlight the next steps and timescales.

The Chief Officer Health and Wellbeing presented the report in detail, referring Members to paragraphs of specific importance.

In referring to the robust Integrated Support and Assurance Process that consisted of four stages, the Chief Officer Health and Wellbeing commented that early engagement and check point 1 had been completed. Emphasis was needed to evidence that Check point 2, which would identify that procurement had been conducted properly, was accomplished. It was anticipated that this would be submitted in November 2018 and Legal advisers were confident that this would work in the Council's best interest.

Reference was made to the need for the MCP organisation to be a single purpose vehicle and that it was intended that the Dudley Group NHS Foundation Trust be separated to create two organisations, namely the Dudley Multi-Specialty Community Provider Foundation Trust and the Dudley Acute Foundation Trust.

The three main components of the transition process for the development and creation of Dudley MCP were referred to and it was noted that the procurement of the MCP would be overseen by the MCP Procurement Board of which representatives of Dudley Council would be Members. A further Board would be established to oversee the creation of the MCP, to be known as the MCP transition Board and a Partnership Board would be established to continue the development of the care model. A Chair of the new MCP organisation would need to be appointed, together with the development of a constitution, all of which were still under discussion.

Following the presentation of the report and in response to a question raised by a Member with regard to the Transfer of Undertakings Protection of Employment (TUPE) of staff, the Chief Officer Health and Wellbeing advised that Dudley employees would not directly be affected by TUPE, but that staff employed within service providers that were moved into the MCP Organisation could be, if the service was not sub-contracted.

In response to a question raised, the Strategic Director People confirmed that the Section 75 agreement would allow the NHS and the Council to undertake obligatory statutory functions jointly and to pull budgets together.

Arising from a question raised it was stated that the CCG would not be a service provider within the MCP but would continue to operate as a commissioner.

Arising from concerns raised by Members in regard to the purposed ICP Contract period, reassurance was provided that the contract could be terminated at any time should the organisation not meet the required outcomes. It was emphasised that the MCP would not privatise the NHS and care services, but that it enabled services to be provided under different governance arrangements, and that there was no risk of going bankrupt or any financial risk for the Council.

**Resolved**

(1) That the information contained in the report on the progress with the development of the Dudley Multi-Specialty Community Provider, be noted.

(2) That a further update be provided to the Scrutiny Committee later in the municipal year.

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20 **Mental Health Services and the Mental Health Investment Standard**

The Scrutiny Committee considered a report on how the Dudley Clinical Commissioning Group had invested in mental health and how it met the national Mental Health Investment Standard.

Members commented positively on the information reported and the continued promotion in raising awareness of mental health issues and services within the community.

**Resolved**

That the information contained in the report on how Dudley Clinical Commissioning Group had invested in mental health and how it met the national Mental Health Investment Standard, be noted.

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The meeting ended at 7.55 p.m.

CHAIR

Dudley Metropolitan Borough Council

**Agenda Item No. 6**

**Meeting of the Health and Adult Social Care Scrutiny Committee – 21st November 2018**

**Joint Report of the Chief Executive, Chief Officer Finance and Legal Services, and Strategic Director People**

# Medium Term Financial Strategy

## Purpose

1. To consult the Scrutiny Committee on the Medium Term Financial Strategy (MTFS) to 2021/22, with emphasis on those proposals relating to the committee's terms of reference. For this committee the relevant items are those relating to Health and Adult Social Care within the People Directorate in paragraphs 29 and 30, and Appendices C and D, and the Public Health budget in paragraphs 31-33. Members may also wish to consider any of the proposals in terms of their wider impact on health and wellbeing.

## Recommendation

2. That the Committee considers and comments on the Cabinet's proposals for the Medium Term Financial Strategy to 2021/22, taking into account the considerations set out in paragraph 45.

## Background

3. At its meeting on 25th October, the Cabinet considered a preliminary Medium Term Financial Strategy to 2021/22 for further consultation, including consultation with Scrutiny Committees, in accordance with the Constitution.

4. In framing their responses to these budget proposals, Scrutiny Committees were asked to consider both the spending and funding implications (including the impact on Council Tax) of any observations they may wish to make.

5. Scrutiny Committees are considering these matters between 13th November and 21st November with an emphasis on proposals falling within the Terms of Reference of each Committee. A verbal summary of their deliberations will be given to the Overview and Scrutiny Management Board on 28th November.

6. The Council approved the General Fund budget for 2018/19 and the MTFS to 2020/21 on 26th February 2018. A report on the 2017/18 outturn was considered by Cabinet on 27th June 2018.

   External Audit

7. The External Auditors (Grant Thornton) presented their Audit Findings Report to the Audit and Standards Committee on 25th July 2018. They gave an unqualified (i.e. favourable) opinion on the Financial Statements for 2017/18.

8. As regards their Value for Money opinion, they recognised an improvement in the Council's position compared to the position at the time of their previous audit. They considered that this was sufficient to remove their previous qualification (i.e. their previous adverse opinion) in respect of financial sustainability. However, in giving this opinion, they noted that risks remain in relation to the Council's financial position. They recommended improvements to the way in which the Council scrutinises delivery of savings and recommended that attention be given to growing the income base, both through careful consideration of the level of Council Tax increases and income generation opportunities.[1]

Forecast 2018/19 Position

9. The Council started the year with a low level of revenue reserves. As at 31st March 2018 unringfenced revenue reserves as a proportion of the net revenue budget were 25% (compared with the national average of 40%). The original budget for 2018/19 was set at a level that would further reduce general reserves by £7.4m. Forecast variances compared with budget are shown in Appendix A and summarised below:

- The People Directorate is forecast to spend in line with its budget by the end of the financial year. However, there are continued pressures within Children's Services offset by forecast underspending in Adult Social Care and Health and Wellbeing.

- The People Directorate is experiencing pressure on the High Needs Block arising from a significant increase in the number of children and young people for whom an Education, Health and Care Plan (EHCP) is appropriate and who require additional support to attend school. This reflects a national trend. Every effort is being made to address this pressure through robust assessment processes for EHCPs, development of the capacity of mainstream schools to support students with additional needs, and redirection of funding from mainstream education into the High Needs Block. This pressure sits within the Dedicated Schools Grant and as such is not included in Appendix A.

- The Place Directorate is forecast to overspend by £0.6m by the end of the financial year. There are pressures in Environmental Services and Regeneration and Enterprise, partially offset by a forecast underspend in Housing.

- The Chief Executive's directorate is forecasting a favourable variance of £0.4m as a result of additional income from recovery of benefit overpayments and vacancies.

- Treasury / Corporate savings of £0.2m are anticipated mainly as a result of slippage in the capital programme.

- Funding adjustments have resulted in extra net income of £0.2m

[1] The External Auditors retained their previous Value for Money qualification in respect of the 2016 OFSTED inspection of Children's Services. While they noted improvements in this area, this qualification will remain in place unless and until OFSTED remove the rating of "inadequate" through a full re-inspection.

10. The current budget for 2018/19 includes £0.5m provision for severance costs to deliver staff savings for 2019/20. This has been reviewed in the light of previous trends and the proportion of proposed savings likely to come from staffing reductions and it is considered prudent to retain this provision at this stage.

11. Progress with delivery of specific savings within the 2018/19 budget is set out in Appendix B. Performance on delivery of savings supports and is consistent with the forecast 2018/19 position outlined above and in Appendix A.

General Fund Balances

12. The latest forecast General Fund Balances position, compared to the original Approved Budget for 2018/19 is therefore as follows:

| | **Original Budget £m** | **Latest Position £m** |
|---|---|---|
| Forecast balance at 31st March 2018 | 25.0 | 25.0 |
| 2017/18 outturn (as reported to Cabinet in June) | | +1.6 |
| **Balance at 31st March 2018** | **25.0** | **26.6** |
| Planned use 2018/19 approved by Council in February | -7.4 | -7.4 |
| Forecast 2018/19 outturn (para 9 and Appendix A) | | +0.2 |
| **Forecast balance at 31st March 2019** | **17.6** | **19.4** |

13. While this is an improvement on the original budget, it shows a low level of reserves in the light of the financial challenges that the Council faces. Directorates will make every effort – through spending restraint, generation of additional income and review of earmarked reserves – to improve on the position set out above.

Medium Term Financial Strategy to 2021/22

14. In updating the Council's Medium Term Financial Strategy, Members will need to consider carefully:

(a) the levels of Government support allocated to the Council;

(b) spending pressures, opportunities to free up resources (including savings), and Council Plan priorities;

(c) the implications of spending levels in later years as part of the Council's medium term financial plan;

(d) the views of consultees;

(e) the external factors and risks inherent in the Strategy;

(f) the impact on Council Tax payers.

(g) the potential impacts on people with protected characteristics as defined in the Equality Act 2010. Members will need to have due regard to the public sector equality duty under the Equality Act 2010. (Further details are set out in the Equality Impact section below.)

Government Funding

15. The 2016/17 Local Government Finance Settlement included indicative figures up to 2019/20, together with an offer to enter into agreement with individual councils to give a guaranteed minimum level of funding[2] up to 2019/20 subject to having an efficiency plan for the period. The Government subsequently accepted our expression of interest in such a guarantee, which is reflected in the forecasts below.

16. During 2017/18 MHCLG identified an error in their calculation of Section 31 Business Rates grant arising from the introduction of the 100% Business Rate retention pilot. Correction of this error has resulted in a reduction in grant income of around £0.5m in 2019/20 compared with previous forecasts.

17. The Government is undertaking a Fair Funding review of the entire system of local government finance to operate from 2020/21 onwards. At this point there have been no specific announcements about how this will work or about the underlying level of funding that Dudley will receive under any new system. We have prudently assumed that the new arrangements will bring to an end to the technical benefits that Dudley receives from being part of the 100% Business Rate retention pilot. In all other respects, we have rolled forward our forecast on the basis that the underlying impact of any new system is neutral. This is noted as a significant area of uncertainty (with the potential to be either negative or positive) and will be kept under close review.

Council Tax

18. Latest forecasts indicate:

- a break even Collection Fund position for the current year, resulting mainly from fewer than anticipated new home completions and an increase in single person discounts, offset by a reduction in Council Tax Reduction (CTR) claimant numbers;
- no overall net change in future income, as a result of an anticipated ongoing reduction in CTR claimant numbers offsetting the impact of new home completions continuing to be fewer than previously forecast.

The position will continue to be monitored closely and any updated forecasts reported to Cabinet in February

19. The Rating (Property in Common Occupation) and Council Tax (Empty Dwellings) Bill, when passed, will enable the Council to increase the “Empty Homes Premium”, thereby increasing the council tax payable on properties that have been empty for more than two years as follows:

- from 1st April 2019 for properties which have been empty for between two and five years a premium of up to 100%, resulting in a 200% council tax charge;
- from 1st April 2020 for properties which have been empty for between five and ten years a premium of up to 200%, resulting in a 300% council tax charge;
- from 1st April 2021 for properties which have been empty for ten years or more a premium of up to 300%, resulting in a 400% council tax charge.

[2] Underlying values of Revenue Support Grant and Top-Up Grant, recognising necessary amendments to reflect changes such as business rate uplifts and revaluation, or moves to 100% business rate retention including local pilots.

The implications for Dudley will be considered, and proposals will be brought forward in due course, subject to the Bill being enacted.

20. No changes are proposed to the Council Tax Reduction (CTR) scheme for 2019/20. Cabinet agreed to recommend to Council continue to document the scheme in such a manner that any personal allowances, premiums, disregards and non-dependent deductions are automatically linked to equivalent annually up-rated values published by central government in either Housing Benefit Legislation or the prescribed Council Tax Reduction Scheme for pensioners (including any other miscellaneous amendments to the aforementioned legislation that are relevant to our local scheme). The Council may wish to consider further scheme changes next year or in subsequent years. By documenting the scheme in the proposed way, it will not need further public consultation or re-approval until such time that further scheme changes are considered.

21. The Government has consulted on technical issues relating to the 2019/20 settlement. These include proposed Council Tax referendum principles for 2019/20 in line with those set in 2018/19 – i.e. a core limit of less than 3% plus an Adult Social Care (ASC) precept increase of up to 2% (provided that precept increases do not exceed 6% between 2017/18 and 2019/20). As Dudley has already used 4.5% of the 6% ASC flexibility, this would mean a limit for 2019/20 of less than 3% core plus 1.5% ASC, i.e. less than 4.5% in total. It should be noted that these are the proposed general principles and are subject to the monitoring of individual authorities and their use of the ASC precept.

Business Rates

22. The original budget for 2018/19 was set against the background of ongoing uncertainty concerning the impact of the 2017 revaluation on our business rate and grant income. We face considerable uncertainty arising from:

- The impact of appeals following the revaluation and the introduction of the new "Check, Challenge, Appeal" process - we are continuing, as are other councils who face the same uncertainty, to make financial provision in line with national government assumptions about the ultimate impact of appeals.
- The extensive re-profiling of high value retail space in the Borough and delays in notification from the Valuation Office Agency about the impact on rates payable.

23. Latest forecasts indicate:

- a Collection Fund deficit at 31st March 2019 of £2.6m (to be charged to the General Fund in 2019/20), resulting mainly from reductions in gross rates payable and increases in reliefs in the current and previous years, being partially offset by increased Section 31 grant income of £1.0m which will be carried forward into 2019/20 as a reserve;
- an ongoing net reduction in underlying income of £0.6m per year for the same reasons.

The position will continue to be monitored closely (in particular the emerging impact of appeals) and any updated forecasts reported to Cabinet in February.

Combined Authority

24. The West Midlands Combined Authority (CA) receives three elements of funding via the constituent authorities as follows:

- The Transport Levy to fund its transport functions, allocated by statute on a population basis.
- Real terms growth in the central share of business rates from 2016/17 onwards to fund its regeneration activities, under the terms of the Devolution Deal.
- A further contribution to fund its non-transport functions currently allocated by agreement partly on a population basis and partly by equal shares.

25. For 2017/18 onwards, the 100% retention pilot gave effect to the Devolution Deal by allowing authorities to retain all business rate growth, including that in the former central share. Measurement of real terms business rates growth, and therefore the amounts due to the Combined Authority, has proved to be particularly difficult as a result of the impact of the 2017 revaluation and uncertainty about the impact of appeals. As an interim solution for 2017/18, the seven constituent authorities made a total contribution from business rate income of £3m (as estimated in the Devolution Deal), shared on the basis of Rateable Values, meaning a Dudley contribution of around £0.3m.

26. In the absence of any realistic alternative, the 2018/19 budget assumed that this arrangement would be continued for 2018/19 with Dudley's contribution being around £0.4m of a total £4.5m. Likewise the MTFS assumes this arrangement will be ongoing, with similar annual increases in line with the estimated Devolution Deal income. Council in February 2018 authorised the Chief Officer, Finance and Legal Services in consultation with the Cabinet Member for Finance and Legal Services to agree final details and make payment to the CA in respect of the contribution for 2018/19 and future years on this basis, subject to all authorities agreeing to contribute likewise.

27. We are awaiting further details from the CA in terms of its proposals for the Transport Levy and funding requirement for its non-transport budget (both currently forecast to be the same as 2018/19, adjusted for the small "one off" element of the 2018/19 Levy). Further details will be reported to Cabinet in February.

Base Budget Forecasts

28. The Base Budget reflects the impact on spending of forecast inflation and other anticipated changes, before directorate spending pressures or savings proposals are taken into account. Details are as follows.

| | **2019/20 £m** | **2020/21 £m** | **2021/22 £m** |
|---|---|---|---|
| 2018/19 base | 238.1 | 238.1 | 238.1 |
| Pay *(note 1)* | 3.1 | 5.5 | 7.9 |
| General price inflation *(note 2)* | - | - | 3.4 |
| Transport Levy *(see para 27)* | -0.1 | -0.1 | -0.1 |
| Income uplift (*note 3*) | -1.3 | -2.6 | -3.9 |
| Pensions *(note 4)* | 0.6 | 2.8 | 3.0 |
| Combined Authority *(see para 26)* | 0.2 | 0.3 | 0.4 |
| Treasury *(note 5)* | 1.6 | 2.4 | 2.9 |
| Fallout of one-off 2018/19 Adult Social Care pressures, and spending funded from the Supplementary Improved Better Care Fund | -3.8 | -6.0 | -6.0 |
| Other adjustments *(note 6)* | - | 0.2 | -0.9 |
| **Base Budget Forecast** | **238.4** | **240.6** | **244.8** |

Notes:

(1) The above figures allow for an overall 2.6% increase in 2019/20 in line with the national agreement with the unions, which includes a minimum increase of 2%, larger increases on the lower pay points to comply with the National Living Wage, and assimilation to a new pay spine. We have estimated further average increases of 2% in each of 2020/21 and 2021/22.
(2) Following several years of making no provision for general price increases on non-pay budgets, it is considered prudent to provide for non-pay inflation from 2021/22 in line with Government forecasts.
(3) Assumes an increase of 2% per year on fees and charges.
(4) Reflects the uplift in pension contributions agreed up to 2019/20 following the last triennial valuation in 2016. The funding level and contribution requirements from 2020/21 will be reviewed again in 2019; we have currently forecast 2020/21 contributions on the basis of no underlying changes arising from that review.
(5) Impact of Capital Programme, treasury management and investment income changes, including recommencing making full Minimum Revenue Provision (MRP) for repayment of debt from 2019/20 as required following the review of MRP Policy in 2015/16
(6) Enterprise Zone funding requirements, non treasury impact of Leisure Centre Strategy, and other minor adjustments.

Spending Pressures

29. Spending pressures provided for are as follows. These are detailed in Appendix C.

| | 2019/20 £m | 2020/21 £m | 2021/22 £m |
|---|---|---|---|
| People | 3.4 | 5.3 | 5.3 |
| Place | 1.2 | 1.5 | 1.7 |
| Chief Executive's | 0.4 | 0.4 | 0.4 |
| **Total** | **5.0** | **7.2** | **7.4** |

Savings

30. In total the following saving proposals have been identified as the basis for scrutiny and consultation. Details are set out in Appendix D.

| | 2019/20 £m | 2020/21 £m | 2021/22 £m |
|---|---|---|---|
| People | 3.9 | 4.9 | 5.4 |
| Place | 0.4 | 0.4 | 0.4 |
| Chief Executive's | 0.3 | 0.3 | 0.3 |
| **Total** | **4.6** | **5.6** | **6.1** |

Public Health

31. The Chancellor's Autumn statement in 2016 confirmed that for 2019/20 the indicative cash reduction in Public Health Grant (PHG) will be 2.6%, and it has been assumed that this rate of reduction will continue in 2020/21 and 2021/22, although grant allocations have not yet been confirmed. It is also possible that the ring-fence will be removed (and Public Health Grant merged into general sources of funding) as part of the overall review of Council funding expected to be implemented from 2020/21. As agreed at 26 July 2018 Cabinet, £11m of Public Health Grant contracts will form part of the Multi Speciality Community Provider (MCP).

32. Headroom between base budget forecasts and expected PHG allocations can be used to fund services that are currently funded by the General Fund. Areas of such expenditure have been identified to a value of £0.425m per year and these are included in the People Directorate savings proposals shown above. These have been reviewed by the Chief Officer (Health and Wellbeing) to ensure that they meet the grant criteria, in that they have a positive impact on the health of people in Dudley Borough.

33. The overall forecast position for the Public Health Grant funded budget can be summarised as follows:

| | 2019/20 £m | 2020/21 £m | 2021/22 £m |
|---|---|---|---|
| Base budget forecast | 19.8 | 19.3 | 18.8 |
| One-off spending plans | 1.4 | 0.9 | 0.0 |
| Existing General Fund services | 0.4 | 0.4 | 0.4 |
| **Total spend** | **21.6** | **20.6** | **19.2** |
| Forecast grant | 20.2 | 19.7 | 19.2 |
| **Deficit** | **1.4** | **0.9** | **0.0** |
| Reserve brought forward | 2.3 | 0.9 | 0.0 |
| **Reserve carried forward** | **0.9** | **0.0** | **0.0** |

Human Resource Implications

34. Redundancy costs required to achieve the proposed savings, including those relating to pension strain, are dependent on the proportion of savings to be met from staffing reductions and the age and length of service of the individuals being made redundant, and therefore cannot be precisely calculated at this stage. It is considered that the provision of £0.5m in the current year (see paragraph 10) should be sufficient to cover the costs of any redundancies necessary to achieve the savings proposed in this report.

35. Cabinet agreed to recommend to Council the delegation for approval of voluntary and compulsory redundancies to the Cabinet Member for Procurement, Transformation and Commercialisation and the Chief Officer for Transformation and Performance up to the maximum provided for in the budget forecasts for direct redundancy costs and the capitalised cost of pension strain in respect of redundancies.

Medium Term Financial Strategy

36. The MTFS reflecting the revised spending proposals set out above, and forecasts of likely resource availability can be summarised as follows.

| | 2019/20 £m | 2020/21 £m | 2021/22 £m |
|---|---|---|---|
| **Base Budget Forecast** - see para 28 | 238.4 | 240.6 | 244.8 |
| **Pressures** - see para 29 | 5.0 | 7.2 | 7.4 |
| **Savings** - see para 30 | -4.6 | -5.6 | -6.1 |
| **Total Service Spend** | **238.8** | **242.2** | **246.1** |
| | | | |
| Retained Business Rates | 86.7 | 88.9 | 91.0 |
| Tariff | -6.0 | -8.1 | -8.3 |
| Business Rate Grant | 11.5 | 10.9 | 11.5 |
| New Homes Bonus | 2.7 | 2.7 | 2.7 |
| Improved Better Care Fund (iBCF) | 12.4 | 12.4 | 12.4 |
| Supplementary iBCF (SiBCF) | 2.2 | - | - |
| Collection Fund – Council Tax | - | - | - |
| Collection Fund Deficit – Business Rates | -2.6 | - | - |
| Council Tax | 122.5 | 127.3 | 132.3 |
| **Total Resources** | **229.4** | **234.1** | **241.6** |
| | | | |
| **Deficit funded from Balances** | **9.4** | **8.1** | **4.5** |
| Balances brought forward | 19.4 | 10.0 | 1.9 |
| **Balances carried forward** | **10.0** | **1.9** | **n/a** |

37. The table above assumes that Council Tax increases by 4.49% in 2019/20 (including the Social Care Precept), and 2.99% in both 2020/21 and 2021/22. Based on current referendum limits, this would not require a referendum in accordance with Chapter 4ZA of Part 1 of the Local Government Finance Act 1992. However, it should be noted that these referendum limits are subject to Government monitoring of our use of the Adult Social Care Precept.

38. Based on the forecasts, pressures and savings proposals set out above, we are forecasting deficits in all future years. While these deficits can be met from reserves for the next few years, this is unsustainable in the longer term and members should also note the significant risks and uncertainties listed in paragraph 40 below and elsewhere in this report. There is therefore a need to identify further savings and/or additional income in order to ensure that prudent balances are maintained.

39. Work is ongoing to challenge all service areas to identify further savings over and above those proposed in this report, in particular from digital transformation, review of business support, improvements to procurement and increasing commercial income. We are also looking to the Combined Authority to support us in improving transport links and driving economic growth, thus increasing Council Tax and Business Rates income.

Estimates, Assumptions & Risk Analysis

40. The proposals in this report are based on a number of estimates, assumptions and professional judgements, which are subject to continuous review:

(a) pay inflation does not vary materially from current forecasts;

(b) the underlying impact of the Fair Funding review of local government finance from 2020/21 is neutral;

(c) income from Business Rates (net of appeals etc.) including grant in respect of the EZ will be in line with current forecasts;

(d) the cost of Council Tax Reduction awarded will not substantially exceed forecasts, and the tax base will continue to grow as anticipated;

(e) The pressure on the High Needs Block is met from within the Dedicated Schools Grant;

(f) cash limited non-pay budgets will be managed so as to absorb any price inflation not specifically provided for in 2019/20 and 2020/21 and any inflationary pressures in 2021/22 will be no more than the amount provided for;

(g) income and expenditure relating to treasury management activity are in line with forecasts;

(h) there will be no other unplanned expenditure (including any resulting from demographic, legislative or case law pressures) or shortfalls in income, which cannot be met from reserves;

(i) there will be no changes to government policy on maximum underlying Council Tax increases without the need for a referendum, and the general referendum principles will apply to Dudley's increases in Council Tax (including the Adult Social Care Precept) as set out in paragraphs 21 and 37;

(j) Improved Better Care Funding (iBCF) is unfettered and received directly by the Council as anticipated and will continue into 2020/21 and 2021/22;

(k) the Adult Social Care market is able to absorb National Living Wage pressures within the proposed provision;

(l) there will be no underlying change in the level of employers' pension contributions in 2020/21.

41. The assumptions set out above are subject to uncertainty and in some cases this uncertainty is significant. Actual outcomes may be more positive or more negative than the forecasts set out in this report. In the event that outcomes are more negative, it may become necessary to take urgent action to reduce levels of expenditure or increase income. In this respect, the uncertainty about the outcomes of the Fair Funding review is particularly significant.

Consultation

42. Following the high profile and extensive Big Question budget consultations held over the previous five years more than 16,000 residents have taken part to have their say. Through this engagement, a significant number of residents are now subscribed to the council's e-bulletin service and to minimise costs, for the last three years, the consultation has been carried out predominantly online through the e-bulletin service, website and social media. Hard copy, printed versions have also been made available in borough libraries and Dudley Council Plus and consultation has been conducted through existing community networks such as the Children and Young People's Alliance. It is proposed to continue to consult through all of these channels. Scrutiny committee meetings will also be held during the consultation period which will run through November, December and January.

43. Detailed consultation will also be undertaken with groups identified as being potentially affected by the specific savings proposals, with a particular emphasis on equalities issues. Further information is set out in the Equality Impact section below.

44. A consultation document will be distributed to representatives of Non-Domestic Ratepayers setting out the provisional budget proposals in this report. Consultees will be offered the opportunity for a meeting to be held if there is sufficient interest. Further detailed information (as required in pursuance of the statutory duty to consult) will be distributed in February for comment before the Council Tax setting meeting.

45. In accordance with the Council's Constitution, the Scrutiny Committees are being asked to consider the issues set out in this report and any related specific issues relevant to their Council Plan and service responsibilities. For this committee the relevant items are those relating to the People Directorate in paragraphs 29 and 30, and Appendices C and D and the Public Health budget in paragraphs 31-33. Members may also wish to consider any of the proposals in terms of their wider impact on health and wellbeing. Senior Management will be available at the meeting to address any queries. In framing their responses, the Scrutiny Committees are being asked to consider both the spending and funding implications (including the impact on Council Tax) of any observations they may wish to make.

## Finance

46. This report is financial in nature and relevant information is contained within the body of the report.

## Law

47. The Council's budget setting process is governed by the Local Government Finance Acts 1988,1992, and 2012 and the Local Government Act 2003.

48. The Local Government Act 2003 requires the Chief Financial Officer to report on the robustness of estimates made for the purpose of final budget calculations, and the adequacy of the proposed financial reserves and this will be included in the final budget report.

49. The Localism Act 2011 introduced a new chapter into the Local Government Finance Act 1992 making provision for council tax referendums to be held if an authority increases its council tax by an amount exceeding principles determined by the Secretary of State and agreed by the House of Commons.

50. The Local Government (Early Termination of Employment) (Discretionary Compensation) (England and Wales) Regulations 2006 are designed to enable a local authority to compensate employees whose employment terminates on grounds of redundancy or in the interests of the efficient exercise of the authority's functions. Any local arrangements in place must also be compliant with the Employment Rights Act 1996 and the Equality Act 2010.

## Equality Impact

51. Section 149 of the Equality Act 2010 - the general public sector equality duty - requires public authorities, including the Council, to have due regard to the need to:
- eliminate discrimination, harassment and victimisation and other conduct that is prohibited by the Act;
- advance equality of opportunity between people who share a protected characteristic and those who don't;
- foster good relations between people who share a protected characteristic and those who don't.

52. Having due regard to the need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to:
- remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic
- take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it
- encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.

53. The legislation states that "the steps involved in meeting the needs of disabled persons that are different from the needs of persons who are not disabled include, in particular, steps to take account of disabled persons' disabilities." In practice, this means that reasonable adjustments should be made for disabled people so that they can access a service or fulfil employment duties, or perhaps a choice of an additional service for disabled people is offered as an alternative to a mainstream service.

54. Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to:
- tackle prejudice, and
- promote understanding.

55. Compliance with the duties in this section may involve treating some persons more favourably than others; but that is not to be taken as permitting conduct that would otherwise be prohibited by or under this Act.

The duty covers the protected characteristics of age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

56. An initial assessment of the budget proposals has been made. Where proposals are likely to have a significant equality impact, they will undergo an equality impact assessment informed by consultation with the protected groups who may be adversely affected, during the autumn. The results of this process and any steps which emerge that might help to mitigate any potential impact of the budget proposals on the protected groups will be reported to Members so that they can pay due regard to the Public Sector Equality Duty in making decisions on the budget. In making decisions on budget proposals, Members will need to weigh the Public Sector Equality Duty against the forecast financial position, risks and uncertainties set out in this report.

57. With regard to Children and Young People, a substantial element of the proposed budget for the People Directorate will be spent on maintaining and improving services for children and young people. The expenditure of other Directorates' budgets will also have a significant impact on this group.

**Human Resources / Transformation**

58. Human Resources implications are set out in paragraphs 34-35.

59. Transformation issues are set out in paragraph 39.

.....  .....

**Sarah Norman**
**Chief Executive**

**Iain Newman**
**Chief Officer, Finance and Legal Services**

.....

**Martin Samuels**
**Strategic Director, People**

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**List of Background Papers**

Budget and Council Tax setting 2018/19 report to Council, 26th February 2018
Revenue Outturn 2017/18 report to Cabinet, 27th June 2018
Local Government Finance Settlement 2018/19 – including indicative figures for 2019/20

**Appendix A**

## 2018/19 Forecast Outturn position

| Service | Latest Budget £m | Latest Outturn £m | Variance £m | Comment |
|---|---|---|---|---|
| Adult Social Care | 91.9 | 91.5 | -0.4 | Pressures on: Community Care £0.4m; Complex and Inclusion £0.5m; other net pressures totalling £0.1m. Offset by Residential care savings £1.4m. |
| Children's Services | 69.0 | 69.9 | 0.9 | Agency staff £1.7m; Psychology £0.1m. Offset by: additional Troubled Families grant £0.5m; supervised contact £0.1m; net saving on care placements £0.3m |
| Health and Wellbeing | 7.5 | 7.2 | -0.3 | In year funding switches to Public Health Grant re. Environmental Protection and Community Council. |
| Integrated Commissioning, Performance and Partnerships | 6.0 | 6.0 | 0.0 | |
| In year savings to be found | 0.0 | -0.2 | -0.2 | |
| **Total People** | **174.4** | **174.4** | **0.0** | |
| Environmental Services | 45.0 | 45.4 | 0.4 | Pressures arising from: additional tonnage and incinerator costs £0.3m; reduced income from Oak Lane £0.1m; additional costs within Transport £0.2m. Offset by: additional income from trade waste fee income £0.1m; part year costs of new street cleansing sweepers £0.1m |
| Regeneration and Enterprise | 8.8 | 9.2 | 0.4 | Pressures on: Catering services £0.5m; Property Services including voids and construction and design fees £0.4m; Town Hall Community Asset Transfer £0.1m; unfunded scheme development costs for VLR/Metro £0.1m. Offset by: one off windfall from fine income £0.3m (rogue landlord); reduced expenditure on EZ £0.3m; vacancies £0.1m. |
| Housing | 2.4 | 2.2 | -0.2 | Vacancies £0.1m and reduced capital programme funding due to additional DFG grant income £0.1m. |
| **Total Place** | **56.2** | **56.8** | **0.6** | |

| Service | Latest Budget £m | Latest Outturn £m | Variance £m | Comment |
|---|---|---|---|---|
| Commercial and Procurement | 0.5 | 0.4 | -0.1 | Vacancies |
| Finance and Legal | 5.5 | 5.2 | -0.3 | Benefits Subsidy surplus £0.3m |
| Transformation and Performance | 0.6 | 0.6 | 0.0 | |
| Levies etc. | 14.0 | 14.0 | 0.0 | |
| **Total Chief Executive's** | **20.6** | **20.2** | **-0.4** | |
| Treasury / Corporate | -12.6 | -12.8 | -0.2 | Under recovery of pension Past Service Deficit £0.3m.<br>Favourable variances: slippage in capital programme so reduced MRP £0.2m; better than anticipated airport dividend £0.2m; surplus from final agreed pay award £0.1m. |
| **Total Service Costs** | **238.6** | **238.6** | **0.0** | |
| **Total Funding** | **-231.2** | **-231.4** | **-0.2** | £0.7m additional Top Up grant received, partially offset by recovery of £0.5m s31 grant overpayment. |
| **Use of Balances** | **7.4** | **7.2** | **-0.2** | |

**Appendix B**

## Delivery of existing Medium Term Financial Strategy

| Saving | 2018/19 £'000 | Comment |
|---|---|---|
| Increase the investment in preventative services to support adult social care client carers, focusing on the high risk caring relationships, in order to reduce or mitigate admissions to residential and nursing care with the aim of overall service savings. | 67 | Implemented |
| Target interventions to people most at risk of falls to make people safe and prevent high cost social care and primary care interventions. | 117 | Implemented |
| Managing Money – Increase funding collected from financial assessments of adult social care clients. | 140 | Implemented |
| Assessment & Review - Implement outcome based commissioning and assessments for all community-based adult social care packages costing more than £500 per week to provide services efficiencies. | 346 | Implemented |
| Assessment & Review - Review all residential and nursing care packages for working age adults costing over £500 per weeks with a particular focus on identifying whether individual needs can be met within the current setting more effectively and economically. | 127 | Implemented |
| Assessment & Review - Review the S117 policy. | 244 | Partly implemented. Assessment tool designed and agreed with NHS |
| Shared Lives - Expansion of the Shared Lives service in respect of adult fostering scheme to achieve additional shared lived placements, enabling more people to be able to continue to live in the community, with independence of public services maximised | 220 | Partly implemented. Recruitment of Foster carers ongoing. |
| Alignment of contract prices at New Bradley Hall with market conditions. | 354 | Implemented |
| Integrated Commissioning, Performance and Partnership team restructure | 50 | Implemented |
| Invest to Save programme to install LED lights on main roads | 150 | Implemented |
| Private sector litter enforcement | 50 | Implemented |
| Street maintenance: issue highway permits | 250 | Implemented |
| Ensuring efficient highway maintenance service by streamlining pothole repair process and focussing carriageway re-surfacing on strategic highway network | 310 | Implemented |
| One Public Estate - savings from ending leases | 200 | Implemented |

| Saving | 2018/19 £'000 | Comment |
|---|---|---|
| Review of events programme and associated land and building assets in order to deliver self financing service by 2019 | 205 | Implemented |
| Review use of halls borough wide to reduce annual subsidy. Review rental income and realise efficiencies at Red House Cone. | 102 | Partly implemented. Community Asset Transfer delayed. |
| Maximising efficiency in Bereavement Service. | 246 | Implemented |
| Financial Services – staffing restructure | 190 | Implemented |
| Savings arising from reductions in software costs, rationalisation of Multi Functional Devices (MFD), changes to mail services and removal of all documents from offsite storage. | 65 | Partly implemented. Requires further council wide process changes. |
| Staffing restructure within Transformation and Performance division | 470 | Implemented |
| Remodelled Communications & Public Affairs and Civic support and increased Graphic Design income generation, as well as self-financing Town Centre Events (e.g. Christmas) through income generation. | 38 | Implemented |

Where savings have been partly implemented, the financial impact is reflected in the 18/19 outturn forecast in Appendix A or is being met from directorate earmarked reserves.

**Appendix C**

## Spending Pressures

| **People** | **2019/20 £'000** | **2020/21 £'000** | **2021/22 £'000** |
|---|---|---|---|
| Living wage - residential care providers | 949 | 2,016 | 2,016 |
| Living wage - care at home providers | 562 | 1,193 | 1,193 |
| Living wage - direct payments | 12 | 26 | 26 |
| Older people (dementia) | 539 | 539 | 539 |
| Living wage - sleep-ins | 38 | 80 | 80 |
| Inflationary award for Direct Payments | 180 | 180 | 180 |
| Children's Services - internal fostering fees | 108 | 224 | 224 |
| Education Outcomes - existing premature retirement costs | 20 | 40 | 40 |
| Connected persons – this will equalise the payment arrangements to all ranges of Dudley foster carers | 18 | 36 | 36 |
| Children's Services – improving staff recruitment and retention and thereby reducing reliance on Agency staffing | 1000 | 1000 | 1000 |
| **Total** | **3,426** | **5,334** | **5,334** |

| **Place** | **2019/20 £'000** | **2020/21 £'000** | **2021/22 £'000** |
|---|---|---|---|
| Waste Disposal - contractual cost increases, Landfill Tax, and pressure on recyclate commodity prices. | 173 | 337 | 507 |
| Impact of National Living Wage on outsourced cleaning contract for administrative buildings | 25 | 50 | 75 |
| School Crossing Patrols | 240 | 240 | 240 |
| Hot Spot Skip provision in each ward to reduce fly tipping | 100 | 100 | 100 |
| Street lighting energy - higher energy costs | 300 | 300 | 300 |
| Operational waste collection pressures | 115 | 200 | 200 |
| Recycling income - reduction in market prices | 250 | 250 | 250 |
| **Total** | **1,203** | **1,477** | **1,672** |

| **Chief Executive's** | **2019/20 £'000** | **2020/21 £'000** | **2021/22 £'000** |
|---|---|---|---|
| Increase in costs of Microsoft Software licenses from April 2019 | 400 | 400 | 400 |
| **Total** | **400** | **400** | **400** |

**Appendix D**

## Proposed Savings

| People | 2019/20 £'000 | 2020/21 £'000 | 2021/22 £'000 |
|---|---|---|---|
| Increase the investment in preventative services to support adult social care client carers, focusing on the high risk caring relationships, in order to reduce or mitigate admissions to residential and nursing care with the aim of overall service savings. | 309 | 309 | 309 |
| Target interventions to people most at risk of falls to make people safe and prevent high cost social care and primary care interventions. | 259 | 259 | 259 |
| Assessment & Review - Implement outcome based commissioning and assessments for all community-based adult social care packages costing more than £500 per week to provide services efficiencies. | 163 | 163 | 163 |
| Assessment & Review – Complete review of the S117 policy and implement | 164 | 164 | 164 |
| Shared Lives - Expansion of the Shared Lives service in respect of adult fostering scheme to achieve additional shared lived placements, enabling more people to be able to continue to live in the community, with independence of public services maximised | 250 | 250 | 250 |
| Reduce Community Equipment Spend via Smarter Procurement - Use of the Croydon Integrated Procurement HUB to purchase all community equipment (including hoists) to support people in their own homes. The current arrangements for the purchase of community equipment are across multiple providers | 100 | 100 | 100 |
| Peripatetic Care Model - To remove the offer of long term internal Peripatetic homecare service | 100 | 100 | 100 |
| Business Support Development - To reduce current levels of Assessment & Independence business support through leaner process design and new models of care | 100 | 100 | 100 |
| General Fund Public Health Grant Switches - Transfer of Emergency Planning, Community Council & part of Environmental Health & Trading Standards from General Fund to Public Health Grant | 425 | 425 | 425 |
| Single handed care - Benefits realisation through the ongoing implementation of Single Handed Care, based on more effective use of technology to facilitate dignified care delivery, supporting people's care related transfers | 200 | 200 | 200 |

| People | 2019/20 £'000 | 2020/21 £'000 | 2021/22 £'000 |
|---|---|---|---|
| Demand management / All Age Commissioning within Dudley Disability Services (DDS) - a focussed approach within DDS services to: reduce initial demand, increase self-assessment, identify placements eligible for Continuing Health Care funding, and develop specific all age commissioning projects targeted at reducing costs over 5 years | 190 | 398 | 398 |
| Residential Care Charging Fraud Initiative - Tackle fraudulent asset disposal in regard to Residential Care financial assessment and charging | 96 | 296 | 496 |
| Redesign of voluntary sector contracts - A bespoke exercise to consolidate a number of existing contracts into a single market opportunity to the Voluntary Sector | 94 | 158 | 158 |
| Home care / Extra Care (new models) - Development of a transformational model for the delivery of home care / extra care provision in the Borough | 112 | 250 | 250 |
| West Midlands Care Home Association Service Level Agreement (SLA) – Cease funding the Care Home coordinator post, as no longer required | 27 | 27 | 27 |
| Dudley Group Foundation Trust Discharge Coordinator SLA – Cease funding the Coordinator post as part of a wider simplification of funding arrangements | 43 | 43 | 43 |
| Re-design Day Opportunities - To re-profile usage of the Dementia Gateways in Dudley whilst retaining both services | 59 | 85 | 85 |
| General Fund Efficiencies - Range of general fund efficiencies on various running cost/over head budgets | 29 | 29 | 29 |
| Teenage Pregnancy (TP) Service - In 2017/18 the TP team was restructured into the Family Solutions service as part of the Early Help service redesign. The nurse roles were embedded within the sexual health provider contract. Public Health still fund a post, but the balance can be used for savings | 46 | 46 | 46 |
| Review contribution to Children's safeguarding board to ensure this is proportionate with contributions from other statutory partners. | 60 | 60 | 60 |
| Tipton Road - To amend the current Statement of Purpose (SoP) for Tipton Road Children's Home so that placements can be offered to children with complex needs as well as those with disabilities alone | 468 | 468 | 468 |
| Children's Transport – Implement new contracts and route management, to ensure services are safe and efficient | 381 | 737 | 965 |

| **People** | **2019/20 £'000** | **2020/21 £'000** | **2021/22 £'000** |
|---|---|---|---|
| Contact Centres - Reviewing the delivery of Family Contact for Children Looked After and Post Adoption support to ensure that the service is delivered effectively, efficiently and offers value for money | 168 | 194 | 250 |
| Special Guardianship Allowances - Rigorous application of existing Policy with regard to Special Guardianship Allowances | 80 | 80 | 80 |
| **Total** | **3,923** | **4,941** | **5,425** |

| **Place** | **2019/20 £'000** | **2020/21 £'000** | **2021/22 £'000** |
|---|---|---|---|
| Street maintenance: issue highway permits | 250 | 250 | 250 |
| Housing - reduction in revenue contribution to capital for Housing Assistance Grants | 100 | 100 | 100 |
| **Total** | **350** | **350** | **350** |

| **Chief Executive's** | **2019/20 £'000** | **2020/21 £'000** | **2021/22 £'000** |
|---|---|---|---|
| Benefits - budget adjustment to fully reflect benefit subsidy and the recovery of benefits overpayments. | 300 | 300 | 300 |
| **Total** | **300** | **300** | **300** |

Agenda Item No. 7

**Meeting of the Health and Adult Social Care Scrutiny Committee – 21st November 2018**

**Report of the Strategic Director People**

# Dudley Safeguarding Adults Board Annual Report 2017/18 and the Deprivation of Liberty Safeguards

| | |
|---|---|
| **Purpose** | |
| 1. | To present the Adult Safeguarding Board's Annual Report to the Health and Adult Social Care Scrutiny Committee. |
| **Recommendations** | |
| 2. | It is recommended that:-<br><br>• Health and Adult Social Care Scrutiny Committee is asked to consider and comment upon Dudley Safeguarding Adults Board's Annual Report for 2017-18. |
| **Background** | |
| 3. | Section 43 of the Care Act 2014 requires the Local Authority to establish a Safeguarding Adults Board (SAB) whose main objective is to protect adults from experiencing, or being at risk of abuse and neglect. Dudley Safeguarding Adults Board has been established since 2008 and works to ensure there is an appropriate response from a whole range of professionals to situations where there is actual or suspected abuse, harm or neglect. The Board considers how partners across Dudley Borough responsible for safeguarding work together and the quality of support provided to people who have been abused, neglected or harmed. The board is required to meet the following three statutory responsibilities. They must:<br><br>• Develop and publish a strategic plan setting out how they will meet their objectives and how their member and partner agencies will contribute<br>• Publish an annual report detailing how effective their work has been<br>• Commission safeguarding adults reviews (SARs) for any cases which meet the criteria for these. |
| 4. | The Board benefits from senior representation from all key agencies – Dudley MBC, Clinical Commissioning Group (CCG), Dudley Group NHS Foundation Trust, West Midlands Police, Dudley and Walsall Mental Health Trust, Healthwatch and the independent sector. |

| | |
|---|---|
| 5. | In 2016-17 the Board established an Executive Group to oversee the work of its subgroups. The subgroup structure consist of the following:-<br><br>• Quality and Performance<br>• SAR<br>• Workforce and Development<br>• MASH Strategic<br>• Communications and engagement |
| 6. | The terms of reference for these groups reflect the Board's declared priorities and are published on the local authorities website. |
| 7. | The Board had three strategic priorities for 2017-18:<br><br>• To improve service user involvement in safeguarding development<br>• To make safeguarding personal for the victim of abuse, harm or neglect<br>• To develop information in order to prevent safeguarding incidents from occurring |
| 8. | The annual report demonstrates the progress achieved in these priorities in 2017-18 and highlights the following themes. There is evidence of effective partnership work, Making Safeguarding Personal is embedded, there has been a 4% increase to 97.4% of all people who have been asked about their desired outcomes have been fully or partially achieved. Additionally there are improved outcomes for individuals who have been or are at risk of financial abuse. A multi-agency development was held on 22nd June and there is a conference on financial abuse scheduled 26th November, this will be named shine a light on the hidden crime of financial abuse. |
| 9. | Our action plan to improve service user involvement in the safeguarding process focused around increased working and formal links with user organisations across the borough. Healthwatch have presented a report relating to the voice of individuals who experienced the safeguarding journey. In addition a number of reference groups which benefit from experts by experience have been held, and the documentation reflects the requirements of the population. |
| 10. | Much work has been done to prevent safeguarding incidents occurring (priority three). Public information has been distributed, self-neglect practice was issued and a multi-agency practice learning event was held to facilitate learning. |
| 11. | Work with Trading Standards on financial abuse has led to the agreement of a Scams Unit to provide support to the Safeguarding Team to raise awareness about financial scams in 2017-18, this work is ongoing |
| 12. | During this year Safeguarding Adult Reviews (SARs) referrals have significantly increased. There are approximately two referrals per month being received. There were previously two SAR's commissioned, it should be noted that the learning from these relating to dysphasia have as yet not been fully embedded, this work will continue to be monitored and regular updates provided |

| | |
|---|---|
| 13. | The creation of the MASH (Multi Agency Safeguarding Hub) has made progress in 2017-18. The MASH has become the central point for all unallocated safeguarding concerns to be reviewed and a timely decision made about how and if to proceed to a section 42 enquiry. There are plans to co-locate the adult MASH with the Children's MASH around January 2019. |
| | **Deprivation of Liberty Safeguards** |
| 14. | These safeguards exist to provide a legal process and suitable protection for people in residential, nursing or hospital settings where deprivation of liberty is unavoidable and in a person's own best interest. |
| 15. | In 2014 different thresholds were applied which has resulted in a significant backlog of cases regionally. |
| 16. | Giving judgement, Baroness Hale said: "If it would be a deprivation of my liberty to be obliged to live in a particular place, subject to constant monitoring and control, only allowed out with close supervision, and unable to move away without permission even if such an opportunity became available, then it must also be a deprivation of the liberty of a disabled person. The fact that my living arrangements are comfortable, and indeed make my life as enjoyable as it could possibly be, should make no difference. A gilded cage is still a cage." |
| 17. | A new scheme for the Deprivation of Liberty Safeguards is currently being developed following national consultation which Dudley contributed to in 2016-17. This recognises the backlog of cases nationally. Dudley had a backlog of 952, which was comparable to many local authorities. However, monies from none recurrent monies have been secured and this has resulted in a specialist Deprivation of Liberty's team being employed, as a result the original backlog now stands at approximately 300 and it is projected that this will be at nil before January 2019. |
| **Finance** | |
| 18. | The Board is supported by the Local Authority in accordance with statutory responsibilities. West Midlands Police and Dudley CCG are also contributors to the Board. |
| **Law** | |
| 19. | The annual Safeguarding Board report shows compliance with the Care Act 2014. |
| **Equality Impact** | |
| 20. | The West Midlands Safeguarding Procedures are implemented within Dudley and are consistent with the Equal Opportunities Policy of the Council. |

| **Human Resources/Transformation** | |
|---|---|
| 21. | There are no direct human resources/transformation arising from the contents of this report |

……..
**Martin Samuels**
**Strategic Director People**

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*Appendix 1 - Dudley Safeguarding Adults Board Annual Report*

Dudley Safeguarding
protecting adults at risk

**Dudley Safeguarding Adults Board Annual Report 2017-18**

## What is Safeguarding for Adults?

People's wellbeing is at the heart of the Care Act 2014, and the prevention of abuse and neglect is one of the elements identified as going to make up a person's wellbeing. In the context of section 42 of the Care Act 2014,, specific adult safeguarding duties apply to *any* adult who:

- has care and support needs; and
- is experiencing, or is at risk of, abuse or neglect; and
- is unable to protect themselves because of their care and support needs.

In addition local authorities have safeguarding responsibilities for carers.

Safeguarding duties apply regardless of whether a person's care and support needs are being met or not. These duties also apply to people who pay for their own care and support services. Adult safeguarding duties apply in whatever setting people live, with the exception of prisons and approved premises such as bail hostels. They apply regardless of whether or not someone has the ability to make specific decisions for themselves at specific times.

If an adult at risk of being abused or neglected cannot keep themselves safe from abuse or neglect because of their care and support needs, then the local authority's safeguarding duty applies. If they are able to protect themselves, despite having care and support needs, then a safeguarding response may not be appropriate.

## What is Dudley Safeguarding Adults Board (DSAB)?

### Overarching purpose

The overarching purpose of an SAB is to help and safeguard adults with care and support needs. It does this by:

- assuring itself that local safeguarding arrangements are in place as defined by the Care Act 2014 and statutory guidance
- assuring itself that safeguarding practice is person-centred and outcome-focused working collaboratively to prevent abuse and neglect where possible ensuring agencies and individuals give timely and proportionate responses when abuse or neglect have occurred
- assuring itself that safeguarding practice is continuously improving and enhancing the quality of life of adults in its area.

The SAB must lead adult safeguarding arrangements across its locality and oversee and coordinate the effectiveness of the safeguarding work of its member and partner agencies. This requires the SAB to develop and actively promote a culture with its members, partners and the local community that recognises the values and principles contained in 'Making Safeguarding Personal'.

It should also concern itself with a range of issues which can contribute to the wellbeing of its community and the prevention of abuse and neglect, such as:

- the safety of people who use services in local health settings, including mental health
- the safety of adults with care and support needs living in social housing
- effective interventions with adults who self-neglect, for whatever reason
- the quality of local care and support services
- the effectiveness of prisons in safeguarding offenders
- making connections between adult safeguarding and domestic abuse.

### Core duties

SABs have three core duties. They must:

- develop and publish a strategic plan setting out how they will meet their objectives and how their member and partner agencies will contribute

- publish an annual report detailing how effective their work has been
- commission safeguarding adults reviews (SARs) for any cases which meet the criteria for these.

Section 43 of the Care Act 2014 requires the Local Authority to establish a Safeguarding Adults Board (SAB) whose main objective is to protect adults from experiencing, or being at risk of abuse and neglect. Dudley Safeguarding Adults Board has been established since 2008 and works to ensure there is an appropriate response from a whole range of professionals to situations where there is actual or suspected abuse, harm or neglect. The Board considers how partners across Dudley Borough responsible for safeguarding work together and the quality of support provided to people who have been abused, neglected or harmed.

The Board is made up of senior representatives from Dudley Council, West Midlands Police, Dudley Clinical Commissioning Group (CCG), Dudley Group NHS Foundation Trust, Dudley Fire Service, Dudley and Walsall Mental Health Trust, Black Country Partnership Foundation Trust, Healthwatch Dudley and West Midlands Probation, as well as voluntary sector organisations. The Care Quality Commission attend and report on their activities at one Board meeting each year.

The Board works to a business plan and produces an annual report which is distributed to key stakeholders as well as Council, Cabinet and Scrutiny. The Board also has a protocol with the Health and Wellbeing Board and the Community Safety Partnership to ensure partnership and accountability is robust. In 2016, partnership with the Dudley Safeguarding Children Board was developed through joint Board meetings during the year looking at the shared priorities which include supporting people who are victims of domestic abuse, modern slavery and preventing violent extremism.

The Board is funded through financial contributions from Dudley CCG, West Midlands Police and the council. Other partners provide staff and resources for meetings and training courses.

**Executive Summary**

The last 12 months have been very exciting for DSAB. The vision of Dudley Multi-Agency Partnership promotes safety and inclusion, aiming to improve life experiences of individuals and families by ensuring that its strategic and business plans reflect the requirements of its residents.

The Board has established its priorities based on the requirements of Dudley residents. These are to:

- Make safeguarding personal
- Ensure the right intervention at the right time
- Ensure that the voice of the individual is heard

As such, the Board has identified specific areas of work which centre on reducing the risks faced by individuals. Consequently investment has been secured to develop a team within Trading Standards that will identify and support victims of financial abuse. This work continues to develop at pace. Furthermore the Board has been active in supporting the Transforming Care Agenda. A case study has been presented to the Board highlighting the excellent outcomes secured for an individual to live safe positive life in the community with the right level of support. The Board values engaging with people and families in forums that consider how best practice can be assured.

Further the development of a Multi Agency Safeguarding Hub (MASH) has streamlined the safeguarding concerns referral process to a central point. This supports and enables immediate multi-agency responses. Information relating to this service is detailed later in this document.

## Message from the Independent Chair

This report covers my second year as the Independent Chairperson of DSAB. This report provides a summary of the safeguarding work carried out by local agencies.

During this year, there have been some important developments in the local safeguarding system including the launch of a Multi-Agency Safeguarding Hub (MASH) to receive and screen safeguarding concerns raised in respect of Dudley residents. Work to tackle financial abuse has also progressed through a dedicated project led by the Council's Trading Standards team.

Engagement with residents has enabled DSAB to begin to review how easy it is for members of the public to make a safeguarding referral in Dudley and to understand how family members experience the safeguarding system. Increasing our engagement with residents remains a DSAB priority and the next stage is to use the experiences of adults with care and support needs to evaluate the effectiveness of safeguarding. This will allow us to further embed the "Making Safeguarding Personal" approach. Data indicates that "Making Safeguarding Personal" is already underpinning safeguarding practice however understanding the experiences of those who receive safeguarding services will enable those services to be even more responsive to an individual's needs.

During 2017-18, the Council's internal audit team completed an audit in respect of how DSAB delivers its statutory functions. A small number of priority actions were identified; progress has been made in delivering the associated recommendations and DSAB sub groups are also progressing a number of areas of Board development, including auditing and training. The Safeguarding Adult Review referral pathway has also been revised during 2017-18.

I would like to take this opportunity to thank DSAB partner agencies for their ongoing support and commitment to safeguard adults with care and support needs in Dudley, and in particular, I would like to acknowledge the work of front line practitioners who, on a daily basis, practice with vigilance and sensitivity.

***Liz Murphy, Independent Chair***

## Adult MASH

The MASH (multi-agency safeguarding hub) includes professionals from the following organisations: Health; Police; Local Authority, Housing; Trading Standards; Probation and Substance Misuse. It receives all adult safeguarding concerns for unallocated cases and assesses whether the safeguarding threshold is reached (as defined in Section 42 of the Care Act), and directs the concerns to the appropriate team or partner agency for a safeguarding enquiry, with an appropriate plan in place for enquiry. This provides consistency of responses to adult safeguarding within Dudley MBC. In exceptional circumstances, MASH social workers will undertake safeguarding enquiries when a very urgent response is required.

Furthermore, having identified high incident rates of self-neglect, local policies and procedures are being developed to inform practice with this group of people, Additionally a self neglect and hoarding audit tool has been developed and training from a nationally recognised trainer has been secured. This training will be open to the partnership

A real success since the start of the year has been our improved partnership working. Thanks to efforts from our colleagues, we now able to report that 97.4% of all people who have received safeguarding services state that their outcomes have either been fully or partially met. This has increased from 93.9% in 16/17 and means that Making Safeguarding Personal is central to the process. The Adult MASH continues to evolve and improve; going forward, we will continue to develop strong links and look to colocate with the Children's MASH.

## Further Partnership Working

### West Midlands Fire Service

West Midlands Fire Service has a team who work with individuals with multiple and complex needs to try to reduce risk and vulnerability for people living in their own homes. This work involves multi agency meetings to agree who is best placed to support each person. The service also undertakes serious incident review processes where there is a serious or fatal fire and information is shared with partners to enable learning and to support future prevention work.

### Dudley Clinical Commissioning Group (CCG)

Dudley CCG has a statutory responsibility for ensuring that the organisations from which they commission services provide a safe system that safeguards adults at risk of or experiencing abuse or neglect. Dudley CCG have ongoing Safeguarding Quality Review Meetings with providers to ensure that robust systems and processes are in place.

As part of their statutory responsibilities the CCG continue to play a key role in core Board business, with the Designated Nurse actively participating in the working groups of the SAB, and recently taking on a role as Chair for the Safeguarding Adult Review subgroup.

Dudley CCG team provides a safeguarding health advisory and support role for GPs and primary care colleagues, Adult Social Care, Care Quality Commission (CQC) and NHS provider services.

Safeguarding GP practice lead meetings are held quarterly and direct face-to-face training is delivered within the practices by the team. During 2017/18 these have particularly focused on raising awareness of adult safeguarding and to embed “making safeguarding personal” into work by recording individuals’ wishes. These has directly led to an increase in GP engagement calls made to designated nurses to advise on the management of adult safeguarding concerns.

Recognition and management of domestic abuse has been a priority for 2017/18 – with the promotion and involvement of health agencies and the embedding of MARAC (Multi-Agency Risk Assessment Conference) processes and the IRIS project (Identification and Referral to Improve Safety relating to domestic abuse) into GP practices. Learning from Domestic Homicide Reviews has been incorporated into training events. This has raised awareness in this area.

The CCG works collaboratively with the DMBC Commissioning Team and other teams within Social Care when safeguarding concerns have the category of neglect or acts of omission in independent provider services. The CCG have a Care Practitioners’ Forum, which helps to identify concerns before they reach the threshold for safeguarding and have also undertaken joint quality assurance visits with Local Authority commissioning professionals to act on any areas of concern.

### Dudley and Walsall Mental Health Partnership NHS Trust

Dudley and Walsall Mental Health Partnership NHS Trust is committed to safeguarding children and adults across the organisation. The welfare of the people who come into contact with its services either directly or indirectly is paramount and all staff have a responsibility to ensure that best practice is followed, including compliance with statutory requirements.

The Trust provides services within the borough of Dudley and is a key member of the borough’s Safeguarding Board arrangements. It continues to progress a significant programme of safeguarding training for staff to ensure that all eligible staff have received the right level of training relevant to their roles and responsibilities.

As part of the Trust's commitment to the safeguarding of adults and children it has a dedicated Safeguarding Team which includes the Vulnerable Adults and Children’s Safeguarding Lead, two

Vulnerable Adult and Children's Specialist Practitioners, Safeguarding Report Writer, Compliance and Safety Coordinator and Safeguarding Administrator.

Dudley and Walsall Mental Health (DWMH) continues to maintain an active and robust presence within the Dudley Safeguarding Adults Arena with key personnel identified to attend the Board and subgroups.

DWMH undertakes all safeguarding enquiries in line with the Care Act for adults who use their services. This data is shared across the partnership via reporting to Dudley CCG to inform a borough wide approach. Processes are followed and information is shared with Dudley MBC via the section 75 agreement.

DWMH engages with the Adult MASH through an agreed information sharing arrangement ensuring that safeguarding responsibilities are met for service users. DWMH also engages with the SAR and DHR processes and participates in multi agency case audits as identified by DSAB

DWMH has a robust safeguarding training catalogue and accesses both internal and partnership training events for all staff. Prevent/WRAP training has now been incorporated into the training provided by the safeguarding team.

**Healthwatch Dudley**

Healthwatch Dudley reminds partners of the importance of listening to real life experiences of abuse and neglect to help them to continually improve local services. As an independent organisation with a passion for involving local people in decision making, Healthwatch were invited by the Board to engage partners in a Communications and Engagement subgroup. Within the Communications and Engagement subgroup, a user group has been instrumental in providing user feedback around the online “report it” function as well as a professional-led group. The key messages, themes and feedback will then be taken to construct a user-involved online “report it” mechanism which is fit for purpose, accessible and, more importantly, user friendly.

Through the group Healthwatch said it would:

- Agree key shared safeguarding messages to be promoted across the partnership
- Identify and champion ways to keep people safe
- Increase awareness of safeguarding adults in Dudley borough and how to report
- Involve adults at risk, carers and advocates in our work
- Be innovative on our approach by involving a diverse range of local people
- Ensure our messages are shared in appropriate meaningful language

A group of creative thinking communications and engagement professionals from a wide range of local organisations have been coming together every two months since first meeting in early 2017. For the first time it has been possible to capture the views of people who have been safeguarded. Lessons learnt were implemented into practice using people as “experts by experience”. In addition the Board held a development day which specifically considered financial abuse. This event benefited from people sharing their experience of a relative being financially abused. The Board produced a work plan relating to preventing financial abuse as a direct result of this event. This will be implemented in 2018/19.

People who visit adults in their own homes such as health professionals, tradespeople or mobile hairdressers are often best placed to pick up on things that don't seem right. But how do these people know what to do if they are think that someone they are visiting might be at risk of abuse, harm or neglect? Visitors to people's homes will be targeted as part of Healthwatch’s safeguarding awareness campaign which has started with making the reporting system more person-centred. Training and awareness-raising sessions will be offered to home visitors and, as part of these, materials will be developed with participants to help them to more easily identify and report safeguarding concerns.

Furthermore Healthwatch was requested to support a group of young adults with complex learning disabilities due to safeguarding concerns. The individuals and their family members were supported to share their experience of being safeguarded. Consequently a great deal of invaluable information was gained, highlighting both areas of good practice and areas which could be improved. Despite all family members recognising the importance of the safeguarding process, it became clear that the way in which individuals and family members were communicated with, could be improved. For example when asked "What should the letter have said?" we were told that "the person writing it should have put themselves in our position and think about what they would have felt happy to receive."

Conversely, other feedback included:

"Safeguarding was something new for us, I was only allowed to attend the first part of the meeting but I definitely wanted my views to be heard. I didn't think anyone would listen to me but I was pleasantly surprised. I was listened to, actions have been set at each meeting and they have been reviewed so I know that things are happening."

The feedback received from the family members has reminded us that the way in which we relay communication is equally important as the actions we take in performing our duties.

Our work does not replace the communications and engagement activity of individual organisations, rather it complements by providing a space for networking, sharing resources and collaborative working on safeguarding campaigns, all adding value to the important work of Dudley Safeguarding Adults Board.

**Dudley Trading Standards**

Dudley Trading Standards continues its work to identify and protect victims of financial scamming in the Borough. In one of the worst cases encountered so far, a Dudley man in his eighties received a telephone call claiming to be from his bank. The caller said that his local branch had been compromised and that there was an investigation into a worker at the branch who was stealing money. The caller instructed the victim to go in to the branch and transfer his life savings, in excess of £50,000 to two bank accounts for which account numbers and sort codes were provided. The victim was told that on no account should they discuss the phone call with anyone in the branch, as the member of staff could be the person stealing money. On the next day the victim duly went to their local branch and transferred their entire life savings to scammers' bank accounts.

Upon discovery of the scam, within a few hours, the bank said they could do nothing about it as the money had already been transferred. The matter is now being investigated by Trading Standards, who are carrying out financial investigations to trace the scammers, and are also taking up the victim`s complaint with the bank, as there are concerns that the bank made insufficient checks before allowing the transfer.

**Black Country Partnership NHS Foundation Trust (BCPFT)**

BCPFT have:

- Maintained consistent representation at DSAB and identified key personnel to attend the Board and subgroup meetings
- Newly appointed an Associate Director of Safeguarding who has ensured consistent input from the Trust
- Refreshed internal training to bring it up to date and inclusive of local lessons learnt
- Refreshed their Training Needs Analysis in 2017/18 to best reflect the training requirements within the Trust
- Participated in multi-agency reviews in the year as identified through DSAB
- Become a virtual partner in the Adult MASH via the Community Learning Disabilities Team

- Supported Trust practitioners via the development and implementation of support and development sessions relating to safeguarding
- Incorporated Prevent training into the refreshed Safeguarding Training within BCPFT

**Safe & Sound (Dudley's Community Safety Partnership)**

Safe & Sound and Dudley MBC's Community Safety Team have contributed to the adult safeguarding agenda through the work of Safe & Sound sub-groups, through commissioning of services, the provision of training and other initiatives. Some examples of this include:

- Safeguarding through the "Safer Estates" meeting – a multi-agency problem-solving meeting focusing on calls for services in respect of public safety, welfare and ASB. Partners respond to underlying issues by working together to ensure individuals receive the support they need
- Victims/survivors of domestic violence and abuse have been safeguarded through MARAC. Dudley's MARAC has good outcomes for those whose cases are heard there. Support is provided through Dudley's Domestic Abuse Support Service as well as CHADD, depending on the victim's/survivor's needs
- Safe & Sound funded a number of training courses in respect of domestic violence and abuse and sexual violence in 2017/18 to raise awareness and contribute to the professional development of practitioners
- The Safe & Sound website has been updated and there are a range of help hubs to support members of the public and professionals. (This links to the Safeguarding website) https://www.dudleysafeandsound.org/

**Online Safety Subgroup**

Inclusion of "adults" into the Online Safety Subgroup formally happened during 2017, with the first formal report being received by the executive meeting in January 2018. Since then the following work has taken place in relation to adults and online safety:

- Adult representation on the sub group has now been confirmed from Adult Safeguarding, Adult and Community Learning, libraries, Healthwatch and the Access and Prevention Team. This is in addition to existing representation from West Midlands Police and Dudley College
- The terms of reference, strategy and work plans have been updated to reflect the inclusion of adults into the work stream
- Work is planned to take place with Healthwatch to look at existing documents that have been created for young people/parents and see how these can be translated to adults at risk and to include the voice of the adult in this information
- The case study template has been circulated to the subgroup to begin obtaining adults' experiences
- Information and presentations raising awareness relevant to adults have been shared with Adult and Community Learning and libraries, and a short input at Adult and Community Learning team meeting to raise awareness of the agenda to staff has taken place
- A frauds and scams sessions took place on 27th February and was well attended (despite the weather) with approximately 50 individuals attending (including members of the public). The sessions consisted of input from the illegal money lending team in respect of loan sharks, Dudley Trading Standards in respect of fraud and bogus callers, and West Midlands Police in respect of cybercrime and how to reduce the chances of becoming a victim of this. The sessions were extremely well received
- Work is taking place to ensure that an online training course is available to the Adult Social Care workforce
- The Safe and Sound website has been re-launched to include a "help hub". A specific online safety page is included in the help hub, with information and links for adults and those who work with adults included. https://www.dudleysafeandsound.org/help-hub

**Modern Slavery**

Three multi-agency awareness raising sessions took place on 17th January, 2018. Following on from the joint Dudley Safeguarding Adults and Safeguarding Children Board meeting on 9th March, 2018 it was agreed that an event in respect of Modern Slavery and Dudley's response would be held for a wider audience. This event took place on 1st May, 2018.

It was clear that a local pathway needed to be developed to complement the Regional Procedures and the National Referral Mechanism. Work is underway to develop a referral pathway and agree an offer of support.

**Forced Marriage and Honour Based Abuse**

Following on from the Joint DSCB and DSAB Meeting a multi-agency action plan was developed in order to take work forward in respect of Honour Based Abuse and Forced Marriage. Multi-agency training was available through the DSCB Training Calendar in 2017/18 and three additional multi-agency awareness raising sessions were delivered on 28th February, 2018.

**Large Scale Enquiries**

A large scale enquiry (LSE) is normally triggered where there are significant concerns and/or a high level of safeguarding activity in relation to adults at risk or where there is a complex concern regarding a number of adults at risk. Dudley MBC has a responsibility to coordinate the enquiry but responses are based upon multi-agency decision making. The process does not negate the need for individual safeguarding concerns to be addressed via the individual safeguarding process, and it is not a replacement for the management of individual concerns.

Examples of triggers for a large scale enquiry include:

- A number of adults at risk being allegedly abused resulting in significant harm or there being potential for significant harm (including people within a particular provider service)
- Receipt of collective concerns in relation to one service setting
- Concerns in relation to a service area of a high volume
- An individual safeguarding enquiry resulting in concerns that indicate that other individuals in the service are at risk of harm
- Receipt of a whistle blowing concern suggesting large scale concerns which suggest more than one suspected perpetrator or relate to custom and practice or a culture in a service that could result in harm to vulnerable adults
- Information received from professionals, the public, the Care Quality Commission, Clinical Commissioning Group, Police or another agency which suggests that the practices of a service are placing adults at serious risk of harm
- Where there may be multiple victims and one alleged perpetrator

A large scale enquiry planning meeting will be convened to discuss:

- Risks to adults using the service and whether immediate actions are required
- Capacity and consent issues
- Whether reviews of the adults in using the service are needed and who should undertake these
- The plan for the enquiry; to consider the level of the enquiry required, the proportionality of the response and identify the lead agency
- How the LSE will interface with any individual safeguarding enquiries that are ongoing
- The commissioning status and inform Care Quality Commission and neighbouring local authorities
- A communication strategy

A further LSE meeting will take place to draw together the strands of the enquiry. This meeting should:

- Review information gathered since the last meeting and the outcomes of enquiries
- Confirm whether any criminal prosecutions will be progressed
- Confirm an improvement plan and designate responsibilities with time scales
- Consider how improvement plans should be monitored
- Confirm the status of placements
- Confirm the status of the provider and any potential suspension of purchasing alongside commissioning
- Consider the status of the provider in respect of their CQC inspection and rating
- Confirm communication strategy with families, partners, and neighbouring authorities
- Confirm the current level of concern and whether the LSE needs to continue

Further meetings may be required depending upon the improvement plan and recommendations made.

**DSAB audit**

Internal auditing is an independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes.

As part of the Audit Plan for 2017/18 a review of the Adult Safeguarding Board was undertaken to provide an opinion in the form of a level of assurance as to the adequacy and effectiveness of controls that are currently in place to manage the risks in relation to the objectives identified.

The objectives for the review were as follows:

- There is an effective governance and assurance framework in place which is in accordance with statutory requirements and best practice, to include: roles and responsibilities; decision making; scrutiny; subgroups; strategic plan; annual report; partnership working; communication and engagement; quality assurance; safeguarding adult reviews; financial resources
- There are adequate and effective performance management arrangements in place (including risk management).
- There are effective arrangements for data gathering and sharing which are compliant with the Data Protection Act.

Overall the audit found that there was reasonable assurance, however there were some weaknesses which could affect the Board's objectives.

The audit found the following high priority areas to address:

- An annual disclosure is not made by Board members to confirm whether they have any interests with the work undertaken by DSAB. Furthermore, Board members are not asked whether they have any interests to declare at the start of a DSAB meeting. **This is now in place for all Board members, and declaration of interests is now a standing agenda item**
- Agendas and minutes for the DSAB subgroups were not being circulated in a timely manner. **The subgroups' terms of reference have now been updated to include timescales**
- A dataset is provided to the Board on a six monthly basis but not all partners provide data and not all relevant information is included. **The dataset has been reviewed and is submitted on a quarterly basis**
- A risk register is in place but some sections were incomplete, it did not correspond with the business plan and there was no evidence that partner risk registers had been

reviewed. **The register was updated to address this and will be reviewed on a regular basis**

**Quality and Assurance**

The Quality and Assurance subgroup undertakes multi-agency audits to provide that the residents of Dudley are benefiting from services which are safe. This work is supported by a robust quality and assurance framework. It is acknowledged by the Board the level of multi agency audits could have been improved. A multi-agency audit tool seeking safeguarding assurance from the partnership was distributed in June 2018, this audit is designed to provide assurance to the Board that appropriate facilities and systems had been established across the partnership. However, the Board recognise that there is further work to do relating to assurances, as previously stated an annual audit calendar will be used to examine specific areas of concern or types and prevalence rate of abuse.

The subgroup will identify any themes or trends relating to types and amounts of concerns being received. The subgroup will report any areas of concern to the Board and make recommendations. The Board will consider these and where required seek assurance from the partner agency/ies. The subgroup has developed an annual calendar to ensure audits are carried out in a timely manner. Examples of this will be audits relating to improved partnership working with hard-to-reach groups to prevent violent extremism, forced marriage and domestic abuse. Training has also been secured in these and other statutory areas of safeguarding.

In addition an audit is planned to consider how the requirements of the Mental Capacity Act and advocacy are embedded in the safeguarding process. New assessment documents have been implemented which consider the Mental Capacity Act 2005 and will provide evidence for this audit. An internal safeguarding audit has been established to monitor timeframes in which concerns are dealt with. Additionally, a threshold tool has been implemented which supports consistency in the decision making process, and dip samples of referrals and activity will be undertaken regularly.

**Multi-agency Learning & Development/Training**

A new safeguarding learning & development strategy has been developed and there is joint work between DSAB and the Dudley Children's Safeguarding Board (DSCB). Furthermore, in conjunction with Community Safety Partnership and the Council's Adult Safeguarding Learning and Development team, there will be online safeguarding training which will be accessible to multi-agency staff. Sessions are planned for late 2018 heading into early 2019. A robust booking and audit system will be developed to record the multi-agency staff levels of training. During 2017/18 training was commissioned and delivered in the following areas: mental capacity; financial abuse; coercion and controlling behaviours; Care Act 2014; self neglect; and level two general safeguarding training.

During 2017/18, a quality assurance exercise for single agency training was completed, the audit consisted of 23 agencies spanning both Adult and Children Safeguarding Boards. The information was collated and fed into a report which highlighted some of the emerging key themes such as:

- A good proportion of agencies has 100% of staff trained to safeguarding basic awareness level with many others who were 90% and above.
- Almost all agencies had a current training strategy linked to local, regional and national safeguarding procedure, processes and protocols
- Evaluation methods were widespread and there was a variety of tools and techniques used within many agencies.

**Recommendations**

A number of agencies need to ensure clarification and confirmation around the percentage and number of staff who are and are not trained. In addition, while there is currently no centralised

training in place, all agencies should be encouraging their employees to make further use of the e-learning safeguarding training packages made available through the Dudley Safeguarding Children Board. These cover legislation and guidance, different types of abuse, recognising signs and symptoms, making referrals, roles and responsibilities. This is already being employed in some sections as part of an induction and therefore could be rolled out more widely. Consideration would need to be given to evaluating this to ensure that learning outcomes have been achieved, and evaluation forms be used to achieve this.

Some agencies would also benefit from local information relating to an evaluation of the training that employees have received. It is suggested that links are forged with national learning and development departments as appropriate, to enable this information to feed back into the training at a local level. Similarly, if information relating to the qualification of trainers is held nationally, this could also be recorded locally against any training being delivered.

These recommendations place accountability on individual agencies to be responsible for their training and its evaluation, but also offer support in terms of putting measures in place to address the concerns raised within their individual audits.

## Social Media Current Developments

DSAB has developed and established a Twitter page to raise the profile of adult safeguarding and DSAB across the borough, Twitter has been a huge step forward for DSAB and, in conjunction with this, there are plans for expansion. Consideration is being given to the introduction of podcasts. These are envisioned to be bite-sized, succinct and savvy information.

## Deprivation of Liberty Safeguards (DoLS) and Deprivation of Liberty in the Community (CDoL)

DoLS ensures that people who cannot consent to their care arrangements in a care home or hospital are protected if those arrangements deprive them of their liberty. Deprivation of Liberty Safeguards were introduced in conjunction with the Mental Capacity Act 2005. However, in 2014 the threshold for a deprivation was significantly lowered by the Cheshire West judgement and the Supreme Court developed the “acid test” to see whether a person is being deprived of their liberty, which consisted of two questions:

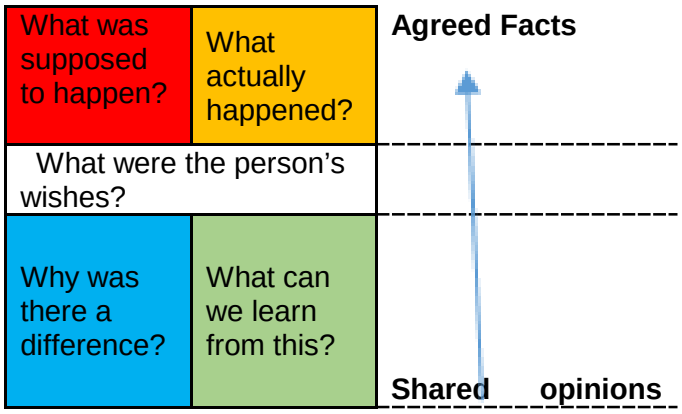
- Is the person subject to continuous supervision and control? and
- Is the person free to leave? – with the focus, the Law Society advises us, being not on whether a person seems to be wanting to leave, but on how those who support them would react if they did want to leave.

This resulted in a large increase in referrals both locally and nationally. For example in Dudley there were 142 DoLS referrals in 2013-14; this increased to 940 in 2017-18. Further developments include Deprivation of Liberty in the Community (CDoL). This is a protection for people over 16 who are in supported living, extra care housing and in their own homes.

## Safeguarding Adult Reviews

### SAR Sub Group

Under the Care Act 2014, local safeguarding adults Boards (SAB) have a statutory duty to carry out a Safeguarding Adults Review (SAR) when an adult with care and support in its area dies and the Board knows or suspects that the death was as a result of abuse or neglect and there is concern about how the SAB, its members or organisations worked together to safeguard the adult.




These questions are supported by reflection on the six safeguarding adults principles that were published in 2011 and embedded within the Care and Support Statutory Guidance 2016. The SAR process is designed to establish whether there are any lessons to be learnt from the circumstances of a particular case, about the way in which local professionals and agencies worked together to safeguard the adult at risk. The SAR brings together and analyses findings from investigations carried out by individual agencies involved in the case, in order to make recommendations for improving future practice where this is necessary.

It is felt that the voice of the adult at risk is explicit in the centre of the review. This includes seeking consent for the review, including their views and that of their family wherever possible, and asking agencies how they have considered the adult's wishes and views throughout their involvement. From feedback from families who felt that they were not heard, a Victim's Code has been developed to ensure that families/carers are kept fully informed when a serious incident has occurred.

Prior to January 2018 Dudley's Safeguarding Adult Review (SAR) pathway was not clearly defined and consequently not embedded into practice. This deficit did not support referrals being made to Dudley Adult Safeguarding Board, from either members of the multi-agency partnership and or single agencies and individuals. However, this position has significantly improved. A clear and robust procedure has now been developed and agreed by the multi-agency partners who make up the SAR Subgroup. This pathway is now published on the Adult Safeguarding Board webpage; additionally seven minute briefs have been developed to raise the profile of SARs and training.

The Board accepts that the recommendations and learning from the two completed SARs have been delayed. This was partly due to a lack of a multi-agency strategic training programme. This has now been addressed and the learning from these reviews will be appropriately shared. Additionally, difficulties were experienced in delivering some of the recommendations due to securing funding for a specialist allied health care professional, this has now been completed. Furthermore, there have been challenges in implementing changes to the social care assessment tool to include any disclosed issues with eating and drinking. Work continues in this area.

## Case Studies

### Adult MASH

***B*** is 88 years old and lives in a residential home. She has a diagnosis of vascular dementia.
A safeguarding contact was received from CQC; a whistle-blower had reported that B had been shouted at by staff and was often forced to go to bed at 5pm without food. It was also reported that she was often tearful.

The concern was considered in the Adult MASH team and forwarded to the social work Reviews team for an enquiry. An enquiry was completed by a social worker who examined care home records and spoke with B. B was assessed as lacking mental capacity to contribute to the safeguarding process and therefore contact was made with her daughter as her representative. The

daughter was told about the safeguarding and asked about her desired outcomes under "Making Safeguarding Personal". The daughter was very happy with the care at the residential home and had no concerns.

The social worker examined the care records; care plans, risk assessments and daily recording. No evidence to support the allegation was found and the safeguarding was closed at the end of the enquiry and no further action was taken in accordance with B's daughter's wishes. Assurance had been gained as to the quality of care and B's care had been reviewed. Her daughter was satisfied with these outcomes.

***K*** is a 45 year old man who is sleeping rough.

He has issues with substance and alcohol misuse.

A relative who was worried about him raised concerns, stating that he was neglecting his own health, not eating or attending health appointments and that his mental health was suffering.

The MASH team were able to share information effectively and quickly with partners; including mental health, primary care GP, homelessness team and substance misuse services. It was quickly established that K was well known to many of these services. A safeguarding meeting was held to discuss our approach. The meeting allocated tasks, coordinated our approach and appointed a lead worker to make contact with K to establish his feelings and his desired outcomes from the safeguarding process. Through the process we were able to establish that K was in fact in quite good health. Although he still had issues with alcohol and substance misuse these were reasonably well controlled. He did not wish to be "safeguarded", but did agree that he would like to work towards accommodation if he were in control of the decision making process. In accordance with his wishes; safeguarding processes did not continue but he continues to have positive engagement with the Homelessness team who are working towards accommodation. K has also been encouraged to have medical checks with his GP and his health is now monitored. All of this is with his consent and because of the relationship building work undertaken by the homelessness team.

**Dudley Disability Service**

***J*** is 20 years old and has a moderate learning difficulty. She initially attended mainstream school, but subsequently moved to a special school to meet her educational needs. The safeguarding alert came from Housing and the Police following an investigation of antisocial behaviour and criminal activity, including the use of illegal drugs taking place at a property within the Dudley locality. The safeguarding alert was made in relation to J, in view of her perceived particular vulnerabilities and concerns of her inability to protect herself from harm. It was also established that J was homeless, sofa surfing across Dudley and pregnant, expecting her first child. The initial risks and concerns were immense. J was in a relationship with a young man who had a long criminal history, including violence that posed significant risks for J and her unborn child. Initially it was viewed that J had a moderate learning disability as opposed to learning difficulties.

The safeguarding alert alleged concerns of J being physically abused, sexually abused, risk of emotional/psychological abuse, financial abuse and potential control and coercion.

As result of multi-agency working across the Police, Housing, Health, Probation Services, Adult and Children's Social Care services under the Inter agency Adult Safeguarding Policy and Procedures we were able to establish a firm diagnosis, undertake mental capacity assessments in relation to specific decisions, agree actions and complete a multi agency risk assessment to manage risks for the protection of J and her unborn child. As part of this process and in line with Making Safeguarding Personal we engaged J in the whole process and were able to offer her access to lot of support, advice and information.

Each agency took a very proactive approach towards supporting J to deliver the best outcome for her and her unborn baby. J did not always engage so this proved a challenge at times in both

supporting her and managing risks. The Children's Safeguarding Investigations ran parallel to this process for the protection of the unborn child.

J moved back home to be supported by her family, her baby was delivered safely and placed into care. The outcome is not what J wanted but the case study is an example of the some of the complex situations that we are dealing with within the Dudley Disability Service and how working within a multidisciplinary approach, with good communication, sharing knowledge, skills and resources support the management of risks we aim to achieve the best outcome for the vulnerable adult , young person and children, whilst also fulfilling our statutory responsibilities to safeguard vulnerable adults and children.

**Primary Care**

Concerns raised by ambulance service when they attended a lady who was caring for her partner who had a palliative diagnosis. They overheard him say that he was going to kill her before he died. Police were contacted and she refused to speak to them as she was frightened of the repercussions and that "it would only make matters worse". A safeguarding concern was raised to MASH and checks were completed with various agencies to gain further details:

- Talking to family who shared that there had been domestic abuse within the household for over 50 yrs and the woman had left five years previously due to her husband's controlling and coercive behaviour
- Palliative care team who visited regularly that the lady had a very strict regime on times when she would go to bed and when she could go out and shared that the lady had told them of one incident where her husband had knocked her teeth out
- It was identified that she was allowed to attend GP appointments on her own
- GP surgery had an appointment booked for a medicines review and it was agreed that this would be an opportunity for the DA officers to speak to the lady on her own
- Referral into MARAC to ensure that safety measures were put in place

With support from IDVA, her family, and several meetings set up at the GP practice, the woman made the decision to move in to a shelter until it was safe to return home.

**Trading Standards**

Dudley Trading Standards are dealing with multiple complaints regarding financial scamming of adults within the borough. In the most extreme cases tens of thousands of pounds have been lost by victims. In one case, an elderly resident was telephoned by scammers claiming to be from his bank. They persuaded him to transfer his life savings to another bank account for "safety". The money was then removed and disappeared. On realisation that they had been scammed, the victim was devastated. Trading Standards are now investigating the criminal accounts with a view to criminal proceedings if the operators can be located and identified. They are also representing the victim in a complaint against their bank, who it is argued should have made greater checks before allowing the transfer of an elderly customer`s life savings.

In March 2017 Dudley Trading Standards successfully completed a ground breaking investigation into a carer who had financially abused a 93 year old man. Over less than two years, the carer took at least £230,000 from the man, including using his money to purchase a detached house for herself in Halesowen. The carer was convicted of Fraud by Abuse of Position and Perverting the Course of Justice, and sentenced to five and a half years in prison. However, the carer appealed both the conviction and the sentence. In July 2018 both appeals were dismissed by the Court of Appeal.

**Dudley and Walsall Mental Health Trust**

Concerns were raised by the community older adults service with DWMH safeguarding team about a 76 year old woman with advanced dementia. She was in receipt of carers four times a day for all aspects of care, however still lived with her son in the family home. The son had been posing difficulties with care agencies, blocking access to his mother, becoming aggressive with care staff

where they felt too vulnerable to provide the care. This led to there being no availability of any care agencies willing to attend the property to provide the care due to the risk.

A safeguarding meeting was held due to the escalating concerns and no services being available to provide the care that she needed to function and maintain her basic needs and dignity. The outcome of the meeting was that it was unsafe to leave this woman in the home over the weekend without the appropriate care and support going into the home. The legal department was contacted and an urgent court of protection application was made. That same night, with the aid of multi-agency working and with emergency services, the woman was removed to a place of safety where a full assessment of her needs could be carried out and care and support provided appropriately.

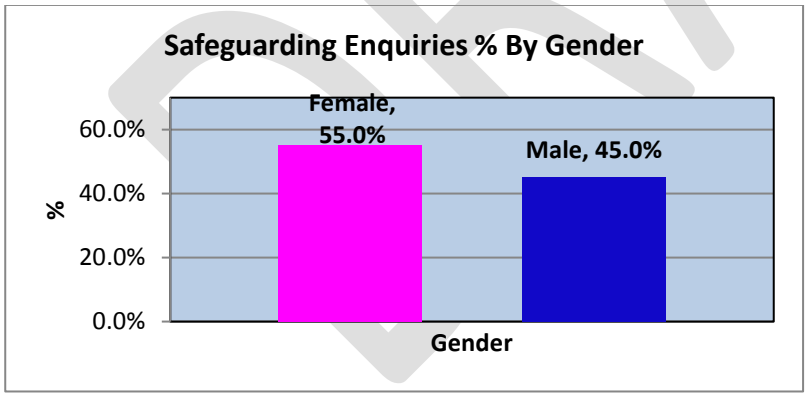
This lady has not returned to the family home despite interventions being offered to support the son, however his behaviour and the home environment was not conducive and deemed unsafe for the return of an extremely vulnerable lady who has no insight or capacity. She is now placed in a nursing home and thriving, with support she now eats and feeds herself. In the family home she was not weight bearing at all and now stands for short periods supported by staff.

## Performance data

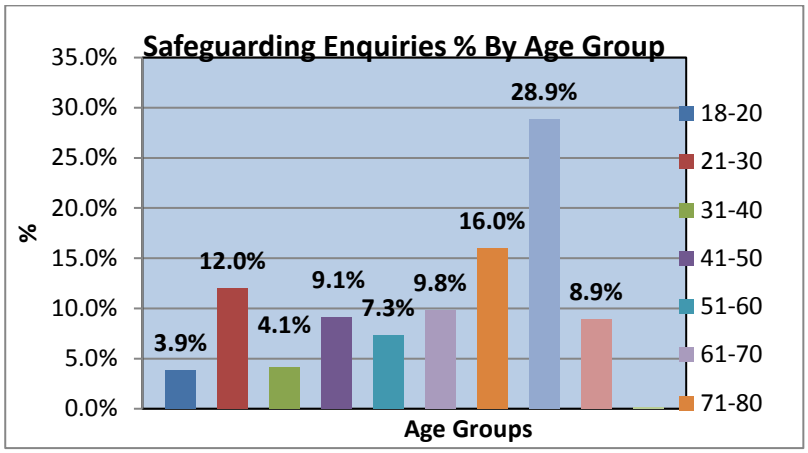
### 1st April 2017 – 31st March 2018

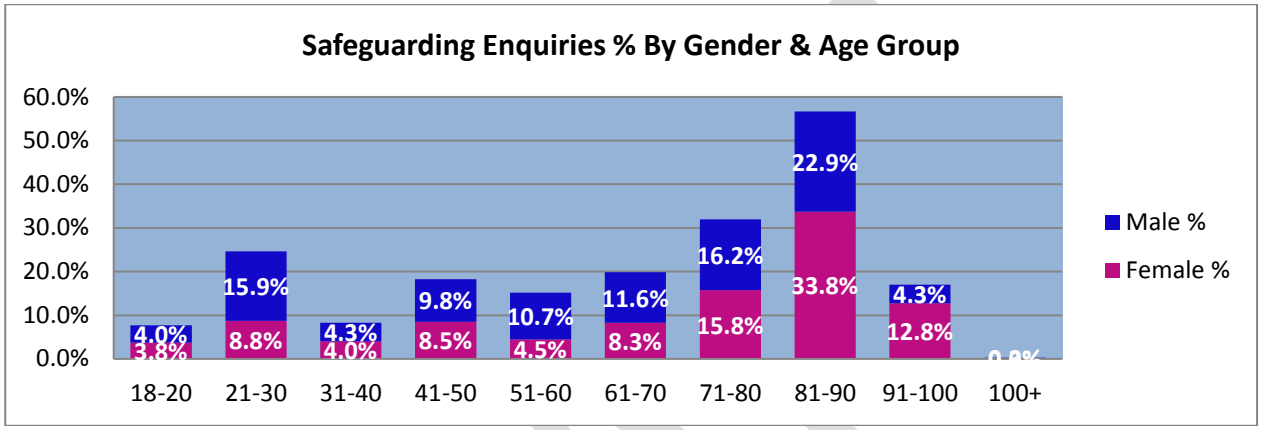
The number of adult safeguarding concerns reported between 1st April 2017 and 31st March 2018 was 3051, continuing the upward trend; 2016-17 at 2809, 2015-16 at 2091 and 2014-15 at 1713. During 2017-18, 727 (23.8%) were progressed through the safeguarding process as enquiries, however during 2016-17, 831 (29.6%), 2015-16, 743 (35.5%) and 2014-15, 726 (42.4%) were progressed, suggesting that the screening process at first contact is continuing to effectively signpost and the MASH implementation is having a positive affect. The following graphs analyse this enquiry data for 2017-2018.

Overall, the majority of enquiries were for females at 55%, with 33.8% of females falling into the 81-90 age group.

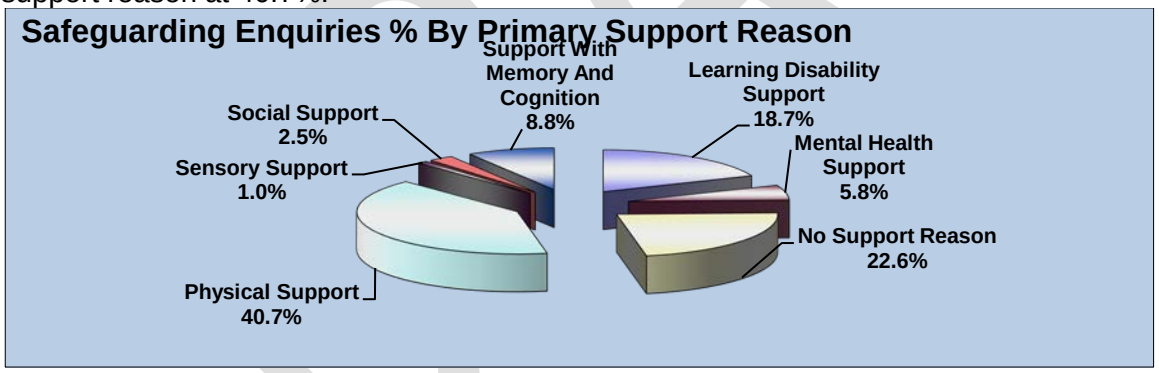


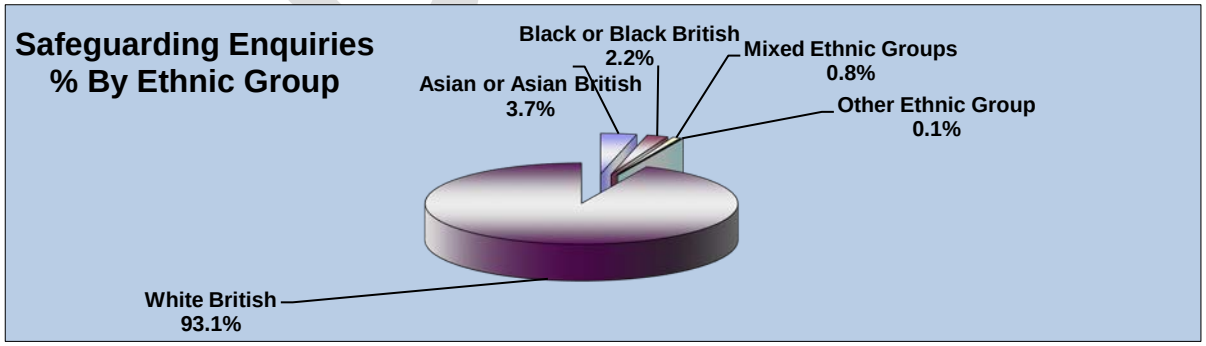

The majority of all enquiries overall were also in the 81-90 age group at 28.9%.



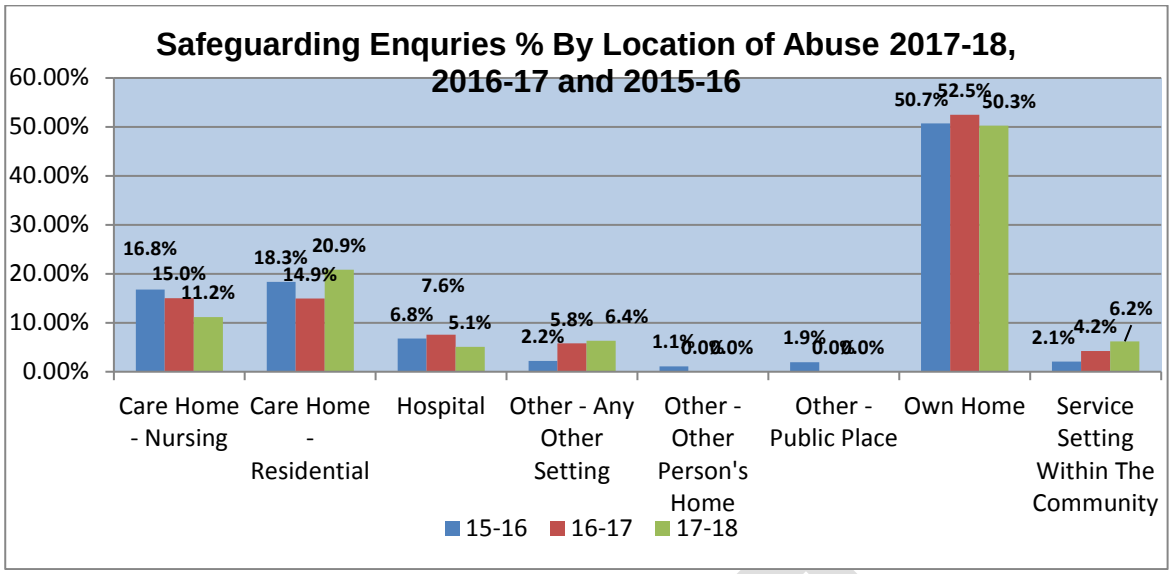




As in 16-17, the majority of enquiries were recorded for people in the physical support primary support reason at 40.7%.

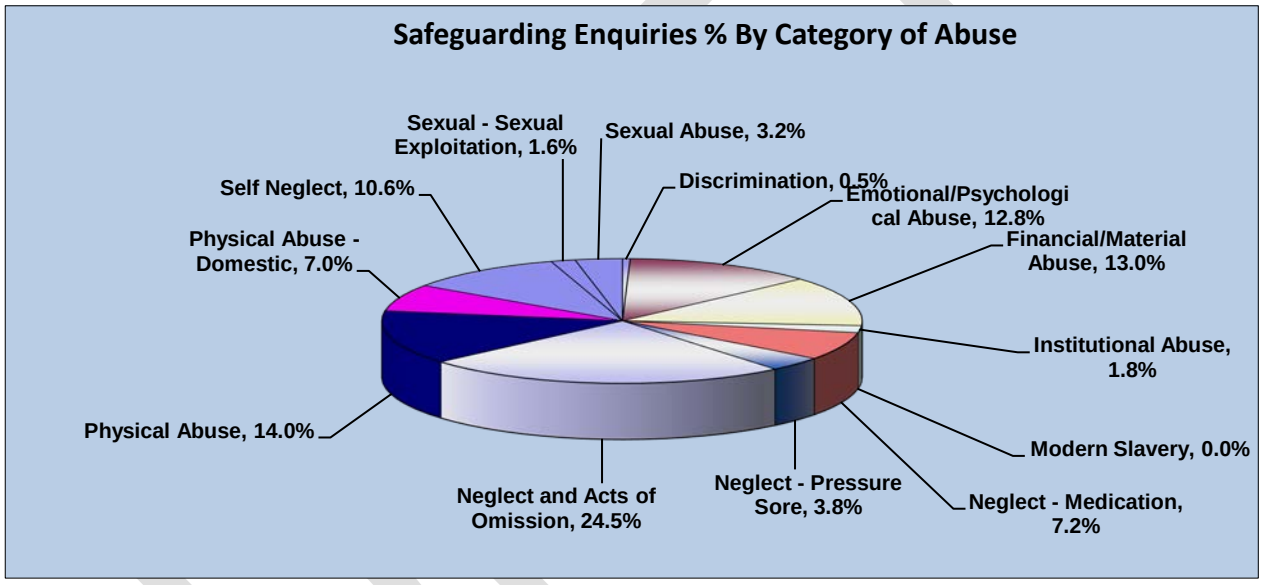



Also the majority of enquiries were recorded for people in the white British ethnic origin group at 93.1%% which is almost exactly the same as for 2016-17 (92.5%).



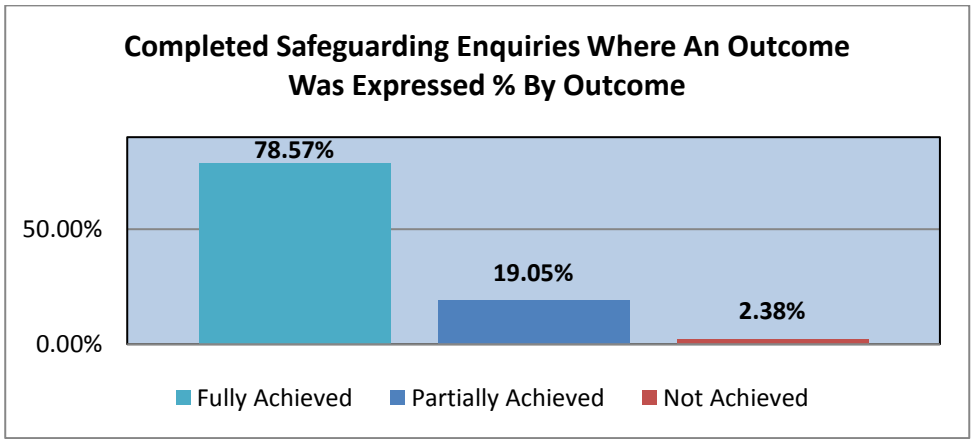

The majority of enquiries were recorded as taking place within the victim's own home at 50.3%. Of these 364 referrals taking place in their own home 54.4% were for females.




The abuse category of neglect and acts of omission was recorded as the highest proportion of all enquiries at 24.5% and similar to 2016-2017 (27.76%), however, if all neglect categories are combined this figure increases to 35.5% and clearly forms the majority of abuse categories overall.

The number of completed enquiries during the same time period, i.e. where all investigations have been completed and an outcome agreed, was 589 compared with 625 during 2016-2017.

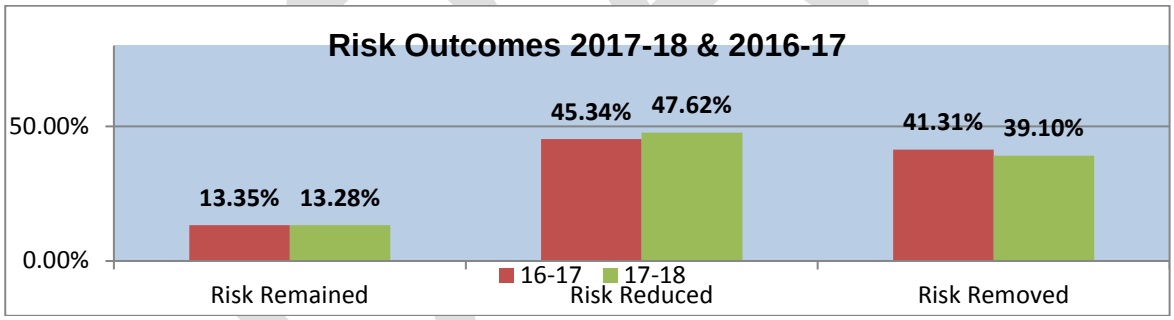
The fact that an enquiry was substantiated or not is no longer collected. In line with the Care Act, Making Safeguarding Personal is recorded to replace this. Of the 420 people that expressed an outcome of their safeguarding experience, 78.57% had that outcome fully achieved.




The Adult MASH has identified the need to improve timeliness of completing contacts. The most recent data suggests that one in three contacts is completed within three days, and three out of four contacts are completed within fifteen days.

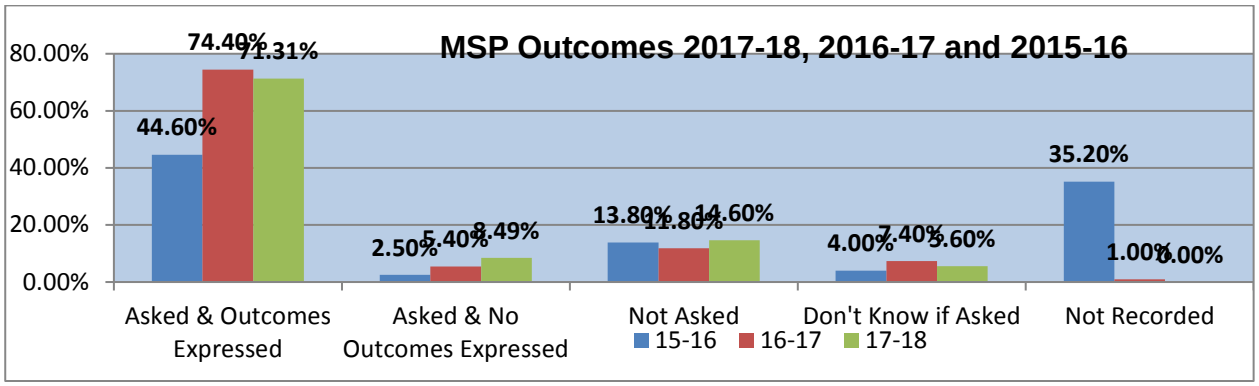
In 2016/17 staff recorded that 86.5% of risks to people were reduced or removed as a result of safeguarding actions. This trend has continued into 2017/18 with 86.75% of risks being reduced or removed.

| Risk Outcome | 16-17 | % | 17-18 | % |
|---|---|---|---|---|
| Risk Remained | 53 | 13.35% | 53 | 13.28% |
| Risk Reduced | 180 | 45.34% | 190 | 47.62% |
| Risk Removed | 164 | 41.31% | 156 | 39.10% |
| Total | 397 | 100.00% | 399 | 100.00% |

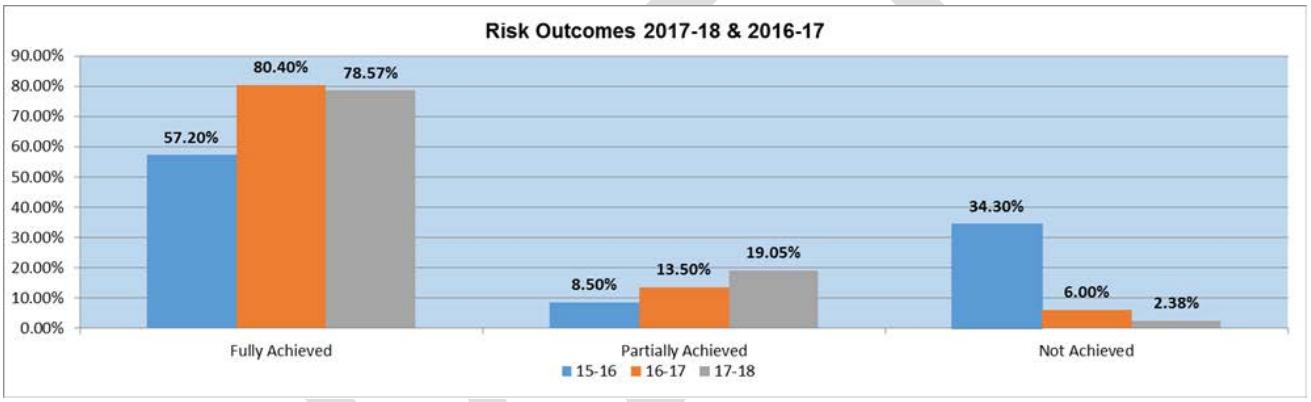



## Making Safeguarding Personal

| MSP Outcomes | 15-16 | % | 16-17 | % | 17-18 | % |
|---|---|---|---|---|---|---|
| Asked & Outcomes Expressed | 236 | 44.60% | 465 | 74.40% | 420 | 71.31% |
| Asked & No Outcomes Expressed | 13 | 2.50% | 34 | 5.40% | 50 | 8.49% |
| Not Asked | 73 | 13.80% | 74 | 11.80% | 86 | 14.60% |
| Don't Know if Asked | 21 | 4.00% | 46 | 7.40% | 33 | 5.60% |
| Not Recorded | 186 | 35.20% | 6 | 1.00% | 0 | 0.00% |
| Total | 529 | 100.00% | 625 | 100.00% | 589 | 100.00% |




| MSP Outcomes Achieved | 15-16 | % | 16-17 | % | 17-18 | % |
|---|---|---|---|---|---|---|
| Fully Achieved | 135 | 57.20% | 374 | 80.40% | 330 | 78.57% |
| Partially Achieved | 20 | 8.50% | 63 | 13.50% | 80 | 19.05% |
| Not Achieved | 81 | 34.30% | 28 | 6.00% | 10 | 2.38% |
| Total | 236 | 100.00% | 465 | 100.00% | 420 | 100.00% |




The percentage of people who have had their personal outcomes either partly or fully achieved has risen from 65.7% in 2015-16, to 93.9% in 2016/17 and again to 97.6% in 2017-18.

Agenda Item No. 8

**Health and Adult Social Care Scrutiny Committee – 21st November 2018**

**Report of the Head of Maternity Service, The Dudley Group NHS Foundation Trust**

# Quality of Maternity Care in Dudley

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| **Purpose** | |
| 1. | To update the committee on the quality of maternity services provided by the Dudley Group NHS Foundation Trust. |
| **Recommendations** | |
| 2. | That the Scrutiny Committee notes and comments on the contents of the report. |
| **Background** | |
| 3. | In October 2017, the Report of the Dudley Maternity Services Quality Improvement Board was published (Appendix 1). The report summarised the work of the Quality Improvement Board (QIB) and acknowledged the improvements that had been made to and by the maternity services during the QIB. All of the families who had been involved in the QIB were contacted and offered a personal copy of the report and an opportunity to meet with the Chief Nurse, Head of Midwifery and Head of Patient Experience. Three families requested meetings and a further two families requested a copy of the report but no meeting. |
| 4. | The maternity service improvement plan continues to be a live action plan including all service improvements in progress or planned by maternity. In the past 12 months, the improvement plan has been shared and challenged on a monthly basis by the executive and non- executive team at Clinical Quality Safety and Patient Experience Group within Dudley Group Foundation Trust (DGFT) and externally by service commissioners and executives at the Clinical Commissioning Group via the Maternity Performance Assurance Group. |
| 5. | Maternity Services continue to look to national and regional evidence of best practice to inform the improvements in the plan. Co-production is the ultimate aim for all service improvement and this has begun to be utilised through the recently established Maternity Voices Partnership (MVP). |
| 6. | Throughout this report you will see the golden thread of improving safety initiatives that maternity services are actively involved in with the aim of reducing incidence of stillbirth, neonatal deaths, maternal deaths and brain injury caused by birth. |

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| | **Care Quality Commission (CQC)** |
| 7. | The Care Quality Commission visited the Maternity Unit during the second week of their inspection of the Trust in December 2017. The CQC assessed the maternity service as Good; many of the recommendations from the CQC team were improvements that the maternity team had discussed and indicated that they already had plans to address or were in the process of addressing. |
| 8. | Several of the actions and the conclusions will be discussed in further detail throughout this report. These include staffing, bereavement care, governance, and improvement in patient experience. |
| 9. | The whole maternity team were very pleased that the improvements and developments since the last CQC visit were recognised by the inspectors. Now that CQC have moved to annual inspections, the team are keen to show that there have been further improvement and development and are striving towards outstanding. |
| | **Leadership and staffing** |
| 10. | Both midwifery and obstetric staffing have benefitted from the review during the past 12 months with active support from the Chief Executive. The plan was in place to increase the consultant obstetric team by two consultants to allow for a consultant obstetrician presence of 98 hours on delivery suite. At a meeting with members of the executive team the consultant team put forward the argument for an increase by a further two consultants to allow for improved involvement in governance and strategic planning. The additional four appointed consultants commenced in post between November 2017 and January 2018. The additions to the consultant body have afforded a dedicated consultant for clinical governance and a clinical service lead for obstetrics. |
| 11. | The Executive Team have also supported an external review of midwifery staffing by Birthrate Plus the organisation nationally recognised for calculating midwifery staffing. The Trust awaits the final report of the staffing review and this will be discussed with the executive team to plan for future requirements. |
| 12. | Dedicated lead midwife has been in place for the Midwifery Led Unit (MLU) for the past 11 months. This has allowed for clinical leadership dedicated to improving care for low risk labours. The numbers of births taking place on the midwifery led unit have increased during this time and overall the numbers of inappropriate transfers out of the midwifery led unit have decreased as all transfers are reviewed and learning shared. The midwifery led unit staff have independently organised two conferences with internationally recognised speakers to raise funds for additional equipment for the MLU. Additionally a midwifery ward manager role has been developed to improve the patient flow in the postnatal ward area enabling reduction in delays for transfer home to community midwife care. The appointment of a ward manager has ensured staffing is optimised and key performance indicators for newborn screening are achieved. |
| | **Clinical Improvements** |
| 13. | Introduction of a birth choice clinic ensures that women who are requesting to birth outside of medical guidance are offered a detailed discussion of risks and benefits. This ensures a fully informed choice is made and risk management plans can be affected to offer not only choice but also improve safety. |

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| 14. | Maternity Triage team are working with Birmingham Women's Hospital to implement the Birmingham Symptom Specific Obstetric Triage System (BSOTS). To ensure that women attending Maternity Triage are seen in a timely manner and triage is standardised against a research based, best practice standard. Training is in progress and roll out is at the beginning of December. |
| 15. | Changes to the induction of labour pathway improved the delays in induction that had previously occurred. This was possible because of the support from the Executive Team to increase the number of beds within the maternity unit. A number of single bedded rooms on the unit were identified as suitable to be converted to double rooms. Two rooms were identified as suitable to be changed to a four-bedded bay. In total a further 5 beds have been established through the changes to the estates. |
| 16. | The increase to in-patient bed numbers also allowed for a lifting of booking restrictions for women who reside outside of the Dudley borough. |
| | **Maternity Transformation Programme and the Local Maternity System - Black Country and West Birmingham** |
| 17. | The Maternity Transformation Programme (MTP) is a strand of the Sustainability Transformation Programme (STP). The ambition of the MTP is to halve the number of stillbirths, neonatal and maternal deaths and brain injuries by 2030. |
| 18. | In March 2017 clinicians from across the Black Country came together to agree a shared vision for the future provision of maternity services for the people of Dudley, Sandwell & West Birmingham, Walsall and Wolverhampton. The ultimate aim of the collaboration was to develop a Local Maternity System for the Black Country and West Birmingham and deliver the nine work streams of Better Births. Clinicians from Dudley Group maternity team have been active participants in this programme from the beginning, with support from the Business and Transformation team for the last ten months. The three-year plan developed by the Local Maternity System was submitted to NHS England in October 2017. In October 2018, the maternity team have commenced pilot projects to ensure that 20% of the women booking with the Trust will be on a continuity of care pathway throughout antenatal, intrapartum and postnatal care March 2019. The team made the decision to include women with diabetes in pregnancy as our initial focus as these are high-risk pregnancies and 8% of our total births are to women with diabetes. Traditionally continuity of care has been less of a focus with this group and the team have been commended by NHS England for including this particular group of women. The low risk pregnancies are also part of the pilot with integration between the midwives from the midwifery led unit into community midwifery clinics and community midwives into the midwifery led unit. Both of these projects have the aim of women being looked after in labour by a midwife who knows them. We are also planning to follow the example of one of the early adopters of Better Births the BUMP- Birmingham Universal Maternity Pathway of ensuring women who are having an elective caesarean section meet the midwife caring for them and their baby in theatre prior to the day of surgery. DGFT already has an excellent record of continuity of care in the antenatal period from a named community midwife of 80%, which compares favourably with our neighbouring trusts in the Local Maternity System. |

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| | **Maternity and Neonatal Safety Collaborative** |
| 19. | The collaborative is a three-year programme led by NHS improvement and launched in February 2017. Dudley Group NHS Foundation Trust is actively involved in Wave two of the programme, which commenced in April 2018. The collaborative is supporting the Trust to build local capacity in quality improvement and is providing structured support to the trust to assess the services in order to develop plans that lead to measurable improvement. |
| 20. | The aim of the collaborative is to:<br><br>• improve the safety and outcomes of maternal and neonatal care by reducing unwarranted variation and provide a high quality healthcare experience for all women, babies and families across maternity and neonatal care settings in England;<br>• contribute to the national ambition, set out in Better Births of reducing the rates of maternal and neonatal deaths, stillbirths, and brain injuries that occur during or soon after birth by 20% by 2020. |
| 21. | The quality improvement project that DGFT maternity and neonatal services have decided on is increasing the number of smoke free pregnancies. Currently the percentage of women smoking at time of delivery is approximately 12-14%. The ambition is to reduce this percentage to 6% as set by Public Health England. The project was launched with the whole maternity team after many weeks of planning, on 16th October 2018. |
| | **Clinical Negligence Scheme for Trusts (CNST)** |
| 22. | In December 2017, the Trust received a contribution notice from NHS Resolution, detailing the organisation's calculated contribution that was required by the Clinical Negligence Scheme for Trusts – CNST. The notification also included details of a maternity incentive scheme, which would be implemented for 2018/2019. |
| 23. | The national Safer Maternity Care update to the Maternity Safety Strategy[11] sets out the Department of Health's ambition to reward those who have taken action to improve maternity safety. Obstetric claims represent the biggest area of spend for all CNST members around £500million in 2016/17. Obstetric claims represent 10% of the volume and 50% of the value of all claims. |
| 24. | The maternity element of CNST contributions will be increased by 10% above all Trusts standard for the financial year 2018/19, to create a national maternity incentive fund. Maternity services that can demonstrate achievement of a specified set of ten requirements detailed in the aforementioned notice letter will be eligible for a share of that incentive fund of at least 10% of their base contribution, plus a share of the balance of undistributed funds, the amount of which will be determined once the results from all services have been gathered. The specific ten safety actions were detailed in a strategy document and will be explained in more detail within this paper. In order to qualify for refund of 10% of the premium the Trust must be able to demonstrate progress to the required standard against all ten of the safety actions. |

[1] https://www.gov.uk/government/publications/safer-maternity-care-progress-and-next-steps

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| 25. | The Maternity department with involvement from theatres and anaesthetics and the corporate governance team support were able to demonstrate achievement of all ten requirements and have received the 10% contribution refund. |
| | **Public Health** |
| 26. | The maternity team work closely with Public Health within the Local Authority specifically in respect of smoking cessation, healthy eating, improved exercise and breastfeeding initiation and continuation. |
| 27. | The Healthy Pregnancy Support Service (HPSS) consists of seven WTE band 4 support staff who work closely with community midwives across community and within the hospital to offer targeted support to women. The team can offer one to one support for smoking cessation, healthy eating/weight management and breastfeeding continuation. |
| 28. | The HPSS are actively involved in the Maternity Neonatal Safety Collaborative improvement project to reduce smoking at time of delivery to the new national target of 6% or less. |
| 29. | Funding from Public Health is also received for our Maternity Infant Feeding Assistants (MIFAs). The MIFAs can offer one to one breastfeeding support whilst women are in hospital and working alongside the infant feeding midwife help to improve the initiation and continuation of breastfeeding. The Trust was reassessed against the UNICEF Baby friendly standards in 2018 and reaccredited as compliant against the standards. The Trust has maintained full accreditation since 2002. In conjunction with breastfeeding support, the Trust has an award winning frenulotomy service delivered by midwives who have trained to become practitioners in frenulotomy (division of tongue-tie). Women travel from across the West Midlands, Wales and Cheshire to access the service, which also offers placements to practitioners on the course at Wolverhampton University. |
| 30. | All women attending for their scan appointments at 12 weeks and 20 weeks are offered vaccinations to protect against Influenza (Flu) between October and February and Pertussis (whooping cough) all year round. This was implemented in January 2018, as an alternative to vaccination in GP surgeries and at the request of Public Health England to improve the uptake of both vaccinations for pregnant women. In January and February 2018, 68 women received flu vaccine. To date nearly 800 women have received pertussis vaccination via antenatal clinic at DGFT. The plan is to deliver far more flu vaccinations in 2018/19 as the antenatal clinic has received the vaccine from the start of flu season this year. |
| | **Bereavement Care** |
| 31. | Improved care and support for bereaved parents was a priority that the maternity team shared with the CQC inspectors. The Executive team have also supported the improvement plans at every stage. Building work has been carried out to convert a room on the delivery suite to a dedicated bereavement suite. The building work has offered a degree of soundproofing and improved privacy, together with the facility to store a cold cot in an appropriate environment. The room allows for family's to be together following a bereavement and for partners to remain overnight in a less clinical setting. |

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| 32. | A bereavement midwife has been appointed who is leading on the implementation of the National Bereavement Pathway at the Trust. The appointment of the specialist midwife allows for continuity of care between hospital and community and a point of contact for bereaved women and families. |
| | **Patient Engagement** |
| 33. | Involvement of women and families in service improvement is one of the important work streams in the Maternity Transformation Programme. It's also essential for the maternity team at DGFT to understand what the women using our service want and need. The response to Friends and Family Test in maternity is generally very good and of those that respond the assessment of the service is favourable. Each month we review the narrative comments and make changes based on these. |
| 34. | In 2018, the team supported the establishment of the Maternity Voices Partnership (MVP). We are very fortunate to have a service user as our chairperson, someone who came to talk to us about areas of our service that she had experienced that needed improvement. Quarterly meetings have been established and are held within one of the Children's Centres. The meetings involve a variety of stakeholders including the Clinical Commissioning Group and Healthwatch. We actively encourage women to become involved in shaping the services. Moving forward all service developments will be discussed at the MVP to gauge women's views on change to ensure co- production. |
| 35. | Also as part of the development of the LMS a "Whose Shoes " event was held in Dudley in March 2018. Whose Shoes is social enterprise providing a standardised approach to getting feedback from a group of stakeholders about maternity services. No one group is seen as more important than another. The event was extremely well attended and a follow up event "We said We Did" was held at the end of September 2018. |
| | **Conclusion** |
| 36. | Maternity services are in the middle of many programmes of change, however the main focus of all of these changes is a safer service that offers safety, choice and continuity for all women and their families. |
| 37. | The maternity team at DGFT are actively involved with a number of strategies that will assist in the improvement of the service. |
| 38. | Our aim is to ensure that the service we deliver offers safety with informed choice and puts women and their families at the centre of all we do. |
| **Finance** | |
| 39. | There are no direct financial implications arising from the contents of this report |
| **Law** | |
| 40. | There are no direct legal implications arising from the contents of this report |
| **Equality Impact** | |
| 41. | This report has no direct implications to equality and diversity. |

| **Human Resources/Transformation** | |
|---|---|
| 42. | There are no direct human resource implications arising from the contents of this report |

**Dawn Lewis**
**Head of Maternity Services**

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**Background Information:-**

Appendix 1 - Report of the Dudley Maternity Services Quality Improvement Board

Appendix 1

NHS

# Report

## of the Dudley Maternity Services Quality Improvement Board



Published October 2017

# Contents

# 1. Foreword

**Early in 2016, NHS England alerted Dudley Clinical Commissioning Group (DCCG) to concerns about the high number of serious incidents in Maternity Services at The Dudley Group Foundation Trust (DGFT).**

This report summarises the outcomes of the work of the Quality Improvement Board (QIB) which was established to look into those concerns.

It highlights the importance of strong clinical leadership and effective governance procedures. It emphasises the importance of understanding why things happen, of learning effectively from issues, and of sharing that learning widely to improve services. And it demonstrates the added value that external advice and support can offer to the improvement process. It also reinforces the importance of communicating with and involving patients and their families in their care.

During the course of the QIB's work, DGFT have introduced a comprehensive improvement plan for maternity services. This addresses the issues identified and provides assurance about the safety and effectiveness of the maternity services in Dudley.

The many improvements that have been made to DGFT Maternity Services as a result of the QIB's work are a tribute to the diligence and hard work of everyone involved, and I would like to thank them for their efforts and offer specific thanks to the families who contributed to the process.

**Mr Steve Wellings**
Chair, Quality Improvement Board

# 2. Context

**Maternity Services at DGFT are responsible for the delivery of around 4,600 babies each year. The unit is well-regarded in the local community and serves not just Dudley and the Black Country area, but also parts of Worcestershire and Staffordshire.**

Within the maternity unit, there is a triage area with four beds, a delivery suite with 10 rooms and a maternity ward with 22 beds. A co-located Midwifery Led Unit (MLU) has five rooms where 608 babies were born last year. The maternity unit has two dedicated obstetric theatres.

Currently the maternity unit is staffed by 168 midwives, which allows for the provision of one-to-one midwifery care in labour. The number of midwives required is assessed using the midwifery establishment Birth Rate Plus Staffing Tool that is recommended by the National Institute for Clinical Excellence (NICE) in the safer staffing guidance. The unit meets these recommendations. There are 32 doctors within the unit, 10 of which are consultant obstetricians and gynaecologists. This enables the service to comply with the Royal College of Obstetrician and Gynaecologists (RCOG) recommendations of 98 hours per week of consultant obstetric cover for the delivery suite.

DGFT has a level two neonatal unit, which has 18 cots, three of which are used to provide intensive care and two for high dependency care. Babies requiring neonatal intensive care that meet defined criteria, are transferred to a level three neonatal unit. These arrangements reflect the British Association of Perinatal Medicine recommendations.

One of the measures used to compare the outcomes for babies is the neonatal and stillbirth mortality rates. This is the number of babies that regrettably die compared to the total number of births. DGFT maternity unit's early neonatal mortality rate in 2014/2015 was 1.8 which meant that for approximately every 1,000 births, fewer than two babies died. This was below the national average of 2.68 per 1,000 births. DGFT maternity unit's stillbirth rate was 3.14 which means that for every 1,000 births fewer than four babies were stillborn. This figure compared favourably with a national figure of 4.64 per 1,000.

DGFT Maternity Services were last inspected by the Care Quality Commission (CQC) as part of an overall review of the Hospital Group in 2014. At that time, the CQC praised the caring nature of maternity staff and the environment in which women and babies were cared for. However, they expressed concerns about staffing levels and felt that the categorisation of incidents and recording of data were, at times, inaccurate. They reported that this prevented the service from fully analysing incidents and learning from these.

The CQC report summarised Maternity Services as 'Good' in relation to the assessments of 'Effective', 'Caring' and 'Responsive' domains, but as 'Requiring Improvement' in the areas of 'Safety and Well Led'. Overall, the CQC assessed the Maternity and Family Services as 'Requiring Improvement'. (The full CQC report can be found at www.cqc.org.uk).

# 3. Introduction

**In January 2016, Dudley Clinical Commissioning Group (DCCG) were informed by NHS England West Midlands (NHSE) that The Dudley Group NHS Foundation Trust (DGFT) had reported a higher number of Serious Incidents (SIs) than for comparable maternity units in the West Midlands between April 2014 to December 2015.**

In addition to this, it was identified by NHSE that there was limited learning associated with these Serious Incidents.

When a Serious Incident[1] happens, it is necessary to objectively establish what happened; what went well and what didn't, alongside what actions should be taken to avoid a similar occurrence in the future. This process should involve the patient and, where appropriate, their family. If incidents happen and are not adequately investigated, the same mistake and harm can be repeated; this is unacceptable. If lessons are not learned, the risk of recurrent harm increases. In maternity services where the health and wellbeing of women and babies is at the heart of care, the processes for investigating incidents are central to ensuring safe high quality care.

Following an initial assessment of the SI Root Cause Analysis[2] (RCA) reports from this period, by the DCCG, and the support of independent reviewers to provide objectivity and challenge, it was confirmed that DGFT maternity Serious Incident investigations were inadequate, that learning was not identified appropriately, and that there was harm in some cases. The DCCG subsequently led the establishment of a Maternity QIB as this was agreed as an open and transparent approach to investigating and addressing the concerns raised. The Maternity QIB commenced in April 2016 and the purpose of this report is to provide an overview of its work.

[1] Serious Incident (SI) - "…events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response";
[2] Root Cause Analysis (RCA) - defined by the NHS as: "a useful tool for thoroughly investigating reoccurring problems of a similar nature …in order to identify the common problems (the what?), contributing factors (the how?) and root causes (the why?). This allows one comprehensive action plan to be developed and monitored and, if used effectively, moves the focus from repeated investigation to learning and improvement".

Both definitions taken from NHS England (March 2015) Serious Incident Framework

# 4. Scope of the Maternity Quality Improvement Board

**From the 43 cases reported as Serious Incidents between April 2014 and December 2015 the Maternity QIB agreed to initially review 25. Of the 25, 19 related to care that affected the baby and 6 cases related to care of the woman. These 25 presented the most opportunity for learning.**

The objectives of the QIB were to:

- work openly and collectively to review and enhance maternity services;
- gain assurance that maternity services provided by DGFT are safe and effective and that processes to manage risk are robust;
- ensure those families whose cases formed part of the review were given opportunities to actively engage in the process and contribute towards any lessons learned, keeping them informed throughout;
- review DGFT system wide Serious Incident processes between April 2014 and December 2015 - addressing governance and reporting; and
- ensure lessons are learned and actions are taken to address issues that were identified.

The work of the QIB was allocated to three sub groups.

Each sub-group was given a set of tasks to ensure the QIB achieved its aims. The main work of each group is explained on the following pages.

## A. Clinical Review Group (CRG)

The Clinical Review Group (CRG) was clinically led and included clinical representatives from both DCCG and DGFT, supported by an independent external consultant obstetrician. The purpose of the CRG was to provide assurance that the maternity service provided by DGFT was clinically safe and effective and involved detailed reviews of the 25 cases. In addition, the CRG was to identify improvements in care and service delivery and to ensure that learning is implemented for the benefit of women who receive maternity services from DGFT in future, their babies and their families.

Each of the 25 cases was clinically reviewed separately and thoroughly. The clinicians challenged decisions made throughout each case, and considered possible links between these decisions and outcomes for women and babies. There were five cases where there was avoidable harm and one death. DGFT have been open with all of the families affected. Where care and service delivery issues affected the outcome for women and babies, this was identified and led to recognition of themes which have been addressed within the DGFT maternity improvement plan.

All families were written to by DGFT and informed of the review into their care. They were offered the opportunity of a meeting with senior staff from DGFT. The point of this letter was to provide the 25 families with the opportunity to share their views on the care they received and to raise any questions they would like answered as part of the review process. Five families responded to the initial letter requesting a meeting. These families met with senior staff and were provided with the outcome of the review of their case by DGFT. Following the review of all the cases, the remaining 20 families were contacted for a second time. Six families were informed there was additional information regarding the care they had received and they were invited to a meeting with DGFT; of these, three families took up this offer. The remaining 14 families were informed that the review had concluded and it did not identify any findings that had not been shared with them previously.

During the review, DGFT identified that due to a disconnection between the DGFT clinicians and the maternity risk management processes, there were missed opportunities to prevent further recurrence of service and care delivery problems that may cause harm.

The CRG acknowledged that DGFT had not systematically investigated maternity Serious Incidents, identified root causes and embedded appropriate learning. The QIB were assured by the Governance Group that by providing training for staff on conducting systematic and objective investigations and redesigning the risk and governance systems within maternity and across the wider organisation, future governance would be robust. The CRG also had oversight of and monitored the maternity clinical improvement plan, to ensure that care and service delivery issues that had been identified, were addressed.

The CRG concluded that the 25 cases demonstrated common themes and opportunities for learning, as detailed in Section 5. The review of further cases was considered, however the CRG consensus was that they would not reveal anything that was not already captured within the improvement plan.

## B. Governance Group

The Governance Group built on the work already underway across DGFT. It comprised clinical and managerial representatives from DGFT, the DCCG and Local Authority Public Health, and focused on improving the management and oversight of SIs across the system as a whole.

The Group:

- reviewed action plans to improve governance and reporting including ensuring clarity of roles of responsibility for assurance across DGFT, DCCG and NHSE. These actions included training for DGFT and DCCG staff and revisions to templates used for Root Cause Analysis reporting;

- agreed measures that could be used to show progress and monitor Serious Incidents on an on-going basis.

The Governance Group were assured that DGFT has taken positive steps to develop its incident, risk management and governance frameworks, with specific assurance gained in respect of maternity services. Oversight of maternity governance has now transitioned to a DCCG-led monthly Maternity Performance and Assurance Group. This provides a forum for ongoing dialogue in relation to the quality and safety of care in maternity services.

Two subsequent external reviews, reported via the DCCG Quality and Safety Committee, have both indicated that they were significantly assured of the improvements made in managing Serious Incidents which have been reported.

## C. Communications Group

The Communication Group membership included communications leads from both DCCG and DGFT and from each of the QIB organisations. The role of Healthwatch Dudley was to be assured that the process was transparent and that Duty of Candour was followed throughout.

The group was instrumental in agreeing an engagement plan and communication concordat which was put in place and signed by all but the independent organisations of the QIB.

The communications group followed the principle of putting those most affected by the review first. They played a key role in the way that families affected were informed of the case review and insisted that the families were the first to receive this report prior to wider publication. Further detail on the involvement of families is included in the CRG section of this report, as it was right that the conversations with families happened at a clinical level.

# 5. Findings of the Maternity Quality Improvement Board

## 5.1. The review identified that Serious Incidents were not routinely reviewed by a Multidisciplinary team of professionals.

While DGFT Root Cause Analysis documentation indicated that clinicians within a Multidisciplinary Team (MDT) were responsible for investigating cases, the review identified that this was not happening. The Root Cause Analysis' were largely undertaken in isolation with limited input from clinicians; there was rarely a connection between the clinical conversations which happened with families, the risk and governance processes and midwifery supervision. This meant that when there were care and/or service delivery issues within individual cases, there was limited learning to help prevent further recurrence and potential harm to women and babies.

DGFT's process for the review of Serious Incidents now mandates that this is always done with input from obstetricians as well as midwives and includes anesthetists, cardiologists, paediatricians and other professionals as required. There is a process for the review of unexpected admissions to the Neonatal unit and that always includes paediatric staff input. There is also increased clinical leadership through the greater involvement of senior medical staff associated with risk management and governance processes.

A senior consultant obstetrician from Birmingham Women's Hospital NHS Foundation Trust attended DGFT's Maternity Governance Meeting on two occasions, to provide an expert independent review of cases and to enable sharing of clinical guidelines as appropriate.

In addition, a consultant midwife with specific expertise in governance, worked with the maternity team to further provide an independent review and assurance of Serious Incident processes being delivered. She has provided DGFT and the DCCG with positive feedback, confirming there has been a significant level of improvement and a clear commitment demonstrated by the DGFT maternity team to address the areas of weakness in governance and risk management.

The sharing of learning is now a priority in the maternity unit. The midwives, doctors and support staff train together with professionals from other disciplines who frequently work in maternity; this includes staff from the neonatal unit, anesthetics and theatres. Numerous methods are used to ensure everyone is informed and kept up to date.

Meetings are held regularly to discuss the care of women and babies. These meetings are attended by a range of clinicians including midwives, paediatricians and anesthetists to discuss cases and learn together on how they can improve care.

## 5.2. The review identified that DGFT assurance processes were not robust and DGFT were being over reliant on, and falsely assured by, the feedback from external organisations

The CCG requested support from an NHS England Midwife in reviewing the Serious Incident RCA's. They had accepted assurance on these from the stated level of MDT investigation.

DCCG has since changed the process of assurance for Serious Incident Root Cause Analysis documentation. This new process has been independently audited on two occasions to validate the improvements in this area.

However, as highlighted in 5.1, the documentation did not reflect the processes that were taking place and this could not have been known to the external agencies. DGFT were also falsely reassured by the fact that their Root Cause Analysis documentation was being produced in a timely way and this was misinterpreted as an indication of thoroughness.

DGFT established a Task and Finish Group in the summer of 2015, chaired by the Chief Executive Officer; to examine six serious incidents. The group met three times to review whether there were any themes or commonalities across those cases which would warrant further investigation and found none. The QIB identified on reflection that had the Task and Finish Group worked differently, it could have identified earlier the issues which have subsequently been highlighted elsewhere in this report. While the Task and Finish Group's actions and findings were taken as internal assurance by DGFT, it represented a key missed opportunity by the Trust to have identified maternity governance issues earlier.

DGFT have recognised the importance of clinical perspective when reviewing cases and they have changed their internal ways of working to ensure the clinical voice is heard.

## 5.3. The review identified fragmentation of governance systems and processes across the organisation and single points of failure across DGFT

DGFT has recognised multiple governance weaknesses which had contributed to the failings in maternity care. There were also wider governance issues identified such as the delayed application of the revised national Serious Incident framework released in March 2015; this was identified during the review in April 2016.

In response to this, DGFT has implemented a new training programme for staff in Serious Incident processes.

There was also a disconnect between the DGFT maternity investigatory and midwifery supervisory processes; this was subsequently investigated by the LSAMO and further case reviews took place.

The governance group monitored that the DGFT system assurance issues were addressed; however the supervisory issues were discussed and assured within the CRG.

Significant national changes of Supervision of Midwifery processes has resulted in the opportunity to ensure that the links between investigations and midwifery practice are strengthened in DGFT.

## 5.4. The review identified that Cardiotocography (CTG) heart rate monitoring was, in some cases, misinterpreted and therefore the wellbeing of the unborn baby was, in some cases, compromised

The CRG reviewed cases where the fetal heart monitoring was interpreted incorrectly and actions were delayed or not taken to avoid the potential of the baby being harmed.

To address this learning, DGFT undertook a thorough review of CTG training, sought advice from a tertiary maternity unit on best practice and has increased the frequency and breadth of training to all staff on CTG use and analysis.

There were also cases where CTG assessment of a baby's wellbeing was not completed before an epidural was sited. Midwifery, obstetric and anaesthetic staff are all now aware and compliant with this requirement. This process is audited on a monthly basis from 1st August 2016 and has shown 100% compliance with this improvement.

The documentation of a structured assessment of the fetal heart recording during a CTG was reviewed and rewritten in April 2016, and is used systematically across all areas of antenatal and labour care. There is also a system by which hourly reviews by senior staff, called 'Fresh Eyes', is used to ensure an objective review of a fetal heart tracing. Although well used there were times when this was not documented, and again the group emphasised the importance of this process being systematically undertaken by all staff. DGFT has been assured by monthly audits of these improvements demonstrating consistent compliance.

A competency assessment based on best practice has been developed and introduced in September 2016, for midwives and doctors regarding the interpretation of CTGs and documentation of the assessments made. Of the 168 midwives employed at the Trust, 158 have attended the fetal monitoring training session within the past 12 months and the remaining 10 have attended within the past 14 months, with dates to attend again within the next two months. All of the doctors employed in obstetrics at the Trust have attended a training session within the past 12 months.

There is now an identified lead consultant obstetrician who, together with a lead Midwife, delivers the training to mixed groups of staff. These sessions are multidisciplinary, attended by both midwifery and medical staff, to promote team working and this has the advantage of encouraging greater discussion of CTGs which are often complex and open to different interpretations.

In addition to the internal training, all staff are encouraged to attend external training courses, such as those run by the Royal College of Obstetricians and Gynaecologists (RCOG) and Baby Lifeline. Training packages provided by K2 and the RCOG, both online training and simulation systems, are available and obstetricians and midwives are required to complete these as part of their mandatory training every two years.

In December 2016, the maternity unit was successful in its bid for additional funding from the Department of Health for maternity safety training. Additional external training courses on fetal monitoring are being accessed by midwives and obstetricians via Baby Lifeline and the Maternity Network.

## 5.5. The review identified that there were, on occasions, delays in concerns being escalated in a timely manner to senior obstetricians

Despite there being a daily ward round where complex and/or high risk cases were discussed, the review identified a lack of documentation reflecting appropriate consultant involvement in decision-making for women under obstetric management. A review of the involvement of senior obstetricians has been undertaken and a revised procedure has been reinforced and monitored; this has improved, and now ensures, a more structured multidisciplinary ward round. The unit has introduced an audit to assure itself that there is early identification of high risk cases, and that senior obstetricians are involved and obstetric support is available when required. The support and involvement in routine care and escalation when required is to be documented in the patient records.

To ensure the Trust meets the RCOG recommendation to have 98 hours consultant cover for the labour ward each week, a further two obstetric consultants have been appointed. The vacancies in the midwifery workforce were addressed with a recruitment drive and concerted effort to improve midwifery staffing, to comply with Birth Rate Plus recommendations. A total of 21 midwives were appointed and all commenced employment between September and December 2016.

## 5.6. The review identified that there was concern regarding the use of drugs to induce labour and coordinate contractions

The review considered DGFT's use of induction agents, particularly in the management of vaginal births after caesarean (VBAC) cases, and the use of syntocinon, a drug used for induction and to coordinate and increase contractions in labour.

Although DGFT guidance for induction of labour reflected normal and acceptable practices, the guidance was reviewed and changes have been made to differentiate the types of induction agents (prostaglandins) used when women have had a previous birth by caesarean section. Specific education was provided for staff regarding the impact of the use of syntocinon on fetal wellbeing in labour.

## 5.7. The review identified that there were concerns that senior paediatric support was not available to assist with baby resuscitation at complex births

The review of cases raised questions about whether the most appropriate senior support was readily available, to support the immediate and ongoing resuscitation of a baby when difficulties arose. Local guidance was reviewed and updated to ensure a clear escalation process is in place to secure senior support when needed.

Subsequent audits have provided assurance that the right seniority of staff have been called and were available. It has been emphasised to staff the ongoing importance of ensuring the process is followed and documented.

The successful maternity safety training fund bid is now enabling DGFT to send an additional 72 midwives on enhanced training in Neonatal Life Support.

## 5.8. The review identified that there was concern that staff, on occasion, were slow to respond in a timely way to urgent situations and in some cases appreciate the deterioration of a woman's condition

External reviewers and members of the CRG identified a theme that staff, on occasion, were slow to respond to urgent situations and, in some cases, did not recognise deterioration in a woman's condition in a timely way.

A review of guidelines relating to care of the deteriorating patient was completed and a midwife lead was identified to participate in the DGFT Deteriorating Patient Group.

Reviews of the care pathways for women with severe pre-eclampsia and eclampsia, sepsis and existing long-term medical conditions were completed and updated to reflect the most up-to-date national guidance where necessary.

Multidisciplinary emergency skill drills study days, which staff attend annually, uses the DGFT Simulation Laboratory - a simulated ward or delivery suite environment. All staff can then practice the skills they need to use in an emergency situation and are given feedback on their performance. This allows for individual support to improve knowledge and skills.

A maternity acute illness management (AIM) course has been established within DGFT and all midwifery staff are attending.

## 5.9. The CRG review supported the importance of DGFT maternity services working with other maternity services, to share good practice and be involved in national initiatives to improve outcomes for women and their babies

As a consequence of the QIB process, DGFT have established a joint working relationship with The Royal Wolverhampton NHS Trust and midwives have shared learning and good practice. There is an effective programme of visiting each other's units, to share good practice across a wider network within the Black Country and more widely across the country.

DGFT contributes to NHS England's quarterly audit, based on the Saving Babies Lives Care Bundle, which aims to reduce the rate of stillbirths from 4.7 per thousand to 2.3 per thousand by 2030. The initial care bundle was launched in March 2016 and implemented by DGFT.

# 6. Conclusion

## The QIB process has demonstrated that where systems work together, they are more effective.

The Quality Improvement Board met its terms of reference and was assured:

- that after the detailed clinical review, and by the subsequent improvement plan, that the maternity services at DGFT are safer and more clinically effective;
- by DGFT that families have been appropriately engaged in the investigation of these cases;
- through the focused work of the governance sub group, that significant improvement has been made to both the Serious Incident reporting processes within DGFT and DCCG, and that these improvements are being embedded across the Trust
- through the active monitoring of the action plans developed, that the lessons learnt have been adopted and the learning is enhancing day-to-day practice at DGFT.

This QIB review has identified that the level of investigation of Serious Incidents in the maternity unit at The Dudley Group Foundation Trust (DGFT) was poor. The absence of effective investigations into cases where there were care and service delivery issues resulted in missed opportunities to share learning from problems and prevent them re-occurring. During the review of multiple cases, clear themes emerged that have been referenced in this report. These have been addressed by the maternity service. Having identified the lack of learning, DGFT has worked to actively involve families directly affected by this review and communicate with them regarding the findings.

The systems and processes have now been strengthened across NHSE, DCCG and DGFT. The organisations have worked closely on the improvement agenda and we have mutual confidence that incidents are now being investigated thoroughly, that all relevant learning is being identified, and the required changes are being made to optimise the safety of women and babies.

A wider benefit of the QIB has been to enhance clinical and managerial working relationships and act as a catalyst to enable DGFT to forge partnerships with other maternity units, to allow the learning at Dudley to be cascaded to others, as well as offering a conduit for DGFT to proactively seek opportunities to further learn and improve.

**Dudley Maternity Quality Improvement Board**
Published October 2017

# 7. Membership of the Maternity Quality Improvement Board

**Chair** - Mr Steve Wellings, Non-Executive Director, Dudley Clinical Commissioning Group

**Vice Chair** - Dr Doug Wulff, Non-Executive Director, Dudley Group NHS Foundation Trust

### Dudley Group NHS Foundation Trust (DGFT)

Dr Paul Harrison - Medical Director, DGFT
Mrs Dawn Wardell - Chief Nurse (until April 2017), DGFT
Mr Adrian Warwick - Consultant Obstetrician, Clinical Director, DGFT
Mrs Steph Mansell - Head of Midwifery (Retired June 2016), DGFT
Mrs Yvonne O'Connor - Head of Midwifery (June 2016 - December 2016)
Ms Siobhan Jordan - Interim Chief Nurse

### Dudley Clinical Commissioning Group (DCCG)

Mrs Caroline Brunt - Chief Nurse & Quality Officer, Dudley CCG
Dr Ruth Edwards - Clinical Executive, Dudley CCG
Dr Tim Horsburgh - Clinical Executive, Dudley CCG
Dr Steve Mann - Clinical Executive, Dudley CCG

### Care Quality Commission (CQC)

Ms Angela Martin - Inspection Manager, CQC

### NHS Improvement

Ms Zena Young - Senior Clinical Lead

### NHS England (NHSE) West Midlands

Ms Alison Tennant - Deputy Director Nursing & Quality, NHS England (West Midlands) (left October 2016)
Ms Helen English - (Quality Lead, joined QIB July 2016)
Ms Barbara Kuypers - Local Supervisory Authority Midwifery Officer (until April 2017)
Ms Jacqueline Barnes - Director of Nursing & Quality (joined QIB June 2017)

### Healthwatch Dudley

Ms Jayne Emery - Chief Officer, Dudley Healthwatch Dudley
Ms Pam Bradbury - Chair, Healthwatch Dudley

# 8. Glossary

| Abbreviation | Meaning |
|---|---|
| AIM Course | Acute Illness Management Course |
| BAPM | British Association of Perinatal Medicine |
| BWNHSFT | Birmingham Women's Hospital NHS Foundation Trust |
| CQC | Care Quality Commission |
| CRG | Clinical Review Group<br>The purpose of the group was to provide assurance that the service was clinically safe and effective and involved detailed reviews |
| CTG | Cardiotocography<br>Is a technical way to monitor a baby's heart rate alongside a woman's contraction during pregnancy and labour |
| DCCG | Dudley Clinical Commissioning Group |
| DGFT | Dudley Group NHS Foundation Trust |
| DoC | Duty of Candour<br>The Duty of Candour is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm |
| Eclampsia | Is a life-threatening complication of pregnancy. Eclampsia is a condition that causes a pregnant woman, usually previously diagnosed with pre-eclampsia (high blood pressure and protein in the urine), to develop seizures or coma |
| MDT | Multidisciplinary team<br>Multidisciplinary and Multi-agency working involves appropriately utilising knowledge, skills and best practice from multiple disciplines and across service provider boundaries, e.g. health, social care or voluntary and private sector providers, to redefine, rescope and reframe health and social care delivery issues and reach solutions based on an improved collective understanding of complex patient need(s) |
| MLU | Midwifery Led Unit |
| MPAG | Maternity Performance and Assurance Group<br>Provides a forum for ongoing dialogue in relation to the quality and safety of care in maternity services |
| NHSE | NHS England (West Midlands) |
| NHSE LSAMO | NHS England (West Midlands) Local Supervisory Midwifery Office |
| NIC | Neonatal Intensive Care |
| NICE | National Institute for Clinical Excellence |

# 8. Glossary

| Abbreviation | Meaning |
|---|---|
| Pre-eclampsia | Is a condition that typically occurs after 20 weeks of pregnancy. Signs of pre-eclampsia include high blood pressure (hypertension) and protein in urine (proteinuria). Symptoms of pre-eclampsia may include headache, visual disturbances, swelling of face hands and feet and upper abdominal pain. However often there are no symptoms and it may be picked up at a routine antenatal appointment by the results of the blood pressure and urine checks. |
| Prostaglandins | Induction agents<br>Is a hormone-like substance that causes your cervix to ripen, and which may stimulate contractions |
| QIB | Quality Improvement Board |
| RCA | Root Cause Analysis<br>Defined by the NHS as: 'a useful tool for thoroughly investigating reoccurring problems of a similar nature in order to identify the common problems (the what?), contributing factors (the how?), and root causes (the why?). This allows one comprehensive action plan to be developed and monitored and, if used effectively, moves the focus from repeated investigation to learning and improvement' |
| RCOG | Royal College of Obstetrician and Gynaecologists |
| RWT | The Royal Wolverhampton NHS Trust |
| Sepsis | Also referred to as blood poisoning or septicaemia, this is a potentially life-threatening condition, triggered by an infection or injury. In sepsis, the body's immune system goes into overdrive as it tries to fight an infection. This can reduce the blood supply to vital organs |
| SIF | Serious Incident Framework (released in March 2015) |
| SIs | Serious Incidents<br>Defined by the NHS as: 'events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response' |
| Syntocinon | A drug used for induction and to co-ordinate an increase of contractions in labour |
| T&FG | Task & Finish Group<br>Group established to assure themselves and providers of internal governance |
| VBAC | Vaginal births after caesarean |

# Notes

Dudley Metropolitan Borough Council

**Agenda Item No.** 9

**Health and Adult Social Care Scrutiny Committee – Wednesday 21st November 2018**

**Report of the Director of Strategy and Business Development - Dudley Group Foundation Trust**

**The Development of Dudley Group Foundation Trust Strategy for 2019-2021**

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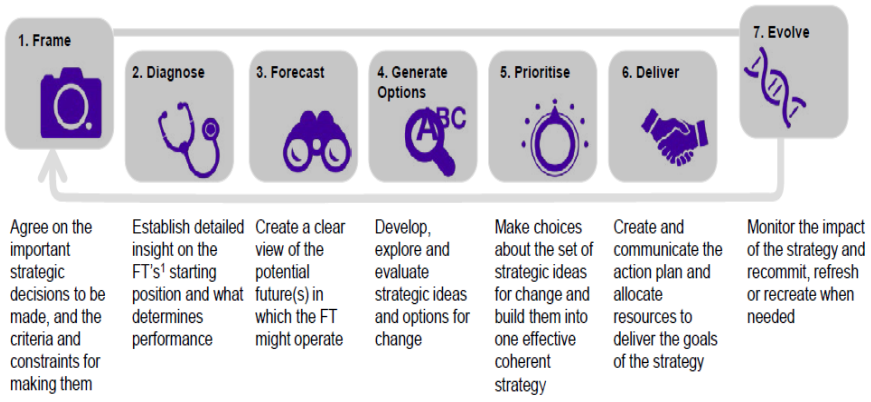
| **Purpose** | |
| 1. | The purpose of this report is to :-<br>• Inform the Committee on the steps taken to refresh the Dudley Group Foundation Trust Strategy;<br>• Gather feedback from the Committee to support the strategy's development. |
| **Recommendations** | |
| 2. | It is recommended that the Scrutiny Committee:-<br>• provide feedback on progress to date;<br>• outline any areas which they would like to see reflected in the strategy that are not evident currently. |
| **Background** | |
| 3. | The current Strategy for Dudley Group Foundation Trust (DGFT) covers the period 2015 to 2020. The strategy was written to meet the then requirements of NHS and is already out of date. A decision has been made by the Trust Board to refresh the strategy for the period 2019-2021. This paper outlines our progress to date. |
| **Process undertaken to date** | |
| 4. | The Trust's Strategy is being refreshed using the seven stages outlined in the NHS Strategy Development Toolkit. The toolkit defines a 'refresh' as being required when an organisation is generally content with their existing strategy but where the external environment has changed. The process tests whether the assumptions and aims of the strategy need to be changed. |




**Stages one (frame) & two (diagnose)**

5. These stages took place between December 2017 to July 2018. The frame stage was used to establish and agree the scope of the strategy development process by identifying the important strategic choices and decisions to be made and the criteria for making them. An engagement plan was also developed at this stage. The diagnose stage assessed the organisation's current performance and provided insights into what lies behind it. During this period, the Trust consulted extensively with patients, the public and its staff. Consultation has focused on:

   i) whether our current vision, values and strategic objectives remain fit for purpose;
   ii) analysis of the internal and external environment, including key issues that the Trust needs to address over the next two years;
   iii) update of the SWOT (strengths, weaknesses, opportunities, threats) analysis.

**<u>Key themes from Consultation</u>**

6. The outputs from consultation have been analysed as part of key themes. This is stage 3 (Forecast) phase of the NHS Strategy Development Model.

7. The key themes include:

   i) Almost universal agreement that the Trust's visions, values and strategic objectives are the right ones. The strap line 'Care better every day' was derived from the Directors' Improvement Practice visioning workshop in July 2018. It is proposed that this is added to the vision.
   ii) Dedicated and caring staff are the Trust's key asset, but staff retention, recruitment and training are key.
   iii) Financial pressures are an issue that the Trust has to address to secure the future of the Trust.
   iv) The volume and complexity of demand/changing demographics are the key local external factors that will impact on the Trust's service delivery. As a result, it was considered that the Trust would need to improve patient flow, improve pathways within and between services to optimise efficiency and productivity, as well as improve patient experience/outcomes.

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| | v) There was an emphasis on care closer to home/in the community with reconfigured pathways (MCP) and better partnership working, including with the local authority.<br>vi) Patients felt that improved communication would enhance patient experience (e.g. signage, nature of leaflets/letters, communication between services and with GPs).<br>vii) There was a lack of awareness of specialist services provided by DGFT – some patients would like services just for Dudley residents.<br>viii) Parking was consistently raised as an issue in all patient focus groups and whether we have a plan to address the cost and amount of parking available. This was also seen as a key factor influencing patient experience.<br>ix) The Electronic Patient Record was seen as a key enabler to securing transformational change to the way that staff work and in helping to improve the quality of care<br>x) Research and innovation were considered by staff to be an area which should have a higher profile and were key to the trust's reputation and future. |
| 8. | These key themes have been aligned with the Trust's six strategic objectives and Key Performance Indicators have been identified as measures for determining success. A Strengths, Weaknesses, Opportunities and Treats (SWOT) analysis has also been compiled. Four key areas for the strategy have been determined:<br><br>i) Workforce<br>ii) Clinically led services<br>iii) Quality improvement<br>iv) Business development and growth |
| 9. | In addition to the strategy, the Trust will continue to ensure that service meet predicted levels of activity though our annual operational planning processes. |
| **Next Steps** | |
| 10. | The Trust will re-commence consultation with patients, public, staff and partner organisations on the analysis from consultation and the SWOT analysis, whilst undertaking stages 4 and 5 of the strategy model (generate options and prioritise). This will take place during November 2018 during which, options generation and analysis will also take place for the four themes (workforce, clinically led services, quality improvement, business development and growth). The strategy document will be drafted in December 2018 with the view to it being reviewed and agreed through the Trust's governance process, culminating in presentation to Trust Board in January 2019. |
| **<u>Finance</u>** | |
| 11. | There are no financial implications relating to this report |

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| **Law** | |
| 12. | There is no legal requirement for a Foundation Trust to produce a Strategy. |
| **Equality Impact** | |
| 13. | The Trust will ensure that an Equality Impact Assessment will be undertaken on the final Strategy in line with Trust procedures. |
| **Human Resources/Transformation** | |
| 14. | There are no direct human resource / transformation implications arising from the contents of this report |

……..
**Natalie Younes**
**Director: Strategy and Business Development**

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Agenda Item No. 10

**Health and Adult Social Care Scrutiny Committee – 21st November 2018**

**Report of the Director of Commissioning, Dudley Clinical Commissioning Group**

**Clinical Commissioning Group (CCG) Policy on NHS Continuing Healthcare**

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| **Purpose** | |
| 1. | To address the challenges raised by the Equality and HR Commission (EHRC) regarding the legality of the CCGs NHS Continuing Healthcare (CHC) policies for funding of Care provided in the home. |
| **Recommendations** | |
| 2. | It is recommended that:-<br>• Scrutiny note and comment on the proposal and provide feedback for the CCG's Commissioning Development Committee on 19th December before a final decision is made. |
| **Background** | |
| 3. | NHS Continuing Healthcare (CHC) is the name given to a package of care that is arranged and funded solely by the NHS for individuals who are not in hospital and who have complex and ongoing healthcare needs to such an extent that the patient can be described as having a "primary health need". |
| 4. | In November 2017, Dudley and ten other CCGs received formal correspondence from the Equality and Human Rights Commission (EHRC) regarding the legality of their policies for funding packages of care provided in the home. |
| 5. | This briefing note sets out the CCG's proposal for addressing this challenge. |
| | **Existing Policy** |
| 6. | Whilst an individual can qualify for CHC regardless of location, in the patient's own home the NHS pays for<br>• healthcare (e.g. community nurse, specialist therapist or GP);<br>• personal care (e.g. personal carers, care workers).<br>In a care home, the NHS pays the care home fees (including board and accommodation). |

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| 7. | The CCG's policy has always placed a financial threshold on packages of care at home based on the equivalent costs of a care home placement for that individual patient plus 20% (other CCGs apply 10%) in recognition that domiciliary care packages are normally more expensive than residential care placements due to issues of economies of scale. |
| 8. | The EHRC has challenged this on the basis that it restricts an individual's right to choose where they are cared for, forcing them into residential care. |
| | **Public/Stakeholder Engagement** |
| 9. | The draft policy has been published on the CCG website for a four week period (12th November to 10th December) with an opportunity for people to get in touch and ask questions. |
| 10. | Patients who may be affected by the policy have been contacted separately either by letter and/or by telephone. Wider stakeholders have also been provided with an opportunity to comment and these include local MPs, elected members, Age Concern, Alzheimers Society, Strategic Director for People, Health and Wellbeing Board, Healthwatch, Local Medical Committee, Local Pharmaceutical Committee and the CCG's GP practices. |
| 11. | Feedback will be considered by the CCG's Commissioning Development Committee on 19th December before a final decision is made. |
| **Finance** | |
| 12. | There are no financial implications relating to this report |
| **Law** | |
| 13. | Legal advice received by the CCG and the other CCGs involved in the EHRC challenge is that the policy is lawful but needs to make clear that:-<br>• there may be exceptional circumstances where the 20% threshold might be breached (currently 2 Dudley patients);<br>• the CCG has a duty to balance the use of resources for its entire population whilst striving for a degree of patient choice. |
| 14. | The CCG's existing policy document has been redrafted to reflect this whilst retaining the 20% threshold. |
| **Equality Impact** | |
| 15. | This report has no direct implications for the CCG's commitment to equality and diversity. |
| **Human Resources/Transformation** | |
| 16. | There are no human resource implications in relation to this report |

**Neill Bucktin**
**Director of Commissioning, Dudley CCG**

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**Background Documents**

Appendix 1 – Commissioning Development Committee Report
Appendix 2 – NHS Continuing Health Care: Choice and Resource Allocation Policy

NHS Dudley Clinical Commissioning Group

# COMMISSIONING DEVELOPMENT COMMITTEE

**Date of Report: 17 October 2018**
**Report: Continuing Healthcare Choice and Resource Allocation Policy**
**Agenda item No: 11**

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|---|---|
| **TITLE OF REPORT:** | NHS Continuing Healthcare Choice and Resource Allocation Policy |
| **PURPOSE OF REPORT:** | 1. To consider a proposed Choice and Resource Allocation Policy for NHS Continuing Healthcare.<br>2. To approve a proposed plan for patient and public engagement. |
| **AUTHOR OF REPORT:** | Mrs J Cale – Commissioning Manager |
| **MANAGEMENT LEAD:** | Neill Bucktin – Director of Commissioning |
| **CLINICAL LEAD:** | N/A |
| **KEY POINTS:** | 1. Following a legal challenge from the Equality and Human Rights Commission the existing policy for NHS Continuing Healthcare has been reviewed and appropriate legal advice sought.<br>2. The revised policy now provides and appropriate balance between patient choice and the appropriate allocation of resources.<br>3. The policy also maintains a buffer in terms of the limit on the cost of a domiciliary care package at 20%.<br>4. Subject to the Committee's approval, it is proposed to carry out appropriate patient and public engagement on the revised policy. |
| **RECOMMENDATION:** | 1. That the proposed Choice and Resource Allocation Policy for NHS Continuing Healthcare be approved.<br>2. That the proposed plan for patient and public engagement be approved.<br>3. That a further report be submitted to the Committee in December 2018. |
| **FINANCIAL IMPLICATIONS:** | The policy contains a financial buffer of 20%. This is in line with the CCG's existing policy. |
| **WHAT ENGAGEMENT HAS TAKEN PLACE:** | To be commenced if agreed by Committee. |
| **ACTION REQUIRED:** | Decision<br>**Approval** ✓<br>Assurance |

**DUDLEY CLINICAL COMMISSIONING GROUP**
**COMMISSIONING DEVELOPMENT COMMITTEE – 17 OCTOBER 2018**
**Continuing Healthcare Choice and Resource Allocation Policy**

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## 1.0 BACKGROUND

1.1 In November 2017 the CCG received formal correspondence (alongside 10 other CCGs across the country) from the Equality and Human Rights Commission (EHRC) regarding the legality of its policy on NHS funded continuing healthcare package at home.

1.2 By way of background whilst an individual can qualify for NHS Continuing Healthcare regardless of location, in the service users own home the NHS pays for:-

- healthcare (e.g. community nurse, specialist therapist or GP); and
- personal care (e.g. personal carers, care workers);
- in a care home, the NHS pays the care home fees (including board and accommodation).

1.3 Commissioning of NHS Continuing Healthcare locally has always placed a financial threshold on packages of care at home, based on the equivalent costs of a care home placement for that individual patient plus 20%, in recognition that domiciliary care packages are normally more expensive than residential care placements (due to the absence of economies of scale).

1.4 This policy forms the basis of the EHRC concerns. The CCG have been working with 10 other CCGs and our legal team to review the policy. The final draft policy has been completed and is attached as Appendix 1.

1.5 The new policy is more detailed and robust, in broad terms, reflects patient choice but also reinforces the need to balance resources. Whilst the proposal within the policy is for a 10% financial buffer the current CCG policy is set at 20%. It is therefore recommended that the 20% buffer remains to avoid challenge that the threshold has been tightened.

## 2.0 PUBLIC ENGAGEMENT

2.1 It is proposed that a period of public engagement including current CHC funded patients, MPs and providers take place. The policy will also be published on the CCG website.

2.2 The timeframe for this consultation is as follows:-

- Commissioning Development Committee provisional approval 17 October 2018
- Public Engagement to commence on 22 October 2018 for a period of 4 weeks to 16 November
- Reporting to Commissioning Development Committee 19 December 2018.

2.2 At the same time as the consultation an Equality Impact Assessment (EIA) will be completed as part of the process.

## 3.0 RECOMMENDATION

3.1 That the proposed Choice and Resource Allocation Policy for NHS Continuing Healthcare be approved.

3.2 That the proposed plan for patient and public engagements be approved.

3.3 That a further report be considered by the Committee in December 2018.

# NHS Continuing Health Care:

# Choice and Resource Allocation Policy

## 1. Introduction and Scope of Policy

1.1. This Policy:

1.1.1. Sets out the commissioning principles that the CCG will work to when commissioning individual packages of continuing healthcare for patients eligible for NHS Continuing Healthcare ("CHC") funding by the NHS[1].

1.1.2. Should be read in conjunction with the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (October 2018, Revised) ("**National Framework**"). The National Framework has informed the terms of this Policy, with this Policy setting out how the matters described in the National Framework will be balanced in individual decision-making by the CCG.

1.1.3. Will apply to all commissioning decisions to commence providing an individual package of continuing healthcare from the date that it is adopted.

1.2. The CCG is entitled to depart from the Guidance set out in the National Framework where it considers appropriate to do so. The CCG acknowledges that parts of this policy could be considered to depart from the Guidance set out in the National Framework. The CCG has carefully considered the Guidance contained within the National Framework and has balanced that Guidance against the legal requirement on the CCG to act efficiently, effectively and fairly in allocating its limited resources between all of the patients for whom the CCG has commissioning responsibility. This means that this is the right policy for this CCG. This policy reflects the best assessment made by the CCG as to how it should make decisions in an attempt to be fair to all patients for whom it has commissioning responsibility.

1.3. For existing packages of continuing healthcare, this Policy will be applied and the decision making process set out hereafter will be followed when the care provided to existing CHC patients is first reviewed following the adoption of the policy.

[1] CHC is sometimes referred to as "fully funded" NHS care or "fully funded CHC". This policy does not cover the approach used by the CCG to calculating its appropriate contribution to meet the costs of medical services provided to patients as part of predominantly social care funded package of care.

1.4. This Policy **does not apply** to minor children under the age of 18 or to section 117 aftercare under the Mental Health Act. The policy will not directly apply to packages of care under section 117, but the CCG will discuss with its relevant Local authority partners whether it is appropriate to apply the same principles as set out in this policy to those packages of care and, if agreement can be reached, will develop a separate policy to implement the principles in such packages.

1.5. This Policy applies after (a) the CCG has made the decision that the CCG is the responsible commissioner for the patient and (b) the CCG has made a decision that the patient is eligible for CHC. The policy does not seek to define the processes that the CCG will follow to determine whether it is the responsible commissioner or to determine whether a patient is eligible for CHC.

1.6. Outside of the types of cases identified in paragraph 1.4, the CCG may be called upon to make arrangements for packages of services to be delivered to patients in circumstances which are similar to patients who are eligible for CHC. Whilst this policy cannot be used to increase the level of obligation owed to patients outside of those who are eligible for CHC, in order to ensure there is equitable use of the CCG resources and fairness between patients in such cases, the CCG will apply this policy to any decision making processes.

## 2. Definitions

2.1. The definitions used in this policy are as follows:

*10% Cost Ceiling*

This term has the meaning set out at paragraph 8.5 of this policy.

*Best Value*

The most advantageous combination of cost, quality and sustainability of care provision commissioned to meet the individual's needs.

*Care Coordinator*

A professional who coordinates the assessment and care planning process; usually the central point of contact for the individual.

*Care/Support Package*

The services commissioned by the CCG to meet a CHC eligible individual's assessed health and social care needs.

*Care Plan or Support Plan*

A document outlining the health and social care needs of the individual and setting out the services that the CCG proposes to commission to meet those reasonable needs which the CCG has agreed to provide services to meet, together with any outcomes which are intended to be achieved for that individual.

*Care Planning or Support Planning*

A process of planning the level and type of support services required to meet identified outcomes based upon an assessment of the individual's needs. This process should be undertaken by CCG staff, other NHS staff, clinicians and individual/family/carer, working in partnership.

*The Clinical Commissioning Group (CCG)*

The [INSERT NAME] Clinical Commissioning Group.

*Commissioning*

The process of planning and procuring services for individual patients or groups of patients in order to meet the statutory obligations owed by the CCG to those patients for whom it has statutory responsibility.

*CHC*

CHC means NHS Continuing Healthcare, as that term is defined in the Regulations. Regulation 20 of the Regulations defines CHC as "a package of care arranged and funded solely by the health service in England for a person aged 18 or over to meet physical or mental health needs which have arisen as a result of disability, accident or illness". The Regulations also define the decision making process that the CCG is required to follow to determine who is eligible for CHC. A person is not eligible for CHC within the meaning of this policy unless the CCG has followed the decision making process under the Regulations and reached a decision that person is eligible for CHC.

*CHC Eligibility*

A decision made by the CCG that a person is entitled to CHC funded care following the process described in Regulation 20 of the Regulations.

*National Framework*

The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (October 2018, Revised).

*Funded Nursing Care or FNC*

Funded Nursing Care Payments made in accordance with Regulation 28 of the Regulations.

*Home Care*

The provision of a package of CHC assessed by the CCG as reasonable to meet an individual's assessed health and associated social care needs in the individual's home or the home of a family member or any other location proposed by the individual where the owner and/or operator of the location is not registered with the Care Quality Commission to provide the relevant health or social case services.

*Individual*

The individual is the service user who has been assessed for a care/treatment package or placement.

*Individual Funding Request*

A request for funding by a clinician on behalf of an individual for a care treatment or service that is not routinely commissioned by the CCG.

*Personal Health Budget*

A sum of money made available to the individual (or their representative) or a Third Party in order to procure services to meet the individual's specific needs in accordance with their care/support plan.

*Procurement*

The process of selecting a provider with whom the CCG should contract to provide care to one or more individuals.

*Protected Characteristics*

Protected characteristics are defined by the Equality Act 2010. The following are protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief sex and sexual orientation.

*Provider*

A person or organisation who provides health and/or social care services to individuals which is funded by the CCG.

*Residential Care*

A residential care home, a residential nursing home or a hospital (as defined in section 275 of the National Health Service Act 2006) each of which is registered with the Care Quality Commission and which is able to offer a package of support including accommodation, health and social care to an individual. This includes a supported living setting as defined below.

*The Regulations*

The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012

*Representative*

Any family member, friend or unpaid carer who is supporting the individual in the process of securing NHS funding for a care or treatment package or placement, as well as anyone acting in a more formal capacity (e.g. welfare deputy or power of attorney, or any organisation representing the individual). Where an individual has capacity, s/he must give consent for a representative to assist the individual and to be provided with information by the CCG relating to the individual.

*Supported Living*

Supported living in this policy has the same meaning as in the Care and Support (Ordinary Residence) (Specified Accommodation) Regulations 2014 namely "accommodation in premises which are specifically designed or adapted for occupation by adults with needs for care and support to enable them to live as independently as possible" or "accommodation which is provided (i) in premises which are intended for occupation by adults with needs for care and support (whether or not the premises are specifically designed or adapted for that purpose), and (ii) in circumstances in which personal care is available if required".

## 3. Purpose of the Policy

3.1. The Policy has been developed to ensure, so far as possible within the policy structure set out hereafter and in as much as it is as far as is reasonably practicable:

3.1.1. Any package of services which is offered to be commissioned by the CCG is sufficient to meet the reasonable requirements of an individual who is eligible for CHC;

3.1.2. A person-centred approach is taken by the CCG in making decisions about any offer of health and/or social care services to be funded by the CCG for that individual;

3.1.3. Decisions are made in accordance with choices expressed by individuals and their representatives;

3.1.4. Decisions are made in a transparent manner;

3.1.5. Decisions are made in a way that is fair, balancing the CCG's duties to the individual and to all the other patients for whom the CCG has commissioning responsibility;

3.1.6. Where the CCG uses financial limits which may constrain the choices of types or locations of services that the CCG is prepared to fund, any decisions about those financial limits have been reached using a fair and transparent process, based on the individual's care/support plan.

3.2. Robust implementation of this Policy will require:

3.2.1. Commissioning arrangements (contracts) with providers that achieve the CCG's specified minimum quality standards and deliver cost-effectiveness;

3.2.2. The regular review of care and treatment packages/placements (as a minimum in accordance with National Framework expectations). The CCG reserves the right to review the care and treatment package/placement at any time and as and when clinically required;

3.2.3. In those cases where a review has identified the individual's needs have changed, the care provision will be adjusted promptly, according to the assessment and in accordance with the principles of this policy;

3.2.4. The use of interim or Discharge to Assess placements upon discharge from hospital, as required, to avoid delayed discharges;

3.2.5. Early determination of the responsible commissioner;

3.2.6. That where an individual is no longer eligible for CHC, the CCG will work with the individual and any other potential funders of care to exit from any CHC arrangements within 28 days or as quickly as is reasonably practicable .

## 4. Key Principles

4.1. Where a person qualifies for CHC, the responsible CCG has a duty to offer to provide a package of health and social care services to meet the individual's reasonable assessed health and associated social care needs. The duty to make and maintain the offer and, if accepted to commission care in accordance with the offer, continues for as long as the individual is eligible for CHC.

4.2. Standard NHS or social care services which can be accessed by the individual in the usual way (such as GP services or the services of an Accident and Emergency Department) can form part of an offer of a package of health and social care services under paragraph 4.1 provided, in the case of social care services, such services can be accessed by an individual without the need for payment to be made by the individual (unless covered by NHS Charging Regulations).

4.3. The CCG will seek to commission services using models that are person-centred. This means including considering the following elements in commissioning decisions:

4.3.1. Ensuring that the individual and/or their representative is or are fully and directly involved in the assessment process where possible;

4.3.2. Taking account of the individual's own views and wishes, ensuring that their perspective is incorporated in the assessment process;

4.3.3. Addressing, as far as reasonably practicable but having made reasonable adjustments where needed, the patient's communication and language needs;

4.3.4. Making reasonable adjustments to the type of services that are offered to be commissioned for an individual to take account of any protected characteristic of the individual or any other feature which makes it appropriate to adapt the offer to the individual's personal circumstances;

4.3.5. Complying with the CCG's obligations under the Equality Act 2010;

4.3.6. Obtaining consent to assessment and sharing of records (where the individual has mental capacity to give this);

4.3.7. Dealing openly with issues of risk; and

4.3.8. Keeping the individual (and/or their representative) fully informed.

4.4. The CCG recognises that an individual's needs may change over time and there may be other changes that the CCG has to take account of, including other demands on its budgets, technology changes or other factors that may change commissioning decisions related to the services that are reasonably required to meet the needs of an individual. Consequently any offer made by the CCG and/or any services that are commissioned by the CCG does not constitute any promise that the services will continue to be offered or commissioned in that manner in the future. Regular case reviews should be undertaken in order to reassess an individual's care needs and eligibility for NHS funded services and/or to determine what services should be offered or commissioned for an individual. The CCG reserves the right to reassess any package of health and/or social care services and/or an individual's CHC eligibility at any time and to amend care plans or any commissioned services in the light of any relevant circumstances.

4.5. The CCG has a statutory duty to break-even financially. When making decisions about commissioning services, the CCG must balance a range of factors including individual choice and preferences, quality/safety and value for money. Throughout the decision making process the CCG needs to recognise the need to achieve best value in its use of financial resources, in order that it can share finite NHS resources equitably across all patients for whom it has commissioning responsibility.

4.6. Other CCG policies may become relevant in individual cases. Where there is a conflict between the requirements on CCG decision makers in different policies, CCG decision makers will seek to follow whichever policy appears to them to be most appropriate in the individual circumstances of the case.

4.7. This policy sets out the principles that the CCG will follow to take decisions but does not describe the internal procedures that the CCG will use to make decisions. The CCG will make decisions using its existing decision making processes including:

4.7.1. Continuing Healthcare Panel;
4.7.2. Personal Health Budgets Individual Cases Panel;
4.7.3. Individual Funding Requests Panel.

## 5. Mental Capacity

5.1. If there is concern that an individual may not have capacity to make a decision about any aspect of their care or the location in which their care is to be provided, the CCG will arrange an assessment of the individual's capacity to make the decision in question in accordance with the

Mental Capacity Act 2005 and the associated Code of Practice (and taking full account of any changes to the mental capacity statutory framework).

5.2. Where it is assessed that an individual lacks the relevant capacity, the CCG needs to follow the processes under the Mental Capacity Act 2005 in devising options for providing services to the individual including involving the individual (if possible) and those who have an interest in the individual (including relatives) to understand the individual's wishes, feelings, beliefs and values and the views of others.

5.3. The CCG will have 2 different types of decision for a person who lacks capacity to make their own decision, namely:

5.3.1. First, the CCG makes decisions as a commissioner of NHS services as to whether the individual is eligible for CHC and, whether eligible or not, what offer should the CCG make to the individual to commission NHS services for that individual; and

5.3.2. Secondly, the CCG makes "best interests" decisions on behalf of the individual as to what services should be accepted on behalf of that individual by selecting between the options identified by the CCG at the first stage under paragraph 5.3.1 above. Those decisions need to be taken by the CCG after following the structured decision making process under the Mental Capacity Act 2005 having regard to the associated Code of Practice.

5.4. Where appropriate in accordance with the Mental Capacity Act 2005 and having regard to the associated Code of Practice, a best interests decision can be referred by the CCG or others to the Court of Protection.

## 6. Care Planning

6.1. If an individual is eligible for CHC and there is a need for an individual package of care or placement, the individual's Care Coordinator will discuss care options with the individual and/or his/her representative/s (where the individual gives consent for such a discussion or where the individual lacks capacity).

6.2. In all instances, the CCG will need to satisfy itself that any health and social care services that are to be commissioned by the CCG for an individual are to be provided in a location which is:

6.2.1. Clinically appropriate to provide the package of health and social care which the CCG has assessed is reasonably required to meet the individual's assessed health and associated social care needs; and

6.2.2. Able to provide a safe and sustainable package of care.

6.3. These considerations apply both when commissioning services for a patient who is eligible for CHC and on every review. Any review must consider whether the location at which health and social services are provided continues to meet the criteria set out at paragraph 6.2 above.

6.4. **The identification of Care Planning Options and patient choice:**

6.5. In most circumstances CCG staff will work with the individual and/or their representatives to seek to identify a range of potential locations and service options which are appropriate to meet the individual's reasonable assessed needs and will communicate those potential options to the individual and any representative identified by the individual.

6.6. The experience of the CCG is that the options for commissioning appropriate packages of care for patients who are eligible for CHC can, in suitable cases, include the following:

6.6.1. Health and social care services provided in Residential Care (as defined above); and

6.6.2. Health and social care services provided by way of domiciliary care in an individual's own home or in the home of a relative or other person, and referred to in this document as "Home Care", as further described in paragraph 8 below.

6.7. A package of care in either Residential Care or as part of Home Care provision may include the provision of specialist equipment.

6.8. The individual and any representative identified by the individual will be invited to indicate the individual's choice between the potential options (including any Home Care or Residential Care options that are put forward by the CCG as potential options). Any expression of choice by or on behalf of the individual between the available options will be carefully considered by the CCG and, subject to the terms of this policy, the CCG will seek to commission care at a location and/or from a care provider:

6.8.1. Which accords with the terms of this policy; and

6.8.2. Which accords with choices expressed by or on behalf of the individual (unless a different decision is required because of the application of the terms of this policy).

6.9. Where urgent decisions need to be made for a CHC eligible patient, because, for example, an individual is in urgent need of a residential care placement or is occupying a hospital bed when fit for discharge, the range of immediate options may be more limited. Whilst the CCG will seek, as far as is reasonably practicable and consistent with the exigencies of the situation, to give effect to choices made by or on behalf of the patient, an urgent decision may not give full effect to the CCG's choice commitment as set out above. However, any such urgent placement will be reviewed by the CCG and effect will be given to the provisions set out at paragraphs 6.4 and 6.8 above in later decisions.

6.10. The CCG may also discharge its duties by offering the patient a "discharge to assess" placement as an interim placement in advance of any final decision being taken as to whether the patient is eligible for CHC and/or, where the patient is CHC eligible, where the patient should receive services on a longer term basis.

**7. Residential Care**

7.1. Where the CCG is exploring a potential option of offering care for the individual in Residential Care, the CCG will ensure any proposed providers:

7.1.1. Are registered with the Care Quality Commission (or any successor organisation) to provide the appropriate form of care to meet the individual's needs; and

7.1.2. Are not subject to an embargo by the CCG or the relevant Local Authority which has been imposed arising out of or related to concerns about the quality of care being provided.

7.2. Wherever possible and subject to this paragraph, the CCG will offer a reasonable choice of Residential Care providers to the individual together with such information about the Residential Care options as the individual may reasonably require to assist him or her to express a choice. Reasonable, in this context, normally means a choice of up to three providers who have established contractual relationships with the CCG that are capable of meeting the individual's needs and that have vacancies at that time. The CCG will be prepared to consider another clinically appropriate location identified by the individual or his or her representatives (unless the proposed change of location materially adds to the costs of providing services to the individual).

7.3. The CCG recognises that most Residential Care placements are run by private businesses and that facilities and costs vary between different such placements. Where the CCG has agreed a framework or other arrangements with local Residential Care providers, the CCG shall be entitled to use that framework or other arrangements to set the costs of any proposed provision.

7.4. The CCG shall not be obliged to offer to commission care for an individual in Residential Care where the CCG concludes that it is likely to be charged more than 10% above the cost of the lowest cost of the other available options. In some circumstances, it may only be possible to offer the choice of one provider.

[*alternative form of clause 7.4: The CCG shall not be obliged to offer to commission care for an individual in Residential Care at a place of the individual's choosing where the CCG concludes that the cost of the individual's preferred option is higher than the cost of the other available options. In some circumstances, it will be possible only to offer the choice of one appropriate provider, in which case the CCG will fulfil its statutory obligations by offering to commission care for an individual at that Residential Care placement".*

7.5. When comparing costs of Residential Care providers, any costs comparison can be undertaken based on an estimate of the costs made by the CCG based on such inquiries as are reasonable and the CCG's knowledge of the cost of providing the care to other patients. As these costs can be accurately predicted by experienced CCG commissioning staff, there is no requirement for the Residential Care placement in question to have carried out an individual assessment and then provide an individual costed plan before the CCG can come to an estimate of likely costs of a clinically appropriate alterative package.

7.6. The CCG will notify an individual (and/or his or her representative/s) of any Residential Care setting where the CCG is prepared to offer to fund a package of care for the individual and, if requested by the individual or representatives, will provide details of any Residential Care settings that have been excluded by the application of the tests in paragraph 7.4 above.

7.7. In the event that individual or their representatives wishes to challenge the decision to exclude a Residential Care setting as an option , the individual or their representatives should make representations within 14 days to explain why the individual or their representatives considers that the Residential Care setting should not have been excluded and the CCG will reconsider the relevant decision. Any reconsidered decision will be a final decision and will be communicated to the individual or their representatives as appropriate.

7.8. Where an individual is eligible for CHC and is currently in a hospital or other care setting and is medically fit to be discharged, the individual (and/or his/her representative/s) will be given a reasonable choice of provider (which, in certain circumstance, may be no choice) and will be given 48 hours to make their choice. This time-limit is necessary in order to avoid delays to discharge and to avoid prejudicing the interests of other patients. Where no decision is communicated within this timescale, the CCG, in conjunction with the hospital, has the right to offer to move the individual to an appropriate interim care setting in order to free up the hospital bed. If this offer is declined, the individual will have no legal right to remain in a hospital bed and may be evicted from the hospital with or without a court order.

7.9. The CCG recognises that, for various reasons, it may not always be possible to accommodate an individual in a care setting in accordance with his or her first choice. If an individual's first choice accommodation is no longer available, the CCG will offer support to the individual to assist him or her to select another available provider as soon as possible. If an individual is placed in a home which is not their first choice, the CCG will consider whether it is possible to move the individual to the home of their choice if and when a vacancy arises.

7.10. If the individual who is eligible for CHC is unwilling to accept any of the offers made by the CCG, the CCG will have fulfilled its duties to the individual and is not required to take further steps to provide services to him or her.

7.11. If the individual's representative/s are delaying placement in a care setting due to non-availability of their first choice and the individual does not have the mental capacity to make decisions him/herself, the CCG reserves the right to work with the multi-disciplinary team involved in the individual's care and to make a 'Best Interests' decision on behalf of the individual in order to secure a prompt discharge.

7.12. Where an individual or their representative declines all of the care settings proposed by the CCG, the individual or their representative can suggest a different care setting so long as it satisfies the following criteria:

7.12.1. The individual's or their representative's preferred care setting satisfies the criteria set out at paragraphs 6.2 and 7.1 above; ; and

7.12.2. The cost of making arrangements for the individual at his/her preferred care setting meets the criteria set out at paragraph 7.4 above.

7.13. In exceptional cases, the CCG may be prepared to fund package of Residential care where the anticipated cost to the CCG is more than it would expect to pay under the terms of this part of the policy having regard to the individual's assessed health and associated social care needs. Very compelling or very compassionate circumstances will need to be shown to justify a higher cost.

7.14. The CCG will take account of an individual's views and wishes, including the individual's particular reasons and family circumstances, in determining whether there are very compelling or very compassionate circumstances that justify a higher cost being incurred to provide care. However, in reaching this decision, the CCG must be satisfied that the proposed overall cost of the Residential Care package is proportionate and a justifiable use of CCG funds in comparison to the cost of commissioning a package of care for the individual in another Residential Care setting.

## 8. Provision of Care in an Individual's own home or other location outside Residential Care (Home Care)

8.1. The CCG acknowledges that many individuals wish to remain in their own homes with a package of care in place to meet their assessed health and care needs. While an individual's views and wishes will be the starting point, the CCG must also ensure fairness across client groups, having regard to the need to share finite NHS resources equitably, and the need to provide value for money from the tax payers' purse.

8.2. The CCG recognises that family members and others may be willing and able to provide elements of care to the individual without funding being provided by the CCG, particularly if the individual continues to live in the same house as family members. The CCG also accepts that individuals are fully entitled to use their own resources or resources provided by others to provide any element of health or social care to them. The CCG fully accepts that family members, friends and any informal carers are under no legal obligation to offer to provide such care to an individual. Equally, the CCG recognises that, even where an individual is eligible for CHC, family members, friends or other paid carers may have become expert carers and both the individual and/or the individual may wish to continue existing care arrangements.

8.3. As part of the care planning process, the CCG will follow good health and social care practice by asking the individual, his or her family members and any other persons who provide informal or formal if they are prepared to continue to do so and whether the individual wishes any existing care arrangement to continue. If both the individual and the carer wish an existing care arrangement to continue, in assessing the individual's reasonable needs, the CCG will be

entitled to take such existing care arrangements fully into account. Accordingly, the CCG shall, as a starting presumption, look to provide a package of health and care services to meet those needs which are not being met by continuing existing care arrangements.

8.4. In the event that the CCG assesses that part of the individual's overall needs will be met by continuing existing care arrangements as set out at paragraph 8.2 above:

8.4.1. The CCG will consider the extent to which additional care should be provided so as to relieve those providing such care to have, for example, regular breaks. Any family members or other informal carers will normally be asked to undergo a carer's assessment by the Local Authority before any respite care is agreed. The outcome of any carer's assessment will determine the need for potential respite provision and whether this should be funded by the CCG or a local authority. The CCG shall take into account the carer's assessment when determining any funding to be given for respite care; and

8.4.2. The individual will have the right to inform the CCG of a change in circumstances in relation to the provision of any existing care arrangements relating to care for the individual which is not commissioned by the CCG (including any decision by a family member that they wish to reduce or cease providing voluntary care) in which case the CCG will, as soon as is reasonably practicable, reassess the situation and will consider whether alternative arrangements are required in order to deliver on the CCG's statutory duties.

8.5. In order that respect is accorded to an individual's views and wishes to receive Home Care, the CCG will normally agree to commission a domiciliary care package to support the individual by way of a Home Care package in the individual's chosen location provided:

8.5.1. The proposed Home Care package satisfies the criteria set out at paragraph 6.2 above;

8.5.2. The CCG is satisfied that a Home Care package is an appropriate and sustainable option for providing health and social care services to the individual; and

8.5.3. Unless the CCG make a decision under paragraph 9 below, the weekly average cost of doing so is able to be up to 10% higher than the lowest cost of providing equivalent care within Residential Care setting ("**the 10% cost ceiling**").

8.6. In considering whether any proposed Home Care package is an appropriate and sustainable option for providing health and social care services to the individual as required under paragraph 8.5 above, the CCG will make an assessment based on all relevant factors. Those factors may include the following:

8.6.1. The extent of the individual's health or social care needs and the sustainability of delivering care to the individual outside a specialist care setting;

8.6.2. The history of success or otherwise of delivering a Home Care package to the individual;

8.6.3. Whether care can be delivered safely to the individual without undue risk to him or her, and to any family members or staff engaged to provide the care. Safety will be determined via a formal risk assessment undertaken by an identified professional. The risk assessment will consider the availability of suitably skilled carers and/or equipment and the appropriateness of the environment;

8.6.4. The acceptance by the individual of any identified risks, notwithstanding any plans which are approved by the CCG which are intended to minimise any risks; and

8.6.5. Whether and how the CCG would be able to discharge its duties to the individual if the chosen domiciliary care provider pulls out of any arrangements and the chance of that happening.

8.7. When comparing the cost of equivalent care, the costs comparison will be on the basis of the CCG's estimated cost of providing the care reasonably assessed to meet the individual's assessed health and social care needs in a Residential Care or suitable alternative setting.

8.8. In the event that the CCG is considering not offering to discharge its statutory duties by offering to fund a Home Care package for the individual, the CCG will notify the individual (and/or his/her representative/s) of the estimated cost of providing care in Residential Care or other appropriate care setting prior to making a decision on whether to provide Home Care, in order to allow the individual (and/or his/her representative/s) to make representations as to the amount of such costs and/or to make representations in favour of extending the 10% cost ceiling.. A minimum period of 14-days will be provided for such representations to be made.

8.9. At any time the individual shall be entitled (but not in any way obliged) to suggest that a greater part of all or part of his or her needs for health or social care services shall be provided by

persons who are not funded by the CCG, as explained in paragraph 8.2 above. In the event that the individual makes proposals that any elements of care from any other source shall be provided, the CCG shall fully take that proposal into account in making decisions under this policy. The CCG shall have no obligation to plan to include any third party offers of care in the care planning process where the CCG has reasonable grounds for considering that the third party offers of care are inappropriate, not sustainable or will not meet the individual's reasonable needs.

## 9. Decisions to Fund a Home Care package in excess of the 10% cost ceiling.

9.1. In exceptional cases, the CCG will consider providing Home Care at a cost which exceeds the 10% cost ceiling.

9.2. In making such decisions the CCG will take account of an individual's views and wishes, including the individual's particular reasons and family circumstances, in determining whether there are very compelling or very compassionate circumstances that warrant providing a higher cost package of Home Care than the CCG would be prepared to support in the case of another patient in similar clinical and personal circumstances.

9.3. Very compelling or very compassionate circumstances may arise if it can be clearly established that not providing Home Care would be significantly detrimental to an individual's health or there are other circumstances which make the individual's case very significantly different to the case of another individual with similar clinical needs.

9.4. If the CCG takes the decision that very compelling or very compassionate circumstances exist in the case of an individual and thus, in principle, the CCG is prepared to consider funding a Home Care package which exceeds the 10% cost ceiling, then the following criteria must be satisfied before the CCG takes the decision to fund a Home Care package above the 10% cost ceiling

9.4.1. The proposed Home Care package must satisfy the criteria set out at paragraph 6.2 above;

9.4.2. The CCG is satisfied that a Home Care package is an appropriate and sustainable option for providing health and social care services to the individual having regard to the factors at paragraph 8.6 above; and

9.4.3. The CCG must be satisfied that the proposed overall cost of the Home Care package is proportionate and a justifiable use of CCG funds in comparison to the cost of commissioning a package of care for the individual in Residential Care.

## 10. Temporary Arrangements whilst a Home Care package is implemented.

10.1. In some cases, even where the CCG agrees to fund a Home Care package, the CCG may discharge its duties to the individual by offering to fund care for the individual in Residential Care for a limited period whilst arrangements can be put in place to implement any proposed Home Care package. This may be needed if time is required, for example to:

10.1.1. Run a procurement or other process to select an appropriate domiciliary care provider;

10.1.2. To set up a contract with the chosen domiciliary care provider;

10.1.3. To permit time to allow the chosen domiciliary care provider to recruit and train staff.

10.2. Where there is a delay in setting up a Home Care package as envisaged in paragraph 10, the CCG will discharge its duties by offering Residential Care to the individual in accordance with the procedures set out at paragraph **Error! Reference source not found.** above.

10.3. Where the CCG decides to offer a package of Home Care, the individual's home becomes the place of work of any staff member/s engaged to provide care. Employee safety is a key consideration and the individual's home must be a reasonably safe environment to work and deliver care.

## 11. Equipment and Wheelchairs

11.1. The CCG routinely commissions a range of equipment and wheelchairs from its core commissioning portfolio. Where the individual's assessed need is for equipment or a wheelchair of this nature, this will be provided through core contracts.

11.2. 'Bespoke' equipment that is not commissioned through the core commissioning portfolio may form part of an individual's assessed health need and be reflected in their care/support plan. Where this is the case, three quotes will be required from suppliers (wherever possible). The quote that reflects best value for money, in terms of maintenance and supply (including guarantee) will be recommended for approval by the CCG at the appropriate panel meeting.

11.3. Requests for equipment and wheelchairs for individuals placed out of area (i.e. not within [*INSERT CCG LOCATION NAME*]) will be considered on an equivalent basis to in-area provision, with individuals receiving the same nature/type of equipment in accordance with the paragraphs above.

## 12. Additional Services in residential care placements or as part of a domiciliary care service.

12.1. The CCG will only commission and fund those health or social care services that are (a) identified in an individual's care plan and (b) are considered by the CCG to be reasonably required by the individual to meet his reasonable needs. This may result in the CCG taking the decision not to provide services to meet every need for an individual identified in a care plan in the same way that the CCG does not fund services to meet every other health need for patients for whom it commissions services. For the avoidance of doubt, the CCG confirms that any care plan produced by the CCG for an individual will only list those services that the CCG considers are reasonably required by the individual. This can include services provided by relatives and other carers arranged by or on behalf of the individual.

12.2. The individual (and/or his/her representative/s) has the right to enter into an agreement with any care provider to provide additional services over and above the package of care that the CCG has agreed to fund and has assessed is required to cover the individual's reasonable care needs. Any costs arising out of any such agreement must be funded by the individual or through third party funding. These costs may, for example, relate to:

12.2.1. Additional non-healthcare services to the individual. For example, hairdressing, provision of a larger room, provision of an en-suite room or enhanced TV packages.

12.2.2. Additional healthcare services to the individual outside of the services that the individual has been assessed as reasonably requiring as part of their NHS funded care/treatment package. For example, the CCG may not consider that the individual reasonably requires a chiropractor or additional physiotherapy sessions but the individual may wish to fund these elements of care themselves.

12.3. Further the CCG respects the fact that an individual and a Residential Care provider or other care provider are entitled to set up arrangements between themselves and a service user or patient in any lawful manner, save that any such arrangements cannot have the effect of increasing the amount that the CCG is obliged to pay to commission care for the individual. The CCG thus recognises that an individual and Residential Care provider may take specified elements of the service to be provided to the individual out of the overall package required to

be funded by the CCG by making separate provision to fund those elements of the overall package. Whilst the CCG does not seek to encourage these types of arrangement, the CCG will respect the rights of individuals and care providers to enter into such arrangements where they occur and will seek to commission a package of health and/or social care services to meet any services that are reasonably required by the individual and are not covered by any such arrangements. However, where such arrangements are proposed as part of an overall care package:

12.3.1. The CCG will require complete transparency from both the individual and any care provider in relation to such arrangements;

12.3.2. The arrangements will need to be properly documented to show precisely what services are the subject of the said arrangements; and

12.3.3. The CCG will have to be satisfied that the individual has properly consented to entering into a bona fide arrangement for part of the services to be provided by the care provider to fall outside of the services that the CCG is being required to fund.

12.4. The decision to fund any additional non-healthcare or healthcare services must be entirely voluntary for the individual. The provision of any NHS funded care package must not be contingent on the individual (and/or his/her representative/s) agreeing to fund any additional services.

12.5. In order to ensure that there is no confusion between the NHS and the privately funded services, the CCG will enter into a legally binding service agreement with the selected care provider which details the provision by that provider of a defined level of health and social care to the individual. This will expressly be independent of any arrangement between the selected care provider and the individual (and/or his/her Representative/s). It will include the right for both the CCG and the care provider to review the placement in the event that any agreement between the care provider and the individual comes to an end for any reason.

12.6. Any payments made by the individual (and/or his/her representative/s) under a contract with a care provider for services cannot relate to any services to be provided under the CCG contract.

12.7. If the individual (and/or his/her representative/s) decides for any reason that the funding of the additional services is to be terminated, the CCG will not assume responsibility for funding any additional services.

## 13. The consequences of a refusal to accept an offer of a package of CHC support.

13.1. An individual is not obliged to accept an offer of an NHS funded care package. Where an eligible individual chooses not to accept a package, the CCG will take reasonable steps to make the individual aware that:

13.1.1. The CCG is not required to make further offers to the individual or offer to fund care in a location of the individual's choice; and

13.1.2. the Local Authority may not assume responsibility to provide care to the individual.

13.2. An individual who has refused NHS funded care is entitled to re-engage with the CCG at any time and, if the individual does so, the CCG will reconsider what offers of services should be made to the individual.

## 14. Reviews

14.1. Individuals who are eligible for CHC will have both their eligibility and any care packages provided to meet their reasonable needs reviewed by the CCG:

14.1.1. Within 3 months of the date of the eligibility decision; and

14.1.2. Thereafter at least annually, although a review may be conducted more frequently where this is justified by, for example, the changing clinical situation of an individual.

14.2. If the case review demonstrates that the individual's needs have changed to the extent that s/he is no longer eligible for CHC:

14.2.1. The CCG will inform the individual and relevant local authority of that ; and

14.2.2. The CCG will substitute the current care package with a care package which is appropriate for a person with the individual's health needs who is not eligible for CHC. This will usually mean that the extent of the CCG's responsibility will be limited to providing:

14.2.2.1. FNC (where appropriate); and

14.2.2.2. The services of appropriate medical professionals,

but will not usually extend to continuing to fund social care and/or accommodation for the individual.

14.3. Where a review demonstrates that the individual continues to be eligible for CHC, the CCG will review the care package provided to the individual. That review may identify that the individual's needs have changed to an extent that his or her care package may need adjusting. In such a case:

14.3.1. Where an individual is receiving a package of Home Care and the individual wishes to remain living at home, the relevant CCG will consider whether an enhanced Home Care package should be provided to the individual applying the criteria set out at paragraphs 8 and, if relevant, 9 above;

14.3.2. If, after applying the criteria set out at paragraphs 8 and, if relevant, 9 above, the CCG considers that it is not appropriate to offer to provide an enhanced Home Care package, the CCG will offer to discharge its duties to the individual by way of a Residential Care package applying the procedures in paragraph 7 above. If the individual declines the offer of a Residential Care package, the CCG will follow paragraph 13 above.

14.3.3. Where the individual is accommodated in Residential Care, the relevant CCG will ensure that the care setting is able to deliver such revised package of care as is required to meet the individual's reasonable needs. Where the care setting is unable to deliver the revised package of care, the CCG will offer to accommodate the individual in an alternative care setting (which is able to deliver the revised package of care) in accordance with paragraph 7 above;

14.3.4. Where the individual is accommodated in Residential Care and the case review has identified a decreased need, the CCG will consider whether it is cost effective for the revised package of care to be delivered in the current care setting. The CCG may discharge its obligations to the individual by offering to re-locate the individual to an alternative care setting (which is able to deliver the revised package of care) in accordance with paragraph 7 above.

14.4. The CCG may withdraw a package of care funded for an individual where there is a substantial risk of danger or violence to or harassment of the staff who are delivering the package of care. Alternative packages of care will be considered and may be offered where there are alternative

options available for the CCG to commission. Any offer of an alternative package of care may be subject to the performance of such conditions as the CCG may reasonably require of the individual, including an Acceptable Behaviour Contract.

14.5. The CCG may also withdraw the provision of an NHS funded package in a particular location where the CCG assesses that the clinical risks are too high for a safe and sustainable package to be appropriate to be delivered in that location. Where a care package is delivered in a Home Care setting, the CCG may offer to discharge its duties by offering a package of care in a registered care setting in accordance with paragraph 7 above as an alternative if the Home Care package is assessed by the CCG to be unsafe or ceases to be sustainable.

## 15. Complaints

15.1. Any person who is aggrieved by any decisions made under this policy may raise a complaint about the decision.

15.2. Any such complaint will be investigated and considered by the CCG through the NHS Complaints Procedures.

15.3. Save in exceptional circumstances, the fact that a complaint has been made about a decision made under this policy will not delay the implementation of the decision. However if the complaint is subsequently upheld, the CCG will consider what (if any) action should be taken to recompense anyone who has been adversely affected by a decision that is changed as a result of the outcome of an NHS complaint.

15.4. If a complaint is not upheld by the CCG, subject to further review, the individual has the right to present their complaint to the Parliamentary and Health Service Ombudsman.

## 16. Personal Health Budgets

16.1. The CCG is committed to using personal health budgets where appropriate and recognises that the use of a personal health budget can enable an individual to have greater choice, flexibility and control over the care and support s/he receives.

16.2. Personal health budgets can operate in a number of different ways, including:

16.2.1. A 'notional' budget held by a CCG commissioner;

16.2.2. A budget managed by a third party on the individual's behalf;

16.2.3. Via a payment to the individual (a healthcare direct payment).

16.3. Where individuals wish to consider having a Personal Health budget, the CCG will follow its established processes leading to a decision whether to offer a Personal Health Budget to the individual.

## 17. Out of area placements

17.1. If a patient wishes the CCG to consider a Residential Care placement or a Home Care package outside of the CCG's geographical area, the CCG will be prepared to consider the request. However the CCG is not obliged to offer to commission care for an individual outside of the CCG's geographical area and may decline to do so if it considers that it is inappropriate to do so.

17.2. If the CCG agrees to offer a Residential Care placement in an area outside the CCG area as suggested by the individual, the CCG will liaise with relevant CCG (for the area where the care home is located as appropriate.

17.3. If the CCG agrees to offer a Home Care placement at a location suggested by the individual outside the CCG area, the CCG will liaise with CCG local to the proposed placement concerning the proposed Home Care placement.

17.4. Where an individual who is eligible for CHC chooses to move to a different part of the country or is placed there because of an arrangement made by the local authority and then registers with a GP practice which is local to the individual's new home, this will not be a placement by the CCG. In such a case, the individual's NHS responsible commissioner is likely to change to the CCG of which that GP practice (CCG) is a member. Where this happens the CCG will liaise with the CCG which has become responsible for commissioning NHS care for the individual.

Agenda Item No. 11

**Health and Adult Social Care Scrutiny Committee – 21st November, 2018**

**Report of the Lead for Law and Governance**

**Feedback from the Health and Adult Social Care Scrutiny Committee (Scrutiny Development) Working Groups**

## Purpose

1. To provide feedback from the Health and Adult Social Care Scrutiny Committee (Scrutiny Development) Working Group meetings that were held on 29th August and 15th October, 2018.

## Recommendations

2. To note and comment on the work that has been undertaken by the Health and Adult Social Care Scrutiny Committee (Scrutiny Development) Working Group.

## Background

3. At its meeting on 23rd July, 2018, the Health and Adult Social Care Scrutiny Committee agreed to re-appoint the Scrutiny Development Working Group to comprise all Members of the Committee and for meetings to be convened at monthly intervals.

4. The Scrutiny Development Working Group was designed to enable issues, within the remit of the Committee and that were included in the Annual Scrutiny Work Programme, to be scrutinised in-depth and in a less formal setting than the main Committee.

5. Since the establishment of the Scrutiny Development Working Groups, two meetings have been held on the following dates:-

   - 29th August, 2018
   - 15th October, 2018

6. 29th August, 2018

   Members considered a report of the Chief Officer, Dudley Clinical Commissioning Group on the changes to Primary Care Contracts.

7. The main areas of discussion following the presentation of the report were as follows:-

- the procedure for closing General Medical Services Branch Surgeries;
- the proposed closures of General Practices;
- Doctor shortages;
- the consultation process for proposed closures of General Practices managed by other Local Authorities;
- the need for consideration to be given when approving new housing development sites to ensure that there were sufficient General Practices and medical care facilities available to encompass new residents.

8. Responses to Members concerns and comments were provided at the meeting.

9. The Dudley Clinical Commissioning Group Officer in attendance at the meeting reassured members that any proposals for General Practice closures managed by other Local Authorities, both commission groups would form part of the consultation process and the needs of the community would fully be taken into consideration.

10. A Health Planner has been appointed within the Office of Public Health to ensure that the wider health care needs were assessed and incorporated into the future planning process, which would address concerns raised in relation to new housing development sites having sufficient medical care facilities available.

11. It was recommended that further updates on changes to primary care contracts be submitted to future meetings of the Scrutiny Development Working Group.

12. <u>15th October, 2018</u>

A Cozens from the Local Government Association (LGA) attended the meeting to assist with scrutiny training. Members considered the scrutiny basics and what made for effective health scrutiny; how scrutiny could add value to complex health and care challenges; how things worked in Dudley and understanding partnership context and governance.

13. The development of the Multi-Specialty Community Provider (MCP) was identified as a topic to help develop the role of Scrutiny and would be considered as a single item on the agenda for the next meeting of the Scrutiny Development Working Group, which is scheduled to be held on 12th November, 2018.

14. A Cozens would attend on 12th November, 2018 to continue to provide LGA support and assistance.

15. Future Scrutiny Development Working Group meetings have been arranged on the following dates:-

- 12th November, 2018 - Multi-Specialty Community Provider (MCP)
- 11th December, 2018
- 3rd January, 2019
- 20th February, 2019
- 21st March, 2019

- 30th April, 2019

**Finance**

16. The costs of operating the scrutiny arrangements will be contained within existing budgetary allocations.

**Law**

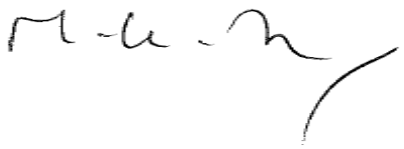
17. Scrutiny Committees are established in accordance with the provisions of the Local Government Act 1972 and the requirements of the Council's Constitution, which was adopted under the Local Government Act 2000, subsequent legislation and associated Regulations and Guidance.

**Equality Impact**

18. Provision exists within the recommended scrutiny arrangements for overview and scrutiny to be undertaken of the Council's policies on equality and diversity.

**Human Resources/Transformation**

19. There are no direct Human Resources/Transformation implications.



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**List of Background Papers**